Consumer Operated and Oriented Plans (CO-OPs): An Interim Assessment of Their Prospects

Timely Analysis of Immediate Health Policy Issues

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Summary

The Patient Protection and Affordable Care Act of 2010 (ACA) included a loan program to finance the creation of Consumer Operated and Oriented Plans (CO-OPs). $3.8 billion is available. CO-OPs are to be nonprofit, member-governed plans that will create innovative care delivery and payment models to compete in states' individual and small group health insurance markets.

The Department of Health and Human Services (HHS) has issued proposed rules and a funding opportunity announcement for the CO-OP program. The first round of applicants will be accepted by October 17, 2011, and the first loans will be made in January 2012. Loans to create and develop CO-OPs must be repaid within five years. Longer term loans (to be repaid in 15 years) will help CO-OPs meet state solvency requirements.

By insuring almost 13 million more people and creating new health insurance exchanges, the ACA creates opportunities for these new health plans. Other provisions will shape the applicant pool. Sponsorship by existing insurance issuers is not permitted, and according to the legislation, "substantially all" of CO-OPs' activities must be in the individual and small group markets. Some potential sponsors will be deterred by application costs and the member-governance requirement.

HHS's Center for Consumer Information and Insurance Oversight reports substantial interest in creating CO-OPs, and a trade association—the National Alliance of State Health CO-OPs (NASHCO)—has been formed to facilitate applications. Potential sponsors from more than 25 states have identified themselves; they include membership organizations, other types of co-ops (e.g., farm), and new organizations led by health reform advocates.

CO-OPs prospects for survival and growth will depend upon market factors, responses of established competitors, and the strength of management teams. Success will also be affected by plan's ability to deal with challenges that are shaped by provisions in the legislation that created the program. These include:

1. Building the needed provider network and administrative structures. Given the tight time frame for getting established, many plans will initially contract for administrative services and provider networks from existing third-party administrators.
2. Building enrollment. This is important for economies of scale and negotiations with providers. Sponsors that already have access to potential enrollee populations will have an advantage. Being ready to accept enrollment in the October 2013 open enrollment period before the exchanges open will be important. Many, perhaps most, will need more time.
3. Overcoming the prohibition on marketing. Marketing is a significant expense for health plans and will be particularly important for new (and unusual) plans. How the legislation's restriction on using loan funds for marketing is implemented in practice will be important.
4. The danger of adverse selection. Setting prices may be difficult for new plans that recruit people who were uninsured before the ACA, because many new enrollees have a backlog of unmet medical needs. Established competitors may be skilled at the marketing methods that can attract the healthiest patients. The reinsurance and risk adjustments provisions of the ACA will be important here.
5. How member governance works. Plans will need board expertise on finance, strategic planning, product development, contracting, actuarial functions, and medical management. Although the rules require that the board be elected by members, boards can include experts who are not plan members.

The legislative sponsors envisioned CO-OPs transforming the health insurance market. Whether they are able to do so will depend upon their ability to move beyond the individual and small group markets, work collaboratively with each other, and evolve beyond reliance on existing administrative organizations and provider networks.

Robert Wood Johnson Foundation

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Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) includes provisions for a "Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers" (Section 1322) to be known as Consumer Operated and Oriented Plans or CO-OPs. The legislation provides for federal loans to be awarded competitively to applicants proposing to set up these member-governed health plans to compete in the individual and small group health insurance market in each state and the District of Columbia. The law directs the secretary of Health and Human Services (HHS) to administer the program, giving funding priority to applications for statewide rather than local plans, integrated care models and plans with significant private support.

Much skepticism was expressed about their feasibility and practical value at the time the provisions of the ACA were being discussed in Congress, but many steps toward implementing the program have been taken by HHS and its Center for Consumer Information and Insurance Oversight (CCIIO). On April 15, 2011, the advisory board that was created under the terms of the legislation issued its final report to help HHS translate the legislation into an operational program.[1] On July 20, 2011, HHS issued proposed rules for the CO-OP program (final rules expected sometime after mid-September) and issued a separate funding opportunity announcement (FOA) shortly thereafter.[2] The first round of applicants will be accepted by October 17, 2011 (and will be accepted quarterly thereafter), and HHS plans to make the first loans in January 2012.

The idea of Congress designing and setting terms for a set of organizations that are intended to survive, grow and provide a genuine alternative in the highly competitive private health insurance market has been tried before, in the Health Maintenance Organization Act of 1973. That measure (as amended in 1976) contributed to the eventual rise of a managed care industry that bore little relationship to the prepaid group practice model that had inspired the legislation.[3] Many of the start-up health maintenance organizations (HMOs)—particularly those that took the form of independent practice organizations or IPAs—converted to for-profit status in the 1980s and became part of the consolidation that resulted in today's health insurance giants.

Like the HMO Act, the CO-OP program was born of a vision for change. It is intended to improve consumer choice and plan accountability, as well as to promote integrated models of care and enhanced competition in the health insurance market.[4] Thus, the questions about the ACA's CO-OPs include not only whether sponsors will come forward to seek funding and whether successful applicants will be able to create health plans that can compete and grow, but also whether CO-OPs can evolve into something that fulfills the vision of the legislative sponsors.

This paper provides a preliminary assessment of the prospects of the CO-OP idea. It is based on the legislation, the hearings and report of the advisory board, the proposed rules and the funding opportunity announcement, interviews with people who were involved in the legislation, the advisory board, CCIIO officials and several potential developers of CO-OPs, as well as participation in a July conference and subsequent conference calls by the newly formed National Alliance of State Health CO-OPs (NASHCO).[5] The yet-to-be created health insurance CO-OPs will certainly face many challenges. Even so, the CO-OP program has features that warrant ongoing attention to their development.

The ACA's CO-OPs: Tensions within the Law

The ACA's provisions for CO-OPs reflect their origins in 2009's highly contentious health reform process. The idea for their inclusion in the health reform legislation came from Senator Kent Conrad (D-ND) in June 2009 as part of the work of the so-called "Gang of Six," led by Finance Committee Chairman Max Baucus (D-MT), that sought to reach bipartisan agreement on provisions for health reform. In trying to ensure near-universal health insurance coverage of the American people, leading Democratic developers of the legislation wanted to give people an alternative to the private insurance industry in the form of a national government-run health plan—the public option. The CO-OP provisions were developed when it became apparent that inclusion of the public option would prevent the health reform bill from garnering the 60 votes needed to halt debate in the Senate.

Senator Conrad introduced the CO-OP idea as middle ground between those who favored a public option and those who opposed it. Although the CO-OPs differ from the public option in many respects—they are to be private rather than governmental, to be state level rather than national and to negotiate separately with providers rather than acting as a single entity—the CO-OPs, like the public option, were intended to create an alternative type of insurance issuer.

Some aspects of the CO-OP idea—their nonprofit nature, consumer control, and the vision of plans in all 50 states—had appeal to supporters of the public option. Other aspects addressed objections that had been raised about the public option, such as the fear of creating a new government entity that, like Medicare and Medicaid, would pay administered prices to service providers. Although the CO-OP provisions were attacked, most notably by Senator Rockefeller (D-WV), as an inadequate substitute for the public option, they generated little of the conservative opposition that the public option had received, in part because of the limitations that the legislation placed on CO-OPs, even while supporting their creation.

The acronym "CO-OP" suggests the cooperative organizational model that Senator Conrad had in mind when proposing the CO-OP program. However, the ACA's CO-OPs differ from

the classic cooperative model in several respects. Ownership and control in a cooperative rests with the people it serves, who, depending on the nature of the cooperative, may be the purchasers, sellers, or consumers of particular products or services. Cooperatives have a long history in many fields, including agriculture and food, housing, child care, public utilities, credit unions and health care.

Like ordinary cooperatives, the ACA's CO-OPs are to be consumer governed by boards elected by the members the organizations serve. However, these CO-OPs will *not* be *owned* by members or established under the state regulatory regimes that apply specifically to cooperatives. Instead, CO-OPs are to be chartered as nonprofit organizations under state laws, as is the case with Group Health Cooperative of Seattle, one of the models on which the CO-OPs' legislative provisions were based. The law also provides a new tax-exempt category—501(c)(29)—for which CO-OPs can apply under the Internal Revenue Code.[6]

The ACA provided $6 billion for getting CO-OPs established, but this was reduced to $3.8 billion in the April 2011 budget agreement between the White House and Congress to avert a government shutdown. The funds are to be used for two types of loans for establishing CO-OPs. First are short-term loans (to be repaid in five years) for start-up costs associated with "creating and developing" a CO-OP.[7] The drafters of the legislation estimated that $500 million would be needed—$10 million per plan, assuming one plan per state—but this amount is not mentioned in the law.[8]

The bulk of the funding is for long-term loans (to be repaid in 15 years, despite being called grants[9] in the legislation) to enable the new plans to meet the state solvency (or reserve) requirements that apply to all insurers to ensure that they have sufficient funds to cover unpaid claims. Though necessary, such requirements constitute a significant barrier to entry of new plans. They vary by state but average about 10 percent of annualized premiums; the amount of reserves required of an insurer thus grows with the number of enrollees.[10] The amount specified in the ACA assumed 50 state plans with an eventual average of 250,000 enrollees per plan.

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Several policy concerns can be seen in the law's provisions. One clear goal is that the CO-OPs will be competitive with but distinct from the commercial health insurance industry. The plans must be nonprofit and member governed, and any "profits"[11] they generate must inure to the benefit of members in the form of lowered premiums, improved benefits, or quality enhancement. (The proposed rules also recognize adding members and building reserves as benefitting members.) The plans are to have a "strong consumer focus, including timeliness, responsiveness and accountability to members," and their governance documents must protect against "insurance industry involvement and interference." In addition, the ACA's CO-OP provisions allow them to join together to create "private purchasing councils" to gain efficiencies in obtaining supplies and services (e.g., claims administration, administrative and actuarial services and information technology).

Other provisions of the law reflect a different set of policy concerns—that CO-OPs not be given too much competitive advantage and that policyholders be protected against the danger of plan insolvency. Thus, the new plans will have to meet the regular state licensure requirements and comply with state insurance laws regarding solvency, payments to providers, network adequacy rules, rate and form filing rules and state premium assessments. Because of antitrust concerns, the money-saving private purchasing councils that CO-OPs can create are prohibited from using their economic power in price negotiations with medical care providers. In addition, HHS is not allowed to participate in plans' negotiations with providers, set prices for reimbursement of services, or otherwise interfere with competition among health plans. There is also a requirement that "substantially all" of CO-OPs' activities must be in the individual and small group portion of the health insurance market, a provision seemingly intended to discourage their competing in the large employer, Medicare Advantage, or Medicaid managed care markets.[12]

In addition to limiting the ways that CO-OPs might gain competitive advantages against other plans or in negotiating leverage with providers, the ACA also placed other constraints on the new plans. Their nonprofit status will preclude their seeking equity capital if they need additional funds for working capital or expansion, although they will be able to seek charitable contributions and foundation grants. Prohibitions on their being sponsored by a state or local government or of having any governmental representative on their board of directors—provisions added to ensure that they would not morph into a virtual public option—could also limit flexibility and ability to negotiate favorable terms with providers. The required governance by members could limit plans' access to needed insurance expertise to bear on strategic decisions, as could the law's provision that neither the CO-OP or any "related entity" or predecessor organization could have been a health insurer as of July 16, 2009.[13] The law also prohibits using the loan funding for marketing or "propaganda."

Will There Be Applicants for CO-OP Funding?

The ACA creates new market opportunities for health insurance plans.

The ACA's combination of an individual mandate, Medicaid expansions and income-related subsidies is expected to bring almost 13 million more people into the individual and small group markets, and plans (including CO-OPs) can participate in the new insurance exchanges through which some 44 million people will purchase coverage.[14] So, who is likely to apply for loan funding to create a CO-OP?

Provisions of the ACA itself will do much to limit and shape the pool of potential applicants. The requirement that CO-OPs be nonprofit organizations and be concentrated on the individual and small group markets are important limiting factors, as is the provision precluding sponsorship by organizations that were insurance issuers as of July 16, 2009. However, the proposed rules define "insurance issuers" as organizations that are licensed as such by a state. Many other types of potential sponsors have relevant experience or access to potential enrollee populations or provider networks. Examples that were identified (or that identified themselves) in the work of the advisory board include Taft-Hartley multi-employer plans, self-funded employee benefit plans, other types of co-ops (e.g., farm), membership organizations (e.g., labor unions), local or regional employer associations and self-insured medical organizations. In addition, development efforts in several states involve newly created organizations led by health reform activists, who include former government health and insurance officials.

The federal officials who are implementing the program report "substantial" interest in creating CO-OPs, and NASHCO, the newly created trade association, held a conference on July 17–18 in Washington, D.C., that was attended by more than 80 potential applicants or vendors hoping to offer services to CO-OPs. Additional potential sponsors have participated in subsequent conference calls organized by NASHCO, which is led by John Morrison, a former Montana insurance commissioner who chaired the Health Insurance and Managed Care Committee of the National Association of Insurance Commissioners,[15] and who is working to establish a CO-OP in Montana.

Various provisions of the ACA and the proposed rules will winnow and shape the potential pool of applicants. Two of the most important pertain to start-up funding and governance.

The Chicken-Egg Problem of Start-up Costs. Starting a new insurance company is an expensive proposition, and nonprofits do not have access to equity capital. For reasons discussed in the next section, potential sponsors with deep pockets may be deterred by the governance requirements that accompany the program. The number of loan applicants will thus be influenced by the costs an applicant faces in preparing an application for a start-up loan.

What are those costs? The FOA specifies that applications must include a feasibility study, a detailed business plan, a detailed budget with narrative and a timeline for meeting various milestones, including the necessary state regulatory approvals. The FOA also explains what these documents entail. A feasibility study must be supported by an actuarial analysis and is concerned with the likelihood of success. It must describe "the target market, products to be offered, regulatory schemes, market impact, financial solvency, economic viability, State solvency requirements and other regulations and other key factors." It should also include "pro forma financial statements with sensitivity testing for alternative enrollment scenarios." The business plan should describe the management team, target market, competing plans, targeted potential subscribers, the process used for pricing products, contracting strategy, proposed methods for provider payment, and plans for use of integrated care models. Budgetary matters, strategies for obtaining enrollment and plans for becoming operational (financial management system, information technology, staffing plans) must also be included. Clearly, the preparation of an application represents a substantial effort by individuals with high levels of expertise.

Participants in the July NASHCO conference were told by CCIIO's Barbara Smith that funding could not be provided by the CO-OP program to cover the costs of preparing an application. This aroused considerable concern among potential CO-OP sponsors, several of whom stated that they do not have the resources to pay for the feasibility and actuarial studies and business plan development required as the basis for CCIIO's funding decisions. The chicken-egg problem was subsequently addressed in the FOA, which stated that successful applicants could apply up $100,000 of their start-up loan for expenses incurred in preparing the feasibility study and business plan for the application.

Though helpful, this source of funding for the costs of preparing an application presents several challenges for potential plan sponsors. First, the feasibility study and business plan represent only a portion of the likely costs of preparing an application, so applicants will need other sources of financial or in-kind support. Second, to minimize application costs, applicants will have to distinguish between the work required to prepare a strong application and the start-up work that can be undertaken after the loan funding has been obtained. Funding will depend upon the strength of the application, and there is no bright line to indicate what work should be done for the application and what can be done once funding is in hand. Third, the $100,000 provision in the FOA presents the potential CO-OP developer with the practical problem that the funding will be available only months after the expenses need to be incurred and is contingent on a successful application.

Many potential CO-OP sponsors could be stopped by this combination of factors. However, Milliman, a large national employee benefit and actuarial firm, has proposed to NASHCO that, for a fee that would be paid by successful applicants and forgiven for unsuccessful ones, it would provide

CO-OP developers with actuarial and other services needed for the feasibility study and business plan. This path toward putting together the information needed for an application appears to be attractive to many CO-OP developers and will result in a degree of standardization on applications for funding. Even so, the cost and complexity of preparing an application is likely to discourage some potential applicants, particularly those that have little or no knowledge about how to start an insurance company.

The Governance Issue. The legislation and proposed rules require that CO-OP members constitute a majority of a CO-OP's governing board, which would be elected by members. These provisions are central to why CO-OPs are expected to be different from most existing insurers, but they may deter many potential applicants. The proposed rules address a pair of issues raised by these requirements. First, the law was silent on how the fledgling nonprofit would be governed while the CO-OP was being made operational—that is, before it has enrollees. The proposed rules follow the advisory board's suggestion that a "formation" board would govern a CO-OP's planning and developmental phases and would transition into an "operational," member-elected board within a year after the plan begins to accept enrollment. Second, to help ensure that this operational board contains the expertise needed to oversee an insurance plan, the proposed rules allow CO-OPs' boards to include a minority of nonmembers who bring needed expertise (finance, actuarial, quality of care, marketing, or human resources) and to have a nominations committee to identify candidates for election.

Even so, the governance requirements may deter sponsorship by some of the very organizations that might be most likely to succeed—those that have a potential pool of enrollees or a provider network. A labor organization, association of small employers or a self-insured hospital or academic health center might be attracted by the idea of creating a health plan to serve its members or employees, but the rules of the ACA would not allow plans to limit enrollment to sponsors' members or employees, and it will be enrollees (not the sponsor) who elect the governing body. Potential sponsoring organizations may hesitate to invest time and money to create an insurance plan over which they would have little control. In addition, if potential sponsors bear all or most of the cost of the health benefits they provide, they could be uncomfortable with a governance structure in which enrollees make decisions affecting plans' costs.

It remains to be seen whether potential sponsors that have access to members or a provider network will be willing to invest the human and financial capital needed to establish a plan under these conditions. Such potential sponsors might see growth beyond their own members or employees as more of an advantage than disadvantage, given the benefits of large size in spreading fixed costs and in negotiating with providers. There may also be ways that sponsoring organizations could influence both who enrolls (via a marketing strategy) and who is elected to the board (via, for example, a board-controlled nomination process). Thus, the public-good aspect of creating a new health plan may not deter all potential plan sponsors that would have access to a member pool or provider network. Even so, the governance rules are likely to limit the number of such entities as plan sponsors. This could mean that the sponsors of CO-OPs will mostly be individuals and organizations that have a particularly strong interest in creating a real alternative to the dominant insurers in their states. That, of course, is the law's intent.

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Notwithstanding the factors discussed in this section, there are indications that there will be serious applications for the funding to establish CO-OPs. Large numbers were never envisioned; the funding in the legislation was based on an assumption of 51 CO-OPs. Potential sponsors from at least 25 states from all parts of the country have identified themselves in the NASHCO meeting and subsequent conference calls, as well as in conference calls involving HHS officials, and several of them are considering submitting applications for CO-OPs in several states. The fact that many potential applicants have come together under the NASHCO framework to share information and resources is a positive sign, as is the fact that Milliman has offered potential applicants a package of needed services under attractive terms.

Will CO-OPs Succeed?

Cooperatives, though not a new idea, are rare in American health care.[16] Having low capital costs (because of the federal loans), being tax exempt because of nonprofit status and having no need to generate a return that is satisfactory to investors may help CO-OPs become price competitive. So should the integrated care models and innovative payment methods that are envisioned. But sustainable operation requires an insurer be able to spread fixed costs across a large number of enrollees, to manage utilization and to negotiate favorable rates from providers. This requires a combination of size and competence that may take years to achieve.

Many factors will affect the prospects of success for any given CO-OP. Some of these, such as the characteristics of the markets in which they try to develop, the responses of established competitors, and the strength of the management team, are beyond the legal provisions that shape the program. However, those provisions have considerable relevance

for five other challenges that will affect plans' success.

1. Building a provider network and administrative infrastructure needed to operate an insurance company. Whether a CO-OP succeeds and grows will depend upon its having a network of providers from whom enrollees can obtain high-quality services at a cost that permits the plan to price itself competitively without losing money. This means it must be successful in negotiating with service providers. This can be particularly challenging for small plans. Building a provider network physician-by-physician is a difficult and time-consuming process, as are negotiations with hospitals and the various other types of providers. A sophisticated infrastructure is also needed to deal with administrative matters (marketing, network management, health information technology, etc.) and for utilization and cost management.

The simplest path toward successfully addressing these challenges is through relationships with existing organizations. Some sponsoring organizations may already have such relationships, but many CO-OPs will probably initially obtain administrative services from existing third-party administrators and "rent" a provider network from a similar source. The terms, however, are unlikely to give the new plan any competitive cost and service advantages.

2. Building enrollment. A concern for any new health plan is how quickly it can get to the membership size needed to achieve financial and operational stability (25,000 was cited in testimony to the advisory board,[17] but is still small for a risk-bearing insurance organization; larger is better). A minimum market share (at least 5 percent was suggested by a consultant to the Senate staff that worked on the legislation) is also needed in negotiations with providers. The number of potential enrollees who might be attracted to the idea of obtaining health insurance from a member-run cooperative is unknown.

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There will likely be people who like the idea of nonprofit CO-OPs, but there is also evidence that the public tends to associate "nonprofit" with lower quality, notwithstanding research evidence to the contrary.[18]

The most promising path to getting critical numbers of enrollees quickly (and avoiding adverse selection) would involve gaining access to groups that already exist, such as people who are in an existing membership organization (e.g., a labor union), members of a different type of co-op (e.g., farm),[19] employees of members of local or regional employer associations, or a self-insured medical organization. All of these types of entities have expressed interest in establishing a CO-OP,[20] but, as was noted earlier, many may be put off by the governance requirements. The enabling legislation's requirement that "substantially all" of a CO-OP's activities must be in the individual and small group markets could deter getting enrollment in large chunks, but it may still be possible for organizations that have an established patient or membership base to participate in sponsorship of a CO-OP. The advisory board recommended flexibility in how "small group" is defined, and CCIIO in its proposed rules defines "substantially all" to mean that at least "two-thirds of the policies or contracts" must be in the individual or small group markets, so expansion beyond those markets may be possible.

Whether or not a CO-OP has access to an existing potential enrollment base, the best chance for early success in building enrollment is to be an option for enrollees when the insurance exchanges open (no later than January 1, 2014). But plans will actually have to be ready by the open enrollment period that precedes that date—October 2013. Putting the necessary pieces in place and gaining the necessary state approvals to offer health insurance before that date will be difficult. Respondents to HHS's request for comments about the law's provision estimate that this will take sponsors 18 to 24 months. HHS intends to make the first loans in January 2012, which would give plans that can meet the October 17, 2011, application deadline about 20 months before open enrollment. Being open for business for the fall 2013 open enrollment period will clearly be difficult. CCIIO's proposed rules acknowledge this in requiring that a loan recipient be licensed and offering health plans in an exchange within 36 months of beginning to draw down its start-up loan.[21]

3. Overcoming the "marketing" restriction. The law's prohibition on using loans for marketing could make it more difficult to reach potential enrollees and explain the nature of a nonprofit cooperative.[22] Marketing is a necessary and significant expense for health plans—they typically spend more on marketing and sales than on medical management and account administration combined[23]—and it would be particularly important for new entrants into the marketplace. Premium dollars could be used for marketing once plans have enrollees, but a substantial marketing effort may be needed to get those initial enrollees, and it may not be easy to find non-loan funds for this purpose.

The advisory board recommended that HHS define marketing in a way that would permit new plans to get the word out regarding what they are and what they offer. The proposed rules do not mention marketing, but the FOA repeated the legislative prohibition and defined marketing expansively as "activities that promote the purchase of a specific health care plan or explain a product's benefit structure, whether targeted at new or current members."

How the restriction on marketing will be implemented in practice remains to

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be seen, but HHS appears to recognize the need for something that is very much like marketing. The FOA indicated that, in evaluating applications for funding, considerable weight (12 points out of a total of 100) would be given to the description of a plan's enrollment strategy and related matters, and it asked applicants to describe their planned "communications channels to the target membership and key approaches to building awareness and understanding of the CO-OP model." Clearly, the legislative restriction on marketing complicates the path to success for the new plans.

4. The danger of adverse selection. CO-OPs will need to set premiums low enough to attract enrollees but high enough to cover costs. But costs may be high and difficult to predict among initial enrollees in a new health plan in the context of the ACA because some number of previously uninsured people may have a backlog of unmet needs.[24] Even though the uninsured population includes large numbers of the young and healthy, some new enrollees will have been previously denied coverage because of preexisting conditions. The mix of enrollees will be important, and established competitors may be skilled at the marketing methods that can attract the healthiest patients.

The dangers that all plans face in accepting previously uninsured enrollees were recognized in the reinsurance and risk adjustment provisions that are part of the ACA's insurance market reforms and that are designed to protect against very high-cost cases and to shift revenues to plans that experience adverse selection.[25] The CO-OPs may provide one of the key tests of the adequacy of those provisions.[26] NASHCO has begun taking steps to create a captive reinsurance company that would be owned by the insured CO-OPs and that would negotiate favorable terms from the reinsurance giants. This may represent the first example of the "private purchasing council" envisioned by the ACA.

5. Whether member governance works. Will the law's governance requirements yield boards of directors that have the expertise in finance, strategic planning, product development, contracting, accounting and actuarial functions, medical management and so on needed to oversee and operate a health insurance plan? The law requires that a CO-OP's "governing documents" contain provisions "protecting against insurance industry involvement and interference." Simply electing a governing board from among a plan's enrollees seems unlikely to yield a body that is competent to oversee the operation of a health plan.

However, that need not be what happens. The law does not require that the board consist solely of members, and there are ways (several of which were identified by the advisory board) to see that a board contains requisite expertise. For one thing, a founding board will have to exist before the plan actually has members, and this body can be supplemented with plan members after the plan becomes operational and can evolve toward the model envisioned in the law. Beyond this, a nominating committee can work to see that a CO-OP's board contains needed expertise. In addition, there are ways other than via board membership for boards to gain access to needed expertise.

Will CO-OPs Transform the Health Insurance Market?

A wide variety of organizations have expressed interest in applying for start-up funding for establishing CO-OPs, and HHS's funding opportunity announcement states that 51 applications are expected. Two months before applications are due, prospective applicants from only about half of the states have made themselves known, and many of these will not be statewide, at least initially. Moreover, given all of the risks and uncertainties of establishing new nonprofit insurance plans where well-entrenched competitors already exist, it is likely that not all the entities that receive loan funds will succeed.

But there is a larger question of what success will mean. The basic point of the ACA's provisions regarding CO-OPs, as a substitute for the public option, was to create alternatives to the existing health insurance industry, and the advisory board's guidance and HHS's proposed rules push further in that direction. The fact that CO-OPs are to be nonprofit and consumer governed will certainly make them unusual. Proposed regulatory provisions are aimed at precluding the sorts of sales to for-profit organizations that transformed the managed care industry in the 1980s. Even so, questions remain about CO-OPs' transformative potential.

If largely limited to the individual and small group markets, can CO-OPs achieve the economies of scale and negotiating power with providers needed to compete on price and be able to grow? The health insurance industry has become highly consolidated because of various economies of scale.[27] Marketing costs are high in trying to reach these markets (and the enabling legislation prohibits use of loan funds for marketing), and achieving enrollment growth when members are added only one or a few at a time will be difficult.

Several provisions of the proposed rules may help CO-OPs with this problem. First, they permit CO-OPs to partner and share services (and provider networks) with other (larger) organizations (the law's restrictions on relationships with existing insurers could have been a barrier). Various ways to share services among CO-OPs are under discussion. Second, as previously noted, HHS proposes to interpret the "substantially all" requirement to mean that some enrollment can come from markets other than individual and small group. So growth may not be as constrained as might first appear.

Finally, will CO-OPs succeed in providing a true alternative model?[28] When a new health plan goes operational, it must have the infrastructure needed for handing the complex range of administrative functions (enrollment, network management, complaint resolution, claims payment, etc.) involved in running a plan, as well as a provider network to serve the enrollees. Given the time constraints, CO-OPs may need to contract with an existing administrative services organizations and "rent" provider networks from existing insurers or third-party administrators. This is not how one would go about creating a true alternative insurance model, which would presumably involve a different organizational structure for providers (perhaps encompassing both physicians and hospitals) and the use of payment methods other than fee for service. A reasonable hope and expectation is that an alternative health insurance model represents the direction toward which CO-OPs will evolve over the years, not something with which they will generally begin. CO-OPs may become important insurance options in some markets, but it is difficult to foresee their having the overall transformative effect that was expected of the public option.

Notes

1 *Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program* (April 15, 2011). Available at http://cciio.cms.gov/resources/files/coop_faca_finalreport_04152011.pdf.

2 The proposed rules, issued on July 18, 2011, are at http://www.ofr.gov/OFRUpload/OFRData/2011-18342_PI.pdf. The Funding Opportunity Announcement was released on July 28, 2011, and can be seen at http://www.grants.gov/search/announce.do;jsessionid=50hfTyGfpP1XMP15DMlp4y3n1ZzjjVt511YHHPGFvtGH2yp4mkz3!683721135.

3 Bradford H. Gray, "The Rise and Fall of HMOs: A Chapter in U.S. Health Policy History," in *History and Health Policy in the United States,* ed. Rosemary Stevens, Charles Rosenberg, and Lawton R. Burns (New Brunswick, NJ: Rutgers University Press, 2006).

4 These terms all come from the CO-OP legislation (Section 1322 of the Patient Protection and Affordable Care Act, Public Law 112-10) or from the proposed rule for implementing the CO-OP program.

5 See acknowledgments.

6 The Internal Revenue Service issued a request for comments regarding requirements for tax exemptions under Sec. 501(c)(29) in March 2011.

7 This language comes from the proposed rule.

8 The $10 million figure is from a brief undated background document entitled "Seed Funding" that was prepared by John Bertko, then of the Brookings Institution, for Senate staffers working on the legislation.

9 Providing grants was deemed not financially feasible when the legislation reached the Senate floor. Repayment provisions were added, but the terminology was not changed.

10 From the "Seed Money" document. See note 8.

11 The law uses the term "profits" to refer to surpluses of revenues over expenses, even though the CO-OPs are to be nonprofit organizations.

12 A congressional staffer who helped draft the legislative language indicated in an interview that the intent had been that the federal seed money would be used to enter the individual and small employer markets, not to preclude the organizations from growing into other markets.

13 This provision was intended to prevent existing insurance companies from establishing CO-OPs, reflecting the sponsors' intent to create real alternative insurance issuers.

14 Matthew Buettgens, Bowen Garrett, and John Holahan, *America under the Affordable Care Act* (Washington, DC: Urban Institute, 2010). Calculated from figures on page 8.

15 CCIO Director Steve Larsen, HHS Director of State Health Insurance Exchange Development Joel Ario, and HHS Secretary Kathleen Sebelius are also former chairpersons of the National Association of Insurance Commissioners' Health Insurance and Managed Care Committee.

16 A 2010 scan conducted under the auspices of the International Health Co-Operative Organisation identified only 13 examples, and only two (Group Health Cooperative of Puget Sound and HealthPartners in Minnesota) were consumer operated and statewide. Some, such as Cooperative Home Care Associates in the Bronx, are worker owned and/or provide only one specialized service. Other examples include Group Health Cooperative of South Central Wisconsin, Group Health Cooperative of Eau Claire, and Colorado Choice Health Plans. The report, entitled *Heath Co-Ops Around the World,* is at http://www.ica.coop/ihco/documents/usa.pdf.

17 John Bertko, testimony before the Consumer Operated and Oriented Health Plans advisory board, January 13, 2011.

18 Mark Schlesinger, Shannon Mitchell, and Bradford H. Gray, "Restoring Public Legitimacy to the Nonprofit Sector: A Survey Experiment Using Descriptions of Nonprofit Ownership," *Nonprofit and Voluntary Sector Quarterly* 33 (December 2004): 673–710.

19 A precedent is the Farmers' Health Cooperative of Wisconsin, which was formed after 2003 enabling legislation and serves as an insurance purchasing pool for farmers.

20 See testimony and letters to the advisory board on the Consumer Operated and Oriented Plan Program at http://cciio.cms.gov/resources/co_op/index.html#coopp.

21 Proposed rule for the CO-OP program, page 29.

22 A congressional staffer who was involved in negotiations over the CO-OP provisions of the ACA explained this prohibition as standard in programs that provide federal support and expressed the view that CO-OPs would be able to obtain funds for marketing from other sources.

23 American Academy of Actuaries and the Society of Actuaries, *Federal Health Care Reform 2009: Start-Up Capital Costs for Health Care CO-OPs and a Public Plan,* Technical Report (October 23, 2009), p. 8.

24 Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2004).

25 Patient Protection and Affordable Care Act/Title I/Subtitle D/Part V. Proposed rules were published July 11, 2011. Available at http://www.ofr.gov/OFRUpload/OFRData/2011-17609_PI.pdf.

26 For an example of how this might work, see Randall R. Bovbjerg, Lisa Clemans-Cope, Paul Masi, and A. Bowen Garrett, *Reinsurance in Washington State,* Report to the Washington Office of Financial Management and Office of the Insurance Commissioner, February 2008, available at http://www.urban.org/url.cfm?ID=411662.

27 James C. Robinson, "The Future of Managed Care Organizations," *Health Affairs* 18 (1999): 7–24.

28 I am indebted to Allen Feezor for this point, though he is not responsible for my formulation.

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