CO-OP FACT SHEET

- Section 1322 of the Affordable Care Act created the Consumer Operated and Oriented Plan program (CO-OP) to foster the creation of new consumer-governed, private, nonprofit health insurance issuers, to enhance competition in insurance exchanges. HHS has stated that priority will go to applicants that will offer CO-OP qualified health plans on a Statewide basis, will use integrated care models, and have significant private support
- The federally proposed rules on CO-OPs allow for a non-profit, non-issuer organization to sponsor and contract with, but not control or govern, the new CO-OP. CO-OPs may not be sponsored by or run by an issuer of health insurance that was in business before July, 2009.
- $3.8 billion in federal loans (originally $6 billion) was made available to capitalize prospective CO-OPs with a goal of having at least one CO-OP in each State.
- CO-OPs must be consumer-governed, with the majority of the operational board being CO-OP members, all of whom are elected by a majority vote of the CO-OP's members
- The CO-OP must offer at least a silver and gold plan in the exchange, and would begin enrollment at the same time as the Oregon insurance exchange (October, 2013)
- Substantially all, or 2/3 of contracts, must be in the small and individual group market
- In addition to the specific rules governing CO-OP, the CO-OP must also meet all state and federal "qualified health plan" criteria in the state exchange where it operates, including providing essential health benefits, minimum MLR requirements, etc
- A CO-OP may not begin to offer their products until all insurance market reforms under ACA have taken effect, presumably January 1, 2014
- A CO-OP may be deemed certified by CMS as a qualified health plan to participate in the state Exchange for up to 10 years following the life of the loan
- A CO-OP's profits can be used to lower premiums, improve benefits, or for other programs which expand or improve the quality of health care delivered to members. Profits are not paid back to members
- Current assumptions for the target market of the CO-OP include:
    - Continuity of Care through addressing "Churn"
        - Nearly 1/3 of CareOregon members (and all OHP enrollees) lose OHP eligibility due to income or other circumstances in a given year. Many are re-enrolled within 90 days.
        - Targeted enrollment for the new CO-OP will likely be former CareOregon and other OHP enrollees who have lost coverage and now are accessing coverage through the exchange
        - CareOregon's extensive provider network will also likely serve as the initial provider network to the new CO-OP
    - Affinity
        - Individuals, small groups, and potentially some large groups may choose the CO-OP as their insurer, due to an affinity for consumer-orientation or member-centric health care

The federally proposed rules on CO-OPs allow for an organization such as CareOregon to sponsor & contract with, but not control or govern, a new CO-OP. As a sponsor, CareOregon is in the process of applying for start-up and solvency loans from HHS on behalf of this new entity, Community Care of Oregon. The initial filing deadline is Oct. 17th, 2011, with award notices made within 75 days