COMMENTARY

And Then There Were Three: The Decimation of the Affordable Care Act (ACA) CO-OPs

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The Consumer Operated and Oriented Plans (CO-OPs), the subject of Section 1322 of the Affordable Care Act (ACA), were to constitute "qualified nonprofit health insurance issuers." Designed with an eye toward increasing competition with the extant commercial and nonprofit insurance sector, the CO-OPs were to enhance consumer choice as well as hold down prices on the state and federal exchanges. To achieve these ends, the consumer-governed state-licensed CO-OPs were to target the individual and small-group markets. At least one qualified CO-OP was to be established in each and every state. By the fall of 2013, however, coincident with the first open enrollment period of the ACA, only 23 CO-OPs were on tap. At the time of this writing, only three of these CO-OPs remain operational in the states of Maine, Montana, and Wisconsin. Viewed in hindsight, the thorough dissolution of the CO-OPs was the product of incremental financial privation effectuated by congressional opponents of the ACA. In this Commentary, we revisit the ontogeny of the CO-OP construct, review its partisan dismantling, and explore the potential resurrection thereof. (J Am Board Fam Med 2022;35:867–869.)

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The Consumer Operated and Oriented Plans (CO-OPs), the subject of Section 1322 of the Affordable Care Act (ACA), were to constitute "qualified nonprofit health insurance issuers."[1] To increase competition with established commercial and nonprofit insurance companies and thereby improve consumer choice, the CO-OPs were to hold down prices on the state and federal exchanges. To accomplish their assigned goals, the private, consumer-governed, state-licensed CO-OPs were to focus on the individual and small-group markets.[1] It was the hope and expectation of the crafters of the ACA that at least 1 qualified CO-OP would be established in each state.[1] By the fall of 2013, however, coincident with the first open enrollment period of the ACA, only 23 CO-OPs were functioning.[2] By 2021, only 3 of these CO-OPs remained operational in the states of Maine, Montana, and Wisconsin.[2] The number of enrollees who signed up with the CO-OPs plummeted from over 1 million at their peak to less than 110,000 in 2020.[2] Viewed in hindsight, the dissolution of the CO-OPs was the product of incremental financial privation wrought by congressional opponents of the ACA. In this *Commentary* we revisit the ontogeny of the CO-OP option, review its politically motivated dismantling, and explore the potential resurrection thereof.

Arising as an alternative to the highly contentious government-run "Public Option" or Medicare-for-all proposals, the CO-OPs, the brainchild of Sen. Kent Conrad (D-ND), were to offer "qualified individual and small group" health insurance plans "in the States in which the issuers are licensed to offer such plans."[1] From the outset, however, the CO-OPs were constrained by several amendments to the ACA. First, the CO-OPs were to be limited to the "individual and small group markets."[1] The more lucrative large-group market was to be off limits. Second, any and all federal funds afforded the CO-

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OPs could not be used for the "marketing" of the brand.[1] Moreover, boards of directors of the CO-OPs were not to include individuals involved with the "insurance industry" the experience of which was bound to prove critical.[1].

Leading the way in assuring the financial underpinning of the CO-OPs was the temporary (through July 1, 2013) appropriation of $6 Billion by the ACA.[1] The latter funds were to be used to underwrite low-interest loans, cover start-up costs, as well as meet state solvency requirements. However, in 2011, section 1857 of the *Department of Defense and Full-Year Continuing Appropriations Act of 2011* (Pub. L. 112-10) rescinded $2.2 Billion of the original ACA appropriation.[3] Later that same year, an additional $400 Million were rescinded by section 524 of the *Consolidated Appropriation Act of 2012* (Pub. L. 112-74).[4] Finally, in 2013, section 644 of the *American Taxpayer Relief Act of 2012* (Pub. L. 112–240) saw to the revocation of an additional $2.3 Billion in unobligated CO-OP program funds.[5] The latter law also saw to the assignment the remaining unobligated balance of the original appropriation to a contingency fund of the *Centers of Medicare and Medicaid Services* (CMS) for the purpose of facilitating oversight of CO-OP loan awardees.[5] The leading operational outcome of these sequential budgetary recissions was that no additional CO-OPs could be funded going forward.

Seeking to minimize premium instability in the individual and small group markets served by the CO-OPs, the ACA (Section 1342) established a temporary "risk corridors" program for "calendar years 2014, 2015, and 2016."[1] The "risk corridors" program was to compensate insurers for unexpectedly unprofitable plans in the new and largely unknown guaranteed issue and modified community-rated individual marketplaces. Specifically, the Secretary of the Department of Health and Human Services (HHS) was to provide the CO-OPs with supplemental funding when and if the "allowable costs" for any plan "are more than 103% but not more than 108% of the target amount."[1] Assurances as to the funding of the "risk corridors" program were afforded by CMS as late as September of 2014 at which point note was made that "[i]n the unlikely event of a shortfall . . . HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."[6] Soon thereafter, however, congressional opponents of the ACA led by Sen. Marco Rubio (R-FL), took to characterizing the "risk corridors" program as a "taxpayer-funded bailout of the health insurance industry."[7] Moreover, a Rider precluding any and all "payments. . .to risk corridors" from general program management funds of HHS was enacted into law under the *Consolidated and Further Continuing Appropriations Act of 2015* (Pub. L. 113–235).[8] Subsequent renewals of the Rider in question during fiscal years 2016 (Pub. L. 114–113) and 2017 (Pub. L. 115-31) all but assured that struggling CO-OPs will likely be forced out of business.

Land of Lincoln, one of the CO-OPs which was forced into liquidation, ultimately sued HHS to recoup funds heretofore withheld. On April 27, 2020, by a vote of 8-1, the Supreme Court of the United States held that HHS was obligated to make over $12 billion in retroactive improperly withheld risk-corridor payments to the CO-OPs for the 2014 to 2016 interval.[9] As Justice Sotomayor's majority opinion put it "the statute meant what it said: The Government 'shall pay' the sum that §1342 prescribes." The opinion went on to say that "the Risk Corridors provision created an obligation neither contingent on nor limited by the availability of appropriations or other funds" and that the appropriation riders did not impliedly or expressly repeal that obligation. Justice Sotomayor went on to pointedly state that the court would follow "a principle as old as the Nation itself: The Government should honor its obligations. Soon after ratification, Alexander Hamilton stressed this insight as a cornerstone of fiscal policy. 'States,' he wrote, 'who observe their engagements . . . are respected and trusted: while the reverse is the fate of those . . . who pursue an opposite conduct.' . . . Centuries later, this Court's case law still concurs. The judgments of the Court of Appeals are reversed, and the cases are remanded for further proceedings consistent with this opinion."[9] For most of the CO-OPs that went out of business, the long-sought relief came years too late.

The rationale undergirding the nongovernmental, state-delimited, exchange-certified CO-OPs remains as fresh as ever. Freestanding member-centric health insurance issuers that put the need of their members first are few and far between. It follows that the "creation of qualified nonprofit health insurance issuers" in the "individual and small group markets in the States" remains in the national interest. Efforts to curtail the ranks of the uninsured and reduce health care spending will also be well served. Resurrection of the CO-OP program

will require that the lessons learned from the surviving CO-OPs are heeded; the "3 little miracles"[10] benefited from having solid financial footing to start out, sound management expertise, and the ability to offer diversified low-cost plans to meet local needs.[11] Similar insights should also be derived from the success of legacy consumer-governed health insurance cooperatives such as the Group Health Cooperative of Puget Sound and HealthPartners. To renew legislative interest, individuals and groups will need to communicate to legislators that CO-OPs are both a viable and practical alternative worthy of the firm congressional commitments to funding needed to support such an undertaking. Until such time that a "public option" constitutes a politically realistic possibility, reviving the CO-OPs initiative may well be just what the doctor ordered.

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