CO-OPs - The Stealth Public Option Under the ACA?

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Last week, the Massachusetts **CO-OP** was approved by the federales under a provision of the Affordable Care Act that was key to the Act's passage, yet not widely known. The Consumer Operated and Oriented Plan, known as the Minuteman Health Initiative, secured a startup loan as part of the approval, intended to cover operational expenses as well as state-mandated reserves. Here's an excerpt from the Minuteman presser, as published by **CommonHealth**:

> Tufts Medical Center, its New England Quality Care Alliance (NEQCA) physicians network and Vanguard Health Systems (NYSE: VHS) are proud to sponsor the Minuteman Health Initiative, which has received an $88.5 million loan from the Centers for Medicare and Medicaid Services (CMS). This new member-governed, non-profit health insurance option for Massachusetts residents intends to offer consumers and employers lower-cost, high-quality care with unprecedented transparency, as well as increased efficiency and satisfaction for physicians, patients and employers alike. Plan members will ultimately govern this health plan via Minuteman's unique ownership structure.

Congressional proponents of "Medicare for All" (aka the public option) took their lumps when the ACA did not include such an animal -- in part, because it did include the CO-OP requirement: one CO-OP per state, to be a nonprofit founded by providers and run by consumers, whose margins are to be plowed back into premium reductions, improving benefits and improving quality of care. (Don't confuse the CO-OPs with co-ops, which are simply group purchasing cooperatives for health insurance that manage to eke out tiny group discounts. In Massachusetts, co-ops are limited in total enrollment to 85,000, a fraction of the small group and individual market population.) CO-OPs are supposed to be operational in every state, ready to enroll members (and therefore with provider networks already in place) by 2014, so they can get started on an equal footing with other health plans on state exchanges, on offer both to individuals and to employers (though 2/3 of enrollees must be from the individual and small group markets). Founded by providers, they are required to transition to member control within a year of beginning member enrollment.

Did that political horse trade make sense? Do CO-OPs make sense?

The CO-OP in any state has the potential to become a serious competitor to existing health plans. Since there is a limit of one per state, the potential enrollment is high, and the attractiveness to providers and provider networks -- including a willingness to enter into pricing and contracting arrangements favorable to the CO-OP, such as global caps and **ACOs** -- is also high. In the Massachusetts example, seventeen non-founder hospitals have expressed interest in participating. (That's about 20% of the state's acute care hospitals interested in the CO-OP before it's even off the ground.) The only other insurance plan on offer statewide is Blue Cross Blue Shield, so if the CO-OP can build or rent a provider network quickly, and differentiate itself in the various markets statewide, it has the potential to become a real powerhouse.

On the downside, a CO-OP has to price its products without having historical claims data, which could be tricky, and it needs to scale up its administrative infrastructure before it has the membership base to support it (of course, it could contract for those services, and the loan from the federales is intended to cover such up-front costs). It's a big gamble: trying to break into a market dominated by a small handful of players is never easy, and trying to do so as a nonprofit that can have no ties to existing insurance companies may make it harder.

The potential difficulties ahead of the CO-OPs explain why CMS reportedly anticipates a 35-40% default rate on the startup loans and may raise an eyebrow (after all, a billion here, and a billion there, and soon we're talking serious money). Do we need CO-OPs to make the ACA work, or is this one of the throw-it-against-the-wall-and-see-what-sticks provisions?

The CO-OPs may well play out as the Medicare for All / Accountable Care Organizations for All sleeper cell of the ACA. A well-managed CO-OP in a state with the right market conditions could end up as a significant player. In Massacusetts, if Minuteman picked off half of the individual and small-group subscribers through its likely more attractive pricing, and the maximum number of larger-group subscribers to go along with them, it could be looking at 375,000 subscribers (and some multiple of that for covered lives) in not too long from now. Let's say, for argument's sake, 1 million covered lives in a state with a population of around 6.5 million. Not too shabby for a startup. While some may say that Massachusetts is a bad example as a poster child for this initiative, because the "big three" health insurers here are all nonprofits and we don't have a significant uninsurance problem thanks to state health reform, there is still room for improvement here -- nonprofits still have highly-paid execs and other elements of high-cost structures that may be different in a member-controlled CO-OP, and there are rural parts of the state that would benefit from the innovations that could be brought to bear by a high-functioning CO-OP partnering with ACOs and PCMHs. And if there's room for improvement here, I think there's room for improvement in most states.

The CO-OPs have the potential to be the tail that wags the dog -- larger insurance companies may well adopt the commercial market pricing and provider network contracting and benefits strategies of the CO-OPs in order to remain competitive. And in an era of legislated medical loss ratios (and the CEO of Aetna saying that he sees his company as a health information company rather than as an insurance company), that dog seems ready to be wagged.

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