WASHINGTON POLICY CENTER for health care

CONGRESSIONAL TESTIMONY February 5, 2014

Roger Stark, MD, FACS

Background

Consumer operated and oriented plans, or CO-OPs, have been part of the American health delivery system since 1929. Although all of the plans that existed during the Great Depression have closed, a few large health CO-OPs formed during, or shortly after, World War II are still in existence.

Thousands of non-health care CO-OPs serve American consumers every day in areas such as agriculture, utilities and credit unions. A CO-OP is designed to be self-owned and be of benefit to its members. Governance is through a member-board and CO-OPs are not-for-profit.

CO-OPs in the Affordable Care Act – Section 1322 [1]

CO-OPs were placed in the Affordable Care Act (ACA) as a compromise to the "public option" health insurance plan. The stated goal is to increase competition and consumer choice in the health insurance exchanges. Two thirds of policies must be sold in the individual and small group markets and silver and gold plans must be offered. CO-OPs must comply with all state insurance laws and regulations. They must be governed by members and have a strong consumer focus. "Integrated" health care delivery models are given priority. These "creative" delivery systems are fundamentally new versions of health maintenance organizations (HMO) that have existed for years.

Initial funding is through two types of federal government loans given at favorable rates. Start-up loans must be repaid within five years and solvency, or reserve, loans must be repaid within fifteen years. The sponsoring group must provide 40% of funds (excluding the federal loans) and no more than 40% of funding can come from state or local governments. CO-OPs can not receive more than 25% of funds from an insurance carrier that existed prior to July 16, 2009. CO-OPs must be very efficient and show a medical loss ratio of 95%.

CO-OPs as of January, 2014

To date, federal loans have been given to 24 new CO-OPs. One of these 24 has closed because it could not satisfy state insurance regulations. It is not clear how its original loans will be repaid. Ten others are projecting financial problems.

[1] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=87

The original ACA called for $6 billion in loans to new CO-OPs. This was cut to $3.4 billion in the broad budget cut of 2011 and further reduced to $2 billion in the "fiscal cliff" negotiations of 2013. Forty applications were withdrawn because of the budget cuts.[2]

Policy Analysis

The overriding concern with the CO-OPs allowed in the ACA is financial solvency. The federal loans can not be used for marketing, clinical services or capital purchases. These CO-OPs are essentially new insurance companies that are starting from scratch. They will need a very significant amount of private money or a very large enrollment premium-base to guarantee solvency. Without the ability to formally advertize, many will need to rely on grass-roots efforts to enroll a large number of people in a short time frame. The inefficient roll-out of the health insurance exchanges has also been a disadvantage for CO-OPs.

Whether they are called accountable care organizations or medical homes, the "integrated" care models given priority in the new CO-OPs are essentially health maintenance organizations (HMO). From my personal experience and from broad experience with HMOs in the 1980s and 1990s, using primary care doctors as gate-keepers can save money by rationing care. Obviously, this is not always in the patient's best interest.

CO-OPs will need to establish provider networks. To have a hope of remaining financially competitive, they will, in all likelihood, be forced to offer providers lower payment rates than

[2] http://www.washingtonpost.com/politics/health-co-ops-created-to-foster-competition-and-lower-insurance-costs-are-facing-danger/2013/10/22/e1c961fe-3809-11e3-ae46-e4248e75c8ea_story.html

established insurance companies will offer. This will be a definite disadvantage in recruiting networks of doctors and hospitals.

CO-OPs will have to deal with the insurance regulations in the ACA. Legacy insurance companies are having a difficult time accurately pricing premiums with the mandates of community rating and guaranteed issue. Without historical actuarial data, new CO-OPs will have no idea where to set plan prices. Without substantial reserves, a few large claims would put them at an extremely high risk for financial failure.

As they do experience growing financial difficulty, the new CO-OPs will have two choices. The first would be to default on the $2 billion already loaned by the federal government. The mechanism for re-capturing this money is unclear. The second choice would be to go back to the federal government and ask for more taxpayer dollars. If this choice was successful and more taxpayer money was given out, CO-OPs would truly be a “public option.”

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BIO – Roger Stark, MD

Dr. Roger Stark is a retired cardiac surgeon and is a health care policy analyst at the Washington Policy Center, one of the largest state-based think tanks in the country. He is the author of numerous health care studies including The Impact of Federal Health Care Reform on Washington State and the book "The Patient Centered Solution". He has had multiple media appearances on both radio and news television. He has testified before Congress on Medicaid and the state health insurance exchanges.

Dr. Stark has served on the Governing Board of Overlake Hospital in Bellevue and is the past Chairman of Overlake's Foundation Board. He is a member of many professional organizations and is an active member of the Woodinville Rotary.

Roger A Stark, MD, FACS

CURRICULUM VITAE

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II. ADDRESS

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III. BIRTHPLACE/DATE

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IV. EDUCATION

University of Nebraska College of Medicine
Omaha, Nebraska
9/70-6/74
Degree: MD

University of Nebraska Graduate College
Omaha, Nebraska
9/72-6/74
Degree: MS Physiology

University of Nebraska
Lincoln, Nebraska
9/66-6/70
Degree: BS Chemistry

University of Southern California
Los Angeles, California
9/65-6/65

Lincoln High School
Lincoln, Nebraska
9/62-6/65

V. POST GRADUATE TRAINING

Cardiovascular/Thoracic Surgery Resident
University of Utah
Salt Lake City, Utah
7/80-6/82

General Surgery Resident
Virginia Mason Medical Center
Seattle, Washington
5/77-6/80

Urology Resident
University of Washington
Seattle, Washington
7/76-4/77

General Surgery Resident
Virginia Mason Medical Center
Seattle, Washington
7/75-6/76

Internship
Virginia Mason Medical Center
Seattle, Washington
6/74-6/75

VI. HONARARIES

Alpha Omega Alpha
University of Nebraska College of Medicine

VII. BOARD CERTIFICATION

General Surgery
Thoracic Surgery

VIII. PRACTICE EXPERIENCE

Private Practice of Cardiovascular and Thoracic Surgery
Bellevue, Washington
1986-2001
Co-founded the Open Heart Surgery Program at Overlake Hospital

Private Practice of Cardiovascular and Thoracic Surgery
Tacoma, Washington
1982-1986

IX. PROFESSIONAL ORGANIZATIONS

American Medical Association
Washington State Medical Association
King County Medical Association
Fellow, American College of Surgeons
Fellow, American College of Chest Physicians
Fellow, American College of Cardiology
Society of Thoracic Surgeons
Seattle Surgical Society
Tacoma Surgical Society
Past President, East King County American Heart Association
Past Chairman, Puget Sound Heart Institute
Past Chairman, Department of Surgery, Overlake Hospital, Bellevue, Washington
Past Chairman, Overlake Hospital Foundation Board
Overlake Hospital Governing Board
Liability Reform Coalition Board
Woodinville Rotary
Washington Policy Center Academic Advisory Board

X. January, 2005 - December 2005

Executive Director – Overlake Hospital Foundation

March, 2008 – Present

Health Care Policy Analyst – Washington Policy Center

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Roger A. Stark, MD, FACS

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2010. Include the source and amount of each grant or contract.

None

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

Washington Policy Center - Health Care Policy Analyst

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None

I certify that the above information is true and correct.

Signature: Roger A. Stark, MD, FACS

Date: dfdsf January 31, 2014