



CCMS Special Alert

Clark County Medical Society

www.clarkcountymedical.org

Consumer Operated and Oriented Plan (CO-OP): Final Rules

Section 1322 of the Affordable Care Act promotes the formation of nonprofit, consumer-governed health cooperatives that will operate as qualified health plans through the state health insurance exchanges and in the individual/small group markets. The concept of health cooperatives envisions physician-led health plans that provide high quality, affordable care to their members. Linking Consumer Operated and Oriented Plans (CO-OP) to integrated delivery systems may ensure that sustainable membership levels are achieved, risk is minimized, and provider accessibility is preserved.

The Department of Health and Human Services (HHS) expected the changes made to the final regulations would help guarantee the sustainability of the newly developed CO-OPs by identifying provider support in governing the formation and governance boards and ensuring CO-OPs will be operated by organizations that are “new” to the insurance market.

The federal government has allotted \$3.4 billion to help establish these health cooperatives by offsetting start-up costs and ensuring long-term solvency. CMS formed a CO-OP Program Advisory Board to develop core principles for awarding the loans. The core principles include: (1) consumer operation, control, and focus; (2) financial solvency and stability of coverage; (3) care coordination promoted; and (4) first loans should be expedited. There must be at least one CO-OP operating in every state. If they are not operational by late 2013, the federal government will develop one in that state.

Eligibility

- A CO-OP eligible for a loan must be a nonprofit, member organization, formed under applicable state law.
- A pre-existing health insurance issuer (existing prior to July 15, 2009) and any unit of government are prohibited from participating as a CO-OP.
- If certain qualifications are met, the final rule clarifies that other CO-OP participants may include non-profit hospitals, physician hospital organizations, or other organizations that obtain financial support from a state or local government.

Standards

- *Governance:* The CO-OP must be operated and controlled by the members in order to ensure proper accountability and responsiveness to its members. The organization must be governed by a board of directors, which are elected by a majority vote of its members. The CO-OP must transition from a “formation board” to an “operational board” within two years after the initial enrollment period.
- *Requirements to Issue Health Plans:* At least two-thirds of the health insurance contracts issued by a CO-OP must be qualified as a health plan eligible to be issued in the individual and small group markets. The organization must always meet this requirement to be considered a CO-OP.

Loan

- *Start-Up Loans:* The start-up loans will support organizations with the start-up costs associated with developing a CO-OP. These loans have a five-year repayment period.

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- *Solvency Loans*: The solvency loans will assist organizations with the reserve requirements and the solvency regulations. These loans have a fifteen-year repayment period.

To read the CO-OP Final Rules, visit www.gpo.gov/.

The “Consumer Operated and Oriented Plan (CO-OP): Final Rules” publication should be used for informational purposes only. The Clark County Medical Society encourages physicians to seek further business or legal advice prior to forming a CO-OP.

For additional information, please contact Susan Lynch, NSMA Practice Management Specialist, slynch@nsmadocs.org.

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