Proposed Establishment of Consumer Operated and Oriented Plans (CO-OPs)

SUMMARY

Background
As an alternative to the controversial public option proposal, the *Affordable Care Act* (ACA) included a provision to offer assistance to individuals or groups interested in establishing non-profit "Consumer Operated and Oriented Plans (CO-OPs)," using the same acronym as cooperative plans already in existence in several states. The goal of the provision is to have at least one health insurance CO-OP in each state, with each becoming a "qualified health plan" eligible for purchase on the state exchanges. The CO-OP Advisory Board charged with helping the Centers for Medicare & Medicaid Services (CMS) draft rules governing the program includes three family physicians: Drs. David Buck (Houston, TX), David Carlyle (Ames, IA) and Michael Pramenko (Grand Junction, CO).

Rather than becoming an ersatz public option, the ACA explicitly prohibits all units of government—federal, state and local (or any part of these, including medical schools)—from forming and operating a CO-OP under the program. For-profit insurers likewise are barred explicitly from participating. The ACA further outlines general rules for governance and notes that it does not pre-empt state insurance law.

The U.S. Department of Health & Human Services (HHS) will issue loans to assist with start-up costs and solvency requirements. The ACA directs HHS to consider plans that adhere to recommendations of the advisory board appointed by the Government Accountability Office (GAO), demonstrate private support, are ready to expand statewide, and utilize integrated care models (the patient-centered medical home likely would qualify and "direct primary care medical home plans" are referenced elsewhere in the ACA). Congress appropriated $3.8 billion for the CO-OP program.

Chapters or family physicians, singly or in groups, could potentially sponsor the creation of a CO-OP.

On July 20, HHS released a proposed rule regarding the CO-OP program. The proposal attempts to clarify qualifications for participation, outline standards for loan repayment, and establish basic governance criteria. The deadline for comments is September 16, 2011. Following on the release of the proposed rule, on July 28, HHS released a Funding Opportunity Announcement (FOA) for those wishing to form health insurance cooperatives under the CO-OP program.

The proposal addresses four primary aspects of the program: eligibility, standards, loan terms, and conversions.

Eligibility
Under its proposed eligibility rules, CMS says more about who cannot participate than who can, leaving fairly broad room for organizations to sponsor applicants and potential health insurance cooperatives. CMS proposes that only nonprofit, not-for-profit, public benefit or similar membership entity organizations, organized as appropriate under state law, may be eligible for CO-OP loans. Existing organizations may sponsor the creation of the CO-OP by helping to establish a nonprofit member organization. However, the new nonprofit, not the sponsor, will be the recipient of any loans granted by CMS. Chapters or family physician members could potentially sponsor applicants for CO-OP loans.

The ACA provides two basic exclusions from participation in the CO-OP program: pre-existing health insurance issuers and any unit of government. Health insurance issuers that existed on or after July 16, 2009 are

prohibited from participating in the CO-OP program. This prohibition extends to related entities and predecessor organizations. CMS proposes defining "related entity" as an organization that shares common ownership or control with a pre-existing issuer or a trade association whose members consist of pre-existing issuers, and satisfies at least one of the following conditions:

1) retains responsibilities for the services to be provided by the issuer;
2) furnishes services to the issuer's enrollees under an oral or written agreement; or
3) performs some of the issuer's management functions under contract or delegation.

CMS proposes that it may permit a nonprofit organization that is not an issuer or the representative of an issuer but shares control with an existing issuer to sponsor or facilitate the creation of a CO-OP. Likewise, a nonprofit that is not a health insurance issuer, but sponsors an issuer, may be eligible to sponsor an applicant. The key filter in both instances is governance: the issuer associated with the nonprofit may not share a chief executive or any members of the board of directors with the loan applicant or cooperative.

CMS further proposes that certain other insurance issuers may be eligible to sponsor CO-OP applicants, including issuers and church plans licensed by the state after July 16, 2009, self-funded and Taft-Hartley group health plans, and three-share or multi-share programs not licensed by the state insurance regulator.

Regarding the prohibition from participation placed on government agencies—"unit(s) of government"—CMS proposes a broad interpretation. The agency specifically states that it believes the prohibition must also apply to medical centers that are part of state or local governments, including public university medical centers, and to medical practice groups that are created and overseen by a medical center owned by state or local government.

Finally, CMS proposes that CO-OP loan recipients may contract with existing issuers for services (provider network access, premium billing, case management, etc.) as long as the governance and control of the two entities remain separate and distinct.

Standards

Governance

CMS proposes that CO-OPs implement policies and procedures to foster and ensure member control of the organization, including a board of directors elected by a majority vote of its members, with every member eligible to vote. CMS makes a distinction between a "formation board," the board governing the organization during its pre-enrollment start-up phase, and an "operational board." The agency proposes that the first election of the operational board must occur no later than one year after coverage takes effect for the first member of the CO-OP.

The proposal would require that all elections for the board of directors have more than one candidate for each open position to prevent entrenchment or undue influence of any individual director. However, no guidance is provided on how a CO-OP should ensure that all elections are contested.

Further, CMS proposes that a majority of the voting members of the board of directors be members of the organization. The agency makes provision for CO-OPs to reserve positions for directors with particular, relevant health care experience (providers, actuaries, etc.). Those directors with specialized experience may not constitute a majority of the voting members of the operational board, even if those directors are also members of the CO-OP. For example, this would preclude an operational board from having physicians as a majority of the voting members. A majority of a board's voting directors must be "average consumer" members of the CO-OP. No government officials, from any level or unit (federal, state or local), may serve on a CO-OP formation or operational board, nor may representatives from existing insurers serve on those boards, either.

In keeping with the requirement that each CO-OP operate with a strong consumer focus, CMS proposes that all directors must meet ethical, conflict-of-interest and disclosure standards. The standards must protect against insurance industry involvement and interference, as well as ensure that each director acts in the sole

interest of the CO-OP and its members and avoids self-dealing. At a minimum, the agency proposes that ethics standards must include:

1) A mechanism to identify potential ethical or other conflicts of interest;
2) A requirement for all of a CO-OP's executive officers and directors to disclose all potential conflicts of interest;
3) A process to determine the extent to which a conflict exists;
4) A process to address any conflict of interest; and
5) A process to be followed in the event a director or executive officer of the CO-OP violates these standards.

Health Plan Issuance

The ACA requires that "substantially all" of a CO-OP's activities consist of the issuance of qualified health plans (QHP, as defined by the ACA and the recently-proposed rule regarding health insurance exchanges). CMS proposes that a CO-OP will meet the "substantially all" standard if at least two-thirds of all contracts issued, not patients covered, by the CO-OP are QHPs. A CO-OP must continually meet this standard.

CMS, interestingly, notes that it proposes this standard to, "allow providers wishing to sponsor CO-OPs to enroll their own employees… and thereby encourage provider participation." CMS further discusses that this standard would permit or encourage CO-OPs to participate in Medicaid and the Children's Health Insurance Program (CHIP), which may offer patients greater continuity of care as they move between forms of coverage.

CMS proposes that each CO-OP receiving a loan, either for start-up or solvency, must offer a silver-level and a gold-level plan on the individual and small group exchanges in the geographic area the plan wishes to serve. This maintains consistency with the ACA's statutory requirement that other insurers wishing to participate in exchanges must offer plans at those two levels, at a minimum. Likewise, CO-OPs may only offer plans and accept enrollment during the enrollment periods proposed in the above-mentioned exchanges rule.

The agency further proposes that CO-OPs receiving a loan must meet the above-referenced governance standards within four and an half years (54 months) of the initial drawdown of a start-up loan or within 18 months of the initial drawdown of a solvency loan.

Finally, CMS or an entity designated by the agency will determine, based on evidence provided by the CO-OP, whether the CO-OP is in compliance with the terms of the program, the standards for CO-OP QHPs and state standards. If found to be in compliance, a CO-OP will be deemed certified to participate on an exchange and will not need to undergo the exchange's issuer and plan accreditation and certification procedures. The CO-OP must still meet all CMS and state standards for QHPs on each exchange in which the plan participates.

Loan Terms

The Advisory Board recommended, and CMS concurred with, four principles for awarding start-up and solvency loans:

1) Consumer operation, control, and focus must be the salient features of the CO-OP and must be sustained over time;
2) Solvency and the financial stability of coverage should be maintained and promoted;
3) CO-OPs should encourage care coordination, quality and efficiency to the extent feasible in local provider and health plan markets; and
4) Initial loans should be rolled out as expeditiously as possible so that CO-OPs can compete in the Exchanges in the critical first open enrollment period.

CMS will award loans to assist CO-OP applicants with costs associated with start-up and meeting the financial solvency requirements of the state(s) in which the plan will operate. The ACA mandates repayment periods of five years for start-up loans and 15 years for solvency loans. CMS retains discretion to develop specific loan terms, though, which are proposed in this portion of the rule. CMS will begin awarding loans in the late 2011 or early 2012 timeframe, as indicated by the FOA referenced earlier. The agency proposes pegging loans'

interest rates to a rate benchmarked to the average interest rate on marketable Treasury securities of similar maturity, but may consider reductions to the benchmarked rate to make loan repayment easier for CO-OPs.

CMS recognizes in the proposal that solvency requirements vary state-by-state and that some states may consider solvency loans as debt rather than risk-based capital. As such, CMS proposes to structure solvency loans to allow CO-OPs to use premium payments to pay claims and meet cash reserve requirements before repayment of the loan to CMS. In its discussion, CMS notes the Advisory Board's recommendation that CO-OPs indicate in their application packages that they have discussed, "appropriate mechanisms" with their insurance regulators for structuring the loans to meet reserve requirements, as well as provide CMS with a clear description of those mechanisms.

In the application, CMS also proposes that applicants be allowed to request individualized repayment schedules, including features such as a grace period, graduated repayments or balloon payments at the end of the repayment period. CMS further proposes to retain the right to execute a loan modification or workout when a CO-OP is unable make repayments or meet other conditions of the loan without adversely affecting coverage stability, member control, quality of care, or the public interest generally, or meet state reserve and solvency requirements. CMS expressly notes in its discussion that, "preventing the failure of a CO-OP should take priority over repayment because insolvency of a CO-OP would harm its members and create disruption in insurance markets."

Penalties
The ACA sets a stiff penalty for loan recipients who fail to meet contractual obligations or use federal funds in a prohibited or improper manner: the recipient must repay 110% of the aggregate amount of loans received, plus interest. CMS proposes that the interest rate be equal, rather than benchmarked, to the average interest rate on marketable Treasury securities of similar maturity.

Conversion
CMS proposes to prohibit participants in the CO-OP program from converting or selling to a for-profit or non-consumer-operated entity. CMS further proposes to prohibit, "any transaction by a CO-OP that would result in a change to a governance structure that does meet the standards" of the proposed rule.

For More Information
Program Web Site
Consumer Operated and Oriented Plan Program, from the Center for Consumer Information and Insurance Oversight within CMS

AAFP Resources
Health Care Cooperatives: Definitions and State Examples
Health Care Cooperatives: 2011 State Legislation

Other Resources
Consumer Operated and Oriented Plan Program Background, from GWU/RWJ's *HealthReform GPS*