The Department of Health and Human Services Office of Inspector General Issues Its First Report on the Implementation of the Consumer Operated and Oriented Plan Loan Program

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On July 17, 2013, the Department of Health and Human Services Office of Inspector General's (OIG) Office of Evaluation and Inspections (OEI) issued a report, "Early Implementation of the Consumer Operated and Oriented Plan Loan Program," OEI-01-12-00290. Under the Patient Protection and Affordable Care Act (ACA), nonprofit, consumer-governed health insurance issuers, or Consumer Operated and Oriented Plans (CO-OP), will offer qualified health plans in the individual and small group markets. The CO-OP program provides two types of loans: (1) startup loans to assist with establishment costs, such as office space, computer networks, and staffing, and (2) solvency loans, to assist CO-OPs to meet state insurance solvency and reserve requirements. As of January 2, 2013, the Centers for Medicare & Medicaid Services (CMS) had awarded loans totaling $1.98 billion to 24 CO-OPs.

OEI's objectives for the study were:

1. To describe how CO-OP Plans will comply with program requirements and achieve their goals.
2. To provide an early assessment of CO-OP progress during the startup phase.
3. To assess CMS's strategy for overseeing CO-OPs both during the startup phase and after the launch of the Affordable Insurance Exchanges (Exchanges).

Because CMS funded CO-OPs on a rolling basis throughout 2012, the study reviewed only the first 18 CO-OPs funded through the program. OEI's review of the early implementation of the CO-OP program found that CO-OPs met 90 percent of their milestones during the review period. An additional study focusing on CMS's review of CO-OP funding applications is in process.

FINDINGS

The study found that, as required, CO-OP consumers will make up a majority of the governing boards, ranging from 51 percent to 100 percent of the board memberships. All of the 18 CO-OPs also had conflict-of-interest and ethics provisions in their bylaws. In addition, eight CO-OPs proposed other ways to involve consumers in developing products, policies, and procedures, with four of these proposing advisory boards that would represent consumers in various aspects of CO-OP management and health care delivery.

OEI also concluded that all of the CO-OP applications described customer service and outreach strategies to ensure consumer responsiveness. Examples of these strategies included tracking interactions with consumers and analyzing outcomes, offering both online and in-person customer service, or text messaging. CO-OPs also described standards for responding to consumers' complaints timely and using surveys and other data sources to analyze the quality of their services.

In their various loan applications, the CO-OPs identified primary care and electronic health data as the main mechanisms to integrate care, improve quality, and reduce cost. The primary care models proposed by the CO-OPs seek to use less specialty care, prevent disease, and reduce unnecessary services. All of the CO-OPs studied intend to offer financial incentives, such as shared savings or bundled payments, to primary care providers to keep their patients healthy. Five CO-OPs included programs to monitor consumers with chronic conditions and to prevent hospitalization, while nine

plan to offer wellness programs.

The CO-OP applications studied by OEI also focused on electronic health data and other information technologies to help control health care costs, and to improve health care quality. However, as OIE noted, because CO-OPs currently do not have patient or physician data to analyze, they will need to build it over time.

According to the report, almost all CO-OPs intend to rely on outsourcing for savings on staffing, training, and technology systems. All of the CO-OPs plan to use outside contractors to handle or assist with customer service, IT support, legal functions, or claims processing.

OEI also evaluated the CO-OPs' progress toward their milestones from February 2012 to September 2012, including achieving licensure, hiring key staff, and contracting with vendors. As of June 2013, 19 of the 24 CO-OPs in the program have been issued insurance licenses by their states, with only one state denying licensure to a proposed CO-OP. The CO-OPs also have hired personnel to manage operations and established transitional boards of governance.

Nonetheless, the CO-OPs reported that they faced specific concerns, including hiring and training staff quickly enough; uncertainties in the new insurance marketplace; and identifying and contracting with the right health care providers and vendors for key services. The CO-OPs reported that uncertainty surrounding the implementation of the ACA had also posed challenges during the startup period. Because five CO-OPs did not reach milestones on time, CMS delayed portions of their startup loans until they met the requirements.

CONCLUSION

In general, while the CO-OPs appear to be making progress, they are still hiring staff, obtaining licensure, and establishing provider network arrangements and technology systems. The OIG report particularly notes that the extent to which any particular CO-OP can achieve program goals and remain financially viable depends on a number of unpredictable factors, including the states' Exchange operations, the number of people who enroll in the CO-OP and their medical costs, and the way in which competing plans will affect the CO-OP's market share.

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