thirds for qualifying individuals with income between 100% and 200% FPL, by one-half for those with income between 201% and 300% FPL, and by one-third for those with income between 301% and 400% FPL.

The second way that cost-sharing subsidies work is to reduce a plan's cost-sharing requirements to ensure that the plan covers a certain percentage of allowed health care expenses, on average, for the individual. This form of cost-sharing subsidy is available to individuals with income between 100% and 250% FPL, and it will directly affect cost-sharing requirements, such as coinsurance and copayments.

For more information about the cost-sharing subsidies, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

Consumer Operated and Oriented Plan (CO-OP) Program

Some have suggested that the creation of new non-profit consumer governed health insurance companies would benefit the private insurance market because the non-profit cooperatives would return profits directly to their members, or would invest in plan members via lower premiums, lower cost-sharing, expanded benefits, and innovations such as wellness programs, chronic disease management, and integrated care.[29] To facilitate the creation of new health insurance cooperatives, ACA creates the Consumer Operated and Oriented Plan (CO-OP) program.

The HHS Secretary is required to use funds appropriated to the CO-OP program to finance start-up loans and solvency loans for eligible non-profit organizations applying to become CO-OP issuers. Awarded entities are to use the start-up loans for assistance with costs associated with creating the CO-OP, and the solvency loans must be used to help the entity meet state solvency requirements.[30] All loans must be repaid with interest; the start-up loans must be repaid within five years and the solvency loans must be repaid within 15 years (from the date of disbursement).

The HHS Secretary began awarding loans to eligible non-profits in January 2012. As of the date of this report, 24 entities in 24 states have received loans.[31] On January 2, 2013, Congress passed the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240), the most recent in a series of laws that rescinded funds from the CO-OP program.[32] ATRA rescinded most of the unobligated CO-OP funds; the only funds remaining for the program must be used to support the 24 entities that have already received CO-OP loans.[33]

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[29] Senator Kent Conrad, "FAQ about the Consumer-Owned and -Oriented Plan (CO-OP)," 2010, available at http://conrad.senate.gov/issues/statements/healthcare/090813_coop_QA.cfm.

[30] States generally set standards for and monitor state-licensed insurers' financial operations in order to ensure that insurers have adequate reserves to pay policyholders' claims.

[31] The list of entities that have received loans is available at http://cciio.cms.gov/Archive/Grants/new-loan-program.html.

[32] As enacted, ACA appropriated $6 billion of federal funds for the CO-OP program. The Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) rescinded $2.2 billion of the appropriated funding, and the Consolidated Appropriations Act, 2012 (P.L. 112-74) rescinded an additional $400 million from the program. The American Taxpayer Relief Act of 2012 (P.L. 112-240) rescinded nearly all other unobligated CO-OP funds.

[33] ATRA directed the HHS Secretary to create a fund to be used to support all nonprofit insurance issuers who were awarded CO-OP program loans prior to the date of the law's enactment (January 2, 2013). The fund contains 10% of (continued...)