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Health Policy Brief

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The CO-OP Health Insurance Program. Twenty-three “consumer operated and oriented plans” are offering coverage through health insurance exchanges.

WHAT'S THE ISSUE?

Since October 2013, people without access to coverage through an employer, Medicaid, or the Children's Health Insurance Program have been 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 (ACA's) key mechanisms for expanding 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 awarded nearly \$2 billion in loans to help create 24 new CO-OPs in 24 states. (One of these has since disbanded. See “Funding” below.) 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 updates a previous brief on the subject posted February 28, 2013. It describes the current status of the CO-OP program and examines issues related to the likelihood of its success now that the ACA implementation has begun.

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). Membership can range from a handful of people to thousands.

A LONG HISTORY: Health care cooperatives have a long history dating back to at least 1929 and the Depression era that followed. As part of 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.

\$200 million

Available funding

Last year's "fiscal cliff" legislation cut 90 percent of remaining CO-OP funds, leaving about \$200 million in the program.

Although most health care cooperatives created during the Depression no longer exist, a few 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 supply 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 such as 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 ACA. Many lawmakers and policy makers wanted the health care law to include a so-called public health insurance option. Such a plan would have

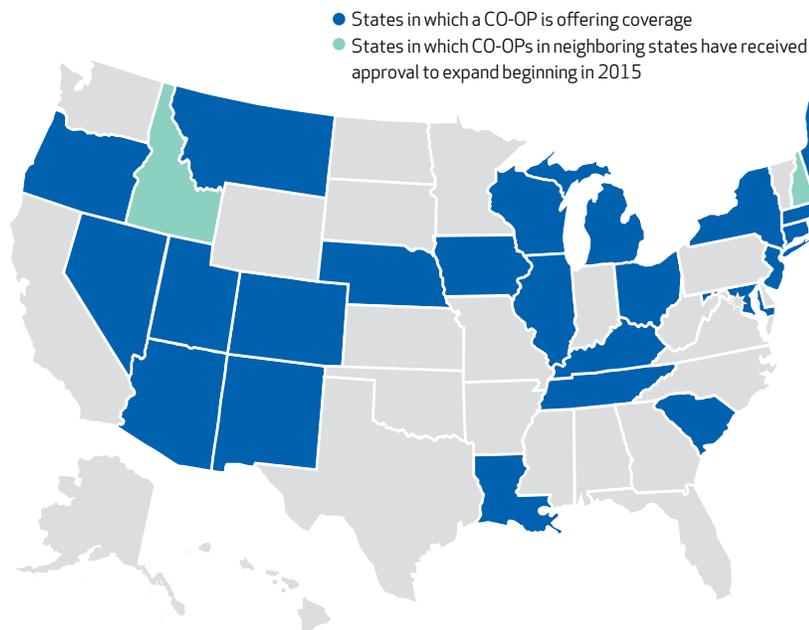
been similar to Medicare but open to all ages, and it could have competed to offer coverage through the exchanges along with private health insurance companies. Ultimately, the public option was not included in the ACA because of concerns among some lawmakers that its presence could undercut the private 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 under "Funding" 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 ACA was signed by President Obama in March 2010.

EXHIBIT 1

States With Organizations That Have Created a CO-OP Under the ACA



SOURCE Department of Health and Human Services, "New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers," Updated January 14, 2014. **NOTE** One CO-OP is serving two states, Iowa and Nebraska, and one state, Oregon, has two CO-OPs.

WHAT'S IN THE LAW?

Under section 1322 of the Affordable Care Act, CO-OPs will offer coverage through the exchanges in the individual market and in the small-group market, which generally serves companies with fewer than 100 full-time employees. Like other plans offered through the exchanges, CO-OPs had to 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 funding cuts, described under "Funding" below, only 23 CO-OPs, in 23 states, have been established and received grants (Exhibit 1). One CO-OP serves two states, Iowa and Nebraska, and one state, Oregon, has two CO-OPs.

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 to provide 40 percent or more in total CO-OP

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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 approved CO-OPs and their sponsoring organizations.

- **Evergreen Health Cooperative**, established by Peter Beilenson, a former Baltimore City health commissioner, offers members a choice of two models of coverage: a primary care model with neighborhood-based health centers that offer one-stop care through a team of salaried health care professionals; and a more traditional insurance plan model built around a network of doctors and hospitals. It received an initial \$65 million loan.

- **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 is based on a patient-centered medical home model. It has been awarded \$76 million in loans.

- **Meritus**, formerly called Compass Cooperative Health Network, is sponsored by local experts in insurance, chronic disease coordination, use of health information technology, and business formation. It is beginning on a regional basis within Arizona and has plans to 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 provides regional coverage in eastern and central Massachusetts but plans to expand statewide. In December 2013 Minuteman received a \$67 million foundational loan from the Centers for Medicare and Medicaid Services (CMS) to expand into the New Hampshire market, with a targeted January 2015 start date.

- **Health Republic Insurance 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 serves residents of Iowa and Nebraska. It has been awarded \$113 million.

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: Two types of awards are available to CO-OPs: 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 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.

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 CO-OPs

37%

Among new entrants, CO-OPs have emerged as price leaders, offering 37 percent of lowest-priced products in the states where CO-OPs are present.

“As new entrants into the health care marketplace, CO-OPs face major challenges.”

that had already been approved, but not to fund any new ones. CMS, which administers the CO-OP program, has interpreted such assistance to include additional loan funding to cover expenses not anticipated at the time of the initial loan award, as well as to fund extension of a CO-OP’s operations to another state. For example, in December 2013 the Montana Health CO-OP was awarded an additional \$27 million in federal funds to expand into Idaho.

One of the 24 CO-OPs originally funded, the Vermont Health CO-OP, was dissolved after it was denied an insurance license by the state and, as a result, had its loans called in by CMS. The CO-OP had received \$4.8 in start-up financing and \$9.8 million for solvency purposes. CMS is requiring that all of the solvency funds be repaid, as they were only to be used to meet state solvency requirements. It is not known how much, if any, of the start-up funding will be repaid.

WHAT ARE THE CONCERNS?

As new entrants into the health care marketplace, CO-OPs face major challenges, which have been exacerbated by the rocky rollout of enrollment through the federally run, as well as many state-based, exchanges that began on October 1, 2013.

FINANCIAL: On top of the federal funding they have already obtained, CO-OPs 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. As newcomers into the health insurance market, it is particularly important for the CO-OPS to be presented alongside other insur-

ers on the exchanges. The exchanges’ troubled launch has caused the CO-OPs to place even more emphasis on marketing strategies, such as partnering with other community organizations in outreach and education efforts and using social media.

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

In July 2013 the HHS Office of Inspector General (OIG) reported on a study it conducted on CMS’s oversight of the CO-OP program. It stated that the CMS oversight strategy includes disbursement of loan funds to each CO-OP based on its meeting key milestones, such as achieving state licensure, hiring key staff, and contracting with vendors. The OIG determined that, from February to September 2012, the CO-OPs were making progress and had met 90 percent of their milestones.

ACTUARIAL CAPABILITY: CO-OPs set their initial premium rates without the historical claims or usage data on which those rates are usually based. Instead, they had 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.)

Early evidence is that the CO-OPs have proposed premium rates that are very competitive. A McKinsey & Co. analysis of exchange plans as of October 15, 2013, found that CO-OPs are offering the most products of all new entrants in the market. Also, among the newcomers, CO-OPs have emerged as price leaders, offering 37 percent of the lowest-priced products in the states where CO-OPs are present.

However, it remains to be seen if the assumptions behind the premium rates hold true. There is some concern that the problems with enrollment through the exchanges

might discourage many younger, healthier individuals from enrolling. While this will affect all plans offered through the exchanges, it may have more of an impact on new market entrants, which need healthy policy holders to keep any plan affordable and sustainable. If enrollment assumptions were inaccurate, and premium rates have been understated, revenues will fall short of meeting claims, and next year's rates will have to be significantly higher, causing serious problems for CO-OPs as well as the system as a whole.

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 qual-

ity 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 Meritus 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 CO-OP program passed the first true test of its viability. All but one of the funded CO-OPs were organized and offering plans on the exchanges in time for enrollment that began on October 1, 2013.

The next significant tests will be to see how many CO-OPs were able to enroll enough people and to see if the CO-OPs' premium rates were realistic enough for them to become sustainable. Evidence will 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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