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CO-OP Health Insurance Program: October 2013 Implementation

As part of the Affordable Care Act (ACA) of 2010, individuals who are without health coverage through an employer, Medicaid, or the Children's Health Insurance Program, may purchase coverage through Health Insurance Exchanges (Exchanges) beginning on October 1, 2013. For more information regarding Exchanges, refer to "Individual Insurance Under Helathcare Reform: A Boon for Policy Holders," published in the July 2012 edition of Health Capital Topics, "HHS Releases Final Rule on State Health Insurance Exchanges," published in the April 2012 edition of Health Capital Topics, "Proposed Rule on State Exchanges Released," published in the July 2011 edition of Health Capital Topics, or "American Health Benefits Exchanges", published in the November 2010 edition of Health Capital Topics.[1] To increase competition among available insurance plans, as well as consumer choices among healthcare insurance providers, the ACA Section 1322 designates loan funding monies for sponsors, e.g., nonprofit organizations, consumer-run groups, membership associations, to create Consumer Operated and Oriented Plan (CO-OP) programs.[2] CO-OP loans were created in lieu of a public health insurance option, the latter eschewed by lawmakers due to concerns regarding its potential to "…*undercut the private health insurance industry and lead to a 'single payer' national health insurance system*."[3]

CO-OPs, organizations that are owned by, and provide economic benefit to, their members, have been utilized in various industries nationwide, including agriculture, finance, and utility services. Healthcare CO-OPs date back to the Depression era, some of which have continued and flourished into high performing health systems in today's market, e.g., Group Health and HealthPartners.[4] The CO-OPs established with the assistance of ACA funds are obligated to abide by the same state and federal requirements as private health insurance companies, and must offer at least two-thirds of their coverage in the small-group and individual markets.[5] In addition, to qualify for federal loans, a CO-OP must be nonprofit; utilize all surplus revenues to improve benefits and quality of care for its members; and, sponsors must provide at least 40 percent of CO-OP funding.[6] The Centers for Medicare and Medicaid (CMS) will closely monitor CO-OPs via stringent reporting requirements and audits,[7] and approved programs will be subject to strict developmental milestones as well as "…*extensive provisions to protect against fraud, waste, and abuse*".[8]

Despite federal funding, CO-OPs will face significant challenges. The original ACA legislation "…*ensure[s] that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State*…",[9] which totaled nearly $2 billion for CO-OPs in 24 states as of February 2012.[10] This same goal was echoed in the December 13, 2011 "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program" with the purpose of expanding consumer options and enhancing insurance plan accountability.[11] However, as of January 1, 2013, new congressional legislation rescinded all but 10 percent of unobligated CO-OP federal funding, leaving approximately $200 million to support the implementation and maintenance of all 24 existing and planned CO-OPs, thereby forestalling the creation of any additional organizations.[12] Significantly, it should be noted that the federal funds designated for CO-OPs are limited to use in defraying start-up costs and meeting state solvency requirements, leaving the costs of marketing, promotion, clinical services, equipment, medical claim coverage, essential personnel, and loan repayment to depend largely on membership premiums and alternative funds.[13] Given the current fiscal environment, despite the initial intent of, and support behind, CO-OP implementation, these organizations may face significant challenges to remain self-sustaining in providing integrated and innovative care delivery models with high efficiency and quality of care.

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1 "American Health Benefits Exchanges", Health Capital Topics, Vol. 3, Issue 11, November 2010

2 Section 1322 of the Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), STAT 187-188; "Health Policy Brief: The CO-OP Health Insurance Program", by Julia James, Health Affairs and the Robert Wood Johnson Foundation, February 28, 2013, p. 1.

3 *Ibid*, p. 2.

4 *Ibid*.

5 *Ibid*.

6 *Ibid*, p. 3.

7 "New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers", The Center for Consumer Information & Insurance Oversight, February 21, 2012, http://cciio.cms.gov/archive/grants/new-loan-program.html (Accessed March 10, 2013)

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8 Federal Register, Vol. 76, No. 239, December 113, 2011, p. 77392

9 Section 1322 of the Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), STAT 187-188

10 *Ibid*, The Center for Consumer Information & Insurance Oversight, February 21, 2012.

11 "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program," Federal Register, Vol. 76, No. 239, December 113, 2011, p. 77392

12 Section 644 of the American Taxpayer Relief Act of 2012, Public Law 112-240 (January 1, 2013), STAT 2362

13 *Ibid*, James, February 28, 2013, p. 4.

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