



**THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP)
PROGRAM UNDER THE AFFORDABLE CARE ACT: POTENTIAL
AND OPTIONS FOR SPREADING MISSION-DRIVEN
INTEGRATED DELIVERY SYSTEMS**

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Invited Testimony before the Federal Advisory Board
On the Affordable Care Act's CO-OP Program

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The Consumer Operated and Oriented Plan (CO-OP) Program Under the Affordable Care Act: Potential and Options for Spreading Mission-Driven Integrated Delivery Systems

**Sara R. Collins, Ph.D.
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Executive Summary

Thank you for this invitation to testify before the Consumer Operated and Oriented Plan (CO-OP) Program Advisory Board on the Affordable Care Act's CO-OP Program. The Affordable Care Act provides \$6 billion in loans and grants for the development of new nonprofit health cooperatives to be sold as qualified health plans through state insurance exchanges and the individual and small-group insurance markets.

The experience of health cooperatives in the United States has demonstrated that the most successful organizations have been those with strong links to high-performing, integrated delivery systems that have been able to provide high-quality integrated and coordinated health care. The Department of Health and Human Services can draw on the experience of successful health cooperatives as it lays the ground rules for the development of a substantial number of new organizations across the country. If these new entities are provided the tools and flexibility necessary to reach sustainable membership levels, attain adequate purchasing leverage in their markets, develop strong links with integrated care systems, manage risk appropriately, and follow a mission-driven roadmap to achieve high-quality and coordinated care, they have the potential to embody the key overarching goals of health reform. These include the delivery of high-quality, effective, and safe care to achieve the best possible health outcomes for populations; the design of care delivery that is in the best interests of patients; and the efficient use of resources.

Key Provisions of the CO-OP Program

- Organizations qualified to participate in the CO-OP program are those that are organized under state law as nonprofit, member corporations.
- Priority will be given to plans that operate on a statewide basis, utilize integrated care models, and have significant private support.
- The governance of the organizations must be subject to a majority vote of its members and the organizations are required to operate with a strong consumer focus, but they are not consumer-owned.
- Profits must be used to lower premiums, improve benefits, or to finance programs aimed at improving the quality of care to its members.
- Any health insurance issuer that existed prior to July 16, 2009 may not qualify for the CO-OP program.
- Grant or loan recipients under the CO-OP program are restricted from using the funds for marketing activities.
- Representatives of federal, state, or local governments as well as representatives of insurance issuers that were in existence on July 16, 2009 cannot serve on cooperative boards.
- Cooperatives may establish private purchasing councils that may enter into collective purchasing arrangements for items and services. But the councils are precluded from setting payment rates for health care facilities or providers that are participating in health insurance coverage provided by the plans.
- The secretary of HHS is precluded from participating in any negotiation between cooperatives, or a purchasing council, and any health care facilities or providers including drug manufacturers, pharmacies, or hospitals. The secretary may not establish pricing structures for reimbursement of health benefits provided by the qualified health plans.

Provisions of the Affordable Care Act Relevant to CO-OPs

- New health cooperatives will enter a vastly different insurance marketplace in 2014 compared with the one that exists currently, and one that is potentially more favorable to them.

- The Affordable Care Act will bring sweeping change to the individual and small-group markets through:
 - the establishment of state insurance exchanges that will offer qualified health plans, including health cooperatives;
 - an individual requirement to have health insurance;
 - new insurance market regulations including prohibition of rating based on health status;
 - a federally determined essential benefit package with defined levels of cost-sharing;
 - sliding scale premium and cost-sharing credits for low and moderate income families;
 - small business tax credits (starting in 2010 and continuing through 2016);
 - insurer cost controls such as federal and state review of unreasonable premium increases and medical loss ratio requirements.

State Flexibility in Designing Exchanges Has Implications for Health Cooperatives

- States will have flexibility in designing their exchanges in ways that may reduce the risk of adverse selection against the exchanges, decrease administrative costs, help lower premiums and improve health care quality.
- One of the most significant areas of state discretion from the perspective of the CO-OP program is the degree to which states may exercise additional regulatory authority with respect to the certification of qualified health plans (i.e., whether exchanges are “active” vs. “passive” health plan purchasers).
- States can decide, at one extreme, to certify all plans for participation in the exchange that meet the minimum set of criteria laid out in the law and by HHS. Or, at the other extreme, states may decide to set higher certification standards for health plans to improve quality, lower price, and shift the competitive dynamic among health plans towards value.
- In highly concentrated insurance markets (one or two plans currently dominate more than 50 percent of the market in most states), exchanges may well be positioned to help level the playing field. That is, such a market may enable nonprofit health plans,

like new or existing health cooperatives closely linked to high quality integrated delivery systems, to enter the field.

- This ability will depend on the degree to which exchanges are able to capture most of the individual and small-group markets, which will likely evolve over time.

U.S. Models of Successful Health Cooperatives and Nonprofit Integrated Delivery Systems

- The most successful existing examples of regional health cooperatives are those with strong links to high performing integrated care systems: HealthPartners in Minneapolis–Saint Paul and Group Health Cooperative in Seattle.
- Both are nonprofit, consumer-governed organizations that serve more than 500,000 members in broad geographic areas. In addition to insurance, HealthPartners and Group Health directly provide health services through nonprofit integrated delivery systems. The cooperatives own or contract with hospitals and clinics and contract with dedicated multispecialty physician groups.
- Keys to these organizations' success include:
 - a consumer-focused mission;
 - accountability resulting from a consumer-elected board;
 - close links with care systems and networks of providers;
 - a regional focus integrating a broad range of services;
 - commitment to evidence-based care and informed patient engagement;
 - strategic use of electronic health records to support care redesign;
 - patient-centered medical home model of primary care;
 - efforts at care coordination and greater accountability for the total care of patients;
 - lean techniques with care teams and frontline staff;
 - a culture of continuous improvement that has included:
 - setting ambitious goals for health system transformation,
 - measuring what is important for improving patient care,
 - agreeing on best practices and supporting improvement at the clinical level,

- aligning payment and other incentives for providers and patients with organizational goals,
 - making clinical performance measures for providers and the health plan publicly available.
- Similar successful examples of nonprofit integrated delivery systems with affiliated health plans, though not consumer governed, are Geisinger Health Systems in Pennsylvania, Intermountain Healthcare in Utah, and Kaiser Permanente.

Potential of the CO-OP Program to Spread Models of High Performing Nonprofit Integrated Delivery Systems

- The CO-OP program could spread highly successful models of nonprofit consumer-focused, integrated delivery systems like HealthPartners and Group Health, and similar nonprofit integrated delivery systems with affiliated health plans like Geisinger, Intermountain, and Kaiser Permanente.
- While it may be difficult for new cooperatives to replicate such models in a short period of time, the provisions of the Affordable Care Act are sufficiently flexible to allow health cooperatives to contract with a wide array of high-performing provider organizations to achieve similar goals including:
 - Contracting with integrated delivery systems. The law precludes existing health plans like the Geisinger Health Plan from serving on the boards of cooperatives receiving grants, but it does not preclude the new cooperatives from contracting with Geisinger’s integrated delivery system.
 - Through such arrangements, the CO-OP program could help replicate the unique nonprofit collaborative environment of Minneapolis–St. Paul area, where shared clinical practice guidelines, evidence-based care, and physician payment and performance standards among stakeholders have made the region a leader in health delivery innovation. Minnesota ranks in the top five states in the Commonwealth Fund’s State Scorecard on the measure of high-performing health systems.

- The CO-OP program has the potential to reinforce the culture and increase the collective market share of these mission-driven organizations in regional markets through contractual arrangements or affiliations.
- Contracting with multispecialty group practices, clinics and hospitals, with a goal of integrating care systems. One example is Marshfield Clinic, a nonprofit, multispecialty group practice in rural Wisconsin with a regional ambulatory care system, affiliated health plan, and related foundations supporting health research and education. Marshfield has engaged its physicians and staff in a program of clinical performance improvement aimed at enhancing patient access, coordination of care, and efficiency of clinical operations. Marshfield Clinic sponsors Security Health Plan of Wisconsin, which provides coverage to 150,000 residents in 32 counties through a network of affiliated hospitals and providers, including Marshfield Clinic physicians. The plan is administratively and financially separate from Marshfield.
- Contracting with community health center networks. Available in every state, community health centers are linked through a common mission and formally through national organizations, such as the National Association of Community Health Centers. They thus have the potential to become multistate networks. Indeed, every qualified health plan sold through the state exchanges will be required to include essential community providers in their networks. One example of a high-performing, community-based system of care that contracts both with individual and group practices and community health centers is Community Care of North Carolina.

Purchasing Leverage and the Ability of Cooperatives to Compete in Highly Concentrated Insurance Markets

- One of the most significant challenges facing newly formed cooperatives will be their ability to gain market share in highly concentrated insurance markets.

- In most markets, large insurance carriers and provider systems individually negotiate prices that ultimately reflect “discounts” off list prices that physicians and hospitals charge patients without insurance. The discounts tend to vary depending on volume or plan enrollment. Thus, prices vary widely and the lowest rates are not available to all health plans.
- Newly formed cooperatives will be at a considerable disadvantage in obtaining favorable provider rates in most local markets, which will in turn make them less competitive in insurance exchanges and the individual and small-group markets.
- The ability to leverage purchasing power to obtain lower rates has been key to the success of cooperatives in other industries. Rural electric cooperatives, for example, are able to purchase power at cost from power marketing agencies that sell power from federal dams.
- Within the health care industry, successful cooperatives have been linked closely with care systems and networks of providers.
- Karen Davis, president of The Commonwealth Fund, points out that for cooperative health care to slow the growth in health care costs, a cooperative health plan would need the authority to purchase care on favorable terms and the ability to offer high quality networks of providers. Davis identifies at least two possibilities for providing cooperatives such leverage:
 - Federal or state governments could guarantee that cooperative health plans are able to obtain the lowest price charged to the most favored customer.
 - A national cooperative organization could be given the authority to negotiate provider prices on behalf of all customers.
 - In Germany, for example, membership “sickness funds,” with trustees representing employers and members, conduct negotiations as a group (i.e., all sickness funds negotiate together) with their regional counterpart provider organizations on behalf of all patients.
 - Such a process could be provided to a national “Health Value Authority” and applied to all health plans participating in an insurance exchange, including cooperatives.

- The private purchasing councils are one potential vehicle by which cooperatives might gain purchasing leverage in provider negotiations. But the law precludes the councils from “setting payment rates” for health care facilities or providers that are participating in health insurance coverage provided by the plans. But it is unclear whether the purchasing councils might be allowed to negotiate provider rates. States might want to consider requiring providers to give health cooperatives the lowest prices they give to other private insurers.
- More generally, for cooperatives to succeed, they will need to link to networks of providers that are accountable for providing access, high quality care, and innovations that slow cost growth.

Moving U.S. Health Care Towards High Performing Integrated Care Systems

- The way states elect to implement their exchanges will be critically important, not only for the long term viability of health cooperatives but the ability to move our current fragmented system of health care to a national delivery system that has the mission, values, capacity, operational systems and strategies of high-performing systems like HealthPartners and Group Health.
- Careful attention by federal regulators and the states to use the flexibility allowed them under the law to effectively reduce the potential for adverse selection against the exchange will strengthen the market presence of the exchanges themselves, allowing them to offer plans with competitive premiums.
- This will further enable state exchanges to devise more rigorous criteria for qualified health plans that will help move insurance markets towards an emphasis on high value models of consumer-focused, patient-centered, integrated delivery systems.
- The concept of health cooperatives envisions mission-driven health plans that are accountable to their members and the public interest for providing accessible, high quality, and affordable care. With exchanges and other provisions of the Affordable Care Act, states, with the support of federal legislation, have the potential to hold all plans and care systems accountable to these goals.

Thank you.

The Consumer Operated and Oriented Plan (CO-OP) Program Under the Affordable Care Act: Potential and Options for Spreading Mission-Driven Integrated Delivery Systems

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Thank you for this invitation to testify before the Consumer Operated and Oriented Plan (CO-OP) Program Advisory Board on the Affordable Care Act's CO-OP Program. The law provides \$6 billion in loans and grants for the development of new nonprofit health cooperatives to be sold as qualified health plans through state insurance exchanges established by the law, as well as newly reformed individual and small-group insurance markets beginning in 2014. The experience of health cooperatives in the United States has demonstrated that the most successful organizations have been those with strong links to high-performing, integrated delivery systems that have been able to provide high-quality integrated and coordinated health care.¹ The Department of Health and Human Services (HHS) can draw on the experience of successful health cooperatives as it lays the ground rules for the development of a substantial number of new organizations across the country. If these new entities are provided the tools and flexibility necessary to reach sustainable membership levels, attain adequate purchasing leverage in their markets, develop strong links with integrated care systems, manage risk appropriately, and follow a mission driven roadmap to achieve high quality and coordinated care, they have the potential to embody the key overarching goals of health reform. These include the delivery of high quality, effective and safe care to achieve the best possible health outcomes for populations; the design of care delivery that is in the best interests of patients; and the efficient use of resources.

The CO-OP Program

¹ K. Davis, "[Cooperative Health Care: The Way Forward?](#)" The Commonwealth Fund Blog, June 22, 2009.

The Affordable Care Act establishes the Consumer Operated and Oriented Plan (CO-OP) program to award grants and loans to support the development of nonprofit, member health insurance organizations that will offer qualified health plans through the insurance exchanges and the individual and small-group markets. Any health insurance issuer that existed prior to July 16, 2009 may not qualify for the CO-OP program. Priority will be given to plans that operate on a statewide basis, utilize integrated care models, and have significant private support. The secretary of HHS will ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state. If no insurance issuer in a state applies for funding, the secretary may use grants and loans for the expansion of a qualified, nonprofit cooperative established in another state into the state in question. The law appropriates \$6 billion for the CO-OP program and the secretary will begin awarding grants and loans on July 1, 2013.

Grant or loan recipients under the CO-OP program are restricted from using the funds for marketing activities or for activities related to propaganda or influencing legislation.

Organizations qualified to participate in the program are those that are organized under state law as nonprofit, member corporations (though not consumer-owned) and whose activities are limited to issuing qualified health plans in the individual and small-group markets. The governance of the organizations must be subject to a majority vote of its members and the organizations are required to operate with a strong consumer focus, including timeliness, responsiveness and accountability to members. Profits must be used to lower premiums, improve benefits, or to finance programs aimed at improving the quality of care for its members. The organizations must also meet state requirements for qualified health plans to be provided through the insurance exchanges.

The law places restrictions on board membership. Representatives of federal, state or local governments as well as representatives of insurance issuers that were in existence on July 16, 2009 cannot serve on cooperative boards or those of the private purchasing councils.

Purchasing Leverage

Cooperatives participating in the program may establish private purchasing councils that may enter into collective purchasing arrangements for items and services including claims administration, administrative services, health information technology, and actuarial services. But the councils are precluded from setting payment rates for health care facilities or providers that are participating in health insurance coverage provided by the plans.

Similarly, the secretary of HHS is precluded from participating in any negotiation between cooperatives, or a purchasing council, and any health care facilities or providers including drug manufacturers, pharmacies, or hospitals. In addition, the secretary may not establish or maintain a price structure for reimbursement of health benefit provided by the qualified health plans.

Provisions of the Affordable Care Act Relevant to CO-OPs

New health cooperatives eligible for loans under the Affordable Care Act will enter a vastly different insurance marketplace in 2014 compared with the current one, and one that is potentially more favorable to them. The law will bring sweeping change to the individual and small-group markets through the establishment of state insurance exchanges that will offer qualified health plans including: health cooperatives; an individual requirement to have health insurance; new insurance market regulations, including prohibition of rating based on health status; a federally determined essential benefit package with defined levels of cost-sharing; sliding-scale premium and cost-sharing credits for low and moderate income families; small-business tax credits (starting in 2010 and continuing through 2016); and insurer cost controls, such as federal and state review of unreasonable premium increases and limits on medical loss ratios. The provisions most relevant to the CO-OP program are discussed below.

State Insurance Exchanges and New Insurance Market Regulations

The Affordable Care Act requires each state to establish a new health insurance exchange for individuals and another for small employers, or a single exchange for both individuals

and small employers.² States can choose to open the exchanges to employers with up to 100 employees or limit enrollment to companies with 50 or fewer employees until 2016. Starting in 2017, states can open the exchanges to employers with more than 100 employees. States can set up their own exchanges, band with other states to establish regional exchanges, or they can opt to set up more than one exchange serving geographically distinct areas. In 2013, if the secretary determines a state will not have an exchange operational by 2014, the secretary is required to establish and operate the exchange in that state. Most states have received a first round of federal grants to help plan their exchanges; federal financing will continue to January 2015. After that, each state exchange must be self-sufficient and can charge assessments or user fees to carriers. In 2017, states may opt out of the federal requirement to set up an exchange through a five-year waiver, if they are able to demonstrate that they can offer all residents coverage at least as comprehensive and affordable.

The individual and small-group markets will continue to function outside the exchange, but new insurance market regulations will apply to plans sold inside and outside the exchanges. The new regulations include prohibition of rating on the basis of health and gender, bans on preexisting condition exclusions and rescissions, and limits on the amount plans can vary premiums based on age. The law restricts variation in premiums based on age to no more than 3-to-1. Premiums may also vary by whether an individual or family is covered and by the geographic or “rating area” in which the coverage is offered, as established by each state or HHS. For tobacco users, the highest premium may be no more than 1.5 times the premium for a nonsmoker. These limits on premium variation do not apply to grandfathered plans.

Essential Benefit Package and Four Levels of Cost-Sharing

Starting in 2014, all health plans sold through the new state insurance exchanges and in the individual and small-group markets will be required to provide a federally determined essential benefit package similar in scope to a typical employer plan. The essential benefit package will be determined by the HHS secretary and must include, at a

² The Commonwealth Fund, [Health Reform Resource Center: What’s In the Affordable Care Act?](#) (Public Law 111–148 and 111–152).

minimum: ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; vaccines; chronic disease management; and pediatric services, including vision and oral care. Health plans may provide benefits in addition to those included in the essential health benefits package. The benefit requirements do not apply to grandfathered plans or self-insured employer plans.

Individuals and small businesses purchasing coverage through the exchanges and the individual and small-group insurance markets may choose among health plans with the essential benefit package and four different levels of cost-sharing. These four levels cover an average 60 percent of an individual's total medical costs per year (bronze plan), 70 percent of medical costs (silver plan), 80 percent of medical costs (gold plan), and 90 percent of medical costs (platinum plan). Out-of-pocket costs are limited to \$5,950 for single policies and \$11,900 for family policies.

Premium and Cost-Sharing Tax Credits

People who must buy coverage on their own will be eligible for a federal tax credit to help pay for the cost of premiums for plans sold through the exchanges. Tax credits are not available for plans purchased outside the exchange. Premium credits will be tied to the silver plan and will cap contributions for individuals and families from 2 percent of income for those with incomes up to 133 percent of the federal poverty level (\$14,404 for a single adult or \$29,327 for a family of four) and gradually increase to 9.5 percent of income for those with incomes at 300 percent to 400 percent of the poverty level (\$43,320 for a single person and \$88,200 for a family of four). In addition, cost-sharing credits effectively reduce out-of-pocket spending under the silver plan to an average 6 percent of total costs for those with incomes up to 150 percent of poverty (\$16,245 for a single person and \$33,075 for a family four). Out-of-pocket costs will be capped at a maximum of 13 percent of total costs for those with incomes up to 200 percent of poverty (\$21,660 for a single person and \$44,100 for a family of four) and 27 percent for those with incomes up to 250 percent of poverty (\$27,075 for a single person and \$55,125 for a family of four). In addition, out-of-pocket expenses will be capped for families earning

between 100 percent and 400 percent of poverty from \$1,983 for individuals and \$3,967 for families up to \$3,967 for individuals and \$7,933 for families.

Qualified Health Plans

Only qualified health plans that meet federally and state defined criteria will be sold through the exchanges. The law specifies that qualified health plans must provide the essential benefit package, be offered by a duly licensed health insurance issuer, comply with market regulations, and offer at least one qualified health plan at the silver and gold levels. Qualified health plans may be sold outside of the exchange but the insurance issuer must charge the same premium for qualified plans sold within or outside the exchange. Health plans do not have to be qualified plans to sell insurance in the individual and small-group markets outside the exchange. Importantly, health plans sold outside the exchange can sell at any level of coverage: they do not have to sell plans at the silver and gold levels. This provides a significant opportunity for adverse selection against the exchange. States will likely have the flexibility to impose more stringent requirements that will reduce such selection risk, such as requiring all health plans selling in the individual and small group markets to be certified as qualified health plans.³

Federal and State Responsibilities for the Exchanges and Qualified Health Plans

The secretary of HHS has a number of responsibilities with respect to the exchanges, in general, and defining the criteria for qualified health plans, in particular. They include:

- establishing certification criteria for qualified health plans;
- defining the essential benefits package and requiring qualified health plans to provide the package;
- requiring insurance carriers issuing plans to offer at least one qualified health plan at the silver and gold levels;
- requiring qualified health plans to meet marketing requirements established by the secretary and not employ marketing practices or benefit designs that discourage the enrollment of people with health problems;
- ensuring a sufficient choice of providers;

³ T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* (New York: The Commonwealth Fund, September 2010).

- ensuring that essential community providers who serve predominantly low-income and medically underserved individuals are included in the networks;
- ensuring that qualified health plans are accredited on clinical quality measures, patient experience ratings, and other measures including consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and network adequacy;
- developing a uniform enrollment form for individuals and employers and presenting plan information in a standard format; and
- providing information on quality measures on health plan performance.

The secretary is required to implement a quality improvement strategy. Under the law, qualified health plans are required to report to the exchange activities related to the implementation of new provider payment structures that provide increased reimbursement or other incentives aimed at improving quality and health outcomes. The secretary is to develop guidelines for activities aimed at improving health outcomes, preventing hospital readmissions, improving patient safety, implementing wellness programs, and reducing health disparities.

In addition, the secretary will develop a rating system that will rate qualified health plans within each benefit level on the basis of relative quality and price. This information will be provided on the Internet portal for individuals and employers and will be used as a model template for an exchange's Internet portal. The portal would be used to direct individuals and employers to qualified health plans, to help them determine whether they are eligible for premium and cost-sharing credits, and to present standardized information about health plans to facilitate ease of choice. The secretary also will determine an initial and open enrollment period as well as special enrollment periods for people under varying circumstances.

The secretary is also required to establish procedures under which states may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for subsidies. Such procedures may include the establishment of rate schedules for broker commissions paid by health plans offered through the exchange.

After HHS issues regulations and sets standards for exchanges, states may adopt before January 2014 the federal standard into their own laws or adopt similar standards that HHS deems equivalent. Once they are operational, state exchanges will be required to certify qualified health plans, operate a toll-free hotline and Web site, rate qualified health plans, present plan options in a standard format, inform individuals of the eligibility requirements for Medicaid and the Children’s Health Insurance Program, provide an electronic calculator to calculate plan costs, grant certifications of exemption from the individual responsibility requirement, and transfer to the Department of Treasury information necessary to enforce the employer responsibility penalties. The exchanges also will award grants to “navigators” who will educate the public about qualified health plans, distribute information on enrollment and subsidies, facilitate enrollment, and provide referrals on grievances. Navigators may include trade and professional organizations, farming and commercial fishing organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, or licensed insurance agents or brokers.

Exchanges: Active vs. Passive Purchasers of Qualified Health Plans

The law sets out broad guidelines for the exchanges that will be further defined by HHS. But states will likely have considerable flexibility in designing their exchanges in ways that may reduce the risk of adverse selection, decrease administrative costs, help lower premiums, and improve health care quality. Timothy Stoltzfus Jost has enumerated several areas where states and the federal government will have to make decisions that will likely have significant implications for consumers and health plans and the long-term viability of the exchanges themselves.⁴

One of the most significant areas of state discretion from the perspective of the CO-OP program is the degree to which states will exercise additional regulatory authority with respect to the certification of qualified health plans (i.e., whether exchanges are “active” vs. “passive” health plan purchasers).⁵ As Jost points out, states can decide, at one extreme, to certify all plans for participation in the exchange that meet the minimum

⁴ Ibid.

⁵ Ibid.

set of criteria laid out in the law and further defined by HHS. Or, at the other extreme, states may decide to set higher certification standards for health plans to improve quality, lower price, and shift the competitive dynamic among health plans towards value. In highly concentrated insurance markets (one or two plans dominate more than 50 percent of the market in most states), exchanges may well be positioned to help level the playing field. That is, the exchange may help enable nonprofit health plans, like new or existing health cooperatives closely linked to high quality integrated delivery systems, to enter the market. But the extent to which exchanges are able to increase certification requirements will depend on the degree to which they can capture most of the individual and small-group markets.⁶ As Jost points out, this will likely hinge on the price of health plans offered through the exchange vs. the outside markets, as well as the quality of customer service offered by the exchanges, particularly that for small employers. The price of plans offered through the exchange will in turn be driven to a large degree by related implementation decisions that states must make, such as additional measures beyond the law to reduce adverse selection against the exchange (e.g., requiring all health plans to meet the standards of qualified plans), the effectiveness of the risk adjustment mechanism that will be applied to exchanges under the law, and the effectiveness of the individual health insurance mandate.

Medical Loss Ratio Requirements and Review of Unreasonable Premium Increases

The law includes two provisions—requirements governing medical loss ratios and review of “unreasonable” premium increases—that will provide the public with information about the increases they experience in their premiums each year and how their premium dollars are spent. Such transparency is unprecedented in the individual and small-group insurance markets on a national basis and will create a new competitive dynamic and incentives to lower costs among carriers. Given the nonprofit nature of plans eligible for the CO-OP program, the provisions could well provide cooperatives a competitive advantage.

Medical loss ratio requirements. In November, HHS issued interim final regulations governing medical loss ratios (MLRs), or the percentage of enrollees’

⁶ Ibid.

premiums that health plans spend on medical care versus the amount spent on administration and profits.⁷ Beginning in 2011, health plans are required to report their total spending on medical care and activities to improve the quality of care relative to their nonmedical costs, such as those for marketing, advertising, underwriting, broker commissions, profits, and compensation. Insurance companies must provide separate reports for each market in each state in which they do business: individual, small group, and large group. HHS will publicly post the reports, with the first reports for 2011 due by June 2012. Beginning in August 2012, health plans in the large-employer group market that spend less than 85 percent of their premiums on medical care and quality improvement activities, and plans in the small-employer group and individual markets that spend less than 80 percent on the same, will be required to offer rebates to enrollees based on their 2011 MLR reports. Carriers will pay rebates to enrollees in the form of a reduction in their premiums or a rebate check. People with employer-based plans will receive rebates that are proportional to their premium contribution.

In calculating their MLRs, health plans are allowed to deduct federal and state taxes on health insurance from their premium revenues but not taxes on investment income and capital gains. The new regulations allow quality improvement activities to count as medical costs but health plans must be able to demonstrate over time that such activities are improving health outcomes.

The MLR regulations make some exceptions and adjustments for certain types of health plans. Very small health plans (fewer than 75,000 enrollees) are either excluded from the regulations or receive an adjustment to their MLRs, and new plans, where 50 percent or more of premium revenues are for policies that have been in effect for less than one year, may delay MLR reporting until the following year.

Review of unreasonable premium increases. The Affordable Care Act calls on the HHS secretary to establish a process for the annual review of “unreasonable” increases in premium rates by insurance carriers across the country. In December, HHS released proposed regulations on the provision, laying out a process for the states and the

⁷ S. R. Collins, [Medical Loss Ratio Regulations Good for Consumers](#), The Commonwealth Fund Blog, November 2010; Department of Health and Human Services, [Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, Interim Final Rule](#).

federal government to review rate increases by insurers, as well as to publicly disclose those increases.⁸ For 2011, the regulations specify that any premium rate increase of 10 percent or more in the individual or small-employer group insurance markets, effective on or after July 2011, will be subject to review by states and HHS. To bring the threshold in line with state cost trends, beginning in 2012, HHS will establish state-specific rate increase thresholds for each calendar year.

The regulations allow states that HHS determines to have an effective premium review process in place to use the standards established under current state law to determine whether an increase that exceeds the threshold is unreasonable. In states that do not yet have an effective review process in place, HHS will determine whether a rate increase is unreasonable based on whether it is “excessive,” or unreasonably high in relation to the benefits provided; “unjustified,” or lacking adequate data to determine whether it is reasonable; or “unfairly discriminatory,” or resulting in premium differences for enrollees that are not permissible under state law or unjustified based on expected cost differences.

HHS will require carriers reporting premium increases above the 10 percent threshold to submit justifications, which will then be posted on the HHS Web site. If HHS determines the rate increase to be unreasonable, it will notify the carrier. If the insurance carrier decides not to implement the increase, or implements a lower increase, the carrier will issue a final notification of the change. If the carrier’s revised increase is still above the threshold, it will be subject to another round of review by HHS. If the carrier decides to proceed with the unreasonable increase, it will provide a final justification to HHS, which HHS will post on its Web site along with its determination that the increase is unreasonable. The insurance carrier will be required to post the same on its Web site.

States conducting their own review process will provide notice to insurance carriers and HHS as to whether they consider the increase to be unreasonable and why. HHS will then adopt the determination made by the state and post it on the HHS Web site. If the insurance carrier in question chooses to implement the increase anyway, HHS

⁸ S. R. Collins, [New Review Process for “Unreasonable” Premium Hikes](#), The Commonwealth Fund Blog, December 2010; Department of Health and Human Services, [Rate Increase Disclosure and Review](#), Dec. 23, 2010.

will post the amount of the increase, the carrier's justification, and the state's determination of why the increase is unreasonable on its Web site.

In 2014, states can recommend that health plans be excluded from participation in the insurance exchanges if they have demonstrated a pattern of excessive or unjustified premium increases.

U.S. Models of Successful Health Cooperatives and Nonprofit Integrated Delivery Systems

The most successful existing examples of regional health cooperatives are those with strong links to high-performing integrated delivery systems: HealthPartners in Minneapolis–Saint Paul and Group Health Cooperative in Seattle.⁹ Both are nonprofit, consumer-governed organizations that serve more than 500,000 members in broad geographic areas. In addition to insurance, HealthPartners and Group Health directly provide health services through nonprofit integrated delivery systems. The cooperatives own or contract with hospitals and clinics and contract with dedicated multispecialty physician groups. Similar successful examples of nonprofit integrated delivery systems with affiliated health plans, though not consumer-governed, are Geisinger Health Systems in Pennsylvania, Intermountain Healthcare in Utah, and Kaiser Permanente. Indeed, the health cooperatives that have performed so well—like HealthPartners and Group Health—have been strongly linked to integrated care systems. Their success has depended greatly on innovative care systems. Recent Commonwealth Fund case studies by Douglas McCarthy and colleagues outline the structure and strategy of several of these organizations.¹⁰ Below are brief summaries of HealthPartners and Group Health.

HealthPartners

HealthPartners is the largest nonprofit, consumer-governed health organization in the United States.¹¹ It was formed through a merger between Group Health, a staff model

⁹ K. Davis, *Cooperative Health Care*, 2009.

¹⁰ D. McCarthy and K. Mueller, [*Organizing for Higher Performance: Case Studies of Organized Delivery Systems*](#) (New York: The Commonwealth Fund, July 2009).

¹¹ D. McCarthy, K. Mueller, and I. Tillman, [*HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda*](#) (New York: The Commonwealth Fund, June 2009).

HMO founded in 1957 and a network-model HMO; and Regions Hospital a 427-bed teaching hospital and level I trauma center. Two 25-bed critical care hospitals also joined the system. HealthPartners currently provides individual, group, and public insurance to more than 1 million people in Minnesota, western Wisconsin, North Dakota, South Dakota, and Iowa. About 30,000 providers provide care to HealthPartner enrollees either through owned or contracted multispecialty medical groups, specialty clinics, hospitals and dental practices. The multispecialty HealthPartners Medical Group employs more than 600 physicians practicing in 50 clinics and serves both members of HealthPartner's health plan and people enrolled in other insurance plans. The system also provides behavioral health, eye care, disease management, integrated home care and hospice, pharmacy, wellness, and personalized health promotion for individuals and groups. HealthPartners employs 10,000 people and has annual revenues of \$3.1 billion.

HealthPartners has placed an emphasis on evidence-based care through the HealthPartners Research Foundation which conducts clinical, health services, and basic science research available to the public. In addition, HealthPartners participates in and financially supports Minnesota's Institute for Clinical Systems Improvement (ICSI), which brings together health plans and medical groups to develop evidence-based clinical guidelines and sponsors collaborative improvement activities. Physicians in the region commit to practicing evidence-based care based on clinical standards developed by ICSI.

McCarthy and colleagues argue that the keys to HealthPartners's success have been its consumer-focused mission and the accountability resulting from a consumer elected board; a regional focus integrating a broad range of services; commitment to evidence-based care and informed patient engagement; strategic use of electronic health records to support care redesign; efforts at care coordination and greater accountability for the total care of patients; and a culture of continuous improvement. HealthPartners developed a comprehensive model for improvement that it disseminates through leadership councils, workforce skills development, and learning collaborations. Components of its improvement strategy include setting ambitious goals for health system transformation, measuring what is important for improving patient care, agreeing on best practices and supporting improvement at the clinical level, aligning incentives for

providers and patients with goals, and making clinical performance measures for providers and the health plan publicly available.

HealthPartners also benefits from a unique market environment. By law, all HMOs must be organized as nonprofits in Minnesota. Minnesota, particularly in the Twin Cities area, has been a national leader in innovative approaches to health care financing and delivery, with a historical emphasis on physician group practice. Several collaborative organizations including Minnesota Community Measurement and the ICSI have been successful in forging agreement among stakeholders on a set of clinical guidelines, quality improvement strategies and metrics, and performance reporting and provider incentive programs.¹² This has helped to create a unique collaborative environment that has been able to achieve broad community-based improvement and change in clinical practice. Indeed, Minnesota ranks in the top five states in the country in the Commonwealth Fund's State Scorecard ranking of states on the measure of high-performing health systems.¹³

Group Health Cooperative

Group Health Cooperative (GHC) is a nonprofit, consumer-governed health care system founded in 1947 in Seattle as a staff-model HMO employing physicians.¹⁴ GHC has since evolved into a mixed-model network health plan that contracts with a large multispecialty medical group (Group Health Permanente) of 900 physicians, as well as 9,000 independent physicians in private individual and group practice, mostly in areas with low population density. The system includes 26 primary care centers, five specialty units, and seven behavioral health clinics, as well as contracts with 41 community hospitals. The health plan provides insurance coverage in the individual, employer-group, and public-insurance markets to more than 650,000 residents of Washington state and northern Idaho. The system and the medical group employ about 9,000 people and realized \$2.5 billion in revenue in 2007.

¹² Ibid.

¹³ D. McCarthy, S. K. H. How, C. Schoen, J. C. Cantor, and D. Belloff, [*Aiming Higher: Results from a State Scorecard on Health System Performance, 2009*](#) (New York: The Commonwealth Fund, Oct. 2009).

¹⁴ D. McCarthy, K. Mueller, and I. Tillmann, [*Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home*](#) (New York: The Commonwealth Fund, July 2009).

Like HealthPartners, GHC has a consumer-elected board of directors. All adult members of the health plan may register to vote at the annual membership meeting and may also speak at the beginning of public board meetings. In addition, members can join focus groups or serve on the council of their local medical centers.

Also like HealthPartners, GHC has made considerable investments in research on improving care. The Group Health Center for Health Studies, which has a staff of 250 and received \$34 million in external grant funding in 2007, conducts epidemiologic, behavioral, clinical, and health services research. Research includes evidence-based practices and innovative approaches to care management that are pilot tested within GHC and have been disseminated to other delivery systems.

According to McCarthy and colleagues, GHC's integrated financing and delivery model, which is supported by a partnership between health plan administrators and medical group physicians, has been critical to its ability to launch delivery system innovations and organize service delivery in ways that have been optimal from both an administrative and clinical perspective. An example is GHC's implementation of a patient-centered medical home model of primary care that optimizes the role of a multidisciplinary care team and uses electronic health records to deliver proactive, coordinated care. Information technology has been integral to improving patients' communication with their care team, engaging them in their own evidence-based care, and reducing fragmentation of services. The Commonwealth Fund is currently supporting a Group Health evaluation of the use of patient-shared decision making aids, which help patients arrive at informed decisions about care by weighing the risks and benefits of various treatment options. GHC is using "lean" techniques to involve care teams and other frontline staff in standardizing their work, an approach that can likely be expanded to include other organizations.

Potential of the CO-OP Program to Spread the Models of HealthPartners and Group Health Cooperative and Other High Performing Nonprofit Integrated Delivery Systems

Through the provision of loans to develop cooperative health plans in each state, the Affordable Care Act opens the possibility of spreading highly successful models of

nonprofit, consumer-focused, integrated delivery systems like HealthPartners and Group Health, and similar nonprofit systems with affiliated nonprofit health plans like Geisinger Health Systems, Intermountain Healthcare, and Kaiser Permanente. But given that these will be newly formed organizations, it will likely be very difficult for them to replicate such models in a short period of time. However, the provisions of the Affordable Care Act are sufficiently flexible to allow contracting with a wide array of provider organizations to achieve similar goals. Indeed, there are likely a number of different arrangements that cooperatives might pursue.

Contracting with Integrated Delivery Systems, Multispecialty Group Practices, or Networks of Community Health Centers

While the law precludes existing health plans like the Geisinger Health Plan from serving on the boards of cooperatives receiving grants, it does not preclude the new cooperatives from contracting with Geisinger's integrated delivery system. If, for example, a cooperative is formed in central Pennsylvania, it could contract with Geisinger Health System. The Geisinger Health Plan is a network model health maintenance organization that insures about 30 percent of Geisinger Health System's patients through group, individual, and Medicare coverage.¹⁵ The Geisinger Health Plan partners with the health system to drive innovation in patient care, such as an advanced medical home model (ProvenHealth Navigator) and its Web-based Physician Quality Summary, which compares the performance of contracted primary care practice sites on nine clinical quality and patient service metrics using a three-star rating system. A newly formed nonprofit cooperative under the CO-OP program would have a culture and goals similar to the Geisinger Health Plan and health system which could spur collaboration. Similar opportunities may exist for cooperatives formed in the Salt Lake City area which could contract with Intermountain Health. Indeed, through such arrangements, the CO-OP program could help replicate in other states the unique nonprofit collaborative environment of the Twin Cities area, where shared clinical practice guidelines, evidence-based care, and physician payment and performance standards among stakeholders have

¹⁵ D. McCarthy, K. Mueller, and J. Wrenn, *Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives* (New York: The Commonwealth Fund, June 2009).

made the region a leader in health delivery innovation. The program thus has the potential to at least reinforce the culture and increase the collective market share of these mission-driven organizations in regional markets through contractual arrangements or affiliations. This could, in turn, reduce the market share of for-profit, fee-for-service insurance models that have forced many health cooperatives to move away from their original consumer-governed structure and mission, or retreat from providing integrated care.¹⁶ In Douglas McCarthy's case study of Group Health Cooperative, Scott Armstrong, Group Health's CEO, observed that competitive trends in private insurance markets are increasingly providing pressure to disaggregate services, which is counter to the Group Health model of achieving high-value care through service integration.¹⁷

In the absence of integrated delivery systems, cooperatives might separately contract with multispecialty group practices, clinics and hospitals, with a goal of integrating care systems. One such example is Marshfield Clinic, a nonprofit, physician-governed multispecialty group practice serving residents of rural Wisconsin through a regional ambulatory care system, an affiliated health plan, and related foundations supporting health research and education.¹⁸ The Marshfield Clinic sponsors Security Health Plan (SHP) of Wisconsin. SHP provides employer-group, individual, Medicaid, Medicare, and Children's Health Insurance Program coverage, as well as third-party administration, for 150,000 residents of 32 Wisconsin counties through a network of 42 affiliated hospitals and 3,800 providers (including Marshfield Clinic physicians). About 22 percent of Marshfield's patients are enrolled in SHP, but the plan is administratively and financially separate from Marshfield.

Another similar example is Rocky Mountain Health Plan in Colorado, a nonprofit plan that was successful in getting started in Grand Junction by working collaboratively with physicians and other providers to create a community-oriented care model that ensures equitable access and rewards quality.

Newly formed cooperatives might also contract with community health centers as a dedicated set of primary care providers. Available in every state, community health

¹⁶ Davis, *Cooperative Health Care*, 2009.

¹⁷ McCarthy, Mueller, and Tillman, *HealthPartners: Consumer-Focused Mission*, 2009.

¹⁸ D. McCarthy, K. Mueller, and S. Klein, [*Marshfield Clinic: Health Information Technology Paves the Way for Population Health Management*](#) (New York: The Commonwealth Fund, Aug. 2009).

centers are linked through a common mission, and formally through national organizations, such as the National Association of Community Health Centers. They thus have the potential to become multistate networks. Indeed, every qualified health plan sold through the state exchanges will be required to include essential community providers in their networks. In addition, the law allocates \$11 billion for the enhancement and development of community health centers. One example of a community-based system of care that contracts both with individual and group practices and community health centers is Community Care of North Carolina (CCNC). CCNC is a public-private partnership between the state and 14 nonprofit community care networks across North Carolina.¹⁹ The networks are comprised of essential local providers that provide a medical home for low income adults and children enrolled in Medicaid and the Children's Health Insurance Program.

Purchasing Leverage and the Ability of Cooperatives to Compete in Highly Concentrated Insurance Markets

One of the most significant challenges facing newly formed cooperatives will be their ability to gain market share in highly concentrated insurance markets. There are only three states in the country where the two largest health plans dominate less than 50 percent of the market. In addition, extensive consolidation in hospital and other provider markets across the country has substantially reduced price competition in those markets, as well.²⁰ Consequently, large insurance carriers and large provider systems individually negotiate prices, with those prices ultimately reflecting “discounts” off list prices that physicians and hospitals charge patients without insurance. The discounts tend to vary depending on volume or plan enrollment. Thus, prices vary widely and the lowest rates are not available to all health plans.²¹ Newly formed cooperatives will thus be at a considerable disadvantage in obtaining favorable provider rates in most local markets, which will in turn make them less competitive in insurance exchanges and in the individual and small group markets.

¹⁹ D. McCarthy and K. Mueller, *Community Care of North Carolina: Building Community Systems of Care Through State and Local Partnerships* (New York: The Commonwealth Fund, June 2009).

²⁰ J. Holahan and L. Blumberg, *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?* (Washington, D.C.: The Urban Institute, 2008).

²¹ Davis, Cooperative Health Care, 2009.

Karen Davis points out that leveraging purchasing power to obtain lower rates has been key to the success of cooperatives in other industries.²² Within the health care industry, success of cooperatives has also depended critically on being linked closely with care systems and networks of providers. One such example of the importance of purchasing leverage are rural electric cooperatives that got their start during the Great Depression through the Tennessee Valley Authority and the Rural Electrification Administration, which provided loans to cooperatives to build lines and provide service on a nonprofit basis. In addition, the federal government developed power marketing agencies (PMAs) to market the power of 133 federal dams across the country. The federal law governing PMAs allows them to sell power at cost to public entities and electric cooperatives, which has offset the cost of serving sparsely populated areas.

Davis argues that for cooperative health care to slow the growth in health care costs, a cooperative health plan would need the authority to purchase care on favorable terms and the ability to offer high-quality networks of providers. She identifies two possibilities for providing cooperatives purchasing leverage. First, federal or state governments could guarantee that cooperative health plans are able to obtain the lowest price charged to the most favored customer. A second option is to have a national cooperative organization negotiate provider prices on behalf of all customers. In Germany, for example, membership “sickness funds,” with trustees representing employers and members, conduct negotiations as a group – all sickness funds together with public oversight—with their regional counterpart provider organizations on behalf of all patients. Davis suggests that such a process could be provided to a national “Health Value Authority” and applied to all health plans participating in an insurance exchange, including cooperatives. This would help cooperatives and other high-value plans with strong ties to integrated delivery systems enter highly concentrated insurance markets.

The private purchasing councils that the Affordable Care Act allows cooperatives to form are one potential vehicle by which cooperatives might gain purchasing leverage. The councils may enter into collective purchasing arrangements for items and services including claims administration, administrative services, health information technology, and actuarial services. But the law precludes the councils from “setting payment rates”

²² Ibid.

for health care facilities or providers that are participating in health insurance coverage provided by the plans. Similarly, the secretary of HHS is precluded from participating in rate negotiations between cooperatives of purchasing councils and providers. But it is unclear whether the purchasing councils might be allowed to negotiate provider rates on behalf of health cooperatives. And states might want to consider requiring providers to give health cooperative plans the lowest prices they give to other private insurers.

Moving the U.S. Health System Toward High-Performing Integrated Care Systems

As noted previously, the way in which states elect to implement their exchanges will also be critically important not only for the long term viability of health cooperatives, but, as Karen Davis writes, the ability of health reform to help move “our current system of health care to a national delivery system that has the mission, values, capacity, operational systems and strategies” of systems like HealthPartners, Group Health, Geisinger, Intermountain, and Kaiser Permanente.²³ Careful attention by federal regulators and the states to use the flexibility allowed them under the law to effectively reduce the potential for adverse selection against the exchanges will strengthen the market presence of the exchanges themselves, allowing them to offer plans with competitive premiums. This will further enable state exchanges to devise more rigorous criteria for qualified health plans that will help move insurance markets toward the high-value models of patient-centered, integrated delivery systems. The concept of cooperatives envisions mission-driven health plans that are accountable to their members and the public interest for providing accessible, high-quality, and affordable care. With exchanges and other provisions of the Affordable Care Act, states, with the support of federal legislation, have the potential to hold all plans and care systems accountable to these goals.

Thank you.

²³ Ibid.