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Health Policy Brief

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The CO-OP Health Insurance Program. Twenty-four “consumer operated and oriented plans” will offer coverage through health insurance exchanges.

WHAT'S THE ISSUE?

Starting in October 2013, people without access to coverage through an employer, Medicaid, or the Children's Health Insurance Program will be able to purchase health plans through health insurance exchanges for coverage taking effect in 2014. These new marketplaces are one of the Affordable Care Act's key mechanisms for expanding affordable coverage.

Recognizing that in some states only a small number of insurance companies offer coverage for individuals and small businesses, the health care law also established a Consumer Operated and Oriented Plan (CO-OP) program to increase competition among plans and improve consumer choice. The federal government has now awarded nearly \$2 billion in loans to help create 24 new CO-OPs in 24 states. The CO-OP sponsors—consumer-run groups, membership associations, and other nonprofit organizations—are now moving forward to offer health coverage in competition with established commercial and nonprofit insurance companies.

Many analysts are enthusiastic about the potential for CO-OPs to bring competition and choice to the market. Others question whether the federal loan initiative has been a wise use of taxpayer dollars, since many CO-OPs will be at a disadvantage competing against well-established insurance companies

and may fail. This policy brief describes the CO-OP program and examines issues related to its implementation and likelihood of success.

WHAT'S THE BACKGROUND?

In general, a cooperative is an organization that provides an economic benefit to its members and is owned and governed by them. Thousands of cooperatives exist nationwide in many sectors, including agriculture (farm and food cooperatives), financial services (credit unions), and utilities (rural electricity and telecommunications). A cooperative's membership can range from a handful of people to thousands. Cooperatives may have hundreds of people working in offices nationwide, or they may not have any employees or fixed places of business.

A LONG HISTORY: Health care cooperatives have a long history dating back to at least 1929 and the Depression era that followed. During the New Deal, a federal Farm Security Administration was established to help address poverty in rural America. About half of all loan defaults by rural farmers were due to farmers' poor health, so the bureau made loans available for the purpose of creating health associations. These associations, run by community members, then paid local physicians for providing health care to local families. The families supported the associations with membership fees based on their ability to pay.

\$2 billion

Federal loans

The federal government has awarded nearly \$2 billion in loans to help create and maintain CO-OPs.

Although most health care cooperatives created during the Depression have since been disbanded or gone out of business, others not only survived but flourished, and today are ranked among the highest performing health systems in the country. Group Health, a large cooperative, was founded in 1947 and has roughly 625,000 members in the state of Washington and in northern Idaho. HealthPartners, founded in 1957, is the largest consumer-governed health organization in the United States with more than 1 million members primarily in Minnesota and Wisconsin. Both of these organizations provide prepaid health care. As such, they provide both insurance and care delivery, directly employing many health care providers.

The key factor that distinguishes organizations such as Group Health and HealthPartners from other nonprofit health systems, such as the Kaiser Foundation Health Plans, is their consumer governance. The policy and direction of organizations like Group Health and HealthPartners are set by a board of directors elected by a majority of the membership.

ALTERNATIVE TO PUBLIC OPTION: More recently, health care cooperatives reemerged during the debate over the Affordable Care Act. Many lawmakers and policy makers wanted the health care law to include a so-

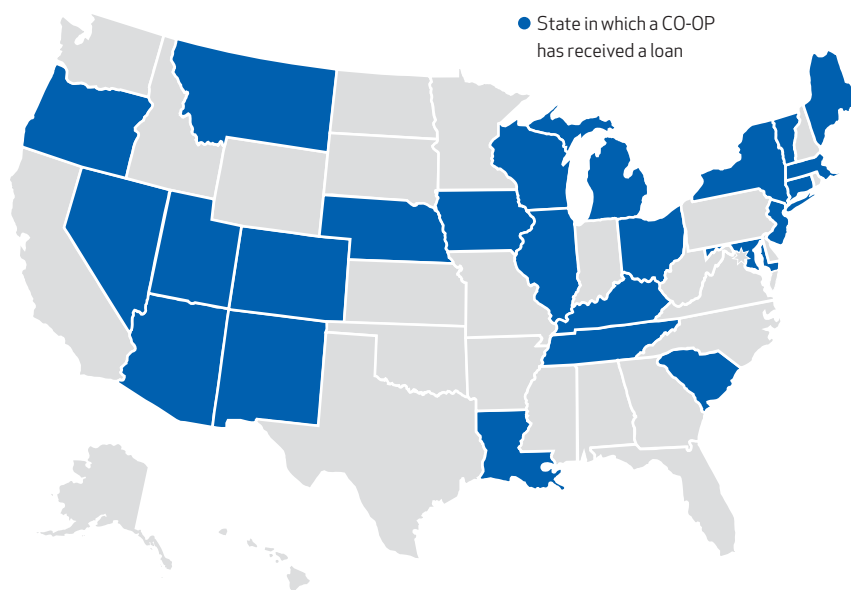
called public health insurance option. Such a plan would have been similar to Medicare but open to all ages, and it could have competed to offer coverage through the exchanges along with private health insurance companies. Ultimately, the public option was not included in the health care reform law because of concerns among some lawmakers that its presence could undercut the private health insurance industry and lead to a “single payer” national health insurance system.

A compromise solution emerged, however, in the form of a proposal to create CO-OPs, first put forward by Sen. Kent Conrad (D-ND). The provision created what was originally a \$6 billion federal fund—reduced by law in 2011 to \$3.4 billion, and reduced again in January 2013 as described below—that would enable sponsoring organizations to apply for loans to create new health insurance cooperatives.

These nonprofit, consumer-driven organizations would offer health coverage—and possibly also care networks—through the exchanges under the same regulatory requirements imposed on private insurance companies at the state and federal level. The provision was incorporated into health reform legislation in the Senate, and became law when the Affordable Care Act was signed by President Barack Obama in March 2010.

EXHIBIT 1

States with Organizations That Have Received Federal Loans to Establish a CO-OP



WHAT'S IN THE LAW?

Under Section 1322 of the Affordable Care Act, CO-OPs will offer coverage through the exchanges primarily in the small-group market, which generally serves companies or organizations with fewer than 100 full-time employees, and in the individual market. Like other plans offered through the exchanges, CO-OPs must be ready for open enrollment beginning October 1, 2013. The law required the Department of Health and Human Services (HHS) to distribute funds to at least one CO-OP in each state. But because of the most recent funding cuts, no more new CO-OPs will be established beyond the 24 that have already been created, at least for now (Exhibit 1).

SPONSORS: The law describes CO-OP sponsors as “persons applying to become qualified nonprofit health insurance issuers.” In practice, these “persons” include consumer groups, community organizations, medical provider organizations, unions, business coalitions, and other stakeholder groups. Regulations further clarified that sponsors need

SOURCE Department of Health and Human Services, “New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers,” Updated December 21, 2012. **NOTE** One CO-OP has applied to operate in Iowa and Nebraska, while two CO-OPs have applied to operate in Oregon.

24

Number of CO-OPs

The federal government has awarded loans and grants to 24 CO-OPs in 24 states.

“Many analysts are enthusiastic about the potential for CO-OPs to bring competition and choice to the market.”

to provide 40 percent or more in total CO-OP funding, not including federal loans. A CO-OP also cannot receive more than 40 percent of its funding from state or local governments or more than 25 percent from an insurance company that existed prior to July 16, 2009, the date when the CO-OP provision was added to the draft Senate health care bill.

Below is a partial list of CO-OPs that have been approved so far and their sponsoring organizations.

- **Evergreen Health Cooperative**, established by Peter Beilenson, a former Baltimore City health commissioner, intends to provide high-quality care to members throughout Maryland with premiums costing 20–30 percent less than those of traditional insurance companies. Evergreen will employ salaried physicians and emphasize preventive care to help keep people from developing more serious illnesses. It has been awarded \$65 million in loans.

- **HealthyCT** is a nonprofit health plan sponsored by the Connecticut State Medical Society (CSMS) and CSMS-IPA, a statewide independent practice association of providers. HealthyCT will focus on encouraging members to use patient-centered medical homes. It has been awarded \$76 million in loans.

- **Compass Cooperative Health Network** in Arizona is sponsored by local experts in insurance, chronic disease coordination, use of health information technology, and business formation. It will begin on a regional basis within Arizona and then expand statewide over time. It has been awarded \$93 million.

- **Minutemen Health** is sponsored by two Massachusetts hospital systems, Tufts Medical Center and Vanguard Health Systems, and has been awarded \$88 million. Initially, it plans to provide regional coverage in eastern and central Massachusetts but will expand statewide by July 2014.

- **Freelancers CO-OP of New Jersey** is sponsored by the Freelancers Union, an association of independent workers. The CO-OP will partner with providers to implement a patient-centered medical home model. The Freelancers Union is also sponsoring CO-OPs in New York and Oregon. The organization has been awarded \$107 million.

- **CoOpportunity Health** is sponsored by a community organization that plans to serve

residents of Iowa and Nebraska. It has been awarded \$113 million and is the only organization funded to date with plans to cover more than one state.

ORGANIZATION AND GOVERNANCE: To qualify as a CO-OP, an organization must be governed by its members and operate with a strong consumer focus. A CO-OP must be organized under state law as a nonprofit corporation, offering at least two-thirds of its policies in the individual and small-group markets through the exchanges. All surplus revenues must be used to reduce premiums, improve benefits, or improve the quality of care for its members. The CO-OP must also comply with state insurance laws and regulations relating to such issues as solvency and licensure, provider payments, network adequacy, rate and form filing, and state premium assessments.

The secretary of HHS was directed to give priority to CO-OP applicants that would offer health plans that would operate statewide, use integrated care delivery models, and have significant private support. A CO-OP cannot have on its board of directors any representative of a government agency, insurance company, or insurance industry organization.

FUNDING: As of December 2012, HHS had awarded nearly \$2 billion in CO-OP loans to 24 nonprofit organizations offering coverage in 24 states. Legislation passed by Congress on January 1, 2013, rescinded all but 10 percent of any funds that hadn't been committed as of that point, leaving only about \$200 million available to assist and oversee the 24 existing CO-OPs but not to fund any new ones. As a result, no additional CO-OPs beyond these 24 will be able to receive government assistance under the law. Reportedly, more than two dozen organizations had loan applications pending when funds were rescinded.

Funds already committed have gone toward two types of awards: loans to cover start-up costs and grants to help CO-OPs meet state solvency requirements, which are funds that every insurance company must reserve, or set aside, to cover potential claims. Although the law refers to these as “grants,” they are actually loans because they must be repaid.

Start-up loans must be repaid within five years and solvency grants repaid within 15 years, but the schedule for doing so can be customized. The loans are subsidized by the federal government with interest rates for start-up loans pegged at 1 percent below the av-

\$200 million

Available funding

Recent “fiscal cliff” legislation cut 90 percent of remaining CO-OP funds, leaving about \$200 million in the program.

“Those CO-OPs that do succeed may offer lessons for other health systems and insurers striving to provide higher-quality care at lower cost.”

average rate earned by Treasury securities when the loans were granted; for solvency loans, the interest rate is 2 percent below the average. CO-OPs will be subject to strict monitoring, auditing, and reporting requirements to protect against waste, fraud, and abuse.

OTHER CAPABILITIES AND REQUIREMENTS:

The Affordable Care Act authorizes CO-OPs to form private purchasing councils that can collectively purchase or contract for items and services at favorable rates because of their aggregate market power. The purchasing councils may be able to reduce administrative costs by negotiating favorable rates with third parties for reinsurance, claims administration, or actuarial and health information technology services. Purchasing councils may also be able to develop specific services in house, such as processing claims, and then provide these services directly to CO-OP members.

By law, a purchasing council cannot have as a member any representative of a government agency, insurance company, or insurance industry organization. What’s more, when a CO-OP purchasing council is negotiating with health care providers, the HHS secretary is barred from participating. The secretary also may not participate in any negotiations among CO-OPs, such as over the pricing of premiums. These measures were introduced into the law specifically to bar the federal government from exerting the type of market clout that some feared the public option would have exhibited.

WHAT ARE THE CONCERNS?

CO-OPs are likely to face major challenges, as follows, as they prepare for open enrollment in October 2013.

FINANCIAL: On top of the federal funding they have already obtained, CO-OPs will need significant private support to be financially viable. Although the federal loans will help CO-OPs meet certain start-up costs and state solvency requirements, those funds cannot be used to pay for clinical services or to purchase equipment. CO-OPs will need enough funds to cover members’ medical claims, and these funds typically come from premium revenues. And before CO-OPs can begin collecting premiums, they will need to have in place essential personnel, provider networks, and systems for claims administration and health information technology.

Over a relatively short period, CO-OPs will have to enroll enough people to generate sufficient revenues for sustained operations. Achieving this goal will require sizable investments in marketing and promotions, but the law prohibits CO-OPs from using their federal loans for this purpose. It remains to be seen whether CO-OPs can effectively market their policies and services to become self-sustaining.

COMPETENCY: CO-OPs will need to recruit and retain employees who have a broad range of talents—from conducting insurance operations to, in at least some cases, delivering care. Not only will these people need expertise in managing risk and administering claims, but they will also need experience operating nonprofit, member-run organizations. And to compete with established companies on price, they will need to achieve administrative efficiency quickly.

ACTUARIAL CAPABILITY: CO-OPs will need to set their initial premium rates without the historical claims or utilization data on which those rates are usually based. Instead, they will have to develop actuarial models for the individual and small-group markets they intend to serve. This challenge may be eased in part by the health care law’s requirement that states or the federal government run risk-adjustment programs to protect insurers in the exchanges from losing money when they cover people with high-cost medical conditions. (See the [Health Policy Brief](#) published August 30, 2012, for more information on risk adjustment in health insurance.)

PROVISION OF CARE: To be competitive, CO-OPs that are in the business of providing care will need to employ or otherwise have access to high-quality doctors, hospitals, and other health care providers. They will also need to offer a range of services, including disease management, wellness and prevention, and utilization management to ensure the provision of appropriate care and quality of service. These services are costly, and even without having to earn enough in revenues to pay profits to investors or cover marketing expenses, CO-OPs may be financially squeezed.

CO-OPS may also need to form relationships with a broad array of health care professionals to provide health care services and test new forms of integrated care delivery. Providers, such as doctors and hospitals, may see CO-OPs as a way to protect or increase their market share. They may also want the opportunity

that some CO-OPs provide to participate in innovative care delivery models and alternative payment arrangements that reward quality care. Conversely, if CO-OPs do not engage the medical community, they are unlikely to gain the market clout they need to negotiate favorable payment rates with providers.

Some of these challenges in providing care—such as having an integrated network of high-quality providers—may be magnified if a CO-OP tries to operate in more rural or medically underserved communities. Some CO-OPs, such as Compass Cooperative Health Network in Arizona and Minutemen Health in Massachusetts, described above, will at first operate only in parts of their states. Only after becoming more established are they likely to expand statewide.

WHAT'S NEXT?

The first true test of the CO-OP program will occur in October 2013 when the exchanges' open-enrollment period begins. At that time, it will be evident how many of the organizations that received start-up loans have gone on to earn approval from state and federal regulators and to offer plans through the exchanges.

The next significant test further down the road will be to see how many CO-OPs were able to enroll enough people to become sustainable. Evidence may also accumulate about which plans are competing well against their commercial counterparts—for example, by offering integrated care delivery or specialized services. Those CO-OPs that do succeed may offer lessons for other health systems and insurers striving to provide higher-quality care at lower cost.■

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