Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EARLY IMPLEMENTATION OF THE CONSUMER OPERATED AND ORIENTED PLAN LOAN PROGRAM

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EXECUTIVE SUMMARY: EARLY IMPLEMENTATION OF THE CONSUMER OPERATED AND ORIENTED PLAN LOAN PROGRAM, OEI-01-12-00290

WHY WE DID THIS STUDY

The Patient Protection and Affordable Care Act established a loan program to foster the creation of nonprofit, consumer-governed health insurance issuers called CO-OPs that will offer qualified health plans in the individual and small group markets. Goals of the CO-OP program include promoting integrated care, quality, and efficiency. As of January 2, 2013, the Centers for Medicare & Medicaid Services (CMS) had awarded loans totaling $1.98 billion to 24 CO-OPs. The applicants that receive this funding are new entities that may face financial and operational challenges in a competitive insurance market. CMS manages the CO-OP program and must implement it in a short time so that CO-OPs will be ready to enter the market of Affordable Insurance Exchanges—i.e., competitive marketplaces for health insurance.

HOW WE DID THIS STUDY

We reviewed applications from the first 18 CO-OPs that were awarded funding. We interviewed senior staff from these CO-OPs to describe how CO-OPs plan to meet program requirements and goals, such as consumer governance, integrated care, and increased quality. We also interviewed CMS staff and reviewed CMS's documentation related to oversight of the 18 CO-OPs to assess their progress during the startup phase and assess CMS's oversight of the CO-OP program.

WHAT WE FOUND

In their applications, CO-OPs broadly described various ways to meet program requirements related to consumer governance. CO-OP applications identified primary care, electronic health data, and outsourcing as the main mechanisms for achieving integrated care at lower costs while improving quality. Despite challenges, CO-OPs have made progress toward achieving licensure and met 90 percent of their milestones during the period of our review. CMS's oversight strategy includes frequent monitoring and early intervention to ensure that CO-OPs adhere to program requirements and goals.

WHAT WE CONCLUDE

Although CO-OPs appear to be making progress, at the time of our review they were still hiring staff, obtaining licensure, and building necessary infrastructure. In addition, the extent to which any particular CO-OP can achieve program goals depends on a number of unpredictable factors, such as each State's Exchange operations, market competition, and enrollment.

TABLE OF CONTENTS

OBJECTIVES

1. To describe how Consumer Operated and Oriented Plans (CO-OPs) plan to comply with program requirements and achieve their goals.
2. To provide an early assessment of CO-OPs' progress during the startup phase.
3. To assess the Centers for Medicare & Medicaid Services' (CMS) strategy for overseeing CO-OPs both during the startup phase and after the launch of the Affordable Insurance Exchanges (Exchanges).

BACKGROUND

The CO-OP Program

The Patient Protection and Affordable Care Act (ACA)[1] established a loan program to foster the creation of nonprofit, consumer-governed health insurance issuers called CO-OPs that will offer qualified health plans in the individual and small group markets.[2]

The ACA originally appropriated $6 billion for this program, which was subsequently reduced to $2 billion.[3, 4] Although the ACA aimed to establish 1 CO-OP in each State, reduced funding limited the program to 24 CO-OPs in 24 States.[5] (See Appendixes A and B for a list of funded CO-OPs). CMS's Center for Consumer Information and Insurance Oversight (CCIIO) manages this program.

In addition to having the goal of improving consumer choice and plan accountability, the CO-OP program seeks to promote integrated models of care and enhance competition in the Exchanges established under the ACA.[6, 7] Existing health insurers and other business cooperatives offer models for this approach. But one major barrier to further development of consumer-driven models in the health insurance market has been the

[1] P.L. 111-148 and the Health Care Reconciliation Act of 2010, P.L. 111-152, collectively known as the ACA.

[2] ACA, § 1322(a)(2). At least two-thirds of the policies issued by a CO-OP must be in the individual and small group markets. 45 CFR § 156.515(c)(1).

[3] Appropriated amounts were reduced from $6 billion to $3.4 billion by the Department of Defense and Full-Year Continuing Appropriations Act, P.L. 112-10, § 1857, and the Consolidated Appropriations Act, 2012, P.L. 112-74, §524.

[4] The American Tax Payer Relief Act of 2012, P.L. 112-240, § 644, rescinded 90 percent of unobligated funds from the CO-OP program totaling $2.3 billion.

[5] ACA, § 1322(b). 76 Fed. Reg. 77392 (December 13, 2011).

[6] ACA, § 1311, established the Exchanges administered by a governmental agency or nonprofit organization, through which individuals and small businesses with up to 100 employees can purchase qualified health plans.

[7] The ACA uses the term "Exchanges" to refer to competitive marketplaces for insurance. CMS now uses the term "Marketplaces."

difficulty of obtaining adequate capital for startup costs and meeting State insurance reserve requirements. The CO-OP program is designed to overcome this barrier by providing loans specifically for these activities.[8]

The ACA authorized both loans and grants under the CO-OP program.[9] CMS has interpreted both funding mechanisms authorized by the ACA as loans because they must be repaid.[10, 11] The CO-OP program created two types of loans: startup loans and solvency loans.[12] Startup loans assist with the costs associated with establishing CO-OPs, such as office space, computer networks, and staffing. Solvency loans help CO-OPs meet State insurance solvency and reserve requirements.[13]

Applicants for and Recipients of CO-OP Funding

The ACA set requirements for applicants that sought CO-OP funding. CMS further interpreted these requirements and issued regulations to set eligibility standards for CO-OP loan applicants.[14] To apply for loans under the CO-OP program, an applicant must:

- be organized as a nonprofit member organization and intend to become a CO-OP;
- not have been a health insurer or a related entity (or any predecessor of either) on July 16, 2009; and
- not be sponsored by a State or local government.[15]

In addition, an applicant had to fully describe in the application its proposed organizational structure and governance, health insurance plans, and business functions.[16] Key portions of the application included a project narrative, a feasibility study, a business plan, and bylaws.

Applicants that received CO-OP loans include small business coalitions; physicians, hospitals, and other providers; agricultural organizations; unions; and community-based sponsors.[17] CMS awarded funding to applicants that demonstrated a likelihood of market viability and ability to

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[8] 76 Fed. Reg. 77392 and 77393 (December 13, 2011).

[9] ACA, § 1322(b)(1)(a) and (b).

[10] 76 Fed. Reg. 77392 and 77394 (December 13, 2011).

[11] ACA, § 1322(b)(3).

[12] 45 CFR § 156.505.

[13] 76 Fed. Reg. 77392 and 77394 (December 13, 2011).

[14] 45 CFR § 156.510. The ACA § 1322(b)(4) established a 15-member CO-OP Advisory Board to make recommendations to CCIIO on the design and implementation of the CO-OP program, including eligibility and operational standards.

[15] ACA, § 1322(c)(1)-(2); 45 CFR § 156.510(a)-(b).

[16] CO-OP Program Amended Announcement. Loan Funding Opportunity Number 00-COO-11-001, December 9, 2011.

[17] CCIIO Fact Sheet. Accessed at www.cciio.cms.gov on February 21, 2013.

repay loans.[18] As of December 2012, CMS had awarded loans to less than one-third of CO-OP applicants.[19]

CO-OP Program Requirements and Goals

To fulfill the basic requirements of the program, CO-OPs must offer consumer-governed, qualified nonprofit health plans. In addition, CMS identified goals that CO-OPs should achieve to fulfill the intent of the program, such as providing integrated care, quality, and efficiency.[20, 21]

To become a qualified health insurer, the CO-OP must meet all the same requirements as other health insurers in the State.[22] When applying for CO-OP funding, an applicant was not required to be incorporated or licensed as an insurance entity, but was required to have a plan for achieving licensure and to be ready to offer qualified health plans in the Exchanges within 3 years of receiving startup loan funds or within 1 year of receiving solvency loan funds.[23]

To become and remain a qualified issuer of health insurance, a CO-OP must continue to meet the program requirements related to consumer governance, the use of its profits, and the types of insurance that it sells. In particular, a CO-OP must have governance that is subject to a majority vote of its members; must have governing documents that incorporate ethics and conflict-of-interest standards; and must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.[24, 25, 26]

Loan Disbursement and Repayment

After CMS approved each application, it negotiated a loan agreement that included a disbursement schedule. The disbursement schedule outlines key milestones and available solvency loans consistent with the CO-OP's business plan and program requirements. A CO-OP must notify CMS 1 month in advance if it believes that it will be unable to reach any of its

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[18] CO-OP Program Amended Announcement. Loan Funding Opportunity Number 00-COO-11-001, December 9, 2011.

[19] Because of funding reductions, CMS did not review applications submitted for the December 31, 2012, deadline.

[20] 76 Fed. Reg. 77393 and 77410 (December 13, 2011).

[21] The ACA gives priority to CO-OP applicants that encourage provider coordination, such as medical homes or other models that encourage provider collaboration. ACA, § 1322(b)(2)(A)(ii).

[22] ACA, § 1322(c)(5).

[23] 45 CFR § 156.515(c)(3).

[24] Both the statute and regulations use the terms "consumer" and "member." For consistency, we will refer to CO-OP members as consumers. ACA, § 1322(c)(3).

[25] ACA, § 1322(c)(1)(B).

[26] 76 Fed. Reg. 77392 and 77401 (December 13, 2011).

milestones. A CO-OP may work with CMS to modify the disbursement schedule and adjust milestones as needed. This enables CMS to ensure that loan money is not disbursed until the CO-OP completes specific tasks.[27] CO-OPs must repay startup loans within 5 years of each disbursement and solvency loans within 15 years.[28]

CMS Oversight and Monitoring

CMS's reporting requirements for startup and solvency loans begin as soon as a CO-OP signs a loan agreement and end 10 years after the final repayment.[29] After a CO-OP signs a loan agreement and has operated for one full quarter, it must submit reports (quarterly and semiannual reports and quarterly disbursement requests) that describe its progress on financial and operational goals. Each CO-OP also provides CMS with updates on its progress toward milestones through other formal reporting processes. As a CO-OP meets milestones in the loan agreement and submits disbursement requests, CMS disburses successive installments of the startup loan on a quarterly basis.

CMS can restrict loan funds if a CO-OP has not met its agreed-upon milestones. In addition, if a CO-OP has not complied with the loan agreement or program requirements, CMS may place it under enhanced oversight and require it to submit and implement a corrective action plan.[30]

METHODOLOGY

Scope

This study reviews how CO-OPs plan to meet program requirements and goals, such as consumer governance, integrated care, and improved quality. It also assesses CO-OPs' progress during the startup phase and CMS's oversight of the CO-OP program. The findings are based on analysis of the first 18 CO-OPs that were awarded funding under the program between February and July 2012.

Data Collection and Analysis

We used four main data sources to address our study objectives: CO-OP applications, CO-OP funding disbursement forms, CMS's documentation related to the oversight of the 18 CO-OPs, and interviews with both CO-OP and CMS staff.

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[27] CO-OP Program Amended Announcement. Loan Funding Opportunity Number 00-COO-11-001, December 9, 2011.

[28] ACA § 1322(b)(3); 45 CFR § 156.520(b). 45 CFR, § 156.520(c).

[29] CCIIO, CO-OP Program Amended Announcement. Loan Funding Opportunity Number 00-COO-11-001, December 9, 2011.

[30] Ibid.

CO-OP Applications. To describe how the first 18 CO-OPs plan to meet program goals, we reviewed their applications for loan funding. We noted plans for offering integrated care, quality improvement, and cost controls. We also gathered information about CO-OPs' governance; conflict-of-interest policies; and business operations (claims processing, customer service, IT support, marketing, and legal services).

CO-OP Disbursement Approval Forms. We reviewed disbursement approval forms for each CO-OP to determine the extent to which CO-OPs are meeting milestones. For each CO-OP, we reviewed forms starting with the first quarter after it received its first funding through the third quarter of 2012. We also gathered information about any delayed milestones and CMS's response.

CMS Oversight Documents. We reviewed documentation that CMS uses to track CO-OPs' progress and CMS's day-to-day oversight. For example, we reviewed notes from CMS's telephone meetings with CO-OPs, "issue logs" that documented unforeseen challenges, and emails between CO-OPs and CMS. These documents covered the period from when a CO-OP received its first funding through the third quarter of 2012.

Interviews With CO-OPs

We interviewed senior staff from the 18 CO-OPs to describe each CO-OP's background and its status. We also asked about each CO-OP's financial or operational challenges and its interactions with CMS staff.

Interviews With CCIIO staff

To assess CMS's process and expectations for overseeing the CO-OP program, we interviewed six CMS staff members within CCIIO. We asked staff to discuss CMS's long-term strategy for monitoring CO-OPs, their assessment of CO-OPs' progress, and any challenges that CMS staff had faced during the startup phase of the program.

Limitations

Because CMS funded CO-OPs on a rolling basis throughout 2012, this review included only the first 18 CO-OPs funded through the program. We did not assess CMS's review of the CO-OP applications or their funding decisions. In addition, we did not assess financial viability of the CO-OPs that received funding. An additional OIG report that addresses CMS's review of applications for CO-OP funding will be forthcoming.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

CO-OP applications broadly described various methods for meeting program requirements related to consumer governance

As required by the ACA, CO-OP consumers will make up a majority of all CO-OP governing boards. According to the bylaws of CO-OPs in our review, CO-OP governing boards will have between 3 and 21 directors. The percentage of consumer positions on these CO-OP boards will range from 51 percent to 100 percent. CO-OP boards may also reserve board positions for persons with special expertise in areas such as insurance or health care. The boards may have advisory or nonvoting positions as well. Finally, all of the 18 CO-OPs we reviewed had conflict-of-interest and ethics provisions in their bylaws.

In addition to having consumer-controlled governing boards, eight CO-OPs proposed other ways to involve consumers in developing products, policies, and procedures. Although they did not spell out the plans in detail, four of these CO-OPs envisioned advisory boards that would represent consumers in various aspects of CO-OP management and health care delivery. For example, three of the four advisory boards would work to identify candidates for the governing board or assist with communication strategies. One CO-OP application generally described an advisory board that would seek input from advocacy groups on care for chronic conditions (e.g., diabetes) or care for the medically underserved population. The other four CO-OPs stated that they plan to empower consumers to participate in their respective management, but they did not offer specifics on those plans.

In general, all CO-OP applications described customer service and outreach strategies to ensure consumer responsiveness. Examples of these strategies include 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.

CO-OP applications identified primary care, electronic health data, and outsourcing as main mechanisms for meeting program goals

The CO-OP program goals emphasize integrated care, improved quality, and reduced costs. In their loan applications, CO-OPs identified primary care and electronic health data as the main mechanisms for achieving

these goals. In interviews, CO-OPs acknowledged that it will be challenging to differentiate their plans from others offered on the Exchanges, given that other insurers use these mechanisms as well.

CO-OPs plan to use primary care models to integrate care, lower costs, and improve quality

Primary care models typically include a primary care physician or group practice as the first point of contact for patients. The physician or group determines a plan of care for patients and coordinates services such as laboratory tests, specialty care, and followup. One primary care model, called a "medical home," integrates care for patients to improve quality and may include specialized programs for patients with chronic conditions, such as hypertension.[31] Our review of CO-OP applications revealed four main features of their planned integrated care: care coordination, disease management, patient behavior modification, and financial incentives for providers. Table 1 shows features of integrated care that CO-OPs proposed in their loan applications. Because CO-OPs are still evolving, their applications did not always include details on their proposed models of integrated care.

Table 1: Features of Integrated Care Described in CO-OP Applications

Care Coordination	Disease Management
• Contractually requiring physicians to communicate with one another • "Telehealth" and video systems that enable rural physicians to interface with providers at urban medical centers • Management of care transitions across health care settings (i.e., hospital, home, physician's office) • Provider data sharing from claims, clinical notes, and peer data to develop best practices in care coordination	• Management programs for chronic conditions and maternal health • Intensive primary care management for patients with multiple complex conditions • Exclusive provider or medical home models that require patients to adhere to a treatment plan
Patient Behavior Modification	**Financial Incentives for Providers**
• Health coaching (e.g., teaching healthy lifestyle habits) • Wellness programs • Tracking emergency room use • IT systems that track patient behavior	• Bonus payments or shared savings for improving outcomes • Provider incentives based on achieving measurable outcomes • Bundled payments

Source: Office of Inspector General (OIG) analysis of CO-OP applications, 2012.

[31] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. *Joint Principles of the Patient-Centered Medical Home*, 2007. Accessed at www.aafp.org on February 25, 2013.

CO-OPs also envision that primary care models will reduce costs by using less specialty care, preventing disease, and reducing unnecessary services. For example, all of the CO-OPs in our review plan to offer financial incentives, such as shared savings or bundled payments, to primary care providers to keep consumers healthy.[32] Five CO-OP applications described programs to monitor consumers with chronic conditions and prevent hospitalization, and nine CO-OPs plan to offer wellness programs.

However, because CO-OPs are new entities, they generally do not have existing networks of health care providers. Fifteen CO-OPs in our review will contract with existing provider networks rather than assemble new networks. Such outsourcing may create additional challenges for CO-OPs that want to engage directly with providers and coordinate provider care. CO-OPs reported that they will need to find networks with providers who are aligned with the CO-OPs' mission to ensure consumer-focused care at competitive reimbursement rates.

CO-OPs plan to use electronic health data to control costs and improve quality

CO-OP applications described how electronic health data and other information technologies will help control the costs of care by providing data that help physicians choose appropriate treatments and reduce potential medical errors. For example, one CO-OP described a Web-based program that analyzes medical data that physicians can use to create treatment plans for patients with chronic or acute diseases. This program would also help to ensure continuity of care as a patient moves among different care settings and physicians. Another CO-OP described a software program that helps identify providers whose outcomes and cost-effectiveness of care are better than average.

CO-OPs also envision that electronic health data will improve health care quality. For example, two CO-OPs plan to analyze medical data to review providers' interactions with patients and referral patterns to ensure that patients' needs are being met. Other CO-OPs will use data to supervise medical care and wellness services. Other CO-OPs described using data to develop best practices for health care providers and track patient satisfaction. Because CO-OPs currently do not have patient or physician data to analyze, they will need to build it over time.

[32] American Hospital Association. A bundled payment is a type of reimbursement methodology whereby the fees for multiple providers and services are bundled into a single comprehensive payment that covers all of the services involved in the patient's care. *Bundled Payment: AHA Research Synthesis Report.* May 2010. Accessed at www.aha.org on February 25, 2013.

CO-OPs plan to outsource operational functions to reduce costs

Almost all CO-OPs described outsourcing as an important cost control strategy. Outsourcing will allow CO-OPs to save money on staffing, training, and technology systems. For example, CO-OPs may contract with vendors that offer the latest technology in billing and claims systems. The cost of building and maintaining such systems would be prohibitive for CO-OPs. Six CO-OPs in our review also plan to use a purchasing council to achieve savings.[33]

CO-OPs met 90 percent of their milestones on or ahead of schedule

We evaluated CO-OPs' progress toward their milestones from February 2012 to September 2012. These milestones covered tasks such as achieving licensure, hiring key staff, and contracting with vendors. Milestones are tied to funding disbursement but also represent important steps in the startup process.

CO-OPs are achieving licensure

CO-OPs reported that they are on track for, or have obtained, insurance licensure. As of June 2013, 19 of the 24 CO-OPs in the program have been issued insurance licenses by their States. However, on May 22, 2013, one State denied licensure to a CO-OP.[34] CO-OPs told us that the application and approval process for licensure can take 2 to 6 months and requires detailed actuarial and business analyses to ensure that the CO-OPs have adequate financial reserves to pay medical claims. In addition, States may require CO-OPs to revise their bylaws to fit existing insurance designations (e.g., health maintenance organizations, preferred provider organizations) and prove that they have broad networks of providers.

CO-OPs have hired key staff

CO-OPs have hired personnel to manage operations and established transitional boards of governance. Examples of such personnel include chief executive or chief operating officers as well as administrative staff. Chief executives may serve as members of the transitional governance board until CO-OPs have enough members to hold elections for a

[33] Purchasing councils allow CO-OPs to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services. 76 Fed. Reg. 77392 and 77394 (December 13, 2011).

[34] Vermont Department of Financial Regulation, *Vermont Health CO-OP Fails State Insurance Standards*. May 22, 2013. Accessed at www.dfr.vermont.gov on May 29, 2013.

permanent board of directors. Executives and other staff are responsible for recruiting and training additional staff, writing operational policies and procedures, and contracting with outside vendors.

CO-OPs have contracted with vendors for essential operations

All CO-OPs in our review plan to rely on outside contractors to perform certain business functions, such as customer service, IT support, legal functions, or claims processing. Fourteen of the CO-OPs in our review plan to outsource their customer service functions, and 16 CO-OPs plan to use a contractor for claims processing. CO-OPs also reported that they cannot hire and train sufficient staff quickly enough to perform all business functions.

CO-OPs face tight timeframes, market uncertainty, and other challenges

To compete on the Exchanges, CO-OPs should be ready to enroll members by the expected launch date of October 1, 2013.[35] Therefore, CO-OPs must hire staff, obtain licensure, market their plans, and enroll consumers within 18 to 24 months from when they received loan funding. All CO-OPs reported these as major challenges.

CO-OPs also reported that they face uncertainties in the new insurance marketplace. For example, CO-OPs told us that existing or new insurers could create significant competition on the Exchanges. In addition, CO-OPs expressed concern about identifying and contracting with the right health care providers and vendors for key services.

Furthermore, CO-OPs reported that uncertainty surrounding the implementation of the ACA posed challenges during the startup period. For example, some States had not decided whether to operate an Exchange. CO-OPs located in these States were uncertain about how to plan for new Exchange requirements, such as benefit design, reporting, and premium collection. Other CO-OPs reported that the Supreme Court's review of the ACA delayed hiring because potential employees worried that the CO-OP program would be discontinued.

After CO-OPs complete their first year of operations, they will face long-term challenges. For example, CO-OPs reported that designing integrated care systems and reducing costs are important long-term challenges, along with continued quality improvement, outreach, and enrollment.

[35] CMS anticipates that Exchanges will be ready to enroll members into plans beginning in October 2013, with insurance coverage beginning January 1, 2014.

CMS's oversight system involves frequent monitoring and early intervention

CMS established a prospective oversight system to safeguard CO-OP funding and ensure timely implementation of the program. CMS described its oversight as an "early warning system" that identifies and addresses problems before they undermine a CO-OP's progress.

CMS account managers meet with CO-OPs two to four times per month to monitor progress

CMS account managers are CO-OPs' primary liaisons with the agency and hold weekly or biweekly telephone meetings with CO-OPs to track their progress.[36] During these meetings, account managers and CO-OPs also discuss challenges, delays, or other issues. Account managers document the discussions and the CO-OPs' progress toward their milestones. If a CO-OP cannot reach a milestone on time, the account manager documents this and determines whether the delay poses a minor, moderate, or major risk to the CO-OP's progress. Depending on the nature of the delay, CMS will work with the CO-OP to reach the milestone, reschedule the milestone to a later date, or delay the loan disbursement associated with the milestone until the CO-OP reaches it.[37]

CMS delayed loan disbursements and issued one noncompliance warning

CMS delayed portions of startup loans for five CO-OPs when they did not reach important milestones on time. For example, CMS stepped in to work with one CO-OP when the CO-OP could not resolve concerns from its State department of insurance regarding the CO-OP's timeline for receiving State licensure. In three cases, CMS delayed funding for CO-OPs that signed core contracts without CMS approval. CMS also issued a noncompliance warning to a CO-OP because it did not submit reporting information on time or in the required format. The CO-OP took remedial action shortly thereafter.

CMS reviewed CO-OPs' major contracts to ensure fair pricing and prevent conflicts of interest

CMS approves major contracts that CO-OPs sign, including employment contracts for executive officers and services such as claims processing. CMS reported that this review process ensures that a CO-OP retains outside services at costs that are consistent with its financial projections

[36] CO-OPs also communicate with account managers as needed between these meetings.

[37] CMS may take any of these actions in combination. Decisions related to milestones may also involve senior CMS staff.

and do not present financial conflicts of interest. For example, one CO-OP planned to contract with its sponsor to perform its main administrative functions. Because the contract covered business operations, CMS closely reviewed the contract to ensure that it was consistent with program requirements and avoided conflicts of interest and to ensure that the CO-OP's budget accounted for the contract's costs.

CONCLUSION

Our review of the early implementation of the CO-OP program found that CO-OPs have made progress and met 90 percent of their milestones during the period of our review. All 18 CO-OPs that we reviewed planned to have consumer-controlled governing boards, and 8 CO-OPs described additional ways they plan to involve consumers. In addition, CO-OPs are working toward program goals related to integrated care, improved health care quality, and reduced costs. Also, CMS has monitored CO-OPs to ensure they adhere to program requirements and meet their milestones.

Although CO-OPs appear to be making progress, at the time of our review they were still hiring staff, obtaining licensure, and building necessary infrastructure such as provider network arrangements and technology systems. In addition, the extent to which any particular CO-OP can achieve program goals and remain financially viable depends on a number of unpredictable factors. These factors include the CO-OP's State's 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.

APPENDIX A

List of CO-OP Program Loan Recipients as of June 2012[38]

Loan Recipient Name	Service Area	Award Amount
Compass Cooperative Health Network	Arizona	$93,313,233
HealthyCT	Connecticut	$75,801,000
Colorado Health Insurance Cooperative, Inc.	Colorado	$69,396,000
CoOpportunity Health	Iowa and Nebraska	$112,612,100
Kentucky Health Care Cooperative	Kentucky	$58,831,500
Maine Community Health Options	Maine	$62,100,000
Consumer's Mutual Insurance of Michigan CO-OP	Michigan	$71,534,300
Montana Health Cooperative	Montana	$58,138,300
Nevada Health CO-OP	Nevada	$65,925,396
Freelancers CO-OP of New Jersey	New Jersey	$107,213,300
New Mexico Health Connections	New Mexico	$70,364,500
Freelancers Health Service Corporation	New York	$174,445,000
Freelancers CO-OP of Oregon	Oregon	$59,487,500
Oregon's Health CO-OP	Oregon	$56,656,900
Consumers' Choice Health Insurance Company	South Carolina	$87,578,208

[38] Centers for Medicare & Medicaid Services (CMS), *New Loan Program Helps Create Customer-Driven Non-Profit Health Insurers*. Accessed at www.healthcare.gov on April 30, 2013.

Loan Recipient Name	Service Area	Award Amount
Arches Community Health Care	Utah	$85,400,303
The Vermont Health CO-OP	Vermont	$33,837,800
Common Ground Healthcare Cooperative	Wisconsin	$56,416,600

Note: CMS began accepting loan applications in October 2011 and announced loan awards in February, March, May, June, and July 2012.

APPENDIX B

List of Additional CO-OPs Funded After June 2012

Loan Recipient Name	Service Area	Award Amount
Land of Lincoln Health (incorporated as Metropolitan Chicago Healthcare Council CO-OP)	Illinois	$160,154,812
Louisiana Health Cooperative, Inc.	Louisiana	$65,040,660
Evergreen Health Cooperative, Inc.	Maryland	$65,450,900
Minutemen Health, Inc.	Massachusetts	$88,498,080
Coordinated Health Plans of Ohio, Inc.	Ohio	$129,225,604
Community Health Alliance Mutual Insurance Company	Tennessee	$73,306,700

Note: The six CO-OPs in this table are funded by CMS but were not included in this evaluation.

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Office of Inspector General

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.