

**America's Health
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September 16, 2011

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-9983-P
Hubert H. Humphrey Building
200 Independence Ave., SW, Room 445-G
Washington, DC 20201

Re: **CMS-9983-P: Proposed Rule Regarding Patient Protection and
Affordable Care Act; Establishment of Consumer Operated and
Oriented Plan (CO-OP) Program**

Filed Electronically: <http://www.regulations.gov>

Dear Sir or Madam:

On behalf of America's Health Insurance Plans (AHIP), the national trade association representing the health insurance industry, we write today in response to proposed rules issued by the Department of Health and Human Services (HHS) establishing the Consumer Operated and Oriented Plan (CO-OP) Program as published in the *Federal Register* on July 20, 2011.

AHIP's member companies provide health, long-term care, dental, disability, and supplemental coverage to more than 200 million Americans in the individual and group markets, with many participating in public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. We appreciate the opportunity to comment on the standards and requirements proposed for CO-OP plans pursuant to Section 1322 of the Patient Protection and Affordable Care Act (ACA).

Recognizing the stated purpose of the CO-OP program is to foster the creation of consumer-run, private, non-profit health insurance issuers to offer qualified health plans (QHPs) in the individual and small group markets, we believe that any regulatory guidance should reflect the importance of fair competition and the Congressional intent to establish a level playing field among CO-OPs and other issuers of QHPs. Strict adherence to the statutory requirements for CO-OPs contained in the ACA will ensure

that the CO-OP program provides consumers with additional options for qualified, solvent, and comprehensive health care coverage that meets federal and state standards for consumer protections, fairness, quality, and access.

Our comments include the following recommendations:

1. Operational standards for health insurance companies offering QHPs through the Exchange should also apply to CO-OPs to ensure that a level playing field exists at all points in the process of establishing a health insurance company and offering a QHP through the Exchange.
2. The threshold for individual and small group activity for CO-OP participation must reflect the ACA requirements and Congressional intent.
3. Standards for eligibility to participate in the CO-OP program should conform more closely to the ACA standards and clarify requirements for nontraditional health insurance entities.

Recommendations

- 1. Operational standards for health insurance companies offering QHPs through the Exchange should also apply to CO-OPs to ensure that a level playing field exists at all points in the process of establishing a health insurance company and offering a QHP through the Exchange.**

- a. CO-OP's Exchange Certification Processes Should be the Same as Those Applied to Other Issuers***

The role envisioned for CO-OPs eligible for the ACA grants is built on the assumption of Exchange participation, and provides for an initial deemed certification, as long as the CO-OP satisfies the requirements related to insurance licensure. However, the proposed rule's statement that "Health plans offered by a loan recipient may be deemed certified as a CO-OP qualified health plan to participate in the Exchanges for up to 10 years following the life of any loan awarded to the loan recipient under this subpart..." (page 43250) extends past initial deeming, raising significant concerns. We are concerned that the proposed rule fails to provide sufficient clarity on this deemed certification process and lacks adequate assurance of the consumer protections that will be required of all other issuers of QHPs in the Exchange market. AHIP appreciates efforts to incorporate state standards into the certification process, but we believe that far more needs to be done and strongly recommend that HHS provide more details in the final rule for the initial deeming regarding how a CO-OP's Exchange

certification will be established and maintained and how HHS will monitor certified CO-OPs to ensure adequate consumer protection and quality of care.

Beyond that initial deeming, the proposed ten-year length of deemed Exchange certification for CO-OPs is clearly unreasonable as it extends far beyond that afforded in the Exchange NPRM of July 15, 2011 for other issuers of QHPs and places consumers at risk if CO-OP programs fail to meet the state certification requirements and the quality and value standards intended in the program. The ten year period is excessive and harms meaningful competition among potential competitors for the Exchange market, and removes incentives for CO-OPs to perform at the market standard. The lack of identifiable standards for certification review and assessment for CO-OPs for such a lengthy period risks consumer safety and presents CO-OPs with an unfair competitive advantage inherent in separate certification processes. As a result, we strongly urge that CO-OPs be held to the same standards and certification processes as other issuers of QHPs in the Exchange market.

b. Market Eligibility Standards Should be Applied Uniformly

The proposed rule allows for access to additional markets for CO-OPs by providing access to the large group and Medicaid markets. We recommend that HHS ensure fairness and competition among all market participants. For example, the preamble to the proposed rule clearly demonstrates the desire of HHS to provide CO-OPs access to both the large group and Medicaid markets, and pays careful attention to the viability of market entry periods. AHIP believes CO-OP plans should be subject to the same market participation requirements and standards as the existing market to achieve the ACA specified requirement of ensuring a level playing field.

When determining Medicaid participation standards or whether a CO-OP is eligible to sell coverage to large groups in the Exchange, care should be taken that no market participant is given a competitive advantage. The ACA stresses the importance of a level playing field to the CO-OP program. We believe that this will be critical to the success of both the CO-OP program and to the viability of the Exchange market as a whole and strongly recommend that the final rule not depart from this clear statutory intent. Providing CO-OPs with access to additional markets not available to other QHPs or restricting access in a manner not anticipated by the ACA threatens to diminish competition, causes market disruption during the precarious early stages of the Exchange, and fails to uphold the concept of fair and equal treatment which is the basis of the level playing field.

We recommend that HHS clarify that any market participation standards and market entry standards will apply uniformly to all Exchange participants, whether CO-OPs or other issuers of QHPs.

c. CO-OPs Should Meet the Same Criteria and Standards Applied to all Other Issuers of QHPs

By specifying in the ACA the requirement for a level playing field, Congress has given its specific endorsement of the critical principle that neither CO-OPs nor traditional issuers should be given unfair competitive advantages in the Exchange. The requirements for compliance with state laws are not negotiable, including standards for provider payments, network rules, rating and form filing rules, financial reporting, risk-based capital and reserve adequacy monitoring, complaints and grievances, taxes and assessments, etc. The rule should clarify that CO-OPs are to be held to the same standards of review, compliance, quality, and market conduct. Further, the rule should confirm that, as entities eligible to participate in the reinsurance, risk corridors, and risk adjustment programs envisioned by the ACA, CO-OPs are required to pay the same premium taxes and costs of these programs as other QHPs. The premium tax has been estimated to increase premiums by as much as three percent or nearly \$5,000 per family over a decade.¹ Exempting CO-OPs from such taxes and other costs will clearly create an unlevel playing field which was not the intent of the statute.

CO-OPs should be treated the same as any other QHP seeking to participate in an Exchange and should be given no special waivers or exceptions to standards or requirements for QHPs. This is particularly important, since newly formed CO-OPs will have the same start-up challenges as any other new Exchange participant, and should be monitored and evaluated on the same terms.

2. The threshold for individual and small group activity for CO-OP participation must accurately reflect the ACA requirements and Congressional intent.

Section 1322(c)(1)(B) of the ACA clearly states that “substantially all of the activities” of a CO-OP must consist of the issuance of QHPs in the individual and small group markets. The proposed rule’s incorporation of the CO-OP Program Advisory Board recommendations defining the activities as a CO-OP in terms of contract issuance, rather than in terms of the number of covered individuals, misinterprets the clear Congressional intent in Section 1322(c)(1)(B). Defining the activities of a CO-OP as contract issuance greatly diminishes the focus on individual and small group coverage and clearly misconstrues the language of the

¹ *Higher Costs and the Affordable Care Act: The Case of the Premium Tax* by Douglas Holtz-Eakin, the American Action Forum, March 9, 2011.

statute. We urge that the measure of activities should be based on the number of enrollees, and not on number of separate contracts. One large group contract could represent a multiple of the total number of enrollees in the individual and small group markets for a new market entrant. Consistent with the intent of the ACA, we suggest the consumer focus was intended to permit enrollee consumers to feel empowered through enrollment in a consumer oriented and operated program. And setting the standard of “substantially all” was intended to assure the grants and loans – which is the purpose of this rule - on entities that would focus their activity in the individual and small group market to make that possible.

Further, the proposed definition of ‘substantially all’ as two-thirds of the policies or contracts issued sets an unacceptably low threshold, conflicting with reasonable interpretation of the statutory language. By including the ‘substantially all’ standard into the definition of a CO-OP, Congress clearly expressed its intent that the focus of CO-OP plans are to provide coverage to consumers in the individual and small group markets. AHIP believes the proposed definition of ‘substantially all’ as two-thirds violates the plain language of the statute to require nearly all of a CO-OP’s activities to be in the individual and small group markets and should be changed to more accurately reflect the intent of Congress by defining the term ‘substantially all’ as establishing a significantly higher threshold in the 80-90% range, rather than two-thirds.

3. Standards for eligibility to participate in the CO-OP program should conform more closely to the ACA standards and clarify requirements for nontraditional health insurance entities.

a. Participation by Government-Controlled or Sponsored Entities

Section 1322(c)(2)(B) of the ACA clearly prohibits participation in the CO-OP program by organizations controlled or sponsored by State or local governments, any political subdivision thereof, or any instrumentality of such government or subdivision. In the preamble to the proposed rule, comment is invited on an interpretation of this prohibition that would exclude medical centers or medical practice groups that are operated or sponsored by or part of State or local governments from eligibility as a CO-OP. AHIP members believe that this interpretation provides clear and accurate guidance in implementing the provisions of the ACA, and agrees with this exclusion from eligibility.

In addition, we request that HHS consider further clarification on whether relationships other than control or sponsorship between a potential CO-OP applicant and a State or local government would cause an entity to be ineligible for the CO-OP program. For example, while many practices and medical centers maintain formal relationships with State or local governments that fall short of

State or local control, they nonetheless entangle the potential CO-OP applicant with government operations (e.g. delegated activities by a State or local government such as care coordination or medical home operation). The proposed rule is unclear whether such relationships will exclude an entity from eligibility for the CO-OP program.

Additional clarification and guidance on the permissible form of relationship between a potential CO-OP applicant and a State or local government would minimize potential expenditure of program funds on entities later deemed ineligible.

b. Participation by Nontraditional Health Insurance Entities Should Be Scrutinized - Clarification of Eligibility Requirements is Necessary

HHS has gone to great lengths in implementing the CO-OP program to ensure that the ACA prohibition of pre-existing issuers from participating in the program is applied in a thoughtful manner reflecting the intent of the ACA. There are, however, some groups as noted by CMS that are not issuers such as Taft-Hartley trusts, church groups, and three-share or multi-share programs, and CMS has asked for comments on the effect of such prior or existing arrangements on the eligibility of such entities to sponsor a new CO-OP under the terms of the proposed rules.

As an initial matter, AHIP believes that, if any such group was actually acting as an issuer, the ACA prohibition in Section 1322(c)(2) clearly disqualifies any such group that was operating as an issuer on July 16, 2009 from qualifying for this grant funding. Further, HHS should clarify that not only pre-existing issuers, but also entities that may be treated as under common control with such issuers (as determined under Internal Revenue Code Sec. 414(b), (c), (m) or (o) and subsequent regulations and guidance) are excluded from eligibility for the CO-OP program. Participation in the CO-OP program by such entities violates the clear statutory language of the ACA and creates practical concerns regarding compliance with market requirements and standards for Exchange participation.

The language in the preamble refers to self-funded and Taft-Hartley group health plans, church plans, and three-share or multi-share programs and discusses any such nonprofit organization (entity) that previously sponsored or currently sponsors health insurance coverage, or has an existing arrangement with an issuer. It appears that the preamble would suggest that these entities as non-issuers would be eligible to either sponsor a CO-OP or participate in the CO-OP program. We urge great caution in this regard. Unanswered questions regarding the form and responsibilities of such sponsorship remain. The practical impact of these entities sponsoring a CO-OP financially or otherwise could create complications for state

review, and lack of a clear line on risks and financing. The rule appears to suggest that the sponsoring entity could in fact seek to become a licensed issuer.

If such entities seek to become licensed issuers, we see another question that must be resolved. That question relates to the “affiliation” aspect of many of those existing programs, which often require some unique affiliation – such as membership in an association or church or trade organization -- in order to be eligible for inclusion in the coverage. We suggest that any such special affiliation would no longer be permitted, and any such new CO-OP would be required to admit all qualified individuals and qualified employers in their Exchange QHPs. To fail to do so would conflict with open access requirements in the Exchange market. CO-OPs should not be permitted to avoid market standards and requirements applicable to other issuers of QHPs. Establishing a different set of standards for CO-OPs in the Exchange not only offends the guarantee issue requirements for an Exchange, but creates an unfair advantage for CO-OP plans that poses a distinct threat of adverse risk selection and will threaten the willingness of other QHPs to participate in the Exchange market.

As a result of these concerns, and the need to implement the ACA with fair and consistent safeguards, we respectfully request that HHS clarify what is intended here. The final rule should specify that entities that may be treated as under common control as an issuer are excluded from eligibility, and should clarify that all CO-OP grant recipients, regardless of sponsorship, are required to comply with participation and operational requirements, including guarantee issue requirements, in order to assure uniform insurer requirements, minimize market disruption and ensure fairness in access by all Exchange qualified individuals.

c. Participation by Preexisting Issuers Prohibited in the CO-OP Program

As previously noted, HHS has gone to great lengths in implementing the CO-OP program in Section 1322(A) of ACA to ensure the prohibition of preexisting issuers from participating in the program, and extends that to cover - in the statutory language - “the organization or a related entity” from participating in the program.

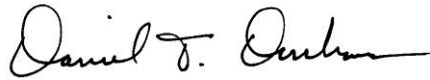
Under the proposed rule, however, the term “related entity” could share common ownership or control with a pre-existing issuer. This is contrary to the intent of the CO-OP program provisions. The proposed rule’s definition of “related entity” and its proposal to permit entities that share control with existing health insurance issuers to sponsor CO-Ops conflict with Congress’s intent when it proscribed the participation of existing issuers and their related entities. And, this language could have the effect of allowing existing issuers to restructure to offer or sponsor CO-OPs under this program, which contravenes the legislative intent of the CO-OP

program. Thus, we recommend the propose rule revise its definition “related entity”, and the provision allowing entities that share control with existing issuers to sponsor CO-OPs, to ensure consistency with the statutory language and purpose. The rule should clarify that neither preexisting issuers nor related entities should be permitted to become, or sponsor, CO-OPs eligible for this CO-OP program, grants and loans.

AHIP appreciates the opportunity to provide comments on the Consumer Operated and Oriented Plan Program. We recommend that implementation of the program recognize the Congressional intent to maintain a level playing field among market participants. Consistent enforcement of the requirements for QHPs and ensuring equal access to markets will guarantee the highest level of consumer protection and create viable and competitive Exchanges.

Please let us know if we can provide any assistance as you move forward.

Sincerely,

A handwritten signature in black ink that reads "Daniel T. Durham". The signature is written in a cursive style with a large, stylized 'D' and 'H'.

Daniel T. Durham
Executive Vice President
Policy and Regulatory Affairs