VIEWS FROM THE FIELD
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Nonprofit Competition in the Health Insurance Exchange: Consumer Operated and Oriented Plans

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When the Affordable Care Act (ACA) was passed, Section 1332 established the Consumer Operated and Oriented Plan (CO-OP) program, which offers a consumer-friendly, high-quality nonprofit competitor to provide affordable insurance products to the small employers and individuals that will be served by the health insurance exchanges. The CO-OP provision was a political compromise, developed as an alternative to the more controversial public option.

Historically, the establishment of a new insurer has been impeded by the difficulty of obtaining start-up capital and meeting reserve requirements. The ACA overcame this barrier to entry by providing low-interest loans to fund CO-OP start-up costs and the even bigger financial hurdle of establishing the insurance reserves required for licensure.

KEY CO-OP FEATURES

CO-OPs are consumer-governed. A majority of the members of the board of directors must be drawn from the customers who purchase the CO-OP's insurance. CO-OPs must remain not-for-profit and cannot be sold to for-profit entities. Any "profits" made by the CO-OP must be returned to the members in the form of lower premiums, improved benefits, or quality enhancement. To ensure more competition in the health insurance exchanges, at least two-thirds of the contracts written by a CO-OP must be offered in the individual and small group markets. They are not prohibited, however, from competing in the large group market. CO-OPs are expected to have a strong consumer focus and to offer innovative delivery and payment models that promote integrated, coordinated, quality affordable health care.

CO-OP FUNDING AND LOCATIONS

In order to qualify for federal loans, CO-OPs must complete a lengthy application and extensive feasibility study, which is then reviewed by the Centers for Medicare and Medicaid Services (CMS). Once approved, they are required to meet regular benchmarks monitored by CMS, designed to make sure they fulfill the goals of the CO-OP program and are capable of meeting their loan repayment obligations. CO-OPs have up to five years to repay start-up loans and 15 years for solvency loan repayment.

Congress originally allocated $6 billion to fund the CO-OP program. In 2011 that amount was reduced to $3.4 billion as part of budget deficit legislation (Gardiner et al. 2012). In a last minute twist that went largely unreported in the press, the most recent fiscal cliff legislation zeroed out all remaining CO-OP dollars, illustrating that ACA funding continues to be vulnerable in an era of deficit reduction. At least 40 applications were pending at the time of the fiscal cliff deal, and, as of now, have no chance of being funded.

By the end of 2012, 24 CO-OPS had been approved by CMS and just under $2 billion had been awarded. These CO-OPs, listed below, will be moving forward.

Region	States
West	Arizona, Colorado, Montana, Nevada, New Mexico, Oregon (2), Utah
Midwest	Illinois, Iowa/Nebraska, Michigan, Ohio, Wisconsin
South	Kentucky, Louisiana, South Carolina, Tennessee
East	Connecticut, Maine, Maryland, Massachusetts, New Jersey, New York,Vermont

Source: NASHCO 2013

Some CO-OPs serve a specific region while others are statewide. They can be found in urban, suburban, and rural settings. There is significant diversity among the sponsoring organizations, from coalitions of businesses and community leaders, to physician organizations or hospital systems, to

unions and community organizations. A complete list of CO-OPs can be found on the Web site of the National Alliance of State Health Cooperatives, the member organization formed to provide support to the health CO-OP movement.

CONNECTICUT

Universal Health Care Foundation of Connecticut (UHCF) began exploring the CO-OP option after legislation to implement SustiNet, the public option the foundation had supported, died in the 2011 legislative session. In the late summer of 2011, the Connecticut State Medical Society and the Connecticut State Medical Society Independent Practice Association approached UHCF, seeking funding for their joint development of a CO-OP application. UHCF approved a $50,000 grant to the Connecticut State Medical Society Physician Health and Education Fund to support research on benefit design and the information systems needed to measure, promote, and report on clinical quality and performance. UHCF felt strongly that introducing a new nonprofit, consumer-governed, innovative alternative into Connecticut's highly consolidated, for-profit, very traditional health insurance market would have a major impact on health reform in the state. In June 2012 CMS awarded $75.8 million to Connecticut's CO-OP, HealthyCT. Once licensed, HealthyCT will be the first new entrant to the state's insurance market since the mid-1980s.

HealthyCT has chosen to focus on implementing new delivery and payment models. It is using some of its loan funds to provide consultation and support to primary care practices throughout the state to achieve patient-centered medical home (PCMH) recognition, an area of health system transformation where Connecticut has lagged behind neighboring states. By the end of the year, this support will have doubled the number of PCMH-recognized practices in the state.

COLORADO AND MAINE

Other foundations also chose to provide planning support for CO-OP development, including The Colorado Health Foundation, which provided a $71,000 grant to the Rocky Mountain Farmers Union Educational and Charitable Foundation to support the feasibility study required of all CO-OP applicants. The Colorado Health Insurance Cooperative was awarded $69.3 million in late July 2012 (NASHCO 2013). The Maine Health Access Foundation awarded $200,000 to the Maine Primary Care Association over two years to help with the development of a CO-OP. The grant was used to build a benefit design that would meet the needs of prospective enrollees and focus on reducing costs and improving health outcomes. Maine Community Health Options (MCHO) was awarded $62.1 million in March 2012 (MeHAF 2013).

CHALLENGES AND OPPORTUNITIES

There are many challenges for new CO-OPs. They are new entrants in a marketplace where competitors are well-established and well-capitalized. In a short period of time, they must build provider networks, develop the infrastructure and information technology (IT) resources needed to pay claims and enroll and track membership, and manage the consumer governance structure required of CO-OPs. In order to succeed, they must become licensed and ready to offer insurance products on the insurance exchanges by October 1, 2013.

At the same time, CO-OPs have the advantage of not being wedded to old ways of doing business. They are coming out of the gate ready to operate in a world where the incentives are rapidly changing from volume of care to value of care. They are being built on partnerships between community leaders and providers and are focused on consumer engagement, keeping health care affordable, and improving individual and population health outcomes. CO-OPs are not saddled with legacy IT systems. They can start up with systems that support innovative and integrated payment and delivery models and provide the information needed to help providers improve performance and consumers to better manage their health conditions.

FUTURE FUNDING OPPORTUNITIES

One of the most significant challenges faced by CO-OPs is that they are banned from using federal loan funds for marketing. In response, the Maine Health Access Foundation has awarded a one-year grant of $300,000 to MCHO to support community outreach, public education, and marketing (MeHAF 2013). Another opportunity is for national and state-based funders to support a coordinated national public information campaign from which all CO-OPs could benefit. A national campaign could be used by all CO-OPs, who could then add local, tailored messaging that is state-specific.

Funders considering funding CO-OPs should understand that while they are not-for-profit entities, they are not 501(c)3s, but have a special designation: 501(c)29. This designation was created exclusively for these newly created health insurance CO-OPs, even though many existing nonprofit insurers have a 501(c)3 designation. Those funders that are generally restricted to donating only to 501(c)3 organizations may wish to identify a 501(c)3 fiscal intermediary or exercise expenditure responsibility.

While the CO-OP program is a very small part of the ACA, it has the potential to have major impact on health reform in the states and markets where they compete. If CO-OPs can gather a critical mass of members in the first two years of the operation of the health insurance exchanges, they have the structure and nimbleness to become market leaders in delivery and payment transformation. Philanthropic investment at this crucial time to ensure the success of CO-OPs could make all the difference in moving the needle on health reform for all of us.

SOURCES

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National Alliance of State Health Cooperatives (NASHCO), "CO-OP Awards Fact Sheet," <http://www.nashco.coop/documents/coop_awards_fact_sheet.pdf>, accessed 2013.

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