CO-OPS: A LITTLE KNOWN PROVISION OF THE HEALTH REFORM LAW

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Section 1322 of the Patient Protection and Affordable Care Act ("PPACA") has been a "sleeper" in the news, overshadowed by other provisions, but could have a real impact on the market for health insurance. Section 1322, which creates the "Consumer Operated and Oriented Plan Program" or "CO-OP Program," requires the federal government to provide start-up funding for "non-profit, member-run health insurance issuers."

This article outlines Section 1322 in detail, discusses the recommendations of the CO-OP Advisory Board, considers ways in which CO-OPs might intersect with other areas of health reform, and outlines open issues.

Background

The CO-OP Program is intended to create not-for-profit member-run cooperative health insurers in each state. The goals of the CO-OP Program are to provide more consumer choice, greater control, and greater plan accountability, as well as promote better models of care. Although not an entirely new concept (not-for-profit member controlled health plans exist in a few states), if successful, this program will give residents of each state a not-for-profit, member-controlled insurance option.

To foster the creation of CO-OPs, PPACA set aside $6 billion in loans to assist with start-up costs and grants to assist in meeting state solvency requirements.[1] Loans must be repaid within five years and grants must be repaid within 15 years, taking into account state solvency requirements.[2] In April 2011, as part of the budget deal, the funding was reduced to 3.8 billion.[3] According to PPACA, these remaining funds must be spent by July 1, 2013.[4] The Centers for Medicare & Medicaid Services ("CMS") is urging loan recipients to have the CO-OPs in place by October 2013 so they can provide coverage to members enrolled through state health exchanges by January 1, 2014.

To advise on the awarding of loans and grants under the CO-OP Program, the statute created a 15-member CO-OP Program Advisory Board (the "Advisory Board" or "Board"). The Board was appointed on June 23, 2010 by the Department of Health and Human Services ("HHS") Comptroller General and promptly began meeting to outline recommendations to implement the CO-OP Program. The fifteen Board members have varied backgrounds, including state health and insurance departments, health policy specialists, actuaries, physicians, small businesses, cooperatives and consumers. The Board was divided into four subcommittees: i) Governance, ii) Finance, iii) Infrastructure and iv) Process, Criteria and Compliance. Each subcommittee made detailed recommendations for regulations in its designated area.

The Board presented its final recommendations to the Secretary of HHS on April 15, 2011 and these recommendations were used to inform the rulemaking process.[5] The Proposed Rule was published in the Federal Register on July 20th, 2011 and comments were due by September 16th.[6]

Providers, business associations and even employer organizations should be following this activity closely and evaluating whether supporting the start of a CO-OP in their market is in their best interests. As healthcare reform is implemented, many providers are interested in opportunities to participate in healthcare as a payer. This may be the logical next step as payment structures move toward bundled payments or quality-based payments because providers seek to have input on or control over the design of these new payment models.

For employers, in 2014 PPACA will require large and mid-sized companies to make payments to the federal government if they do not offer health insurance to their employees and dependents.[7] For small employers, Small Business Health Options Programs, or "SHOP Exchanges," allow small businesses to pool together to buy insurance.[8] Accordingly, across the spectrum of employers, there is interest in creating or promoting competition in the health insurance market to ensure real choice among insurance options and competitive premiums.

The funding opportunity was announced the last week in July and HHS will begin accepting loan applications on October 17, 2011 and quarterly after that until December 31, 2012.[9] Because these loan applications require detailed business plans and feasibility studies and also because HHS will not loan funds to more than one applicant for any service area, those interested in starting a CO-OP need to respond promptly.

Framework of the CO-OP Program

Provisions of the Law

Section 1322 establishes a program for granting loans for planning and start-up costs and grants for meeting solvency requirements to applicants applying to become "qualified non-profit health insurance issuers."[10] The Proposed Rule anticipates that $600 million would be

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used for five-year startup loans and $3.2 billion for 15-year solvency loans.[11] For the reasons set forth below, most CO-OPs will be new entities, or at least new entities to the insurance industry.

First, to be considered a qualified non-profit health insurance issuer, an organization must meet statutory requirements for its ownership, governance, distribution of profits and health insurance products offered. Section 1322 requires that a CO-OP:

- be a non-profit member corporation;[12]
- be governed by a majority vote of its members;[13]
- operate with a strong consumer focus;[14] and
- require all profits be used to lower premiums, improve benefits or improve quality of care.[15]

In addition, the CO-OP's governing documents must incorporate ethics and conflict of interests standards and protect against "insurance industry involvement and interference."[16]

This prohibition against insurance industry interference is reinforced by a requirement that the CO-OP *not* have been a health insurer as of July 16, 2009. The proposed rules says that prohibited "pre-existing issuers" include organizations that share common ownership or control with a pre-existing issuer or trade associations whose members are pre-existing issuers if either retains responsibility for, or provides services on behalf of the issuer.[17] Further, a CO-OP cannot be sponsored by any state or local government,[18] and no member of the CO-OP's board can be a representative of government *or* a health insurer.[19]

PPACA imposes restrictions on the CO-OP's business activities. The CO-OP is required to conduct "substantially all" of its activities in the individual and small group markets.[20] It must coordinate with state insurance reforms and offer products in the health insurance exchange in each state in which it operates.[21] Further, CO-OPs are not exempt from state licensure requirements[22] or antitrust laws.[23] In addition to the requirements for recognition as a CO-OP, the law requires the Secretary of HHS ("Secretary") to give priority in awarding loans and grants to those applicants offering state-wide plans, using integrated care models and showing significant private support.[24]

HHS has a limited role reviewing applications for CO-OP funding and verifying continued compliance with CO-OP Program requirements during the term of the loan. However, the law restricts HHS involvement in negotiations between CO-OPs and providers or in setting provider payment rates.[25] Section 1322 imposes an accelerated repayment obligation with interest on CO-OPs that fail to comply with the law and with their loan agreement with HHS.[26]

Advisory Board Recommendations

In drafting its recommendations, the goal of the Board was to develop criteria that were flexible enough to accommodate the diversity of market conditions and of sponsor configurations that might arise. The Board identified and endorsed four "major principles" for awarding loans and grants, and these principles shape all of the recommendations:

1. consumer operation, control, and focus must be the salient feature of the CO-OP and must be sustained over time;
2. solvency and the financial stability of coverage need to be maintained and promoted;
3. CO-OPs should encourage greater care coordination, quality and efficiency to the extent feasible in local provider and plan markets; and
4. "first loans should be rolled out as expeditiously as possible if the CO-OPs are to compete in the Health Benefit Exchanges in the critical first open enrollment period (2014)."[27]

These principles are generally reflected in the proposed rulemaking.

Governance

The Governance Subcommittee expanded on the concept of the CO-OP's member-controlled board, defining a "member" as an insured individual, and these recommendations were tightened further by the Proposed Rule. As proposed, the Rule requires that each director be elected by the members. Although a majority of board positions must be held by members enrolled in the CO-OP, a minority of board positions may be reserved for provider representatives, employer representatives, non-members with specific expertise, etc. The Advisory Board also recommended that a CO-OP have an initial board made up of those involved in the planning and launch of the CO-OP. The Proposed Rule allows such an initial board, so long as a plan exists to transition to the operational (member-run) board within one year following the enrollment of the first members.[28]

The Advisory Board suggested information to be included in applications for loans and grants. The CO-OP entity must be formed at the time of application, and set up as a not-for-profit entity under state law. It need not have received tax-exempt status at the time of its application for the loan.

The Advisory Board recognized that a newly forming CO-OP may not have the time and resources to "build" all administrative services it needs to function on January 1, 2014

and suggested that it may be expedient to form or join group purchasing arrangements with payors allowing the CO-OP to buy administrative services economically.

Finance

The Financial Subcommittee recommended that loan funds be available in two phases: planning loans to assist organizations with financing studies to determine the planning and feasibility of moving forward with the CO-OP, and development loans to finance the actual start-up. The Advisory Board recommendation did not require the two-stage process, but the planning loan could assist an applicant to develop the detailed business and operating plan, including financial projections it would need to qualify for the development loan.

When considering the repayment of loaned funds, the Finance Subcommittee recommended that the loan repayment process allow a CO-OP to build reserves necessary to maintain solvency, indicating that building reserves would be consistent with the statutory requirement to use profits to benefit members. In addition, the Finance Subcommittee recommended that any federal funds provided to meet state solvency requirements be structured to accommodate state reserve requirements.[29]

The Proposed Rule builds on this recommendation, stating that CMS proposes to structure solvency loans to each loan recipient in a manner that meets state reserve and solvency requirements so that the loan recipient can fund its required capital reserves.[30] In order to do this, applicants are encouraged to discuss the appropriate mechanisms with their insurance regulators for structuring the loans to meet reserve requirements and to include a description of those mechanisms in their applications so that loan and repayment terms for that applicant conform to the state's requirements.[31] This may be a high hurdle for some applicants, especially given the relatively short application timeframe.

Recognizing the need for the CO-OP to reach "critical mass" quickly to remain financially viable, the Finance Subcommittee recommended that the Secretary "exercise maximum flexibility" in interpreting the statutory requirement that "substantially all" of the CO-OP's activities be in the individual and/or small group markets.[32] HHS adopted this approach by proposing that a CO-OP would satisfy the "substantially all" test if at least two thirds of the contracts for insurance that it sold are qualified health plans in the individual and small group markets.[33] Therefore, presumably if a CO-OP sold two contracts of insurance to individuals, it would be free to sell one contract to a large group. In addition, HHS proposed to allow CO-OPs to offer plans to small groups outside of the exchange, but to do so, the CO-OPs must commit to offering at least two types of qualified plans (through the small business exchange) in each market where they are licensed.[34]

As another approach to achieving economies of scale, the Finance Subcommittee suggested that start-up CO-OPs look to combine with labor unions, large employers and others to buy/build administrative and provider services.[35]

Infrastructure

The Infrastructure Subcommittee focused its recommendations on ensuring that CO-OP loan recipients are ready to participate in Health Insurance Exchanges at their launch and that CO-OPs are "sustainable in a competitive marketplace." Even so, the Infrastructure Subcommittee urged the Secretary to consider applicants who would not be ready to launch by January 1, 2014 and needed extra time to become "better organized" and develop "a more comprehensive set of provider relationships" if they could show a detailed strategy for how they would attract membership in subsequent open enrollment periods.[36]

As further evidence of its focus on sustainable entities, the Infrastructure Subcommittee urged the Secretary to minimize the statutory preference for an applicant showing a state-wide plan in favor of an applicant that shows a strong network capable of coordinating care effectively.[37] It also recommended that the Secretary consider the relative strength and experience of an applicant's management team, and whether it shows a committed provider network and functional information technology ("IT") system. If applicants are to outsource administrative operations, the Infrastructure Committee suggests requiring an oversight plan as well as information on the qualifications of contractors.[38]

In support of the statutory requirement that loans be given preferentially to applicants incorporating integrated care models, the Infrastructure Subcommittee recommended that each applicant be required to show how it will deliver integrated care. In an effort to define integrated care flexibly, the Subcommittee referred to several definitions in its detailed appendix.[39]

In another practical recommendation, the Subcommittee suggested that the statutory prohibition on using loan funds for "marketing"[40] be limited to direct sales and marketing efforts only and not be construed to prohibit the CO-OP from conducting community outreach, community education and membership education and development. In addition, to eliminate any impediment to adequate enrollment, the Subcommittee recommended that use of funds from other sources, including premiums, for direct marketing be expressly allowed.[41]

Process, Criteria and Compliance

The Criteria, Process and Compliance Subcommittee (which referred to itself during the hearings as the "Everything Else Subcommittee") responded to the statutory preference for applicants showing

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"private support" by defining private support as committed funding from other sources, committed in-kind support, letters of intent from key stakeholders and letters of support from key community leaders.

The Everything Else Subcommittee also made recommendations for struggling CO-OPs by asking the Secretary to provide or arrange for technical and management support; set up a technical assistance center, including through private support; and arrange for additional funding as needed for struggling CO-OPs.[42] The Subcommittee recognized the challenges these rapidly built start-up organizations could face competing with established insurers. The Subcommittee recommended a process for increased federal oversight for non-compliant CO-OPs and eventual discontinuance of funding for CO-OPs with continued compliance issues or failing to meet developmental targets.[43] The Proposed Rule reflects HHS' concern that it may not be feasible to discontinue funding to a struggling CO-OP and adopted a process involving increased oversight along with loan modifications or workouts where necessary.[44]

Intersections with Provider Activities

Accountable Care Organizations and Provider Organizations

It has occurred to many watching the CO-OP program develop that CO-OPs may fit naturally with accountable care organizations ("ACOs") or similar types of provider organizations. In fact, several commenters have given public testimony to the Advisory Board requesting safeguards to prevent providers from becoming CO-OPs.

Given the constraints on ownership and governance of a CO-OP, it is unlikely that an ACO would directly own a CO-OP. For providers that have established or are creating an ACO or similar entity, and have a proven system for delivering coordinated care efficiently, the ACO/entity could be a key player in setting up the CO-OP and influencing its design. Providers may also have an advantage in that the CO-OP Program is designed to favor CO-OPs that utilize integrated care models.

At the outset, interested provider entities, whether or not they have formed ACOs, will need to consider:

- Whether the non-profit structure required by the CO-OP Program is feasible and how the CO-OP would be related to the ACO;
- How the ACO and CO-OP are best structured to avoid overlapping regulatory requirements (*i.e.*, subject the ACO to possible state insurance solvency requirements and the CO-OP to provider requirements);
- Whether the employer market in the provider's area is interested in the CO-OP model—this could be source of "private support" for the CO-OP;
- Whether it would be desirable, in setting up a CO-OP, to contract with an insurer or third party administrator ("TPA") for administrative services.

Alignment with Providers

For providers that are not interested in creating a CO-OP, CO-OPs may still be strong partners or leaders for patient-centered care, such as patient-centered medical home initiatives. Because CO-OPs must be consumer focused and oriented, their relationships with providers will be critical to meeting that mission.

Providers may partner with CO-OPs by:

- Entering into fair and reasonable participation agreements with them;
- serving as a source of "private support" for the CO-OP;
- serving on the board of a CO-OP; or
- working jointly with the CO-OPs on integrated care models and payment structures.

Open Issues

As of this writing, key questions remain unanswered. For example, neither the Advisory Board recommendations nor the Proposed Rule mention how a loan will be secured. Other open issues include:

- What is considered "significant private support"?
- What if any liability will a sponsoring organization have for repayment of a loan?
- How will the program be affected by challenges to PPACA, especially the individual mandate that may move additional consumers into the insurance market?
- Will the CO-OP be permanently prohibited from abandoning the CO-OP model, including as a result of acquisition?

The Proposed Rule also does not say whether all applications received within a given state will be reviewed competitively at the same time or whether loans will be awarded as acceptable applications are received.

Until these key questions are answered and the CO-OP Program has the relative certainty of regulations, potential applicants may well hold back. Although the CO-OP Program as envisioned by the Advisory Board has the potential to be a "game changer," as of this writing it remains to be seen whether the final rules will allow the CO-OP Program to be a viable option to those seeking to create alternatives to current insurance offerings.

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Endnotes

1 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 § 1322(b)(1).

2 *See id.* § 1322(a)(3).

3 "Department of Defense and Full-Year Continuing Appropriations Act, 2011," P.L. 112-10, 4/15/11, § 1857.

4 Pub. Law 111-148, § 1322(a)(3).

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

6 Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program, Proposed Rule 76 Fed. Reg. 43,237 (July 20, 2011) (proposed to be codified at 45 CFR Part 156).

7 Pub. Law 111-148, § 1513.

8 *Id.* § 1311.

9 Consumer Operated and Oriented Plan [CO-OP] Program Initial Announcement July 28, 2011; https://www.cfda.gov/index?s=program&mode=form&tab=step1&id=64fffbd861586108dfb9ca580ebea397.

10 Pub. Law 111-148 *at* § 1322(b)(1).

11 76 Fed. Reg. at 43,247.

12 *Id. at* § 1322(c)(1). Note the statute establishes a new category of tax-exempt status at 26 USC § 501(c)(29). *Id.* § 1322(g).

13 *Id. at* § 1322(c)(3)(A).

14 *Id. at* § 1322(c)(3)(C).

15 *Id. at* § 1322(c)(4).

16 *Id. at* § 1322(c)(3)(B).

17 76 Fed. Reg. at 43248 (proposed to be codified at 45 CFR 156.505). Proposed Rule at pg. 19.

18 Pub. Law *at* § 1322(c)(2).

19 *Id. at* § 1322(e).

20 *Id. at* § 1322(c)(1)(B).

21 *Id. at* § 1322(c)(6).

22 *Id. at* § 1322(c)(5).

23 *Id. at* § 1322(d)(3).

24 *Id. at* § 1322 (b)(2)(A).

25 *Id. at* § 1322(f).

26 *Id. at* § 1322(a)(2)(C)(iii).

27 Advisory Board Report, *supra*, at page 5.

28 76 Fed. Reg. at 43242.

29 Finance Subcommittee recommendation #9.

30 76 Fed. Reg. at 43244.

31 *Id.*

32 Finance Subcommittee #11.

33 76 Fed. Reg. at 43249 (proposed to be codified at 45 CFR 156.515(c)(1)).

34 76 Fed. Reg. at 43243.

35 Finance Subcommittee #11-a.

36 Infrastructure Subcommittee #4

37 Appendix A, Subcommittee Reports, Infrastructure ¶3.

38 Infrastructure Subcommittee #5-7.

39 Appendix A, Subcommittee Reports, Infrastructure ¶2(b)(ii) "Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency."

40 Pub. L. 111-148, § 1322(b)(2)(C)(ii)(II).

41 Infrastructure Subcommittee #1.

42 Criteria, Process and Compliance Subcommittee #3&7.

43 Criteria, Process and Compliance Subcommittee #4&5.

44 76 Fed. Reg. 43245.