Consumer Operated and Oriented Plan (CO-OP) Advisory Board

**Summary:** Requires the Secretary to award loans for start-up costs and grants to meet solvency requirements, until July 1, 2013, to member-run nonprofits that will offer qualified health plans. Establishes an Advisory Board with members appointed by the Comptroller General, to terminate by 2016. Prohibits health insurance issuers that existed on July 16, 2009 or governmental organizations from qualifying for the program. Allows participants to form a private purchasing council to enter into collective purchasing arrangements for items and services, but which may not set provider payment rates. Prohibits government representatives from serving on the board of directors of participants or the council. Appropriates $6 billion for the CO-OP program, and exempts participants from taxation.

**Status updates:**
- On July 18, 2011, Department of Health and Human Services (HHS) proposed standards for establishing CO-OP health insurance plans, and published the proposed rule in the Federal Register on July 20, 2011. Eligible organizations seeking to establish a CO-OP will be able to apply for a portion of the $3.8 billion in repayable loans made available under the Affordable Care Act to fund start-up and capitalization costs.
- On July 28, 2011, HHS issued a notice regarding the availability of loans for the formation of co-ops.

**Next steps:**
- June 23, 2010 – Comptroller General of the Government Accountability Office (GAO) shall appointed the 15 member advisory board (meeting the statutory deadline). The Department of Health and Human Services (HHS) filed a Federal Register notice announcing that the charter for the Advisory Board had been filed on June 18, 2010.
- December 28, 2010—HHS announced a meeting on January 13, 2011, regarding the creation of qualified nonprofit health insurance issuers and the awarding of grants and loans related to Section 1322 of the Affordable Care Act.
- January 6, 2011 (5 pm EST) – Deadline for the January 13 meeting registration, presentations, and comments.
- January 13, 2011 – First HHS meeting regarding this section
- January 27, 2011 – HHS announced a meeting on February 7, 2011 on this topic.
- February 2, 2011 -- HHS issued a Federal Register notice requesting public comments in advance of future rulemaking and grant and loan solicitations.
- February 3, 2011 (5 pm EST) – Deadline for the February 7 meeting registration, presentations, and comments
- February 7, 2011 – Second HHS meeting regarding this section
- March 2, 2011 – CMS announced the third meeting on March 14, 2011 regarding this section.
- March 4, 2011 (5 pm) -- Comments due to the February 2, 2011 Federal Register notice.
- March 8, 2011 -- CMS announced a location change for the March 14, 2011 meeting.
- March 10, 2011 (5 pm) – Registration closes for the March 14, 2011 meeting.
- March 10, 2011 -- The Internal Revenue Service (IRS) in Notice 2011-23 explained the requirements for tax-exemption for qualified nonprofit health insurance issuers under this program.
- March 14, 2011 – Third HHS meeting regarding this section.
- March 14, 2011 – Advisory Board releases draft report.
- April 14, 2011 -- House passed, by a vote of 260-167, H.R. 1473. Section 1857 rescinds $2.2 billion of the $6 billion in start-up funding provided for the Consumer Operated and Oriented Plan (CO-OP) program.
- April 14, 2011 -- Senate passed, by a vote of 81-19, H.R. 1473.
- April 15, 2011, the President signed H.R. 1473, making it P.L. 112-10.
- Not later than July 1, 2013 – Secretary of HHS shall promulgate regulations regarding the repayment of loans and grants under this section.
- March 30, 2011 – CMS announced the fourth meeting of the advisory board on April 15.
- April 15, 2011 – Fourth meeting of the advisory board.
- July 18, 2011 – HHS proposed standards for establishing CO-OP health insurance plans.
- July 28, 2011 -- HHS issued a notice regarding the availability of funds for loans for the formation of co-ops.
- Until July 1, 2013 – Secretary of HHS shall award loans and grants for the development of consumer operated and oriented plans (CO-OPs)
- December 31, 2014 (and every two years after that) – GAO shall provide a report to Congress regarding the competition and market concentration in the health insurance market (and include recommendations as necessary)
- December 31, 2015 – Advisory Board terminated on this date or when it completes its duties, whichever is earlier

**Additional information:**
- July 28, 2011 notice regarding the availability of funds -- [http://www.grants.gov/search/search.do;jsessionid=QBj6Ty7MzwNbGx6lS2MCxNyP14L1PvKdNWbimG2jblhYXHDTerBW!‐1176040633?oppId=109093&mode=VIEW](http://www.grants.gov/search/search.do;jsessionid=QBj6Ty7MzwNbGx6lS2MCxNyP14L1PvKdNWbimG2jblhYXHDTerBW!‐1176040633?oppId=109093&mode=VIEW)
- Information on H.R. 1473 -- [http://hdl.loc.gov/loc.uscongress/legislation.112hr1473](http://hdl.loc.gov/loc.uscongress/legislation.112hr1473)
• June 23, 2010 Federal register notice -- http://edocket.access.gpo.gov/2010/2010-15223.htm (regarding the advisory board’s charter)

**Long summary:**
Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

*Establishment of program.* Requires the Secretary to establish a Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans (QHPs).

*Loans and grants under the CO-OP program.* By July 1, 2013, the Secretary must award (1) loans to provide assistance in meeting their start-up costs and (2) grants to provide assistance in meeting any state solvency requirements. In awarding loans and grants, the Secretary shall take into account the recommendations of the advisory board (described below); give priority to applicants that will offer QHPs on a statewide basis, will utilize integrated care models, and have significant private support; and ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state, except that this does not prohibit the Secretary from funding the establishment of multiple issuers in any state if the funding is sufficient to do so. If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a state, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the state or the expansion of a qualified nonprofit health insurance issuer from another state to the state. As a condition of a loan or grant, the recipient must enter into an agreement with the Secretary to meet and continue to meet the requirements for the loan or grant, including an requirement that no portion of the funds made available by any loan or grant under this section may be used for carrying on propaganda, or otherwise attempting, to influence legislation; or for marketing. Provides for sanctions in the event of a recipient’s failure to meet the requirements. Loans must be repaid within 5 years and grants be repaid within 15 years, taking into account various situations.

*Advisory board.* Requires the GAO to appoint 15 members to an advisory board among individuals with qualifications described in §1805(c)(2) of the SSA (relating to the qualifications for MedPAC commissioners). Requires appointees to meet ethics and conflict of interest standards protecting against insurance industry involvement and interference. Allows for no compensation except for travel expenses, including a per diem.

*Qualified nonprofit health insurance issuer.* Defines a qualified non-profit health insurance issuer as an organization organized under state law as a nonprofit, member corporation; substantially all of the
activities of which consist of the issuance of QHPs in the individual and small group markets in each state in which it is licensed to issue such plans and meets other requirements of this subsection. Provides that an organization are ineligible if it, or a related entity (or any predecessor of either), was a health insurance issuer on July 16, 2009 or it is sponsored by a state or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision. To be qualified, the governance of the organization must be subject to a majority vote of its members; its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and, as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members. Any profits made by the organization must be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members. Requires, in addition, that the organization meet all the requirements that other issuers of QHPs are required to meet in any state where the issuer offers a QHP, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, any applicable state premium assessments and any state law specified in §1324. Limits eligibility to an organization in a state that has in effect (or the Secretary has implemented for the state) the market reforms required by this Act.

Establishment of private purchasing council. Issuers participating in the CO-OP program may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services. However, the Council may not set payment rates for participating facilities and providers.

Limitation on participation. Prohibits a representative of any federal, state, or local government from serving on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council.

Limitations on Secretary. Prohibits the Secretary from participating in any negotiations between one or more qualified nonprofit health insurance issuers (or a private purchasing council) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and from establishing or maintaining a price structure for reimbursement of any health benefits covered by such issuers. Clarifies that this section is not meant to authorize the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

Appropriations. Appropriates $6 billion to carry out this section. (Note: Subsequent law rescinded §2.2 B of the $6 B provided.)

Tax exemption for qualified nonprofit health insurance issuer. Amends §501(c) of the IRC (relating to list of exempt organizations) to provide a tax exemption to a qualified nonprofit health insurance issuer which has received a loan or grant under the CO-OP program, but only with respect to periods for which the issuer is in compliance with the requirements of the section and any agreement with respect to the loan or grant. Requires the reporting of certain information to the IRS.

GAO study and report. GAO must conduct an ongoing study on competition and market concentration in the health insurance market after the implementation of the reforms made by this legislation, including an analysis of new issuers of health insurance in such market.
Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(a) Establishment of Program.—

(1) IN GENERAL.—The Secretary shall establish a program to carry out the purposes of this section to be known as the Consumer Operated and Oriented Plan (CO-OP) program.

(2) Purpose.—It is the purpose of the CO-OP program to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.

(b) Loans and Grants Under the CO-OP Program.—

(1) IN GENERAL.—The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) Requirements for awarding Loans and Grants.—

(A) IN GENERAL.—In awarding loans and grants under the CO-OP program, the Secretary shall—

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have significant private support; and

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) States Without Issuers in Program.—If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) Agreement.—

(i) IN GENERAL.—The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—

(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(II) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) Restrictions on Use of Federal Funds.—The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) Failure to Meet Requirements.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer’s tax-exempt status under section 501(c)(29) of such Code.

(D) Time for Awarding Loans and Grants.—The Secretary shall not later than July 1, 2013, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

(3) Repayment of Loans and Grants.—Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.

(4) Advisory Board.—

(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) Rules Related to Appointments.—

(i) Standards.—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards protecting against insurance industry involvement and interference.

(ii) Original Appointments.—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this Act.

(C) Vacancy.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

(D) Pay and Reimbursement.—

(i) No Compensation for Members of Advisory Board.—Except as provided in clause (ii), a member of the advisory board may not receive pay, allowances, or benefits by reason of their service on the board.

(ii) Travel Expenses.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) Application of FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.
(F) TERMINATION.—The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(6) COORDINATION WITH STATE INSURANCE REFORMS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act (as amended by subtitles A and C of this Act).

(7) LIMITATION ON PARTICIPATION.—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

(8) LIMITATIONS ON SECRETARY.—(1) IN GENERAL.—The Secretary shall not—

(9) APPROPRIATIONS.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.

(b) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—

(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

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(25) CO-OP HEALTH INSURANCE ISSUERS.—

(A) IN GENERAL.—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—

(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.”
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(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns by exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

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''(m) ADDITIONAL INFORMATION REQUIRED FROM CO-OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:
''(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.
''(2) The amount of reserves on hand.''
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(3) APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS.—Section 4958(c)(1) of such Code (defining applicable tax-exempt organization) is amended by striking “(3) or (4)” and inserting “(3), (4), or (29)”.

(i) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.