Health insurance CO-OPs:

Challenges and opportunities

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The federal government pledged $3.8 billion[1] (originally $6 billion) in grants and loans in the Patient Protection and Affordable Care Act (PPACA)[2] to assist in the establishment of nonprofit, member-run health insurance issuers or Consumer Operated and Oriented Plans (CO-OPs). The CO-OPs will compete directly with insurers selling products inside exchanges. Most of the insurance industry probably only briefly read this section and assumed there was a low probability of any CO-OPs actually emerging. As the implementation of exchanges gets closer and becomes a reality, CO-OPs may have a role in changing the health insurance paradigm.

This briefing paper provides background on CO-OPs, reviews activity since the enactment of the PPACA, and identifies challenges and opportunities for potential CO-OPs.

BACKGROUND

The grants and loans provisions in the PPACA are intended to assist CO-OPs with start-up costs and meeting state solvency requirements. The grants assist CO-OPs with state solvency/reserve requirements to be repaid in 15 years while the loans assist with start-up costs to be repaid in five years.

Grants and loans are to be awarded no later than July 1, 2013. The PPACA restricts the grants and loans from influencing legislation or intervening in political campaigns (IRS 501c29) while net earnings must be used to improve quality, reduce premiums, or improve benefits to members.

The PPACA wanted to fund at least one CO-OP in each state; priority would be given to those organizations that provided statewide coverage, primarily in the individual and small group markets.

A key provision of the PPACA enables CO-OPs to create purchasing arrangements to achieve economies of scale for claims, administration, technology, and actuarial services.

RECENT ACTIVITY

The PPACA required the Comptroller General to appoint a 15-member advisory board. This was done on June 23, 2010. The advisory board met for the final time on April 15, 2011, and voted on the final report, which provides the operational framework for the program[3].

With the grants and loans available on July 1, 2013, there is significant work ahead, such as organizing the CO-OP, market and operational assessments, financial feasibility studies, provider network discussions, and more, before applying.

THE LANDSCAPE

The most likely candidates to create a CO-OP are as follows:

- Accountable care organizations
- Integrated delivery systems
- Chambers of Commerce
- Associations

Hospital and physician groups appear best situated to create CO-OPs because they hold the key to creating a competitive product. One of the criteria for governmental approval is use of an integrated care model, which is easier for provider groups to achieve. For the other entities listed above, the more stakeholders that are involved the more likely the various missions and priorities of these stakeholders would diverge and make it difficult to create a single focus for a CO-OP. While these other entities already have a governance structure in place, they would still have to create or rent a network of providers, adding another layer of complexity and time to the CO-OP development.

1 H.R. 1473, Section 1857 (April 11, 2011)
2 Section 1322 of the PPACA
3 Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program (April 15, 2011)

CHALLENGES

The first step and challenge in developing a CO-OP will be identifying the senior management team. The team should include individuals with nonprofit, insurance, and governmental backgrounds. The management team will need to find the right balance between the nonprofit mission, maintaining sound insurance principles, and establishing appropriate levels of surplus/reserves to be in a position to repay the grants and loans. Management may get pressure from members and/or the government regarding the need to use profits for lowering premium, increasing benefits, or for improving quality instead of building surplus/reserves.

The management team will also need to educate providers and members so that each entity understands how its actions (or inactions) directly impact the financial situation of the CO-OP and, ultimately, the premium rates.

As with any start-up health insurance operation, CO-OPs will most likely start with small enrollment; however, costly administrative systems and technology need to be in place from the beginning. Marketing will also be needed to educate the public about the CO-OP. Government money cannot be used for marketing, so funds over and above the government grants and loans will be needed and put up at the risk of CO-OP failure.

Finally, the CO-OPs will not have any claim or other data to establish the initial premium rates. Actuarial models will be critical to assessing the risks in the individual and small group markets.

OPPORTUNITIES

Exchanges will reduce private pay and uncompensated care for providers because these types of patients will now be covered by insurers operating within them. Depending on the market dynamics and possible shifts in payor mix, providers could lose market share depending on the network used by an insurer.

Providers associated with a hospital- and/or physician-sponsored CO-OP could set their reimbursement rates at competitive levels, similar to the largest payors. Assuming they can establish competitive administrative cost ratios, CO-OPs could produce competitive products and the sponsoring providers could maintain or even increase their market share.

Purchasing arrangements among noncompeting CO-OPs could help to create economies of scale that would accelerate the premium competitiveness and position the CO-OPs on a similar playing field as the market leaders.

Net earnings have to be reinvested in the covered members, so provider-owned CO-OPs can promote initiatives that improve quality and ultimately reduce costs. These initiatives are directed towards moderating cost trends and keeping premiums competitive while still maintaining margins to support surplus/reserve requirements and the ability to repay the grants and loans.

SUMMARY

Historically, there has been no easy path to establishing a nonprofit health insurer. Establishing a CO-OP includes the added complexity of requiring some member involvement with the government, which is providing the largest source of capital. At the same time, these challenges provide an opportunity to change the relationship between the providers and the insurer while they all work toward a common goal of improving the access, affordability, delivery, and efficiency of healthcare.

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