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Co-Ops Remain Available in Health Insurance Marketplace Despite Low Enrollment

The first installment of this four-part series on Health Insurance Exchanges highlighted the issues beneficiaries and insurers faced in the Marketplace during the 2014 enrollment period. This second installment will address the *Consumer Operated and Orientated Plans* (CO-OPs) that are operating within the Marketplace, as well as the benefits and drawbacks of offering these plans to beneficiaries.

Healthcare cooperatives, also known as co-ops, which are governed by members and provide these members with an economic benefit, have been present in the healthcare industry since at least the *Great Depression*.[1] Between the 1930s and 2010, the popularity of cooperatives in the healthcare industry decreased, as many of these organizations failed due to difficulties in attracting beneficiaries.[2] However, during the drafting of the *Patient Protection and Affordable Care Act* (ACA), cooperatives reemerged. Originally, policymakers discussed creating a public insurance option, similar to Medicare, to provide to beneficiaries.[3] This idea was rejected, however, as many policymakers believed that a public insurance option would steer the insurance industry toward a single-payor system.[4] The rejection of this proposal led to the creation of the *Consumer Operated and Oriented Plan (CO-OP) Program*.

CO-OPs, which are customer-directed, non-profit organizations designed to offer quality health insurance at a reasonable cost, both within, as well as outside, the Marketplace,[5] were likely approved to be part of the ACA due to their ability to offer consumer-directed insurance, while increasing competition with other insurers.[6] The provision establishing the CO-OP Program allowed for the creation of a federal fund that would be distributed by the *Centers for Medicare and Medicaid Services* (CMS) to support organizations interested in becoming CO-OPs.[7]

CO-OPs intend to offer additional insurance plans to individuals and companies with fewer than 100 full-time employees, both of which are markets that have limited coverage options in some states.[8] In order for organizations to qualify as CO-OPs, they must adhere to the same federal and state regulations as private insurers.[9] However, CO-OPs must also: (1) be consumer-focused and ruled by their members; (2) repay CMS for any start-up loans within five years of receiving funding; (3) be considered non-profit organizations; and, (4) offer at least two-thirds of their plans through the Marketplace.[10] Additionally, CO-OPs are prohibited from having any representative of an insurance organization or a government agency on their board of directors.[11]

In 2011, the *Center for Consumer Information and Insurance Oversight* (CCIO) of CMS took the first steps in implementing CO-OPs by inviting interested parties to apply for federal funding.[12] CMS hired Deloitte, an international consulting firm,[13] to review these applications for participation.[14] Milliman, an international firm providing actuarial service,[15] also reported on the applications.[16] Deloitte and Milliman analyzed various aspects of the business plans of the prospective CO-OPs, particularly the qualifications of the management team; the strategies for repaying federal loans; and, the "*financial feasibility*" of participation.[17] After the applications were processed, the CO-OPs were interviewed by CMS, which then provided the final decision regarding the selection of participants for the program and the amount of funding each CO-OP would receive.[18] Under the ACA, CMS was required to provide start-up loans to one CO-OP in each state.[19] However, due to a reduced budget, CMS ceased distributing start-up funds after providing financial support to the first 24 CO-OPs, which totaled more than $2.1 billion.[20]

Although 24 CO-OPs were initially approved to participate in the CO-OP Program, only 23 CO-OPs were available when the Marketplace opened on October 21, 2013.[21] Vermont Healthcare CO-OP was prevented from operating,[22] because it failed to meet the basic licensing requirements as set forth by the Vermont Department of Financial Regulation.[23] During the 2014 enrollment period, the 23 CO-OPs offering plans enrolled approximately 451,000 of the 8 million Americans who purchased insurance through the Marketplace, falling short of Deloitte's projected enrollment of 575,000 CO-OP beneficiaries.[24]

Since the inception of the CO-OP Program in 2013, various issues have arisen, suggesting that CO-OPs may not be sustainable. Of the 23 CO-OPs, only nine enrolled more beneficiaries than Deloitte projected.[25] Because CO-OPs are start-up organizations, their success relies heavily on the number of beneficiaries

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enrolled. If these organizations do not meet their enrollment goals, these CO-OPs will likely not be able to generate enough revenue to repay their start-up loans to CMS, potentially jeopardizing their status as insurance providers.[26]

The lack of enrollment experienced by the majority of CO-OPs may have been a result of internal flaws, i.e., improper decisions made by oversight committees due to a lack of experience as insurers,[27] and external flaws, i.e., technical issues and regulatory restrictions.[28] During the first year of open enrollment, which was also the first year of CO-OP operation,[29] the federal Health Insurance Marketplace website, HealthCare.gov, experienced an array of technical problems when beneficiaries attempted to enroll, which affected both commercial insurers and CO-OPs.[30] The reverberations of these technical issues were more acutely felt by CO-OPs, because they did not have the ability to rely on the revenue generated from previous beneficiaries, as did commercial insurers.[31]

Another issue potentially affecting the number of enrollees purchasing CO-OP plans was the restriction from using federal funds for marketing purposes, as established by the ACA.[32] CO-OPs were unable to use money from their start-up loans to promote their plans, and were forced to utilize grassroots funds to encourage beneficiaries to purchase their coverage options, rendering it difficult to reach a large market.[33]

CO-OPs also struggled to set the price of their plans at rates that were competitive with established commercial insurers participating in the exchanges.[34] As organizations without previous experience in the insurance industry, some CO-OPs may have priced their plans too high, which discouraged consumers from purchasing their plans, or too low, which may have prevented these CO-OPs from obtaining sufficient funding to cover unexpected medical costs.[35] Of the 14 CO-OPs that were unable to meet their target enrollment in 2014, 13 missed the target enrollment by 50% or more, suggesting that pricing may have been an issue in over half of the functioning organizations.[36]

The nine CO-OPs that were successful in 2014 have shed some light on the positive aspects of these organizations, which can be useful for CO-OPs that fell short of enrollment projections; organizations considering participating in the Marketplace as CO-OPs; or, beneficiaries considering purchasing plans through CO-OPs. These CO-OPs have "*emerged as price leaders, offering 37% of lowest-price products*" in the states where CO-OPs are operating.[37] CO-OP executives believe that these low premiums, in conjunction with uncomplicated structures and new benefit designs, e.g., free generic drugs and office visits,[38] have attracted enrollees.[39] Other strengths of CO-OPs include being "*member-centric*"; allowing beneficiaries to have a voice in the decision-making and policy-setting processes; focusing on preventative medicine and care coordination; and, reimbursing providers through models other than the traditional fee-for-service model.[40] Finally, as non-profit organizations, CO-OPs often allocate their generated profits toward offering better benefits; improving the quality of care provided; and, decreasing beneficiary premiums.[41]

Despite low enrollment during 2014, executives of CO-OP oversight committees maintain a positive outlook on the future of these organizations. These executives have reported that their CO-OPs will continue operating and believe they will be in a position to fully repay their start-up loans within the five-year loan-repayment period.[42] Oversight committee members are looking to their successes and failures during the 2014 enrollment period in order to improve operations in the coming years.[43] Many executives plan to reduce premiums and offer insurance plans outside of the current individual and small business exchanges, in an effort to increase enrollment.[44]

The final two installments of this series will highlight the benefits and drawbacks of the health insurance exchange from the viewpoint of providers and the healthcare organizations with which they are employed.

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