**HEALTHCARE FINANCING REFORM: USING THE PPACA’S CO-OP PROGRAM TO IMPACT HEALTHCARE AND THE INSURANCE MARKET**

by

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The intent of this essay is to provide an overview of the Patient Protection Affordable Care Act (PPACA) Consumer Operated and Oriented Plan (CO-OP) program, to discuss its performance, and address challenges CO-OPs have to overcome in order to achieve the program goals. The outcome of the program is important as the healthcare landscape continues to evolve and stakeholders continue to debate the most effective healthcare financing models. The public health importance of this topic is represented by the potential of the program to heighten market competition, increase affordability for consumers, and improve access to health insurance.

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**HEALTHCARE FINANCING REFORM: USING THE PPACA’S CO-OP PROGRAM TO REVOLUTIONIZE HEALTHCARE AND THE INSURANCE MARKET**

Dee U. Abasute, MHA

University of Pittsburgh, 2014**ABSTRACT**

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# Introduction

Millions of Americans obtain health insurance through private health plans, which include health plans sold in the individual and group insurance markets. Historically, these markets have been highly concentrated with some markets having one or two dominating insurance companies.1 Higher concentration may indicate a less competitive market with limited consumer choice and potentially higher than average premiums.2 During the 2009 health reform debates, law makers recognized this unfavorable market trend and initially proposed a public insurance option, but settled on creating the Consumer Operated and Oriented Plan (CO-OP) program, a federal loan initiative that supported the creation of new nonprofit health insurance companies. The purpose of the program is to increase competition among insurers and improve consumer choice, increase plan accountability, and promote integrated care models.3 CO-OPs will potentially achieve the program goals by operating statewide, having a member-governed governance structure, and using some type of primary care model to integrate care.

The Patient Protection Affordable Care Act (PPACA) directed the Centers for Medicare & Medicaid Services (CMS), within the Department of Human and Health Services (HHS), to manage the program and administer funding for qualified applicants. PPACA appropriated $6 billion for the program to create a CO-OP in every state, but funding was later reduced to $2.1 billion thus limiting the amount of CO-OPs. The funding supported the creation of 24 new CO-OPs in 24 states, one CO-OP operates in Iowa and Nebraska and two serve Oregon. However, the Vermont CO-OP rescinded its funding because it was not able to obtain state licensure and the Ohio CO-OP did not participate in the Exchange, although Ohio’s CO-OP offered plans off the Exchange.4 Altogether, twenty-two of CO-OPs participated on the individual and small group Exchanges in their respective states.

The CO-OP program has received mixed reviews from analysts and members of Congress with some hopeful that the program will succeed in increasing market competition and others questioning the sustainability of the federal loan initiative.4 CO-OPs face several disadvantages by entering a now uncertain insurance market, but have the advantage of federal funding to support them during their initial years of operation. This essay will provide an overview of the PPACA CO-OP program; discuss its performance and viability, and review the challenges CO-OPs must overcome in order to achieve some level of success.

## HEALTH INSURANCE MARKET

Historically, the US health insurance market, particularly the individual and small group markets, have been described as an oligopoly with most states having one insurer that dominates the market, a trend that has been consistent since 2002.1 In 2010, when the PPACA was signed into law, a single insurer dominated at least half of the individual market in 30 states and the District of Columbia.2 Several obstacles impede true competition in the private health insurance market including inadequate anti-trust policies, also known as competition laws, and a high barrier to entry.5 For example, it is very difficult to amass the capital to start and fund an insurance company and also meet state requirements for reserve funds. Recognizing the trends in the industry and its effects on the public, lawmakers included various provisions in the PPACA that aimed to reform the health insurance market for the better. First, the PPACA prohibited certain restrictive insurance practices such as underwriting, denying people with preexisting conditions, and setting lifetime dollar limits on necessary care. Additionally, insurers now have to provide essential benefits that include items and services within at least 10 categories (e.g., preventative and wellness services, emergency services, hospitalizations, etc.).6

## overview of co-ops

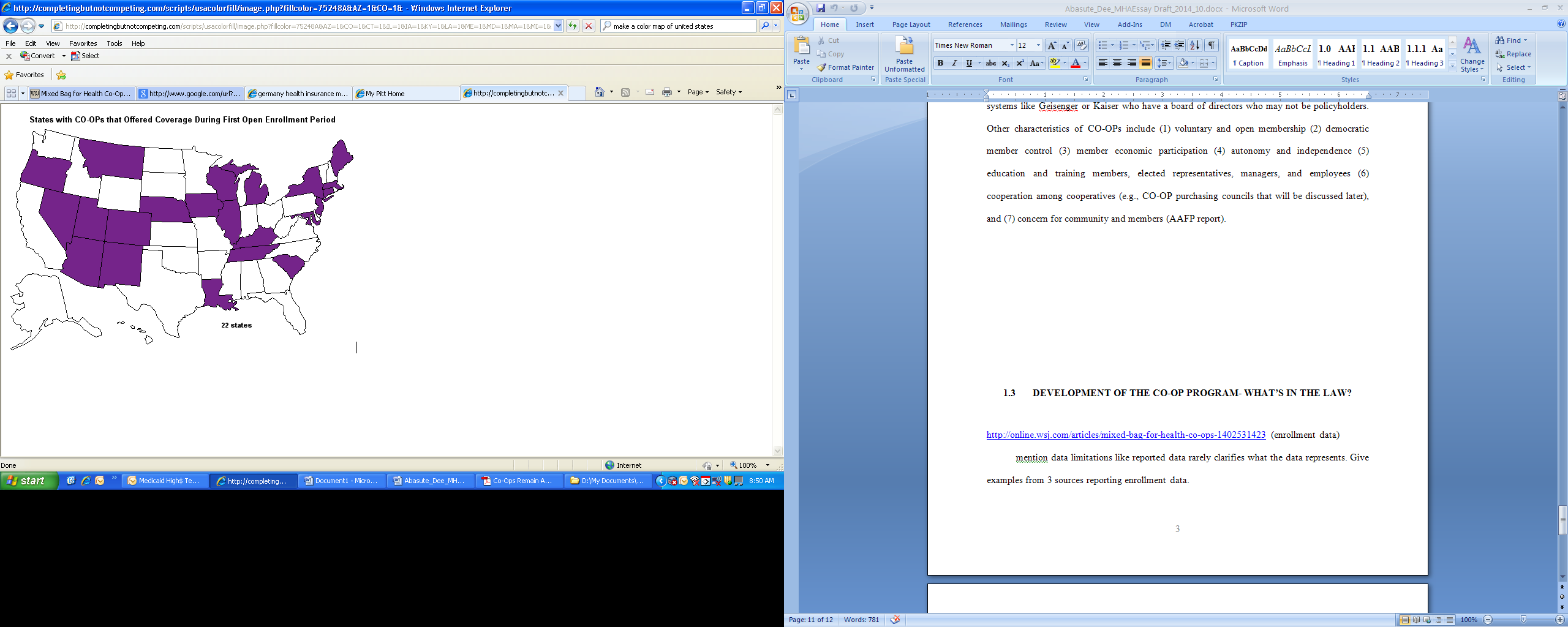
Cooperatives exist in several industries such as agriculture (e.g., food co-ops) and finance (e.g., credit unions), but are less common in healthcare. Health insurance cooperatives were first proposed as insurance alternatives during the Great Depression era and reemerged as a healthcare financing option during debates over PPACA.4 Most Great Depression Era CO-OPs disbanded, but a few survived and became successful. Group Health of Washington and Health Partners in Minnesota both are the most well-known health insurance cooperatives. Founded in 1947, Group Health is an integrated finance and delivery system (IFDS) that has over 600,000 members in Washington and Idaho. Health Partners, founded in 1957, is the largest member-governed IFDS health organization in the United States with over 1 million members in Minnesota and Wisconsin.4

The consumer governance structure distinguishes CO-OPs from other non-profit health systems like Geisinger Health System or Kaiser Permanente who have a board of directors who may not be policyholders. Other characteristics of CO-OPs include (1) voluntary and open membership (2) democratic member control (3) member economic participation (4) autonomy and independence (5) education and training members, elected representatives, managers, and employees (6) cooperation among cooperatives (e.g., CO-OP purchasing councils), and (7) concern for community and members.7

PPACA required CO-OPs to be private nonprofits with a consumer-focused operational strategy and a consumer governance structure, encouraged care coordination, quality and efficiency to be eligible to receive funding.6,8 Ineligible organizations included those licensed by a State as a health insurance provider prior to July 16, 2009; those affiliated with such a provider, organizations sponsored by a State, or local government or any political subdivision of a State or local government.6,8

### PPACA CO-OP PROGRAM

In 2009, the PPACA originally included a government-run health insurance agency, also known as the public option, which would have been similar to Medicare without an age restriction. However, when the PPACA was passed on March 23, 2010, the CO-OP program replaced the public option due to heavy contention from mostly Republican members of Congress and the health insurance industry.3 Both groups claimed a public option would create an unfair market where other insurers would not be able to compete with the Medicare-like premium rates. In addition, an industry executive stated the government would have conflicting roles as a player and regulator in the market.9 The CO-OP program was a better alternative because it would not lead to a “government takeover of the healthcare system” and proved to be a successful model in other industries. PPACA appropriated $6 billion dollars for the program, which was later reduced to $2.1 billion due to the fiscal cliff.4 Although the PPACA aimed to establish a CO-OP in every state, reduced funding only allowed for the creation of 24 CO-OPs in 23 states (See Figure 1). During the first open enrollment period, October 1, 2013 through March 31, 2014, only twenty-two CO-OPs offered coverage. The Vermont CO-OP did not receive State licensure due to the Vermont Department of Financial Regulation citing their business plan was unrealistic, their rates were higher than market premium rates, and there was suspected conflict of interest between the CO-OP and the president of the board. Ohio only participated off the Exchange; however, they will offer plans on the Exchange in 2015.4



Notes: Blue star indicates a state that did not participate on the Exchange during the first open enrollment period. Green star indicates a state that did not participate in any Exchanges.

**Figure 1. States with CO-OPs that Offered Coverage during the First Open Enrollment Period**

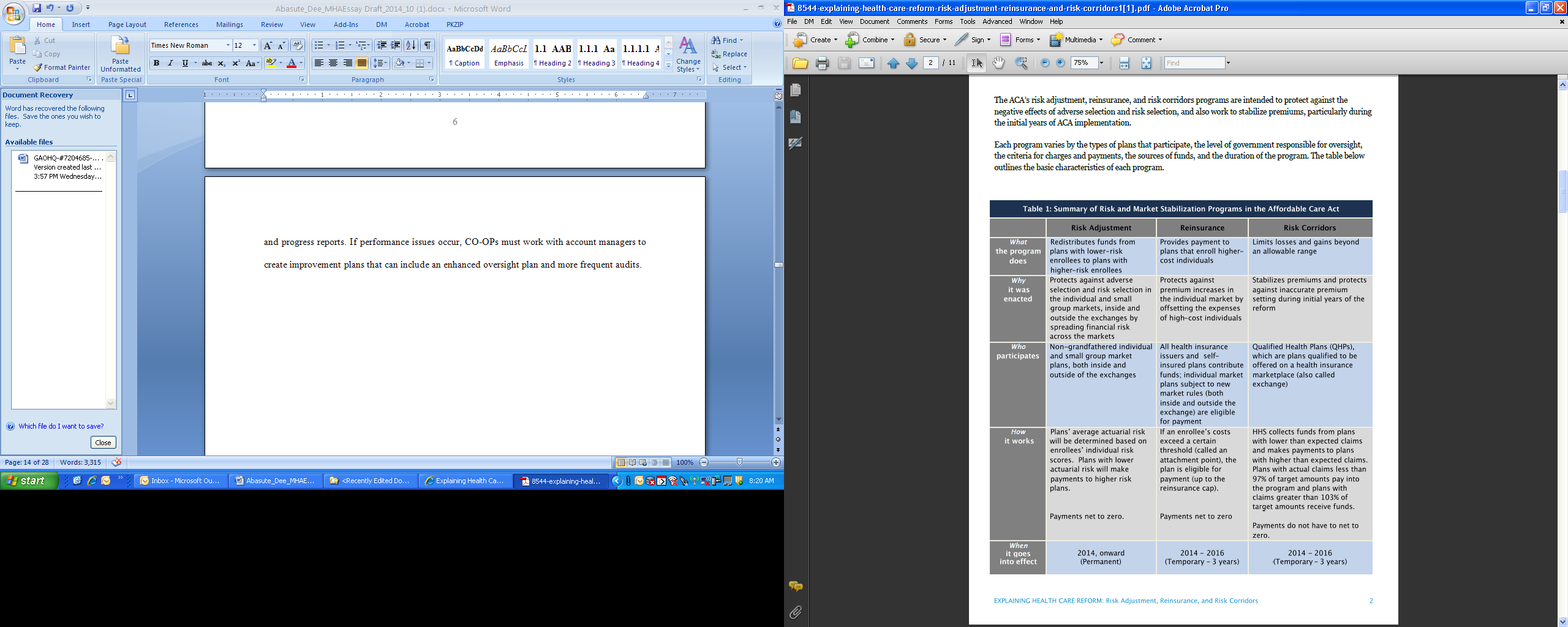
### FUNDING

The funding for the CO-OP program is in the form of two types of loans: start-up and solvency loans.6 The start-up loans can only be used for start-up costs such as initial hiring of staff or renting workspace and CO-OPs are prohibited from using the funds for marketing and propaganda activities. Solvency loan money can be used to cover the cost of meeting state licensure and solvency requirements (i.e., the reserve amount of money needed to pay claims). Start-up loans must be repaid within 5 years of the first disbursement and solvency loans must be repaid within 15 years of the first drawdown.6 CO-OPs can only receive disbursements once they have met the milestones (e.g., establishing provider network) they proposed in their business plan submitted to CMS.10

#### Risk Mitigation Programs

PPACA established three risk mitigation programs--- permanent risk adjustment program and the temporary reinsurance and risk corridor---to help stabilize the market for all qualified insurers during the first few years of implementation.10 The programs will help insurers manage the uncertainty given the new provisions required in the health insurance markets (See Table 1). In addition, the programs aim to protect against the negative effects of insurers unknowingly enrolling too many high-risk enrollees, or adverse selection, and risk selection, or denying certain types of people. Specifically, the risk adjustment program is intended to reinforce PPACA rules that prohibit risk selection by insurers.10 Risk adjustment achieves this goal this by redistributing funds from plans with lower-risk enrollees to plans with higher-risk enrollees. It will be a permanent program that all insurers help fund. Reinsurance is similar to risk adjustment but differs in that reinsurance is meant to stabilize premiums by reducing the incentive for insurers to charge higher premiums to financially protect themselves for possibly high cost enrollees, whereas risk adjustment is meant to help mitigate the effects of risk selection across plans.10 Lastly, the risk corridor is intended to encourage accurate premium rate setting by limiting gains and losses of insurers. Plans with higher than projected claims will receive payment from HHS. The reinsurance and risk corridor programs will end after 2016.

Table . Summary of Risk Mitigation Program in the Affordable Care Act 10



Source: Kaiser Family Foundation

### LEGAL REQUIREMENTS

The PPACA requires the following standards for CO-OPs to remain compliant:

**Governance.** CO-OPs must be governed by a board comprised mostly of members and operate with a strong consumer focus.4 However during the first few years of implementation, a “formation” board that governs the planning and developmental phases will suffice. The board is to transition to an “operational” member-elected board within a year of providing coverage to its first member.6 The board should also include experts in finance, strategic planning, marketing, etc. 11

**Service Coverage**. Statewide coverage is not required although during the application process organizations received additional points for offering statewide coverage.12

**Health plans.** At least two-thirds of plans issued by a CO-OP must be qualified health plans (QHPs) offered on the individual and small group market.11 QHPs are certified by the Exchange in which they are sold, provide essential benefits, and offer coverage based on one of the four metal levels (i.e., bronze, silver, gold, and platinum). Each metal level corresponds to different cost-sharing structures and depending on the metal level, plans pay from 60 to 90 percent of claims costs. CO-OPs must offer QHPs at the silver and gold levels.12

Table . Table 2 PPACA Qualified Health Plan Metal Levels

|  |  |  |  |
| --- | --- | --- | --- |
| Metal Level | Premiums | Out of Pocket cost | Plan Pays (% of essential benefits) |
| Bronze | Lowest | Highest | 60 |
| Silver | Moderate | Moderate | 70 |
| Gold | Higher | Lower | 80 |
| Platinum | Highest | Lowest | 90 |

### MONITORING AND OVERSIGHT

CMS is authorized to manage and monitor the CO-OP program. It established a prospective “early warning” oversight system that identifies and addresses issues, such as an organization anticipating not being able to meet a milestone, before they intervene and interrupt a CO-OP’s operations.13 Each CO-OP has a CMS account manager that meets with CO-OPs on a biweekly basis to discuss progress towards milestones, challenges, delays, or other issues. CMS requires CO-OPs to submit reports detailing financial and performance data and progress reports. If performance issues occur, CO-OPs must work with account managers to create improvement plans that can include an enhanced oversight plan and more frequent audits.13 Lastly, CMS is responsible for monitoring and overseeing the CO-OP program over the length of the loan repayment periods plus 10 years for each CO-OP.

# METHODOLOGY

The Center for Healthcare Research and Transformation (CHRT) conducted the original analysis for bronze and silver premium rates and this reports extends the analysis to gold and platinum level premium rates.14 To determine the competitiveness of CO-OP premium rates compared to other insurers, data on 2014 PPACA Exchange rates in CO-OP states were analyzed. PPACA allows premiums to vary based on age, tobacco use, family size, and rating areas, so the comparison scenario was for a single, non-smoking 27 year old with no children in the most populated county of each CO-OP state.14 Although the rates for a 27 year old are not representative for all people, the CO-OP premium rates were consistent regardless of age. All metal levels were compared. Plans were limited to the individual insurance market. Catastrophic, Medicare, Medicaid, and employer-based health plans were not included in this study. Premium data was obtained from Value Penguin, a health insurance comparison website for Exchange health plans.

To evaluate each CO-OP’s enrollment performance, expected and actual enrollment data were compared for the first open enrollment period (October 1, 2013 through March 31, 2014). Some CO-OPs submitted data through May 1, 2014 due to limitations in extracting data for the specific time period or their numbers being linked to effectuation dates. Expected enrollment data and actual enrollment data were compared because this data helps both CMS and the CO-OPs monitor their performance as outlined in each CO-OP’s business plan. In addition, enrollment projections (calculated for multiple years) partly determined each CO-OP’s loan amount. Enrollment data came from the House Committee on Oversight and Government Reform 2014 report.15

**Limitations:** The House Committee on Oversight and Government Relation’s enrollment data did not specify whether the data captured a combination of individual and small group, on and off Exchange, and paid and unpaid enrollees. In addition, the timeframe the enrollment numbers represented varied for each CO-OP with one CO-OP submitting data up until May 1, 2014. However, their report offered the most complete enrollment data compared to other available sources.

## Findings

### COMPARED TO OTHER INSURERS, CO-OP PREMIUM RATES VARIED SIGNIFICANTLY ACROSS STATES

**Bronze Plans**

In five of the 22 CO-OP states, CO-OPs offered the lowest cost bronze plan in the state’s most populated county (Figure 2 and Table 1).14 In five other states, the cheapest CO-OP bronze plan was less than 6 percent more expensive than the cheapest overall plan. However, in six of the 22 states, the cheapest CO-OP bronze plan was between 10 to 25 percent more expensive than the overall cheapest bronze plan. In five CO-OP states, CO-OP plans were between nearly 25 to 65 percent more expensive. Michigan had the largest percent difference, with its CO-OP plan being almost 65 percent more expensive than the cheapest bronze plan in its most populated county.14

Figure . Percent Difference of CO-OP Premiums Compared to Other QHPs, 2014 Bronze Plans

**Silver Plans**

Premium rates for CO-OP silver plans were not as competitive as the rates for CO-OP bronze plans. In three of the 22 CO-OP states, silver CO-OP plans were the lowest priced silver plan (Figure 3 and Table 1).14 In an additional six states, CO-OP silver rates are less than 10 percent more than the overall cheapest silver plan. In six of the 22 states, silver CO-OP plans were between 10 and 20 percent more expensive than the lowest-cost silver plan. The remaining 7 CO-OP plans were more than 20 percent more expensive than the lowest-cost silver plan. Michigan’s CO-OP had the largest percent difference with its plan being over 65 percent more expensive than the lowest overall competitor.14

Figure . Percent Difference of CO-OP Premiums Compared to Other QHPs, 2014 Silver Plans

**Gold Plans**

CO-OP premium rates were slightly more competitive with six CO-OP states having the lowest priced gold plans. Colorado and South Carolina’s CO-OPs did not offer a gold plan in the most populous county of their state. Again, Michigan had the highest percent difference (over 75 percent) compared to the lowest priced plan (Figure 4 and Table 1). In two states, the cheapest CO-OP gold plan was less than 5 percent more expensive than the cheapest overall plan. Ten states had plans between 10 to 30 percent more expensive than the lowest-priced plan and one CO-OP state’s plan was over 40 percent more expensive.

Figure . Percent Difference of CO-OP Premiums Compared to Other QHPs, 2014 Gold Plans

**Platinum Plans**

Fewer platinum plans were offered in the most populated county in CO-OP states with CO-OPs in fourteen out of 22 states not offering premium plans. Oregon is counted in the total because Oregon Health Co-op did not have a platinum plan for the most populated county. CO-OPs offered the lowest platinum plan in 6 out of the 8 states. In three states CO-OPs were more expensive by 10 to 30 percent (Figure 5 and Table 1).

Notes: Asterisk indicates states with a CO-OP that offered the lowest cost platinum plan. Excluded states did not have CO-OPs that offered plans in the selected region.

Figure . Percent Difference of CO-OP Premiums Compared to Other QHPs, 2014 Platinum Plans

**Summary**

For all metal levels, the lowest CO-OP premiums in the most populous area were generally higher than the premium rates of other insurers. Kentucky’s CO-OP consistently charged the lowest premium rate for both bronze and silver plans. However, Michigan and Maryland’s CO-OPs had premium rates that were significantly higher (greater than 40 percent different) across all metal levels except platinum. Although, there is no established competitive price range, most CO-OPs had rates that were 20 percent higher than the lowest rate of its competitor.

Table . 2014 Qualified Health Plan rates for a 27 year old in the most populated county of each CO-OP state



### MOST CO-OPS DID NOT MEET OR EXCEED ENROLLMENT PROJECTIONS

Overall, CO-OPs enrolled more than 450,000 members which was under their 2014 goal of 575,000 members. The total number was skewed by seven CO-OPs that enrolled nearly 80 percent of the total number of enrollees across all CO-OP states. Fourteen out of 22 CO-OPs enrolled fewer members than they projected for 2014 open enrollment period. Eight out of 22 CO-OPs exceeded their enrollment projections while six CO-OPs more than doubled their enrollment numbers. Several obstacles prevented some CO-OPs from gaining a higher enrollee base such as technical problems with the Exchange, lack of brand recognition, predatory pricing by larger insures, early renewal initiatives for plans that existed prior to the PPACA, and limitations on the use of loan funding for marketing. Some plans that performed well priced themselves lower than other insurers, received outside funding sources for marketing, and/or implemented grassroots style marketing. Currently, no causal relationship can be determined between premium prices and enrollment numbers due to several factors. These factors include not all insurers competing on the Exchange and it not being clear how Exchange shoppers made their plan decisions.

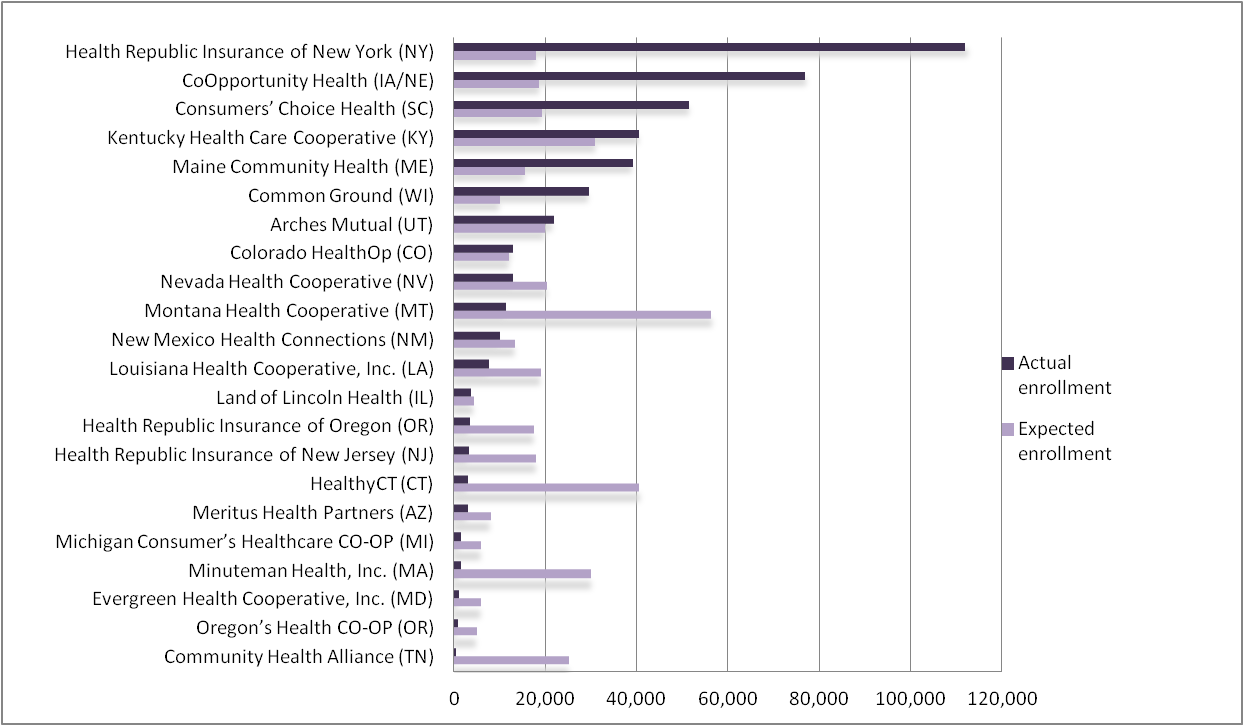


Figure . CO-OP Expected and Actual Enrollment Figures for First Open Enrollment Period

# Discussion/conclusion

**Discussion:** The competitiveness of CO-OP’s premium rates varied significantly across states. Kentucky was the only state whose CO-OP charged the lowest rates for all metal levels in its most populated county.14 In contrast, CO-OP plans in some states, like Michigan, have premium rates that are much higher than other insurers. This trend could be consistent outside of the most populous county since most CO-OPs offered coverage statewide. All insurance companies faced trouble pricing in the new market, but CO-OPs were at a greater disadvantage because they have no bargaining power, no experience with pricing plans and paying member claims, and new market provisions only made pricing even more challenging. Technically, most CO-OPs did not achieve the goal of “increasing plan affordability”. However, it is too early to conclude that more CO-OPs will not be able to do this in the future once they gain additional market experience. For the CO-OPs that had the lowest prices, it will be interesting to see how their premium prices change since first year performance does not bear much weight in the long-run. Collectively, CO-OPs achieved nearly 78 percent of their enrollment goals during the first open enrollment period.

**Conclusion:** CO-OPs ability to impact the market depends on market factors, activity of competitors, and the expertise of management teams. Their success and viability will also be determined by how well they manage the challenges of being new market entrants and limitations set forth by provisions in the law. These include:

**1.** **Establishing provider networks**

Most CO-OPs had limited time to build provider networks and had to “rent” networks from existing third-party administrators which in-turn affected the price of the plans. Also, having the same network as existing insurers does not help set CO-OPs apart from their competitors. Moving forward, they need to build relationships with providers and establish a high-quality network that would justify the pricing of their plans, allow them to be competitive, and not lose money. CO-OPs will have to negotiate rates with providers and hospitals and the task will be difficult especially for a small plan with no history of a large member base.

**2. Gaining sufficient enrollment**

Many CO-OPs did not meet their enrollment projections and membership size is important to financial and operational stability. CO-OPs will not have strong bargaining power without a member-base that is attractive to providers, they cannot generate premium profits without members, and premium rates will likely be higher with a smaller member base. In contrast, CO-OPs do not want to grow too quickly and have to draw down from their solvency reserves more frequently than projected. They also do not want to price their plans so low as to attract a disproportionate population of sick people and in turn compromise their financial health.

**3.** **Implementing creative marketing strategies**

Marketing is an essential and large expense for most health plans, but the law prohibits using loans for those purposes. Some CO-OPs received outside funding for marketing and/or utilized grassroots-style marketing to reach potential members. CO-OPs need to build their marketing budget through premium revenue and solicit private funding as well as continue to perform grassroots marketing to gain more exposure. In addition, they could petition HHS to lessen the restriction on marketing until they individually reach a certain level of financial stability.

**4. Expanding to large group market**

The law only allows CO-OPs to have up to one-third of their business in the large group and Medicaid markets. As CO-OPs gain stability, they should aggressively pursue enrollment in the large group market since it is the most profitable insurance market. This will give them additional negotiating power with providers.

**5. Financial performance after end of risk mitigation programs**

Once the reinsurance and risk corridor programs end in 2016, all insurers will have to deal with the cost of risks previously covered under the programs and will have a more accurate picture of their financial position. Hopefully, CO-OPs position themselves so that they do not feel negative financial effects of the end of these programs.

Overall, it is too early to determine the impact of CO-OPs on the health insurance market mainly due to lack of historical data, but in three to five years, when most of the PPACA provisions have been implemented and CO-OPs have more market experience, analysts and lawmakers can properly assess the program’s effectiveness and sustainability. However, it may be difficult to correlate the presence of CO-OPs in markets to effects on premium prices in CO-OP states. This would be exceptionally challenging in states with 3 or more insurers. Further research on the relationships between variables will also help make more grounded claims about the program’s performance. Some variables include the relationship between premium price, plan benefits, number of market competitors, enrollment numbers and the use of solvency loans, etc. CO-OPs may become key players in certain markets, but it is unlikely they will transform the health insurance market as a whole if they cannot overcome the previously identified challenges.

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