BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

March 14, 2011

Mr. Allen Feezor
c/o Anne Bollinger
Center for Consumer Information and
Insurance Oversight, CMS
200 Independence Avenue, SW.,
Washington, DC 20201

Re: Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program

Dear Chairman Feezor and Advisory Board members,

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Advisory Board on its draft report on the Consumer Operated and Oriented Plan (CO-OP) Program.

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that currently provide health care coverage to nearly 98 million Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), and the Federal Employees Health Benefits Program.

BCBSA believes properly designed, market-based state exchanges can help foster competition for consumers and small businesses. Our Plans welcome competition in the health insurance market from new CO-OP plans. To ensure true competition all insurers must compete based on the same rules. This will ensure that consumers have the same protections regardless of which coverage option they choose and government investments are spent wisely. Section 1322(c)(5) of the Affordable Care Act (ACA) specifically requires CO-OP Plans to compete on a level playing field.

While most recommendations in the draft report will help to ensure that new CO-OP plans are created that meet consumer protections applicable to other health plans, we have significant concerns regarding the recommendation in the draft report to allow certain existing health plans to restructure to become CO-OPs

The draft Advisory Board recommendations would allow certain existing non-profit plans to restructure in order to seek participation in the CO-OP program (see recommendation 9 on Page 8). Such plans would need to have a "small market share," a stated mission at the time of their organization to provide partially subsidized health care coverage for the uninsured or underinsured, and meet other specified conditions under the draft Advisory Board recommendations.

We do not believe there is a statutory basis for this recommendation. Section 1322 of the ACA was designed to encourage the formation of new organizations which are not related to, or influenced by, preexisting companies in the health insurance industry.

Specifically, Section 1322(c)(2)(A) of the ACA states that any organization that was a health insurance issuer – or related entity or predecessor – on July 16, 2009, is ineligible for loans and grants under the CO-OP program.

The statute does not provide exceptions for small companies or companies with certain specified missions, as recommended by the Advisory Board. Allowing existing entities to restructure and compete as CO-OPs ignores the clear prohibition on "related entities or predecessors" participating in the CO-OP program.

Allowing existing companies to restructure to take advantage of the special treatment for CO-OPs -- including $6 billion in grants and loans, avoidance of federal income tax payable by many non-profit health plans, and a fifty percent reduction in the new insurance excise tax that applies beginning in 2014 – would:

- Require taxpayers subsidize development costs for existing health insurance issuers that restructure, which would waste federal resources.
- Create an unlevel playing field by allowing certain non-profit health plans to restructure to obtain 50 percent reduction in the insurance excise tax, while members of other non-profit health plans would have to pay 100% of the tax.
- Cause disruption for consumers by creating incentives for existing health plans to terminate coverage to take advantage of CO-OP funding and tax preferences.

Recommendation: The Advisory Board should eliminate the recommendation that certain health plans in existence on July 16, 2009 be permitted to restructure to participate in the CO-OP program, as this would conflict with the statute.

Additional Technical Comments

We have several other technical issues we wanted to raise concerning the draft report:

1. Definition of Health Plans that Could Take Advantage of CO-OP Funding

The Advisory Board recommends a new definition of an existing health insurance issuer for the purpose of defining which other existing entities might be eligible for the CO-OP program. Specifically, recommendation 8 on Page 8, states that:

> "For purposes of determining applicant eligibility for the CO-OP program, a health insurance issuer is defined as an entity that is regulated by any state Department or Commission of Insurance and is licensed as an issuer by the state. Examples of entities that would not meet this definition include Taft Hartley plans, existing risk-bearing entities that provide health care coverage and are exempt from state insurance regulation (e.g. self-funded plans), and nonprofit organizations that do not bear risk."

This definition may create ambiguity with regard to certain existing health insurance issuers that are regulated by the states, but not the department of insurance. For example, under California law, would HMOs regulated by the Department of Managed Health Care be eligible if this definition were used.

Recommendation: The Advisory Board should adopt the existing definitions of health insurance issuers in federal law to assure consistent application of this term.

2. Preference Given to Accountable Care Organizations

We are also concerned about the recommendation that Accountable Care Organizations (ACOs) could receive priority consideration from HHS for CO-OP funding.

To adequately protect consumers, all insurers participating on and off the exchange must be held to the same standards. There have been many examples where provider-sponsored organizations have failed or health care providers have experienced problems managing risk under capitation arrangements.

While some elements of the ACA, such as exchanges and risk mitigation programs, may encourage formation of provider-sponsored organizations, they do not eliminate the need to have effective business plans, adequate capital and insurance management expertise.

Recommendation: We recommend that the Advisory Board add language to this section to clarify that the primary considerations in selection of applicants for the CO-OP program should be their ability to become viable health plans, irrespective of whether an entity is an ACO.

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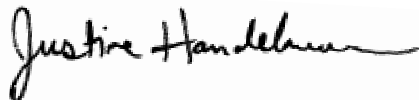
We appreciate the opportunity to comment on the Advisory Board's recommendations on the Consumer Operated and Oriented Plan Program. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,



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