



March 1, 2011

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

RE: File Code OCIO-9983-NC

To Whom It May Concern:

The National Association of Community Health Centers, Inc. (“NACHC”) is pleased to respond to the above-cited solicitation from the Department of Health and Human Services (“DHHS”) Office of Consumer Information and Insurance Oversight (“OCIO”) for comments regarding provisions of Consumer Operated and Oriented Plan Program (the “Request for Comments”).

NACHC is the national membership organization for federally supported and federally recognized health centers (hereinafter interchangeably referred to as “health centers” or “FQHCs”) throughout the country, and is an Internal Revenue Code Section 501(c)(3) organization.

I. Background

There are, at present, more than 1100 FQHCs nationwide. Most of these FQHCs receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care (“BPHC”), within the Health Resources and Services Administration (“HRSA”) of DHHS. Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas (invariably poor communities), (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing.

Except for a limited number of public health centers (i.e., health centers operated by local governmental units such as health departments), each health center is a charitable, nonprofit, tax-exempt IRC Section 501(c)(3) corporation formed under the laws of the particular State in which it operates. Although there are some slight differences in the grant requirements for each of these four program types, for all intents and purposes, the ways in which these health centers operate are identical.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center’s board of directors must be composed of at least fifty-one percent (51%) users of the health center, and the health center must offer services to all persons in its catchment area, regardless of their ability to pay or insurance status.

BPHC’s grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to

uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities who are not indigent and able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 37.1% of the patients served by health centers are Medicaid recipients, approximately 7.3% are Medicare beneficiaries, and approximately 38.2% are uninsured.

FQHCs provide comprehensive primary care services and serve as medical homes for the over 20 million patients they serve. As such, FQHCs utilize a team model approach with primary care services provided by physicians, nurse practitioners, nurse midwives, physician assistants, case managers, health educators, and other staff. Most health centers also provide dental services and behavioral health services, and staff for such services is integrated into the medical team.

II. Comments on the Provisions

A. Section 1322(a) of the Affordable Care Act

Section 1322(a) of the Affordable Care Act directs the Secretary to establish a program to foster, through grants and loans, the establishment of qualified nonprofit health insurance issuers. Substantially all of the activities of the qualified nonprofit issuers must be in the individual and small group markets. The issuers must be licensed in the State(s) in which they operate. The CO-OP program shall provide for the awarding of loans and grants to provide assistance for the establishment of qualified nonprofit issuers.

Section 1322(c) of the Affordable Care Act defines a "qualified nonprofit health insurance issuer" as one: (1) that is organized under State law as a nonprofit member corporation, (2) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets, and (3) that meets other requirements of section 1322(c). To qualify for a loan or grant, the qualified nonprofit issuer (or a related entity or predecessor) must not have been a health insurance issuer on July 16, 2009 and must not be sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision. Section 1322(c)(4) provides that an organization cannot be a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, and for other programs intended to improve the quality of health care delivered to its members. Section 1322(e) provides that no representative of any Federal, State, or local government (or any political subdivision or instrumentality thereof), and no representative of a health insurance issuer or a related entity, may serve on the board of directors.

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

Under Section 1322(c) of the Affordable Care Act, the definition of a qualified nonprofit health insurance issuer requires the entity to be a recently created organization. The entity cannot have offered insurance on or before July 16, 2009 nor be an affiliate or successor to an insurance company. (Sec. 1322(c)(2)A) of the Affordable Care Act.) Moreover, the nonprofit issuer may not begin operation in a given State until that State has in effect the market reforms required under the Act. (Sec. 1322(c)(6) of the Affordable Care Act.)

Given these restrictions, few organizations appear to currently exist that would satisfy the statutory eligibility criteria for nonprofit health insurance issuers under Section 1322(c). No doubt, there are organizations which exist today that are truly structured under State law as non-profit, member organizations, e.g., HealthPartners in Minnesota (www.healthpartners.com) and the Group Health Cooperative in Washington State (www.ghc.org). These organizations, however, were not recently created but were established in an earlier era by union members, farmers and people from other cooperatives seeking a progressive, prepaid medical care system.

This means that the Secretary of Health and Human Services (“the Secretary”) must enlist a sponsor of some sort to help establish a new nonprofit member organization. Sec. 1322(c)(2)(B) of the Affordable Care Act prohibits the sponsor from being a public entity such as a State or local government or any political subdivision or instrumentality of a government political subdivision. Thus, it is critically important for the Secretary to identify private organizations that can assume this sponsorship role. Health Centers, health center-controlled networks (HCCN) and State or Regional Primary Care Associations (S/RPCAs) can fill this role and many are ready to do so.

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

As noted above, we believe that health centers, or groups of health centers (such as those constituted as HCCNs) and state-wide PCAs whose memberships are composed primarily of health centers would make ideal sponsors of qualified nonprofit health insurance issuers. Except for a limited number of public health centers (i.e., health centers operated by local governmental units such as health departments), health centers are private nonprofit organizations. Furthermore, health centers and qualified nonprofit health insurance issuers share many important similarities as consumer-governed organizations.

- **Consumer Governance.** Health centers must be governed by a board of directors composed of at least fifty-one percent (51%) users of the health center and which is responsible for establishing the policies of the center and evaluating center activities. (42 C.F.R. § 51c.304.) Similarly, qualified nonprofit health insurance issuers must be membership organizations governed by a majority vote of its members and operated with a strong consumer focus, including timeliness, responsiveness, and accountability to members. (Sec. 1322(c)(3)(A), (C) of the Affordable Care Act.)
- **Conflict of Interest Standards.** Health centers must adopt written standards of conduct for the performance of its employees that addresses conflict of interests in the award or selection of contracts. (45 C.F.R. § 74.42). Similarly, qualified nonprofit health insurance issuers must adopt governing documents that incorporate ethics and conflict of interest standards protecting

against insurance industry involvement and interference. (Sec. 1322(c)(3)(B) of the Affordable Care Act.)

- **Use of Funds.** Health centers must use any program income in furtherance of the project goals and objectives for which it received Federal grant funds. Similarly, qualified nonprofit health insurance issuers must funnel any profit back into its operations to further the purposes and mission of the organization. (See Sec. 1322(c)(4) of the Affordable Care Act.)

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

Another advantage of health centers (or HCCNs or PCAs) serving as sponsors of such qualified nonprofit health insurance issuers is that the relationship between the two entities would encourage health center patients to become CO-OP enrollees. The CO-OP Program is likely to be completely unheard of by most potential CO-OP enrollees. Therefore, to the extent that potential enrollees can identify a particular nonprofit health insurance issuer with existing health centers in the community, the more likely it will succeed in promoting initial and continued enrollment in the health insurance issuers.

Health centers are commonly known to provide services to all persons in their catchment area, regardless of their patients' ability to pay or insurance status. Accordingly, it will be critical for the nonprofit health insurance issuer to be recognized for providing insurance to individuals who have been previously unable to obtain affordable health insurance in the private market. There is no clearer way to demonstrate that shared mission to potential enrollees than by having health centers serve as the sponsor of such qualified nonprofit health insurance issuers.

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

If a qualified nonprofit issuer lacks an established connection to the provider community, that issuer is likely to encounter many obstacles in developing an adequate provider network, particularly in rural areas that have a shortage of medical providers. The community's providers may be distrustful of the nonprofit issuer's motives and be disinclined to execute provider contracts especially if they come to learn that the nonprofit issuer purchases administrative or claims-related services from existing national private health insurers.

A qualified nonprofit issuer that is sponsored by a health center or group of health centers would be less likely to face these obstacles in developing provider networks. To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. Thus, health centers already serve in rural and medically shortage areas. Furthermore, health centers are expected to develop affiliations with other local community providers in order to promote access to specialty and hospital care for their patient population. Accordingly, a qualified nonprofit issuer sponsored by health centers will be able to access the health centers as well as their affiliated community providers in developing their provider networks in rural and medical shortage areas.

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

Based on the experience of health centers that established Medicaid managed care organizations, we would estimate that a new qualified nonprofit issuer would need somewhere between twelve and twenty-four months to become operational.

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

Prospective applicants should be prepared to submit qualifications and business plans similar to the applications of entities applying for Federal grants under Section 330 of the Public Health Service Act (42 U.S.C. §254b) from the Bureau of Primary Health Care (“BPHC”), within the Health Resources and Services Administration (“HRSA”) of DHHS.

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

It is difficult to estimate accurately the amount of investment required to develop sufficient administrative and claims processing information technology (IT) systems in isolation from the size of enrollment and breadth of provider network. Nevertheless, we expect that roughly \$5-8 million would be required at a minimum.

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

In regard to the level of investment for the information technology (IT) systems required for claims processing, please see the response above. Until regulations applicable to the health insurance exchanges are issued, it is impossible to estimate accurately the amount of investment required for separate IT systems to operate a health plan in the health insurance exchange market.

9. What is the range of funding necessary to capitalize and fund the establishment of a new qualified nonprofit issuer? How much of that amount can be raised privately, or funded through non-Federal government support? What factors should be considered in determining the appropriate amount of Federal loans and/or grants that would be needed to support the establishment of a new nonprofit

health insurance issuer? To what extent do the funds needed to capitalize a qualified nonprofit issuer, and the degree of Federal support necessary likely to vary across issuers?

The amount of funding necessary to capitalize and fund a new qualified nonprofit issuer would depend in part on the solvency requirements applicable to issuers licensed in a particular State.

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

No comment

11. Are you aware of any State laws that could create opportunities for or barriers to the formation of qualified nonprofit issuers? Do you think States are likely to create or amend licensure laws to accommodate the formation of qualified nonprofit issuers? Under what circumstances could regional qualified nonprofit issuers serving multiple states be formed? Is there a role for a federation of qualified nonprofit issuers to serve more than one state or region, with risk shared among the issuers? Would this approach be desirable for specific types of communities (for example, agricultural/rural communities)? How would such a federation be organized? How would it be capitalized? What are the advantages and disadvantages of a regional qualified nonprofit issuer or a regional federation of issuers? What barriers would need to be overcome? What would be the advantages of, and barriers to, serving a metropolitan area that crosses State lines?

It is certainly conceivable that some States will make the establishment of qualified nonprofit issuers impossible, or at least inhospitable, through certain licensing and solvency laws. In such circumstances, it will be essential to make some provision to allow qualified nonprofit issuers to operate by preempting such State requirements and substituting some solvency requirements applicable to commercial insurers.

It is also conceivable that regional qualified nonprofit issuers that serve multiple states could be formed, possibly as a federation. However, such an approach may not be desirable because the operation of a distant nonprofit issuer, if it operated across a large geographic area, might undermine the virtue of a locally-based cooperative model. The enrollees would not necessarily see the benefits of the governance model or know individuals who participate in its governance.

In addition, a regional qualified nonprofit issuer that serves multiple states might not be responsive to the needs of a local community, especially one that is medically underserved. The health plans that operate under a cooperative model are mostly localized to a particular community, sometimes a single metropolitan area. This may be a consequence of operating under the cooperative model which demands a high level of participation and involvement by the communities they serve.

An alternative would be to follow the health center model, in which independent health centers participate in an association of State health centers (PCAs) for training, advocacy, and education, and sometimes form networks to furnish common services to all of the networks' member health centers. Under this model, the health centers remain independent entities, each accountable to a local board of directors.

Applied to nonprofit issuers, the issuer might participate in a regional association for training, advocacy and education or form a regional network to furnish common services to all of the networks' member

nonprofit issuers. However, the qualified nonprofit issuers would remain independent entities, accountable to a local consumer board.

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

If a qualified nonprofit issuer could meet the general licensing requirements to serve as a managed care organization or health maintenance organization, then it would be desirable for those issuers to also participate in Medicaid or the Children’s Health Insurance Program (“CHIP”). That is because many individuals who will be served by the State insurance exchanges are expected to be the near-poor and may cross back and forth between Medicaid and eligibility to purchase coverage from the State insurance exchanges. In order to maintain continuity of care, it would be beneficial for individuals enrolled in the qualified nonprofit insurer to remain with the same caregivers throughout any changes in eligibility for coverage..

This would be particularly true for qualified nonprofit insurers that are sponsored by health centers or a health center network. Approximately 38.2% of health center patients are uninsured, many of whom will now be eligible to purchase insurance on the State insurance exchanges. Similarly, approximately 37.1% of the patients served by health centers are Medicaid recipients. Consequently, as many as 75% of health center patients could benefit from a seamless set of health care providers if their health center sponsored a qualified nonprofit insurer that also participated in Medicaid or CHIP.

13. Are there other considerations that should inform what costs would be eligible for a CO-OP loan? Should there be limited time periods for which Federal loans for start-up costs may be available? Are there any start-up costs that would be incurred after the qualified nonprofit issuer begins to provide coverage under one or more plans?

It is worth emphasizing that most people, even those enrolled in a qualified nonprofit issuer, will be unfamiliar with the cooperative model of governance and start-up costs related to training and technical assistance should be eligible for a CO-OP loan. Such training and technical assistance is necessary to educate members of nonprofit issuers on their on-going governance responsibilities and provide support to the management team of qualified nonprofit issuers, particularly after a qualified nonprofit issuer begins to provide coverage under one or more plans.

If health centers or groups of health centers sponsor a qualified nonprofit issuer, then NACHC and State Primary or Regional Care Associations (“S/RPCAs”) stand ready and willing to coordinate training and assistance activities. Prior to the qualified nonprofit issuers becoming operational, NACHC and the S/RPCAs could convene small businesses and health center sponsors to help determine the scope of services and structure of the particular qualified nonprofit issuer. Once operational, NACHC and the

S/RPCAs could provide on-going training and education to board members and staff of the qualified nonprofit issuers.

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

Over the long term, access to a high quality provider network will be essential to establishing qualified nonprofit issuers in the market because that is one of the first, if not most important, ways that consumers evaluate health plans. Consumers want to know that their personal physicians participate in the health plan so that they may continue to go to their physician for care. In addition, consumers want to see that their local community hospitals as well as regionally or nationally known hospitals participate in the provider network as well. Consequently, it will be essential for qualified nonprofit insurers to secure the cooperation of providers in order to provide a high quality network.

However, it will be extremely challenging for a new entry to establish a provider network. The first challenge will be finding the physicians and hospitals to include in the network. Once a new entry has identified the providers to include, it will need to negotiate contracts with those providers. Since those providers already have contracts with insurance companies, and the new entry will have few enrollees, providers are not likely to accept a reimbursement rate as low as they have negotiated with the existing insurers. Due to its lack of market power, a new entry will be disadvantaged by a higher cost structure than its competitors.

Health centers, however, already have established affiliations with other providers in order to be able to facilitate access to specialized and hospital care for their patients. It is conceivable that health centers and affiliated networks could use their pre-existing affiliations to help establish desirable provider networks for qualified nonprofit insurers and negotiate reasonable reimbursement rates. As sponsors of such insurers, they could ensure that enrollees of the qualified nonprofit insurers would continue to have access to health centers to receive their primary and preventive care while, at the same time, ensure that the qualified nonprofit insurers have the appropriate providers in their provider networks.

Finally, while we believe, as stated in the previous paragraph, that health centers pre-existing affiliations will help them establish desirable provider networks, we also recommend that the Secretary consider establishing some mechanism or incentive *that would facilitate a new entry's being able to gain access to hospitals and specialists at preferred rates* or perhaps incentivizing States to require or incentivize these providers (hospitals and specialists) to provide "best price" or "lowest price charged" to the new entry

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

No comment

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

To the extent that health centers and affiliated networks are sponsors of qualified nonprofit issuers, it would be advantageous to have NACHC and R/SPCAs furnish technical assistance, for the reasons indicated in the response to Question 13. Due to the fact that health centers are key components of health reform, NACHC and the R/SPCAs are already providing a great deal of technical assistance to health centers. With additional resources from the Secretary, NACHC and the R/SPCAs would be pleased to furnish assistance for establishing qualified nonprofit issuers.

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

Qualified nonprofit issuers are more likely to be successful in rural areas where there are fewer providers of care. In these rural areas, health centers are oftenthe sole source of primary care for all people, regardless of insurance status or income. It would not be surprising for patients who already appreciate the level and quality of services from their local health center to favor a qualified nonprofit issuer sponsored by the same or affiliated health center.

18. How can qualified nonprofit issuers build provider networks? What strategies have proven effective?

For all of the reasons previously mentioned in response to Question 14, qualified nonprofit issuers can be most effective at building provider networks by ensuring that patients may continue to see their personal physicians and have access to recognized systems of hospitals and other specialists. To this end, qualified nonprofit issuers sponsored by health centers or affiliated entities appear better positioned to assist in the development of these provider networks. Health centers are well respected in their communities and already affiliated with hospitals, specialists, and other providers. Accordingly, health centers could exercise the leadership needed to ensure that the qualified nonprofit issuers have a high quality provider network.

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

At this point, the Consumer Operated and Oriented Plan (“CO-OP”) Program is not well known by potential enrollees of qualified nonprofit issuers. While there are certain geographic areas, particularly in the upper Midwest, where the model does exist, that is likely because a cooperative health plan already exists. Ironically, persons living in those geographic areas might have the least interest in forming qualified nonprofit issuers under Section 1322 of the Affordable Care Act due to their satisfaction as members of the existing cooperative health plan.

B. Section 1322(b) of the Affordable Care Act

Section 1322(b) of the Affordable Care Act requires that the Secretary shall give priority to applicants that will offer qualified health plans on a statewide basis, utilize integrated care models, and have significant private support.

1. How should the term “integrated care model” be defined in the context of section 1322? How should the degree of integration and the degree to which integrated care is used be measured? Should qualified nonprofit issuers formed by primary care networks, even if they contract with secondary and tertiary providers, also be given priority for the award of a grant or loan? To what degree should priority be based on whether providers share risk?

Integrated care is the seamless and coordinated provision of health care services, from the perspective of the patient and family, across the entire care continuum, irrespective of institutional and departmental boundaries. As mentioned in the introduction, FQHCs provide comprehensive primary care services and serve as medical homes for the 23 million patients they currently serve. FQHCs have invested significantly in electronic health records and participate in regional health information exchanges to be able to share medical records with other providers. As a medical home, FQHCs have demonstrated the ability to coordinate patient care with other types of providers, including specialists and hospitals.

In addition, FQHCs provide a broad continuum of care, utilizing a team model approach with primary care services provided by physicians, nurse practitioners, nurse midwives, physician assistants, case managers, health educators, and other staff. Moreover, most health centers also provide dental services and behavioral health services, and staff for such services is integrated into the medical team under the same roof to enable “one-stop shopping”.

Accordingly, the term “integrated care” in Section 1322 should be defined to mean primary care providers that operate under the medical home model, regardless of whether the primary care network contracts with second and tertiary providers. The important aspect is not whether all of the providers operate under a single legal entity, but rather, whether the patient’s care is being coordinated among disparate providers of care.

2. How should “significant private support” be defined in this context?

“Significant private support” should be defined to include support from the local business and labor community. The history of cooperatives in America is rooted in efforts by local businesses and labor to create services beneficial to their respective communities.

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

No comment

4. What types of organizations are most likely to be successful in meeting any or all of the statutory priority criteria?

Health center and health center networks should be most successful in meeting all of the statutory priority criteria under Section 1322(b) of the Affordable Care Act. First, they can provide a statewide network of providers, drawing first upon existing health centers in a State, and contracting with other providers on an as-needed basis to fill in any geographic gaps. Second, health centers utilize integrated care models that effectively coordinate care across different providers and integrate care across a broad continuum of providers. Third, health centers have long-standing ties to local business communities, in part due to business leaders who have served as non-consumers of health center governing boards. Business leaders with direct experience in seeking insurance in the individual and small group markets will be most likely to offer significant private support.

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

Section 1322(b)(2)(a)(iii) of the Affordable Care Act requires the Secretary to ensure that there is sufficient funding to establish at least one qualified nonprofit issuer in each State, except that nothing shall prevent the establishment of multiple issuers in a State if the funding is sufficient. Section 1322(b)(2)(B) provides that if no issuer applies to be a qualified nonprofit health insurance issuer in a State, the Secretary may use the amounts for the awarding of grants to encourage the establishment of an issuer or the expansion of another qualified nonprofit health insurance issuer from another State into the State where no issuer applied.

1. How can the Secretary best ensure sufficient funding to establish at least one qualified nonprofit issuer in each State?

No comment

2. How might the Secretary encourage the establishment of a CO-OP in a state without a qualified nonprofit issuer?

In a State without a qualified nonprofit issuer, the Secretary could offer planning grants to that State's association of health centers in order to encourage a health center or network of health centers to form a qualified nonprofit issuer. In addition, the Secretary could offer planning grants to an established qualified nonprofit issuer in a neighboring State to encourage its expansion to a State without a qualified nonprofit issuer. Alternatively, the Secretary could offer planning grants to NACHC to help identify and support the expansion of an established qualified non profit issuer into a State without a qualified nonprofit issuer.

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

Section 1322(b)(C)(ii) of the Affordable Care Act restricts the use of loan and grant funds for (i) carrying out propaganda, or otherwise attempting to influence legislation, or (ii) for marketing.

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

It will be essential for qualified nonprofit issuers to educate consumers who are eligible to purchase coverage on the State insurance exchange about the benefits of enrolling in a cooperative health plan.

The Secretary should examine how the Centers for Medicare and Medicaid Services (CMS) distinguishes marketing from educational activities when performed by Medicare Advantage Organizations. It may be possible to designate certain types of communications from qualified nonprofit issuers as educational, and not marketing.

2. What other sources of financing for marketing would be available to qualified nonprofit issuers?

Applicants that had significant private support may be able to use that support for financing marketing activities.

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

The Secretary might consider using the cost accounting concept of “program income” for permitting premium revenue to be used for marketing purposes.

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

Section 1322(b)(2)(D) of the Affordable Care Act requires the Secretary to award and begin the distribution of loans and grants not later than July 1, 2013.

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

It is essential for new qualified nonprofit issuers to be operational by 2014 so that they can attract sufficient membership to keep the health plan viable. If a new qualified nonprofit issuer is not operational in 2014, other plans will have “first-mover” advantage in the exchanges, and it will be very challenging for a later entrant to catch-up.

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

Health centers operate in every State and are affiliated with each other through a national membership organization, the National Association of Community Health Centers (NACHC). The Secretary could offer planning grants to NACHC in order to coordinate efforts to ensure that health centers and affiliated networks apply for funding to establish a CO-OP in every State.

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

No comment

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

Section 1322(b)(3) of the Affordable Care Act requires that regulations regarding the repayment of loans and grants be “consistent with State solvency regulations and other similar State laws that may

apply.” Loans shall be repaid within 5 years and 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 to provide for repayment prior to awarding loans/grants.

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

No comment

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

No comment

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

No comment

4. What data are available about the potential success and failure rate of nonprofit health plans who may apply for grants and loans? If data are not available, what proxy data would be useful to inform benchmarks, or other performance standards?

No comment

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

Section 1322(c)(2) of the Affordable Care Act provides that an organization shall not be treated as a qualified nonprofit issuer (and therefore shall not be qualified to apply for loans and grants under the CO-OP program) if the organization or a related entity (or a predecessor of either) was a health insurance issuer on July 16, 2009. Section 1322(c)(2) of the Affordable Care Act also provides that an organization shall not be treated as a qualified nonprofit issuer if it is sponsored by a State or local government, political subdivision thereof, or an instrumentality of such government or political subdivision.

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

The Secretary should consider a qualified nonprofit issuer to be a “related entity” of a health insurance issuer if: (1) the health insurance issuer shares any common ownership or control through an individual or entity with a qualified nonprofit issuer or (2) if the health insurance issuer has a financial arrangement with a qualified nonprofit issuer that accounts for more than 50% of the qualified nonprofit issuer’s revenue.

The Secretary should define “predecessor” to mean an entity that no longer exists but that had an individual or entity with an ownership or controlling interest that is in common with an entity that exists today.

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

Section 1322(c)(3) of the Affordable Care Act requires that a qualified nonprofit issuer must be a nonprofit, member corporation and meet a number of governance requirements including the following:

- ***The governance of the organization must be subject to a majority vote of its members;***
- ***Its governing documents must incorporate ethics and conflict of interest standards against insurance industry involvement and interference; and***
- ***The organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.***

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

Prospective applicants should have a history of consumer governance, either through the organization itself or through parent entities that own or control the organization. Consumer governance could be demonstrated by operating as a membership organization in which the members are consumers of the products or services of the organization and elect the governing body of the organization. Alternatively, it could be demonstrated by an organization in which at least 50% of the individuals on its governing body are consumers of the products or services of the organization.

In addition, prospective applicants should be able to demonstrate how their history of consumer governance has resulted in a strong consumer-focus, including responsiveness and accountability. Specific examples should be given that describe initiatives, changes, or campaigns that reflect responsiveness or accountability. Finally, the applicant should be able to demonstrate how those examples dealt with diverse population groups.

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

Qualified nonprofit issuers should have a consumer governance model, but not a model that neglects the importance of having members on the governing body with experience and qualifications necessary to govern an insurance entity. Consequently, we recommend a hybrid model in which the members of the nonprofit organization (who are consumers of services from the qualified nonprofit issuer) elect the governing body and that a majority of seats on the governing body (*i.e.*, 51%) be reserved for members of the organization. However, we believe that it is essential to have individuals on the governing body with backgrounds in insurance, health care, finance, law, accounting, and retail. These individuals

contribute in important ways and bring expertise to the governing body that it may not possess otherwise.

Furthermore, to ensure consumer engagement and responsiveness, the governing body should have specific governance authorities and responsibilities. This includes, for example, responsibility for approving the products offered by the qualified nonprofit issuer (*i.e.*, HMO, PPO or other), the scope and benefits offered in each of the products, and the premiums charged by the issuer to consumers for coverage. The governing body should also have oversight of a qualified nonprofit issuer's quality improvement program and that program should encompass patient-centered quality measures such as consumer engagement and satisfaction in addition to clinical quality measures. Lastly, the governing body should be required to approve the use of excess revenues to ensure that such revenues are used for the benefit of members.

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

Section 1322(c)(4) of the Affordable Care Act provides that an organization cannot be a qualified nonprofit health insurance issuer unless any profits made by the organization are required to be used to lower premiums, to improve benefits, and for other programs intended to improve the quality of health care delivered to its members.

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

As described in the response to the prior question, the governing board should have specific responsibility for approving the use of any excess revenues to ensure that such revenues benefit members of the qualified nonprofit issuer. The accounting standards and metrics used to determine how such funds are applied should be similar to those that are used in the industry, particular those by mutual insurance companies. The governing bodies should be given wide discretion to determine the use of excess revenues so long as they are used for the statutory purposes described in Section 1322(c)(4) of the Affordable Care Act.

Nevertheless, we believe that using excess revenue to provide rebates to members in the year in which it was earned would be an important method of distinguishing qualified nonprofit issuers from its competitors and encourage the purchase of coverage from the issuer, resulting in greater market share. Accordingly, the provision of rebates should be encouraged over other potential uses of the profit, *e.g.*, reducing premiums in subsequent years, improving benefits, implementing programs to improve the quality of health care delivered to its members, or funding the prepayment of loans or grants.

2. How should programs intended to improve the quality of care be defined and measured in this context?

Programs to improve the quality of care are too important to be contingent on the availability of "excess" revenue. Instead, funds for that purpose should be specifically identified and included in the

issuer's budget. The quality improvement program should encompass patient-centered quality measures such as consumer engagement and satisfaction in addition to clinical quality measures.

Qualified nonprofit issuers should seek accreditation from a national organization such as the National Committee on Quality Assurance (NCQA) and achieve levels at or above the level of its competitors in the State insurance exchange.

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

Section 1322(c)(5) of the Affordable Care Act requires qualified nonprofit issuers to meet all the requirements that other issuers of qualified health plans are required to meet, including solvency and licensure requirements, rules on payments to providers, network adequacy rules, rate and form filing rules, any applicable State premium assessments and any other State laws described in section 1324(b).

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

No comment

K. Other Considerations

What other considerations should be addressed relating to the CO-OP program? Please include in your comment letter any additional questions or comments you have about the CO-OP program.

III. Conclusion

Thank you for the opportunity to comment on the provisions of the Consumer Operated and Oriented Plan Program. NACHC appreciates your consideration and favorable action on these comments.

Please do not hesitate to contact me by telephone at (202) 296-0158 or by e-mail at rschwartz@nachc.org if you have any questions or comments or if you require any clarification on the comments presented herein.

Sincerely,



Roger Schwartz
Associate Vice President of Executive Branch Liaison