



**THE
COMMONWEALTH
FUND**

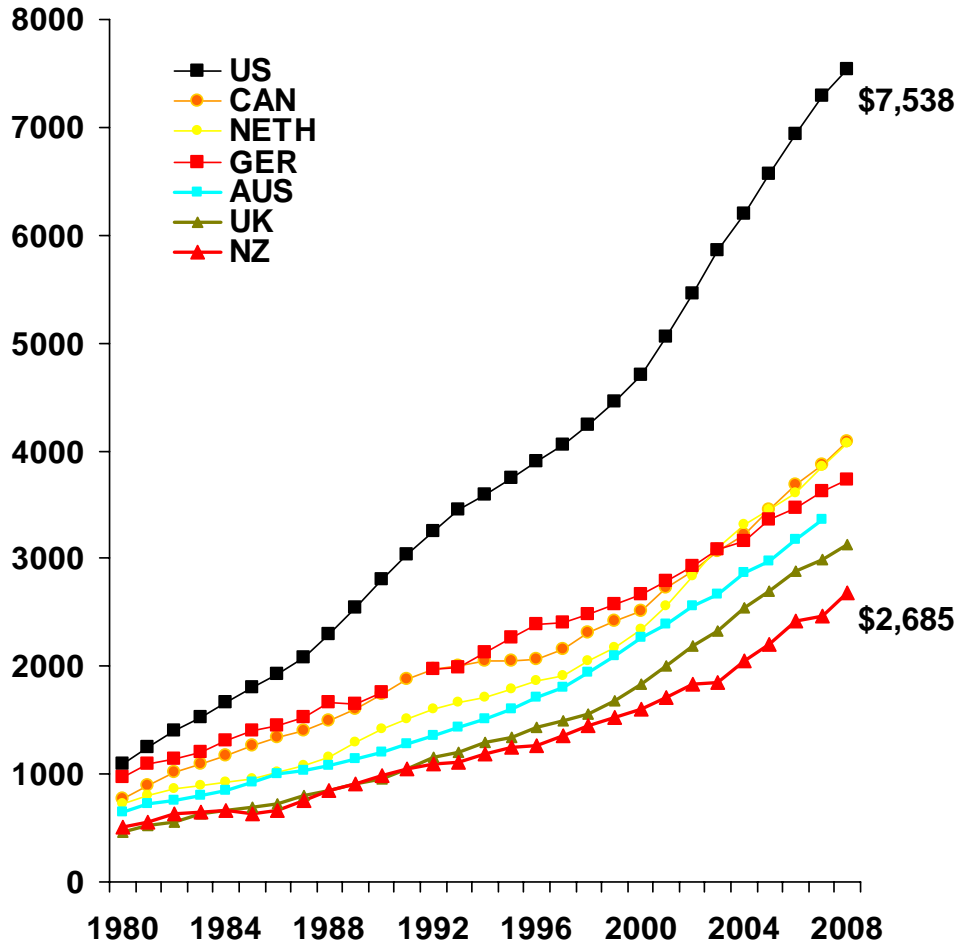
**The Consumer Operated and Oriented Plan (CO-OP) Program Under
the Affordable Care Act: Potential and Options for Spreading
Mission-Driven Integrated Delivery Systems**

**Sara R. Collins, Ph.D.
Vice President, Affordable Health Insurance
The Commonwealth Fund**

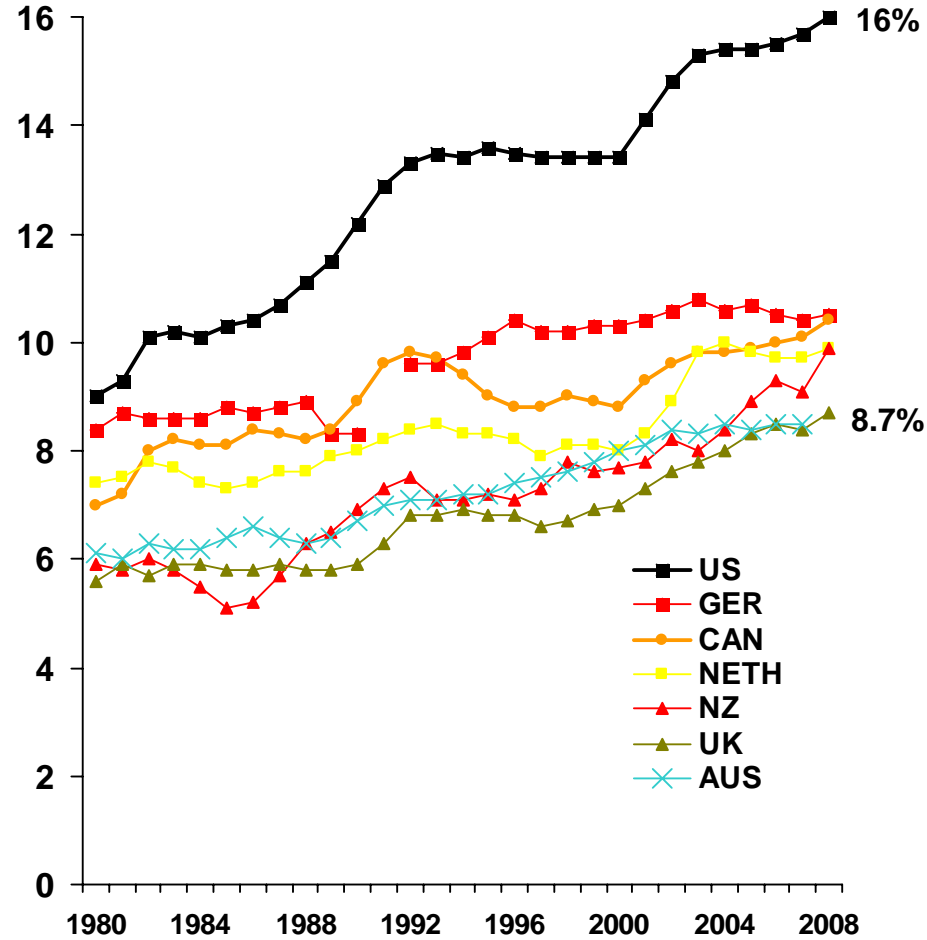
**Invited Testimony before the Federal Advisory Board
On the Affordable Care Act's CO-OP Program
January 13, 2011**

International Comparison of Spending on Health, 1980–2008

Average spending on health per capita (\$US PPP)



Total expenditures on health as percent of GDP



Note: \$US PPP = purchasing power parity.

Source: Organization for Economic Cooperation and Development, OECD Health Data 2010 (Paris: OECD, October 2010).



Overall Ranking

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00



	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,558	\$3,837*	\$2,454	\$2,992	\$7,290

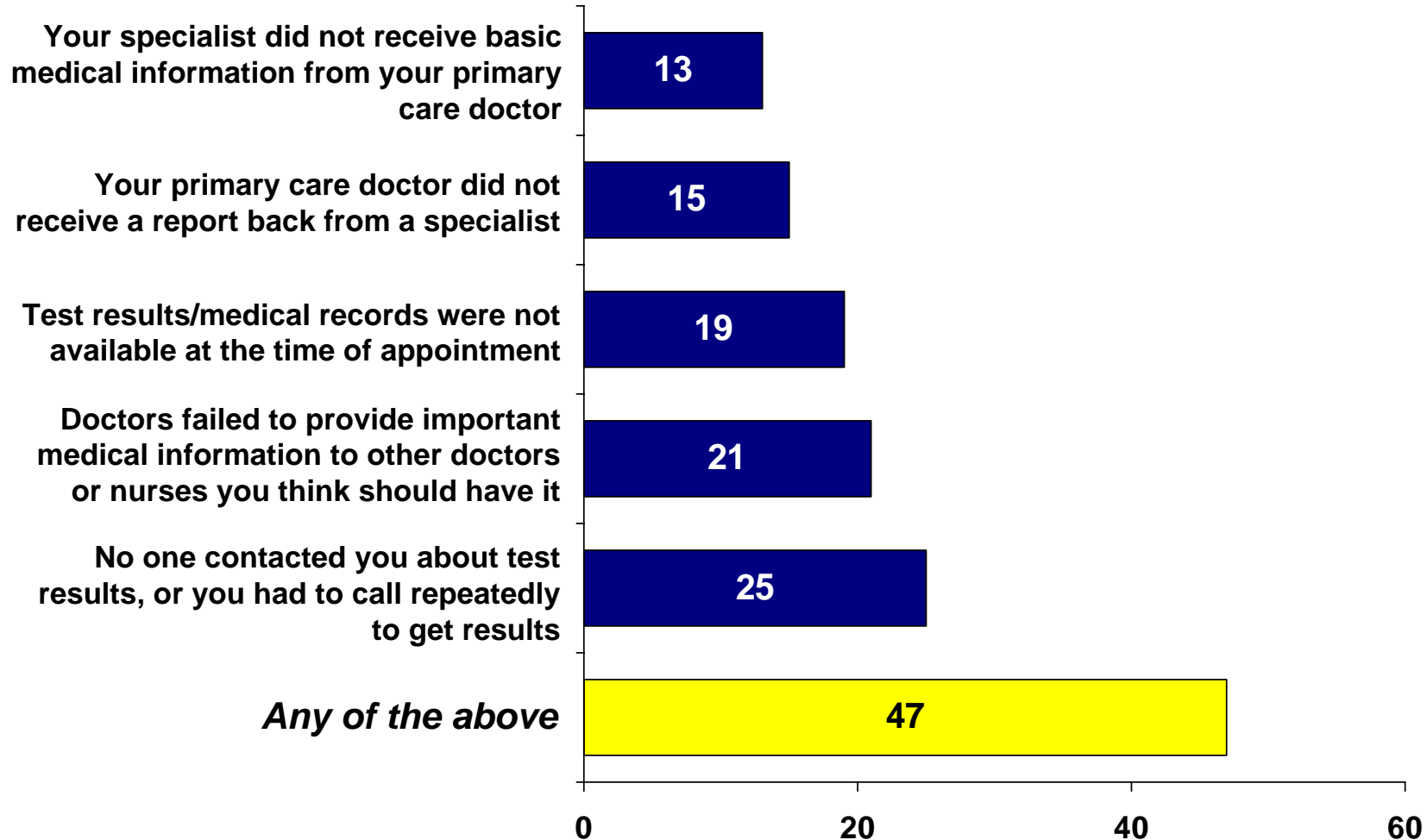
Note: * Estimate. Expenditures shown in \$US PPP (purchasing power parity).

Source: K. Davis, C. Schoen, and K. Stremikis, *How the Performance of the U.S. Health Care System Compares Internationally 2010 Update*, (New York: The Commonwealth Fund, June 2010).



Poor Coordination: Nearly Half Report Failures to Coordinate Care

Percent U.S. adults reported in past two years:



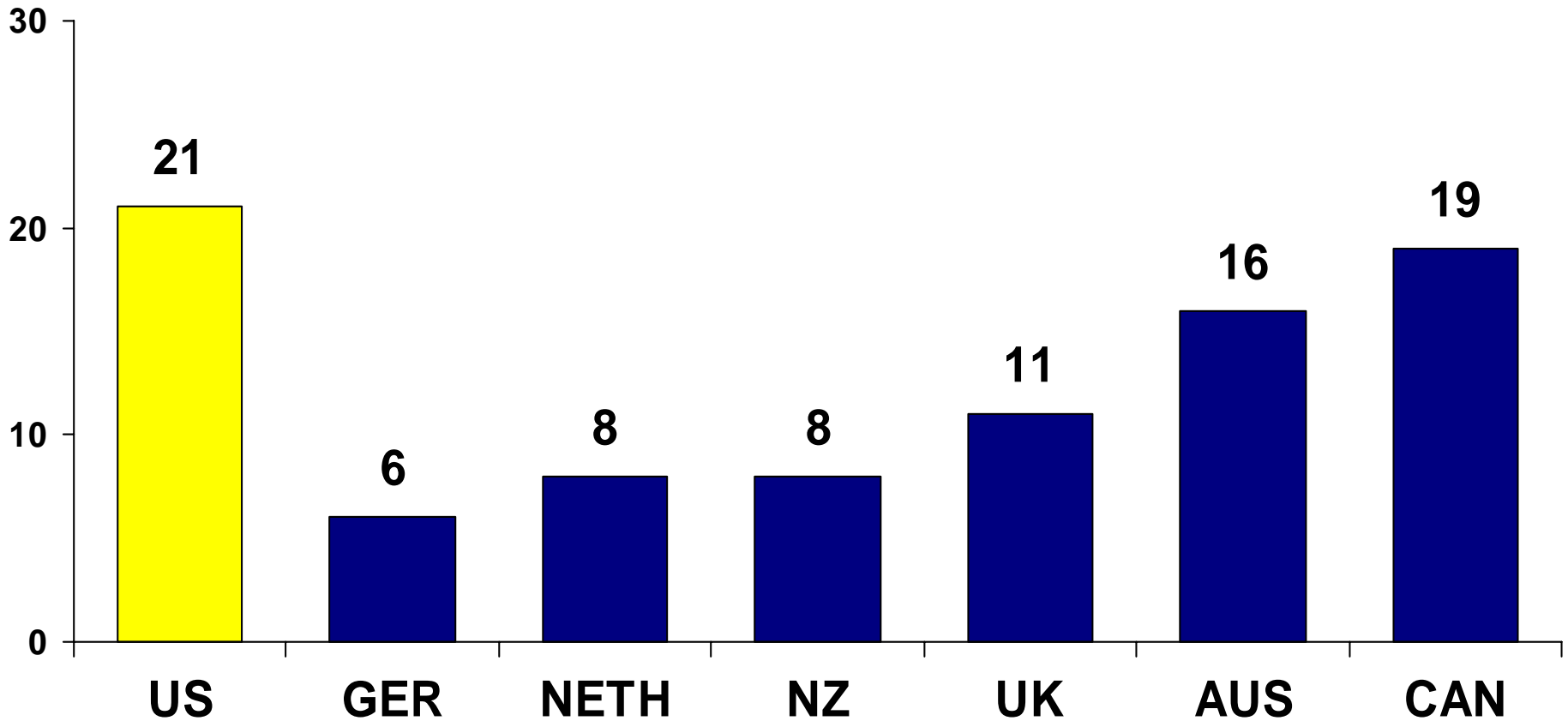
Data: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

Source: S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions*, (New York: The Commonwealth Fund, August 2008).

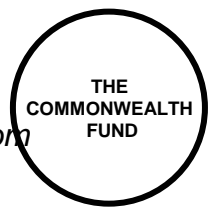


Went to Emergency Room for Condition That Could Have Been Treated by Regular Doctor, Among Sicker Adults, 2007

Percent of adults who went to ER in past two years for condition that could have been treated by regular doctor if available



AUS=Australia; CAN=Canada; GER=Germany; NETH=Netherlands; NZ=New Zealand; UK=United Kingdom.
Source: The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008*, (New York: The Commonwealth Fund, July 2008).



Key Provisions of the CO-OP Program

- **Organizations qualified to participate: nonprofit, member corporations.**
- **Priority given to plans that operate on a statewide basis, utilize integrated care models, and have significant private support.**
- **Governance of cooperatives subject to a majority vote of members, must operate with a strong consumer focus, but not consumer-owned.**
- **Profits must be used to lower premiums, improve benefits, or to finance programs aimed at improving the quality of care to 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 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. 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 to today, and one potentially more favorable to them.**
- **The Affordable Care Act will bring sweeping change to the individual and small group markets through:**
 - **state insurance exchanges that will offer qualified health plans including health cooperatives:**
 - **states have flexibility in designing their exchanges to reduce the risk of adverse selection against the exchanges, decrease administrative costs, help lower premiums and improve health care quality.**
 - **most significant area of state discretion from the perspective of the CO-OP program is whether exchanges are “active” vs. “passive” health plan purchasers.**
 - **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 for coverage through the exchanges;**
 - **small business tax credits (starting in 2010 and continuing through 2016);**
 - **insurer cost controls such as federal/state review of unreasonable premium increases and medical loss ratio requirements.**

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

- **Most successful regional health cooperatives have strong links to integrated care systems: HealthPartners (Minnesota's Twin Cities); Group Health Cooperative (Seattle); Group Health Cooperative of Eau Claire, Wisconsin.**
- **These nonprofit consumer-governed organizations serve members in broad geographic areas; in addition to insurance directly provide health services through nonprofit integrated delivery systems; own, or contract with, hospitals and clinics and contract with dedicated multispecialty physician groups.**
- **Keys to success include:**
 - **consumer-focused mission and accountability resulting from a consumer elected board;**
 - **close links with care systems and networks of providers;**
 - **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;**
 - **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/other incentives for providers/patients with organizational goals,**
 - **making clinical performance measures for providers/health plan publicly available.**
- **Geisinger Health Systems (Pennsylvania), Intermountain Healthcare (Utah), Kaiser Permanente, examples of nonprofit high performing integrated delivery systems with plans**

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

- **CO-OP program could spread successful models of nonprofit consumer-focused, integrated delivery systems and similar nonprofit integrated delivery systems with affiliated health plans.**
- **Challenge for new cooperatives to become integrated delivery systems initially, but provisions of law sufficiently flexible to allow health cooperatives to contract with a wide array of high performing provider organizations to achieve similar goals**
- **Contracting with high performing integrated delivery systems:**
 - **Through such arrangements, CO-OP program could help replicate unique nonprofit collaborative environment of Minnesota's Twin City area, a leader in health delivery innovation. Minnesota ranks in top 5 states in the Commonwealth Fund's State Scorecard on states with high performing health systems.**
 - **CO-OP program has potential to reinforce the culture and increase 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:**
 - **Marshfield Clinic, a not-for-profit, multispecialty group practice in rural Wisconsin with a regional ambulatory care system, an affiliated health plan, and related foundations supporting health research and education.**
 - **Sponsors Security Health Plan of Wisconsin which provides coverage through network of affiliated hospitals and providers including Marshfield Clinic physicians. Plan is administratively and financially separate from Marshfield.**
- **Contracting with community health center networks. Community health centers linked through a common mission, national organizations. Potential to become multi-state networks. Qualified health plans are required to include essential community providers in networks. Community Care of North Carolina an example of high performing community based system of care.**

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

- **Significant challenge facing new cooperatives is ability to gain market share in highly concentrated insurance markets.**
- **In most markets, large carriers and provider systems negotiate prices; prices reflect “discounts” off list prices that depend on volume; prices vary widely and lowest rates are not available to all health plans.**
- **New cooperatives at disadvantage in obtaining favorable provider rates in most local markets; less competitive in insurance exchanges, individual/small group markets.**
- **Key to success of cooperatives in other industries is ability to leverage purchasing power to obtain lower rates: rural electric cooperatives purchase power at cost from power marketing agencies that sell power from federal dams.**
- **In health care industry, success of cooperatives also depends on strong links with care systems and provider networks.**
- **For cooperative health care to slow growth in health costs, need authority to purchase care on favorable terms and ability to offer high quality provider networks.**
 - **Federal or state governments could consider requiring providers to give health cooperatives the lowest prices they give to other private insurers.**
 - **A national cooperative organization could be given the authority to negotiate provider prices on behalf of all customers.**
 - **In Germany, membership “sickness funds,” conduct negotiations as a group.**
 - **“Health Value Authority”**
- **Private purchasing councils are one potential vehicle for cooperatives to gain purchasing leverage in provider negotiations. But the law precludes the councils from “setting payment rates” for health care facilities or providers**
- **Unclear whether the purchasing councils might be allowed to negotiate provider rates.**
- **Cooperatives will also have to link to networks of providers 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 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 tools and flexibility necessary to reach sustainable membership levels, attain adequate purchasing leverage, develop strong links with integrated care systems, manage risk appropriately, and follow a mission driven roadmap to achieve high quality and coordinated care, health cooperatives have the potential to embody the key overarching goals of health reform:**
 - **delivery of high quality, effective, safe care to achieve the best possible health outcomes for populations;**
 - **design of care delivery that is in the best interests of patients;**
 - **efficient use of resources.**
- **The way this provision, and other key aspects of the law, are implemented is important not only for the long term viability of cooperatives but 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.**

Acknowledgements



**Karen Davis,
President**



**Cathy Schoen,
Senior Vice President
for Research and
Evaluation**



**Douglas McCarthy,
Senior Research Advisor**



**Rachel Nuzum,
Assistant Vice
President, Federal
Health Policy**



**Kristof Stremikis,
Senior Research
Associate**



**David Squires,
Program Associate**

For more information, please visit:

www.commonwealthfund.org

