

# **Montana Health CO-OP**

## Montana Health CO-OP

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### **What is a Health CO-OP, and how does it differ from traditional health coverage plans? How is it created?**

A health care CO-OP is a nonprofit health insurance company operated by a group of individuals for their mutual benefit. It is a business, but CO-OPs are not created to make a profit. They are created to provide services to their members. CO-OPs are run by the people who use the service; in this case the service is health insurance. CO-OP members will form a majority of the board of directors.

The Affordable Care Act, which was passed in 2010, contained a section which created Consumer Operated and Oriented Plans (CO-OPs) to foster the creation of new consumer-governed nonprofit health plans. CO-OPs will provide health insurance to individuals and small employers as part of the "Exchange", which is a competitive health insurance marketplace. CO-OPs can offer products both on and off the Exchange.

Large groups can participate though these are usually self funded. The CO-OP could act as an administrator for self funded plans.

Unlike traditional insurance, any profits will be used to either lower premiums or to improve benefits.

To encourage the establishment of a CO-OP in each State, the Affordable Care Act will provide up to \$3.4 billion in loans, not grants, to capitalize eligible prospective CO-OPs. This supplies the financing needed for both short term start-up loans and longer term solvency loans as required by state insurance departments.

In the first round of evaluation, the Montana Health CO-OP was one of six organizations serving seven different states to be identified by the Department of Health and Human Services (DPHHS) as meeting the qualifications necessary to establish a successful health CO-OP. We applied in October of 2011 and learned of the successful application in early February, 2012. Based on this process MHC signed a contract with DPHHS to create a CO-OP in Montana.

MHC will receive periodic loans necessary to develop the CO-OP health insurance company in Montana. These loans initially will be for creating the structure of the company. Once successfully created, there are Montana State requirements for insurance companies to have reserves in order to provide insurance. DPHHS will also provide loans to meet these reserve requirements.

### **How will CO-OPs address the rising costs of health care?**

CO-OPs will enhance competition in the newly-created competitive health insurance marketplace (Exchange) and provide additional plan choices for consumers and small businesses.

Consumer choice will increase by providing competition in markets traditionally dominated by one or a few insurance companies.

CO-OPs will drive cost savings through improving and focusing on primary care access and management. We expect to have lower administrative costs. We will focus on looking for services that supply the best outcome. Care coordination and risk management will be important components. Preventive services will also be emphasized.

### **Why is the Montana Health CO-OP necessary?**

There are still too many people in Montana and across the country that do not have access to quality and affordable health care. 23% of adults in Montana are currently uninsured, and this number is growing every year. People without insurance are often faced with medical costs that they cannot pay. They frequently do not get the medical care they need until it's too late. When they do get care it is often in the most expensive place possible, the hospital setting. Those who have health insurance end up paying for much of this cost through higher premiums.

Many states, especially rural states like Montana, lack insurance options. When health insurance is offered to all Montanans in 2014, having effective competition among health plans will stimulate all insurance companies to provide lower cost and better quality of insurance and medical care. The CO-OP will be one of the approved plans on the exchange.

The goal of DPHHS is to have a CO-OP established in all states.

Other approaches to health coverage have been tried, with mixed results. Cooperatives have been successful and popular in other industries and service areas, especially in rural states such as Montana. We believe, along with many others across the country, that it is time to bring this model to the health insurance industry.

### **What advantages does Montana Health CO-OP have?**

There are many. For one, MHC is starting with a blank slate and can design plans based on what will be best for our customers. This gives us the opportunity to implement some proven and innovative practices that traditional insurers may not be using.

As opposed to a for-profit insurance company, any savings we encounter will be applied towards reducing cost or expanding benefits for our customers. Since our governance is member-controlled, the consumer will have much more say in how we operate the CO-OP. We believe this will result in insurance plans better tailored to meet the needs of Montanans.

### **Why would people leave their current insurance to participate in the CO-OP?**

There are thousands of Montanans in need of health insurance. In 2014 many of these people will receive financial assistance to buy health insurance through a competitive health insurance marketplace, also known as an exchange. They will want affordable insurance and will be

looking for good choices. For people who already have health insurance, they will be attracted by different approaches to health insurance that puts more control in the hands of the consumer.

Ultimately, we aren't trying to put existing insurers out of business; we're just trying to offer a different alternative to boost competition and drive down costs for average Montanans. CO-OPs are not the entire solution to health care in our country, but they should certainly be part of the solution.

### **How much will premiums be?**

We were awarded the loan based on our ability to be competitive with existing insurers, and we fully expect to offer a high-quality product at a competitive price. On average, Montanans pay \$288 more per year than their neighbors in Idaho. We believe that Montana can do better.

We hope to provide low cost, high quality health insurance through a combination of low administrative costs, and an increased emphasis on wellness, prevention, and improved primary care access.

### **How can the Montana Health CO-OP be successful in a tough industry?**

The Montana Health CO-OP team includes physicians, former health insurance executives, benefit managers and experts, and the former insurance commissioner of Montana. Our leadership understands the health insurance industry, and can provide it with invaluable institutional knowledge as we get MHC up and running.

We have received numerous letters of support, along with loans and thousands of in-kind volunteer hours. Clearly, there is a great deal of interest in what we are doing, and a lot of people are passionate about helping us in our efforts. People are ready for change.

Many consumers simply do not like the way insurance companies are run, and want more control over their plans and coverage. A CO-OP gives its members – or customers – more control over their own plan. More control and independence is an idea most Montanans can get behind.

### **How much money is the CO-OP getting from the federal government?**

We have signed an agreement with the federal government to start a consumer directed health insurance plan in Montana. We estimate that it will take up to \$6.7 million to start this plan. This will be distributed to the Montana Health CO-OP on a quarterly basis over the next two years, depending on meeting certain goals. It will not be distributed in one lump sum.

Once the CO-OP is formed, the state requires adequate reserves to protect the members who are buying health insurance. We expect to be successful and could eventually need as much \$51 million in reserve loans to meet these requirements. This will be borrowed from the federal

government as needed in order to maintain adequate reserves requirements. Start up loans will be paid back over five years and the reserve loans will be paid back over 15 years.

**Once the federal funding ends, will you be able to sustain yourself through the private sector?**

We will not need ongoing federal support. This will be a self sustaining business. Federal funds are in the form of loans to start the company and to supply insurance reserves. Our business plan and our ongoing operations have been evaluated and will be monitored by the Department of Health and Human Services, the federal department which is providing the loans. We and DPHHS have looked carefully at the existing Montana market and have come to the conclusion that a new health insurance company based on the CO-OP concept will do well. We will be able to pay all of the startup money and the reserve money back to the government. We would not have received the loan if we could not garner private support.

Our dedicated supporters have committed over 2,000 hours of in-kind volunteer hours to get MHC off the ground. We have obtained 30 letters of support from potential provider groups, elected officials, and business and community leaders. Over \$100,000 has been provided by private support to start this project. This support, both monetarily and through volunteer work, has been invaluable in getting MHC off the ground.

**Can the public view the Montana Health CO-OP's application for the federal loan?**

Our 300-page application contains extensive proprietary information concerning our business plan and strategic goals. Releasing the entire application would unfairly benefit our potential competitors. We are happy to answer any specific questions you may have about the application and the process, as long as it does not put us at a competitive disadvantage with our competition.

**When will the CO-OP be licensed to sell insurance in Montana and where is MHC in the process?**

MHC cannot begin to offer fully insured health insurance products until certain state and/or federal market reform provisions of the Affordable Care Act are implemented in Montana. Under the Affordable Care Act, these market reforms must be in force by January 1, 2014. This will be the first date when MHC can provide fully insured coverage. MHC insurance products will be offered starting in October of 2013 in preparation for this January 1, 2014 starting date.

**How many jobs will the CO-OP create?**

We estimate the CO-OP will have 20-25 full time employees to be ramped up between now and January 2014.

### **Who will provide the network of providers and hospitals for MHC?**

MHC will initially rent an existing network and will use a Request for Proposal process for the network selection.

### **How was MHC's board chosen? How does it change?**

Board composition was developed to represent many different perspectives on health care. Members of this initial Board have a wide variety of exposure to health insurance and the health care system gained over the course of their careers.

People who are receiving insurance from the CO-OP will elect half of the Board no later than one year after the effective date of providing initial coverage. Within two years of providing the first coverage, all Board members are elected. At that point, at least half of the Board will be people who are receiving insurance through the CO-OP.

### **National Alliance of State Health CO-OPs**

The National Alliance of State Health CO-OPs (NASHCO) is a trade association of state health CO-OPs which was originally started here in Montana. This alliance of CO-OPs will serve a number of functions for the new insurance plans including group purchasing of actuarial services and re-insurance. It will provide for ongoing collaboration in best practices and opportunities as well as serving the role of a national voice for these organizations.



# Realizing Health Reform's Potential

## *Innovative Strategies to Help Affordable Consumer Operated and Oriented Plans (CO-OPs) Compete in New Insurance Marketplaces*

TERRY GARDINER, ROGER NEECE, AND MICHAEL MENDELEVITZ

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**Abstract:** The Affordable Care Act paves the way for groups to develop innovative, affordable health insurance and care options known as Consumer Operated and Oriented Plans (CO-OPs). These CO-OPs will be nonprofit, consumer-controlled entities that are designed to serve individuals and small businesses, especially in noncompetitive markets. The CO-OP provision was included in the Affordable Care Act to address the lack of affordable health plan alternatives in many state and regional markets and to counter a trend toward market concentration. Despite their promise, CO-OPs face a number of business challenges that go beyond typical start-up hurdles. This issue brief lays out a number of innovative strategies CO-OP organizers are developing to increase the odds of long-term sustainability and economic success. These strategies—aimed at building market share, creating integrated provider networks, and achieving cost savings through payment reform—could establish CO-OPs as a viable new entrant in the health care field.

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### OVERVIEW

The Affordable Care Act includes an important provision that facilitates the development of nonprofit, member-run health insurance companies known as Consumer Operated and Oriented Plans (CO-OPs) in every state. One of the main reasons the CO-OP provision was included in the health reform law was to address the lack of affordable health plan alternatives and competition in many state and regional markets, as well as a trend, documented in studies conducted by the American Medical Association and the Department of Justice, toward further market concentration.<sup>1</sup>

Groups interested in forming a CO-OP will have to overcome start-up challenges that include earning enough money to sustain long-term operations, recruiting and retaining experienced management and staff, and obtaining funding for growth and expansion. But in addition, the CO-OP health plans must also offer coverage that is affordable and meets the unique needs of their customers in the individual and small-group markets. To do this, CO-OPs face the added challenge of working with a range of providers to develop innovative models of payment and care delivery systems.

For more information about this study, please contact:

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Despite trepidation about entering a market dominated by well-financed commercial and non-profit insurers, CO-OP organizers have enthusiastic potential leaders with a clear-eyed view of the risks and challenges. These CO-OP founders understand that a business-as-usual model that duplicates existing health plans will not meet the congressional vision and mandate for CO-OPs nor offer a new alternative for consumers and employers. In this issue brief, we summarize potential strategies and support structures CO-OP organizers can utilize to gain sufficient market share, improve the delivery of health care, achieve economic success, and overcome the primary challenges they face. The strategies discussed here will help establish CO-OPs as a viable new entrant in the field and a contributor toward improved patient health outcomes at affordable costs.

## BACKGROUND

Alternative health insurance models like the CO-OPs have a long history in the United States. Health cooperatives differ from traditional health insurers in that they are nonprofit entities governed by their members and are focused on coordinating care and coverage for their beneficiaries. The most successful examples include HealthPartners in Minnesota, with 1.5 million members, and Group Health Cooperative in Washington State, with 700,000 members. Both of these large cooperatives are fully integrated health systems with their own physicians and health care facilities. Independent studies have placed these cooperatives in the ranks of the highest-performing health plans in the country in terms of providing value and quality care to their customers. The CO-OP model is not confined to the U.S. There are successful cooperatives in Spain, Brazil, and Japan, among other nations, which together cover 200 million individuals.<sup>2</sup>

CO-OPs under the Affordable Care Act—not to be confused with other legal entities known as cooperatives that operate in many economic sectors and are typically formed under state law—are intended to increase consumer choice and control and stimulate competition in health insurance markets. CO-OPs

must be nonprofit, consumer-controlled entities focused on health insurance coverage and care, among other requirements. Following are the main features of the CO-OP program:

- A CO-OP's primary purpose is to promote the health and well-being of its customers as affordably as possible over the long term.
- CO-OPs will be exempt from federal taxes.
- Each CO-OP must operate with a strong consumer focus, and profits must be used to further its mission through lower premiums, improved benefits, or improved quality of care.
- The federal government will distribute \$3.4 billion in funding for the program in the form of loans to cover start-up costs and to meet solvency requirements in states where some CO-OPs seek to be licensed as insurers.
- The funding must be disbursed by July 1, 2013, and the Department of Health and Human Services (HHS) must disburse it in a way that ensures the establishment or operation of at least one CO-OP in each state.
- Health insurers in existence before July 16, 2009, are not eligible for funding from the CO-OP program.

A 15-member HHS advisory board was appointed in July 2010 with the objective of making recommendations that would ensure the effectiveness and success of the health CO-OP program. The Board, comprising health system experts including providers, regulators, administrators, actuaries, and businesses, gathered a wide range of public and expert testimony and studied the history of health cooperatives. It concluded that a variety of models and program flexibility are needed to match the diversity of market conditions and challenges across the 50 states.<sup>3</sup>

HHS has proceeded expeditiously to define the CO-OP program, fostering a strong response by potential applicants. In July 2011, HHS proposed regulations<sup>4</sup> and issued a funding opportunity



announcement, which closely follows the advisory board's recommendations.<sup>5</sup> The first application deadline passed in October 2011 and the initial loans to eight different organizations, to cover approved start-up costs, were awarded in February and March of this year (see exhibit on next page). These include:

- Midwest Members Health (Iowa and Nebraska)
- Maine Community Health Options
- Montana Health Cooperative
- Freelancers Union (New Jersey, New York, and Oregon)
- New Mexico Health Connections
- Oregon's Health CO-OP, and
- Consumers' Choice Health Insurance Company (South Carolina), and
- Common Ground Healthcare Cooperative (Milwaukee, Wis.).

There will be subsequent application periods quarterly through December 31, 2012. The number of applications is robust and covers a majority of states with a diversity of sponsoring groups and business models. HHS is now reviewing applications from the latest quarterly filings.

Based on our analysis of interviews with 54 experts, many of whom were interested in forming CO-OPs, as well as information gleaned from historical assessments of past successful cooperative group plans, we estimate there are 15 to 28 CO-OPs in formation that intended to apply for HHS funding in 2011. More applicants will likely follow in future application periods. The CO-OPs in formation include those being organized by cooperative and small-business organizations, nonprofit groups providing services to freelance workers, and community organizations historically involved with health care reform.

Other organizations have sponsored CO-OPs, including health care provider groups and their affiliated health care plans and industry-affiliated groups

that provide insurance products to their small- and large-group members. These organizations are already involved and invested in health care and health insurance and are interested in CO-OPs for both defensive and offensive reasons. On one hand, they will have to respond to the presence of CO-OPs in their market for competitive reasons; on the other, they see CO-OPs as a new business opportunity. The strongest CO-OP applicants are those that have secured participation from groups with health care and business experience and access to resources such as provider organizations and integrated health systems. Many of the CO-OP applicants are focused on meeting the challenges of rural areas, communities, providers, and patients. Examples are the CO-OPs approved for loans in Iowa, Maine, Montana, Nebraska, and New Mexico, which have extensive rural populations and agricultural communities.

### PRIMARY CO-OP OPPORTUNITIES

The primary objectives for CO-OPs are to improve the delivery of health care and attain enough economic success to position the member-controlled plans as a viable and affordable new entrant into the health care field. CO-OPs have opportunities to:

- utilize private sector funding and revenues generated from member services in addition to federal loan funding;
- promote the CO-OP's nonprofit, member-governed structure as an attractive alternative to traditional insurers;
- cultivate member loyalty to guard against inappropriate care utilization and adverse selection and give the CO-OP resilience in the marketplace in the face of short-term predation by competitors;
- develop a consumer governance and participation structure, so that CO-OP members continuously and systematically shape the business decisions that lead to a more patient-focused, quality organization;

### Federal Loans in Support of Consumer Oriented and Operated Plans (CO-OPs)

CO-OP	State/Region	Grant Amount	About the CO-OP
Midwest Members Health	Iowa, Nebraska	\$112,612,100	Sponsored by the Iowa Institute, which provides training programs and news updates for members from various industries, including: agriculture, credit unions, rural electric, rural telephone, and farm credit.
Maine Community Health Options (MCHO)	Maine	\$62,100,000	Sponsored by the Maine Primary Care Association, a membership organization comprising community, tribal, migrant, and homeless health centers.
Montana Health Cooperative	Montana	\$58,138,300	Sponsored by a coalition of small businesses and community leaders seeking to add primary care capacity to Montana's rural and medically underserved communities.
Freelancers CO-OP of New Jersey	New Jersey	\$107,213,300	Sponsored by the Freelancers Union, an organization of self-employed, freelance, and independent workers that partners with health care providers using a patient-centered medical home model.
New Mexico Health Connections	New Mexico	\$70,364,500	Sponsored by a coalition of community groups, business leaders, and providers that plan to work with their provider community to improve health outcomes in 11 counties. Plans to expand statewide within two years.
Freelancers Health Service Corporation	New York	\$174,445,000	Sponsored by the Freelancers Union (see above).
Oregon's Health CO-OP (Incorporated as Community Care of Oregon)	Oregon	\$56,656,900	Sponsored by CareOregon, a nonprofit Medicaid Managed Care Organization.
Freelancers CO-OP of Oregon	Oregon	\$59,487,500	Sponsored by the Freelancers Union (see above).
Consumers' Choice Health Insurance Company (CCHIC)	South Carolina	\$87,578,208	Sponsored by the South Carolina Business Group on Health, volunteers from nonprofits, and member-driven employer groups with expertise in the state's health care and insurance markets.
Common Ground Healthcare Cooperative	Wisconsin	\$56,416,600	Sponsored by Common Ground, a community organization that represents small businesses, churches, unions, colleges, and community groups. Beginning in southeastern Wisconsin, it plans to provide insurance coverage statewide within five years.

Source: Healthcare.gov, "New Loan Program Helps Create Customer-Driven Non-profit Health Insurers," available at <http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html>.

- work with other CO-OPs to develop a common means to raise expansion and working capital from members, as well as share services to get membership, insurance operations infrastructure, and reinsurance to scale to lower costs;
- better the average risk curve of a typical insurance company by providing insurance products that motivate consumers to change their behavior, increase use of preventive services, and include a value-based health care and prescription drug design;
- partner with doctors and other care providers that share in the CO-OP's vision and values, are committed to changing the way care is delivered, and will share accountability for members' health and the overall financial stability of the CO-OP;
- increase member satisfaction and contain costs by enlarging and supplementing provider

networks through the use of nurse practitioners and other nonphysician health care providers as well as complementary and alternative providers; and

- create provider payment structures with incentives for innovations that reduce members' health care costs and give the CO-OP the economic margins required to offer competitive premiums and enjoy long-term success.

The primary known challenges to CO-OP success are:

- achieving funding;
- effective management that allows the CO-OP to be competitive in the state health insurance exchanges;
- governance and operational infrastructure development;
- developing provider networks;

- implementing innovative care models; and
- developing and executing innovative payment mechanisms.

Interviews with CO-OP applicants confirmed that the program organizers are assessing and dealing with these known challenges in their business plan development. These challenges are also being thoroughly examined by federal regulators as part of the HHS loan approval process.

What concerns CO-OP founders are the unknowns: the shifting federal funding landscape, which hinges on deficit and budget politics; the willingness of talented staff and management to take on such a large challenge; and the lack of progress in states on implementing the state insurance exchanges called for by the Affordable Care Act. When the exchanges go live in January 2014, as many as 30 million Americans will use these insurance marketplaces to acquire health coverage. As envisioned by the health reform law, the CO-OPs would offer consumers a new, competitive health insurance choice on the exchanges and help meet the legislation's goal of creating a marketplace that drives innovation and controls costs.

Based on our review, the CO-OPs being formed can meet the congressional vision of creating health insurance plan competition in markets that are currently noncompetitive, including rural areas.

## CHALLENGES AND STRATEGIES FOR SUCCESS

New nonprofit health insurance CO-OPs organized under health reform face funding and organizational challenges in development, start-up, and, eventually, operating within the state health insurance exchanges. CO-OPs will need to adopt a number of strategies, from sharing resources and best practices with similar entities, to developing robust provider networks that offer comprehensive care models to members and innovative payment mechanisms to providers.

## Funding

Funding for CO-OPs is critical in the development phase as well as during start-up and operation. However, there is little private financing to develop CO-OPs, and the extent of federal funding has been thrown into question. Congress's decision this year to reduce HHS funding for CO-OP development from \$6 billion to \$3.4 billion has introduced uncertainty among groups forming CO-OPs and those considering whether to do so. For some, that decision has led to a wait-and-see attitude, especially as negotiations over federal budget cuts continue. While it is possible that the \$3.4 billion set-aside for development, start-up, and operations could meet the initial financial needs for CO-OPs in all 50 states, it may not be enough to meet the future funding needs for all the CO-OPs currently in development.

Any significant reduction of that \$3.4 billion would have a dramatic impact on CO-OP formation. Those who have not started the process may decide not to try. And uncertainty surrounding federal funding to complete start-up operations and meet regulatory capital requirements could lead many groups that are forming CO-OPs to reconsider.

Private-sector financing is a difficult alternative. A CO-OP's nonprofit structure greatly limits private funding for development and operation, but finance experts and CO-OP representatives have said there is a need for such financing to supplement federal funding so CO-OPs can grow and expand. This will require finding innovative ways to create a rate of return attractive enough to draw financiers.

A CO-OP's funding needs are various. The Affordable Care Act provides 15-year loans for solvency and regulatory capital requirements, but new CO-OPs eventually will have to replace that regulatory capital. CO-OPs will need financing to meet requirements that may develop from their participation in federal and state temporary reinsurance and risk-pooling arrangements. They also need nonfederal dollars for marketing, since this is not an allowed use of federal funding.

There are potential solutions. Several developing CO-OPs have found nonfederal dollars to help get off the ground. The Evergreen Project, a CO-OP forming in Maryland, has received funds from Maryland foundations in support of its objective of serving uninsured and working families that will be eligible for premium-support subsidies under health reform. At least two CO-OPs forming in the Midwest are developing a base of support by forming partnerships with existing cooperative and consumer-oriented organizations like farmers' supply cooperatives, rural electric and telephone cooperatives, membership organizations for senior citizens, and small-business advocacy and service organizations.

### Strategic Vision

CO-OPs also have significant advantages they can use to meet their funding needs. Success will require having creative vision that allows them to capitalize on those advantages.

The nonprofit membership organization of a CO-OP is an important advantage for the business side of the organization. Membership organizations typically offer benefits, and CO-OPs, in returning profits to members as envisioned in the Affordable Care Act, can offer benefits tied to the health care side of the operation. By associating the CO-OP with a concept of care beyond medical care, the CO-OP can differentiate itself in the market and cultivate member loyalty. CO-OPs can develop a mechanism of returning profits to members, where the profits are based on the use of preventive and medical care services in addition to the overall financial results of the CO-OP. Profits could be returned in the form of a prepaid card that can be used to reduce premium costs, pay for basic medical care like vaccinations and flu shots, or reimburse costs for a range of services like prevention information, CPR training, and wellness programs like fitness, stress reduction, or nutrition consultation.

Such practices will have other advantages. When members understand and feel that the CO-OP is theirs, they will guard against inappropriate care utilization and adverse selection. Also, a CO-OP with

high consumer input, participation, and positive health outcomes can sustain member loyalty in the marketplace in the face of short-term competitive predation.

CO-OPs can emulate strategies employed by organizations like the large integrated insurance company USAA, which provides insurance and financial services to its membership of active military service members, veterans, and their families. Another good model is AARP, the membership and advocacy organization for older adults that provides a whole range of benefits to members beyond insurance. For instance, CO-OPs can offer members access to long-term care, automobile, homeowner, disability, and life insurance products. They can offer financial services like retirement plans and savings and investment options. They can even offer group purchasing for travel products. These products and services are potential sources of revenue that benefit members by increasing a CO-OP's financial stability. They also lower the financial risk to the federal government and other financiers.

Innovative care and cost approaches can lead to long-term cost containment, which will directly benefit members and provide the CO-OP a foundation for long-term economic viability.

### Management

A significant challenge facing CO-OPs at the outset will be to hire experienced senior executive and operational management and installing a well-qualified board of directors. There is a concern that there is not a deep bench from which to draw these crucial people, and that the start-up nature and uncertain funding for potential CO-OPs will prevent some—particularly those with critical financial and legal skills—from signing on.

Executive management will need expertise in nonprofit membership organizations, the specialized consumer governance structure required of CO-OPs, corporate finance, insurance regulation and compliance, reinsurance, provider network negotiation, sourcing and pricing of operational infrastructure, and sales and distribution within the field of health insurance. They also must have the leadership skills and public persona

to develop the vision and mission of the CO-OP and communicate its value in the market both internally to rally the staff during a complicated start-up journey and externally to the public, governmental officials, and potential CO-OP members. Successful public relations and a positive embrace by consumer and business organizations will be key factors in gaining acceptance of the unproven CO-OP insurance plans by the marketplace.

How a CO-OP interacts with the state insurance exchanges called for in the Affordable Care Act also will be critical. The design of state exchanges has the potential to create a level playing field and lower the cost of distribution for new market entrants like CO-OPs; but exchanges may also be designed to favor established insurers. Allowing the maximum choice of plans to individuals and employees of small businesses will put new and small health plans like CO-OPs on a more equal footing with insurers that dominate the market today. Spreading the cost of the exchange out over the entire health insurance market will reduce the overhead burden health plans have to pass onto consumers and employers. A robust and effective navigator program that educates the public and employers about the new exchange system and all the health plan alternatives—including new health CO-OPs—will greatly assist the launch of these new entities.

### **CO-OP Infrastructure and Outsourcing**

To be competitive in the marketplace, CO-OPs must develop the core competencies and information technology systems needed to process transactions and perform insurance administration activities. This is a challenge, because CO-OPs must have excellent operational service at a low cost, but the claims and membership systems they will need—and the personnel to implement, operate, and maintain them—are expensive. Used at low volumes, the systems are inefficient and costly. And once a CO-OP moves beyond the basic processing of transactions, the requirements for membership and claims functions to support new and innovative provider risk-sharing and partnership arrangements become difficult and the solutions and

vendor landscape become increasingly complex, expensive, and unproven.

There is, however, a lively market for insurance administrative and transaction processing services, and outsourcing these functions is a time-honored strategy. Solutions can come from traditional health plan and business vendors, third-party administrators, systems and application vendors, and established health plans with excess capacity. CO-OPs can negotiate favorable service agreements and pricing for these services, but there may be a loss of flexibility and customization. The best financial terms for these services may come from vendors that propose legacy systems that cannot be customized or incrementally improved to meet future requirements. To reap the benefits of the lowest cost points for internal and outsourced operations, CO-OPs must be sure to have operations infrastructure that can be scaled up as membership grows.

Our discussion with CO-OP developers reveal that they expect that the standard operating procedure will be to outsource most components of their insurance operations while making membership, product distribution, provider relations, payer systems, and nonprofit governance internal core competencies. In the future, CO-OP managers intend on reconsidering which infrastructure components to bring in-house.

CO-OPs will need state-of-the-art information technology (IT) to support membership, governance, and insurance operations. Outsourced operational services should be able to provide information technology services required for reporting results and providing management information to the CO-OP. This will lower the technology development burden borne by the CO-OP. Certain aspects of the CO-OP's core competencies can also be outsourced, such as membership administration and board election administration, without compromising the ability to meet federal CO-OP requirements for consumer-oriented operation and control. However, a CO-OP will have to recruit, retain, and manage an IT staff that is sufficient to develop, oversee, and manage the technology component of core competencies and outsourced operations.

A consumer governance structure is a core part of the CO-OP identity, with members continuously and systematically shaping the business decisions that lead to a more patient-focused, quality organization. To support member engagement, CO-OPs will need dedicated staff focused on ensuring that the CO-OP's member-elected board is an integral part of strategic decision-making and that consumers have the opportunity to provide input into the development of the organization. CO-OPs will need to provide formal opportunities for consumers to contribute their ideas, and foster a different kind of business consciousness that encourages this engagement.

### **Overcoming Start-Up Challenges with Shared Resources**

The Affordable Care Act stipulates that all CO-OPs must be start-ups, and start-ups in all fields—whether for profit or nonprofit—have high failure rates and face many challenges. A new trade association, the National Alliance of State Health Cooperatives (NASHCO), is being developed to act as an important resource for those interested in starting CO-OPs. It will act as a central repository for information and best practices and speak with an organized voice on policies and issues affecting CO-OPs. The National Cooperative Business Association, a longstanding cooperative business group with the experience and resources to assist cooperative development, is helping NASHCO and its members form an alliance. Already, NASHCO has launched a Web site and hosted an informational conference in Washington, D.C., for start-up CO-OPs. The trade association has also partnered with Milliman, the highly respected national actuary and consultancy firm, to provide assistance to CO-OPs that are submitting applications for funding to HHS.

One crucial role for NASHCO is to have a purchasing council that allows CO-OPs to join forces to purchase services required for development, start-up, and operations. CCA Global Partners, a cooperative purchasing council for 3,900 retailers, provides an excellent example of how this can work and is a good model for NASHCO to follow.

Through the collaboration fostered by such trade organizations and purchasing councils, CO-OPs can work together to develop a common means to raise expansion and working capital from members. CO-OPs can collaborate to expand membership and scale up insurance operations infrastructure. This is crucial because IT and insurance operations providers report that the lowest per-member per-month administration and operations costs are available at enrollment levels of 250,000 or more. It is unlikely that many CO-OPs will reach such enrollment levels individually in their first years of operation, so they will need a purchasing council or similar strategy for aggregating enrollment and standardizing technology, administration, and operational requirements to get the lowest costs.

A purchasing council can also be helpful when a CO-OP insurer purchases a reinsurance policy, which is required by state insurance regulators to ensure that all claims can be paid. CO-OPs can lower the cost of reinsurance through such risk-retention strategies as forming a “primary captive” reinsurer—basically a reinsurer established by the CO-OP itself—and reinsuring some of its own specific “captive risk.” The captive then must obtain reinsurance for itself at lower rates in the traditional reinsurance marketplace. The CO-OP might also wish to utilize a CO-OP trade association, such as NASHCO, to develop bids jointly in the reinsurance market.

### **Provider Networks**

Provider networks are a critical component for successful CO-OPs. The provider network of physicians and hospitals—along with other allied practitioners and complementary and alternative care providers—is a key element to ensuring that CO-OPs offer high-quality, low-cost products that attract members. The ability of a new CO-OP with limited market share to attract and retain desirable providers and facilities will be affected by the contracts providers already have with competing health plans. Without a large membership, a new CO-OP plan may not be able to command competitive pricing and productivity goals from providers. And without price concessions, the CO-OP may be unable to deliver

a low-cost network and competitively priced products. CO-OPs that want to depend on discounted fee reimbursement and/or episode capitation arrangements must, from the beginning, get discounts equal to, or better than, the prevailing rates enjoyed by their competitors.

To do this, CO-OPs will have to develop networks that extend beyond the current system. In addition to meeting state regulatory and exchange coverage requirements at an attractive price, CO-OPs will need to find network providers that will work as partners and share in the plan's vision and values. They must also be committed to changing the way care is delivered. Provider partners must make their support for the CO-OP known to the public. They need to continually improve the quality, consumer experience, and cost-effectiveness of the care that the CO-OPs provide to their members. These partnerships must be based on shared accountability for members' health and responsibility for the overall financial stability and reputation of the CO-OP. If full risk-sharing cannot be achieved, then CO-OPs must incentivize the care and financial performance of providers and members, and, at a minimum, implement some form of shared-savings approach. To have a chance to bend the cost curve, CO-OPs must also build strong relationships with provider networks that are open to payment arrangements other than fee-for-service care. CO-OPs will need to examine approaches to care that cut costs and look for doctors who use electronic health records and patient management protocols to coordinate care more broadly.

CO-OPs may better the average risk curve of a typical insurance company if they use these strategies to provide insurance products that motivate consumers to change behavior, increase use of preventive services, and include a value-based health care and medicine design.

Once provider networks are in place, managing them and supporting them becomes an important task for a CO-OP. This is a highly specialized field, particularly in supporting the medical and case management activities required to control costs associated with catastrophic and chronic diseases. Newly formed CO-OPs with new network relationships will find this is a substantial challenge. CO-OPs can rent or subcontract

existing networks from more established plans, but they may not get the significant pricing concessions that will lead to medical cost savings.

### **Innovative Care Models**

As start-ups, CO-OPs can make innovations in care that will be attractive to members while also helping the business side of the organization. They can define health care more broadly by offering complementary and alternative care, and promoting community-level prevention efforts and support groups that directly engage members. Internationally, the Japanese approach of enrolling members of a large organization into small local groups of CO-OP members with similar health care needs best illustrates how integrated health care can be enhanced in insurance cooperatives. Members of these smaller local groups have many more opportunities to interact personally with the CO-OP than if they were only participating in the larger organization's governance and policies. Such personal networks can, for example, provide nonmedical support for members after they have been hospitalized or undergone outpatient procedures. This reduces complications and hospital readmissions and helps CO-OPs achieve cost-containment and quality-of-care objectives.

CO-OPs can increase the satisfaction with care and contain costs by enlarging and supplementing provider networks through the use of nurse practitioners and other nonphysician health care providers and by allowing complementary and alternative providers to offer primary care. Best practices of international cooperatives in this area include delivering health care, much of it by nonphysicians, in the home or place of business and in a timely manner.

CO-OPs starting with a clean slate may have more opportunities to develop integrated provider networks than current health plans and insurers, which are hampered by a reliance on fee-for-service reimbursement and broad provider networks. However, there are some difficult challenges ahead in achieving new provider network payment structures and contracts that reflect the CO-OP's integrated care approach. When providers are not employed by a health plan,

most innovations focus on narrow areas rather than the full spectrum of care. These narrow innovations will not materially change the current economic risk-and-reward spectrum for providers.

To really affect the health cost curve, CO-OPs will need to foster a broader set of care innovations to develop truly integrated provider networks. As willing payers, CO-OPs can potentially take more radical approaches to the required care integration and economic incentives for providers. They can take the Kaiser Permanente approach and develop and implement a provider and payment system based on directly employing or contracting with primary, specialty, and allied providers. Existing federally qualified health centers or safety-net plan providers could become CO-OPs, or partner with them to increase the use of their care centers. A CO-OP could refashion independent or group practice providers into a network of employed or directly contracted primary and specialty providers. This approach would mirror recent moves by commercial insurers to purchase and operate formerly independent and group medical practices; it would also emulate efforts by health plans and hospital-led integrated medical practices to form accountable care organizations.

### **Innovative Payment Mechanisms**

CO-OPs have the potential to create provider payment structures that include incentives for successful innovation, which can reduce members' health care costs and give the CO-OP the economic margins required to offer competitive premiums and enjoy long-term success. But as stated above, current provider care integration and payment innovations tend to focus on narrow areas of treatment and not the full spectrum of health care. Examples include Prometheus Payment, which focuses mainly on surgical procedures for which costs are well known and comparable, and other regional integrated care and payment reforms, such as those being developed and implemented by the Healthcare Transformation Institute, that focus on universal payments for conditions that have been identified by employers as causing disproportionate use and cost (for example, muscular-skeletal injuries and migraines).<sup>6</sup>

CO-OPs may be able to bring together these various approaches and implement them in their service areas to achieve a measure of integrated service delivery and payment reform with existing provider networks. But they should be aware that developing and implementing new integrated care and payment approaches will directly impact the initial administrative and information technology requirements and operational cost structure of the CO-OP. It will also increase the complexity and cost of developing and implementing procedures to process claims and conduct medical utilization and review procedures. Most vendors providing claims, medical management, and other systems at scale do not have the systems developed to support such new provider integration and payment approaches. Still, internal or vendor development costs for new CO-OP systems should be recouped quickly, as new integrated care and cost approaches should lead to long-term administrative procedure simplification and direct measurable cost containment.

As willing consumer-controlled payers, CO-OPs can develop and propose payment systems that are not based on direct employment or contracting of providers but that do realign the current economic risk-reward spectrum for providers. On a long-term basis, a CO-OP can develop a payment system that would deliver to the integrated provider group an overall payment for the care of CO-OP members on a monthly basis. That payment is determined by the dollar value of the required medical loss ratio determined in the Affordable Care Act for the CO-OP. The integrated medical practitioner care network and system would bear all costs and responsibility for delivering the highest standard of care for the total overall payment from the CO-OP.

### **CONCLUSION**

The U.S. Department of Health and Human Services has moved forward rapidly and systematically to implement the health CO-OP program. This has triggered an immediate response by a wide range of groups frustrated with what they see as a broken health care



system. Health CO-OP start-ups have garnered the interest and support of health care experts as well as consumer, business, and provider groups. The strongest applicants are those that have participation from groups with significant expertise, depth, and resources, including provider organizations, business groups, and high performance integrated health systems. The establishment of NASHCO as a national support alliance and the enlistment of the national actuarial firm Milliman as the actuarial backbone have added needed support for these start-up CO-OPs.

The innovative CO-OPs proposed for HHS funding have the potential to provide new health care coverage options to individuals and small businesses, especially in noncompetitive markets. These health plans could be attractive, because the CO-OP founders understand that to thrive they must provide a new, affordable coverage alternative, one meeting the health needs of individuals and working with providers to develop new payment and delivery systems.

Moreover, CO-OPs could be important to the mission of the new state health insurance exchanges called for in the Affordable Care Act to create competitive marketplaces for individual and small-group health plans. As many as 30 million newly insured Americans will find competitive new insurance alternatives, potentially including a CO-OP health plan offering, when exchanges go online in January 2014. To succeed and grow, health CO-OPs will need access to robust exchanges, in addition to capital support from HHS and other sources. In those states that choose not to establish exchanges themselves, it will be important for HHS to design ones that work for newly formed CO-OPs.

Those who want to create successful CO-OPs and a new way of doing business in the field of health insurance face myriad challenges. However, these CO-OP founders and HHS, as the main financier, have a clear-eyed view of the risks and obstacles that lie in front of them. They know that they cannot rely on the current models used in the health insurance industry and, with the typical spirit of U.S. entrepreneurialism, are developing business plans that use innovative methods to ensure that CO-OPs succeed.

## NOTES

- 1 The American Medical Association, in their "Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update" (<http://www.ama-assn.org/ama/pub/news/news/health-insurance-competition.page>), noted that the concentration of the health insurance market is significant. In all of the 43 states studied, the top two insurers have a combined market share of 44 percent or more. In half of the states, the top two insurers have a combined market share of 69 percent, while in half the states *one* insurer has a 44 percent share. The Government Accountability Office (GAO) reported that the median market share for Blue Cross Blue Shield carriers in 38 states was about 51 percent, up from 44 percent in 2005 and 34 percent in 2002. See GAO, "Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market," Feb. 2009, <http://www.gao.gov/new.items/d09363r.pdf>.
- 2 The International Health Co-operative Organisation provides information about health cooperatives around the world; see <http://www.ica.CO-OP/ihco/about.html>.
- 3 Center for Consumer Information and Insurance Oversight (CCIO), *Report of the Federal Advisory Board on the Consumer Operated and Oriented Plan (CO-OP) Program*, April 15, 2011, p. 4.
- 4 Notice of Proposed Rulemaking, "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program," 76 *Fed. Reg.* 139 (July 20, 2011), 43237-50, <http://www.gpo.gov/fdsys/pkg/FR-2011-07-20/pdf/2011-18342.pdf>.
- 5 HHS Funding Opportunity Announcement, July 28, 2011, <http://www.grants.gov/search/search.do;jsessionid=yR2TxyLKtFvCPzLqm8Zd7qjf7N102tGMT1ZRm42gmXQTpl56smq!1170416000?oppId=109093&mode=VIEW>.
- 6 For more on Prometheus Payment, see <http://www.hci3.org/node/4/#/1>. The Healthcare Transformation Institute is led by Denis A. Cortese, M.D., formerly head of the Mayo Clinic; see <http://www.healthcaretransformationinstitute.org/>.

#### METHODOLOGY

The development of this issue brief proceeded in three stages. In the first stage, input from HHS Health CO-OP Advisory Board members and the public comment process was gathered, and HHS and CO-OP thought leaders were identified as well as key implementation and regulatory issues. In the second stage, 54 CO-OP thought leaders including CO-OP practitioners, a diverse range of leaders of CO-OPs in formation, and integrated health system executives participated in a structured interview process in which they provided their views on the risks and challenges and issues that they foresaw, specifically:

- A. The risks and challenges of CO-OP development;
- B. Key CO-OP implementation and regulatory issues; and
- C. Strategies for health insurance CO-OP formation and sustainability.

In the third stage, the key issues, risks, and challenges identified were assessed, and potential strategies for health insurance CO-OP formation and sustainability were identified from interview data and the experience of the team.

## ABOUT THE AUTHORS

Terry Gardiner is the vice president of Policy and Strategy for Small Business Majority. He has worked as a policy advocate for state and national health reform since 2005. He is a member of the U.S. Department of Health and Human Services Health CO-OP Advisory Board. His public policy experience includes five terms as a state representative in the Alaska Legislature and many leadership positions including Speaker of the House. In this legislative capacity, he helped organize a state cooperative bank, an insurance company for physicians to acquire malpractice insurance, and other public/private institutions to address societal challenges. His private sector experience includes two decades as founder and CEO of NorQuest Seafoods, start-up of a fisheries cooperative, and service on boards of several other companies.

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