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Erika C. Ziller PhD

University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

Zach T. Croll BA

University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

Andrew F. Coburn PhD

University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

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Health Insurance CO-OPs: Product Availability and Premiums in Rural Counties

Erika C. Ziller, PhD • Zachariah Croll, BA • Andrew F. Coburn, PhD

INTRODUCTION

Created by the Affordable Care Act (ACA), Consumer Operated and Oriented Plans (CO-OPs) are private, non-profit health insurers that were designed to increase insurance plan choice and lower premiums in the Health Insurance Marketplaces (Marketplaces). Early analyses of the ACA suggested that CO-OPs may be particularly beneficial for rural communities, where fewer individual and small group health insurance options have traditionally been available.¹ This brief explores the early availability and role of CO-OPs in rural and urban counties. We describe the regional distribution and market prevalence of CO-OP products* in rural and urban counties, and compare the number of products available in counties with and without CO-OP plans in 2014 and 2015. We also examine the proportion of lowest cost silver products for 27 year olds offered by CO-OPs in both years. To better understand the impact of CO-OP closures on consumer choice in the 2016 Marketplaces, we examine how these closures may have affected the prevalence of CO-OP products in rural versus urban counties and overall product availability.

BACKGROUND

CO-OPs were created by the ACA to offer individuals and small businesses affordable, consumer-friendly health insurance options. To qualify as a CO-OP, an organization must be member-governed and maintain a strong consumer focus by using all surplus revenue to reduce premiums, enhance benefits, or improve the quality of care delivered to members.² CO-OPs were intended to increase consumer choice and affordability in the Marketplaces, as individual and small group markets in many states have long been highly concentrated, contributing to higher costs for consumers.³⁻⁵ In 2013, the three largest insurers captured at least 80 percent of total enrollment in the individual market in 39 states, in the small group market in 37 states, and in the large group market in 40 states.⁴ In over half of the states in each market segment a single insurer had more than 50 percent of all enrollees, and in five states the largest insurer captured at least 90 percent of enrollees in at least one market segment.⁴ While an increase in the number of insurers does not by itself produce a more competitive marketplace (especially if one or two large companies control a majority of the market), there is some evidence that greater health plan presence is associated with lower premiums.⁶

*Commercial and CO-OP health plans have varying numbers and combinations of insurance offerings (i.e. metal level, family composition, and age) in each of the areas in which they operate. In this paper we refer to these multiple offers as products.

Key Findings

CO-OPs represented a larger overall share of Marketplace products available in rural versus urban counties in 2014 and 2015.

From 2014 to 2015, CO-OP products increased in absolute numbers and grew modestly as a proportion of all offerings in both rural and urban counties.

In 2014 and 2015, CO-OPs were more likely to offer the lowest cost silver product available for purchase in rural counties than in urban counties.

Recent closures of CO-OPs are likely to disproportionately reduce product availability in rural counties.

For more information about this study, contact Erika Ziller at erika.ziller@maine.edu

Health insurers also have fewer incentives to market plans in rural areas where there are fewer potential enrollees and providers with whom to contract,⁷ and where residents tend to be older, experience higher rates of chronic disease, and earn lower incomes.⁸ The rate of private insurance coverage has long been lower among rural residents, who are more likely to be unemployed, work for small employers, be self-employed, or work part-time.⁹ Notably, insurers of small firms are less able to keep premiums low by pooling risk across a large numbers of enrollees¹⁰ and, given higher per-employee fixed costs for billing and marketing, must allocate a greater proportion of premium revenues to administrative costs.¹¹ Insurers seeking a return on new investments in rural areas must contend not only with the abovementioned health, demographic and economic characteristics, but also inherently smaller risk pools and a greater number of non-system-affiliated providers with which to negotiate.¹² Importantly lower overall provider supply and greater geographic dispersion of residents in rural areas present significant challenges for building adequate provider networks.¹³ Following passage of the ACA, rural health experts suggested that CO-OP plans could help address these challenges in rural markets.¹ Under the CO-OP program, 24 non-profits were awarded \$2.5 billion in low-interest startup and solvency loans. Beginning January 1, 2014, CO-OP products were available to consumers in 22 states. By January 1, 2015 there were CO-OP options in 25 states, following the launch of Ohio's CO-OP, Montana's expansion to Idaho, and CO-OPs in Maine and Massachusetts offering coverage in New Hampshire.^{14,15}

Early anecdotal evidence suggested that hospitals and other providers had accepted CO-OPs and that their presence may have contributed to lower premium rates in some areas.¹⁶ A report from McKinsey & Co. showed that, among new health plan entrants in the 2014 Marketplaces, CO-OPs were price leaders offering 37 percent of the lowest price products in states.¹⁷ In Maine, the CO-OP plan (one of just two qualified health plans in the state in 2014) secured 80 percent of new enrollment that occurred through the federally-run Marketplace.¹⁸

However, a July 2015 performance audit of CO-OPs conducted by the Office of Inspector General (OIG) showed that overall enrollment and profitability have been substantially lower than projected, with just two CO-OPs (Maine and South Carolina) exceeding enrollment and profitability projections in their first year of operation, and only one (Maine)

reporting positive net income in 2014.¹⁸ By the close of 2015, twelve CO-OPs had announced they would cease operations. In early 2015, Iowa state insurance officials liquidated CoOpportunity Health due to adverse claims experience,¹⁹ and by July it was announced that Louisiana Health Cooperative would voluntarily halt operations at the end of the year.²⁰ In August, the Board of the Nevada Health CO-OP voted to close due to high claims costs and challenging market conditions.²¹ Finally, a flurry of closures hit in the fall of 2015, with CO-OPs in New York, Kentucky, Tennessee, Colorado, Oregon, South Carolina, Utah, Michigan, and Arizona announcing they would cease operations.²² This reduced the total number of states with a CO-OP presence from 25 in 2015 to just 13 heading into 2016 at the time of our analysis. Four additional CO-OPs have subsequently closed as of July 2016 (in Connecticut, Illinois, Ohio, and Oregon), and Health Republic of New Jersey announced in September of 2016 that their existing products would terminate at the end of the year, leaving just six operational CO-OPs.

Given these closures, it is important to understand the role that CO-OPs have played in the rural health insurance landscape as well as the potential implications of their diminished number. Beyond the recent OIG report, there is limited analysis of the early experiences of CO-OP plans and their role in insurance markets. This study examines the extent to which CO-OPs sold products in the Marketplaces, their relative premium prices compared to traditional insurance products, and the relationship between CO-OP participation and overall product availability in rural and urban market areas (by age and metal level).

METHODS

In collaboration with researchers from Washington University in St. Louis, our team collected availability and premium pricing data for 2014 and 2015 qualified health plan products (N=205,208) sold on the state and federal Health Insurance Marketplaces. Forty-nine states and the District of Columbia (DC) are represented in the data,** including 34 states that use the federal Marketplace and whose plan information was downloaded from the Centers for Medicare and Medicaid Services (CMS) website.²³ Collection for the remaining states and D.C. required extensive manual searching and downloading of data from state Marketplace websites. All catastrophic products were excluded from our analysis. Because our data set includes

**Qualified health plan data for Hawaii is not included in this analysis due to data collection problems. Also, given our interest in understanding how CO-OP presence in a market impacts pricing and product availability, and because CoOpportunity Health of Iowa and Nebraska had a market presence at the beginning of the 2015 plan year, we kept products offered in 2015 by CoOpportunity Health in our analysis.

the universe of non-catastrophic health insurance products offered in these states and D.C. in 2014 and 2015, statistical significance tests are not reported.

To facilitate analyses, we converted product-level information into county-level data. One potential limitation of this county-level approach is that the geographic rating areas used by insurers to set premiums and market products do not always align with county boundaries. While most states use counties to define their rating areas, many rating areas contain multiple counties, four states use 3-digit zip codes, and one state uses a combination of both.²⁵

Rural and urban counties were defined by the 2013 Urban Influence Codes.²⁶ We analyzed the availability, distribution, and pricing of CO-OP products in rural and urban counties. This included analyses of the regional distribution of rural and urban CO-OP products, the prevalence of CO-OP products as a proportion of all products, and overall product availability in counties with and without CO-OPs. Finally, to better understand the scope of the impact of impending CO-OP closures on consumer choice in rural markets, we also examined the potential change in product availability in states losing CO-OPs at the end of 2015. A list of CO-OPs and their service geography in 2014 and 2015 is included in the Appendix.

This study has several key data and analytic limitations. Due to a lack of enrollment and other data we could not address a number of questions of potential research interest. For example, we were unable to examine the relationship between enrollee health status (risk), premium pricing, and CO-OP viability. Given the complexity of measuring competition and the impact on pricing, this brief does not analyze the level of competition or insurance market concentration in the Marketplaces. While we were able to identify the frequency with which a CO-OP offered the lowest cost silver plan in a county, we lacked the market and demographic data necessary to fully study the relationship between CO-OP presence and pricing.

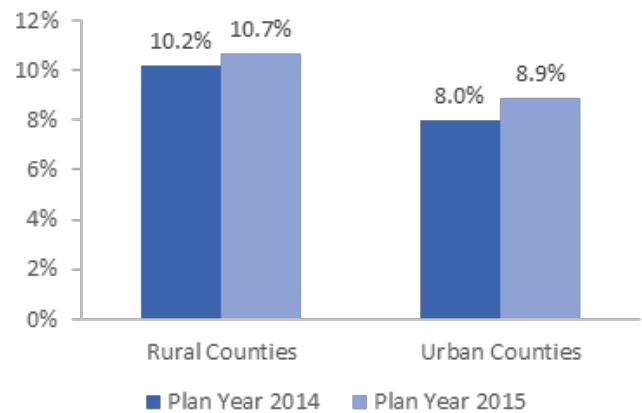
FINDINGS

Prevalence of CO-OP Products in Rural and Urban Counties

CO-OP products were available in 22 states in 2014, and 25 states in 2015. We measured the prevalence of CO-OP products in rural and urban counties by calculating the proportion of all products that were offered by CO-OPs in each county. There were 1,004 counties with a CO-OP plan presence in 2014 (62.7 percent rural and 37.4 percent urban), and 1,207 counties with a CO-OP plan presence in 2015 (62.6

percent rural and 37.5 percent urban). CO-OPs represented a larger proportion of the products available in rural versus urban areas (Figure 1). In 2014, CO-OP market prevalence was 10.2 percent of products offered in all rural counties versus 8.0 percent in all urban. These proportions rose modestly to 10.7 percent of product offerings for rural and 8.9 percent for urban in 2015, indicating that CO-OP presence grew in both rural and urban areas. (Within only those counties where CO-OP products were offered in 2014, CO-OPs represented 32.1 percent of all products in rural areas versus 24.9 percent in urban, data not shown.)

Figure 1. National Prevalence of CO-OP Products in Rural and Urban Counties, 2014 and 2015



Regionally, we found counties with a CO-OP presence to be disproportionately concentrated in the Western census region, particularly in rural areas. For example, while the West represents only 15 percent of all rural counties, it contained 30 percent of the rural counties with CO-OPs in 2014 (data not shown). CO-OPs in the West and Midwest offered a greater proportion of all products sold in their census region (about 14 percent each) than did CO-OPs in the Northeast, and South (Table).

This shifted in 2015, with CO-OPs in the West (16.1 percent) and Northeast (13.5 percent) surpassing and offering a greater proportion of all products than CO-OPs in the Midwest and South. This growth in the Northeast may reflect the expansion of Community Health Options of

Table. National Prevalence of CO-OP Products in Rural and Urban Counties, 2014 and 2015

Census Region	Plan Year 2014			Plan Year 2015		
	Total	Rural	Urban	Total	Rural	Urban
Midwest	14.0	14.9	11.9	12.0	12.7	10.3
South	4.8	4.6	5.0	6.2	6.2	6.1
West	13.7	15.4	10.1	16.1	18.0	11.9
Northeast	8.5	5.8	10.4	13.5	11.7	14.7

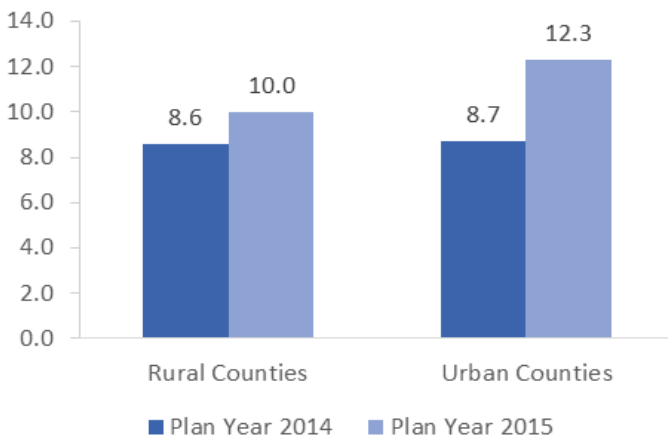
Maine and Minuteman Health of Massachusetts into neighboring New Hampshire, and the increase in the West may reflect the entrance of Mountain Health CO-OP in Idaho.

CO-OPs were a particularly high proportion of rural product offerings in the West during 2014 and 2015, representing 15.4 and 18.0 percent of all products available in these rural counties, respectively. CO-OPs were also a large segment of the offerings in the rural Midwest, comprising 14.9 and 12.7 percent of all products in those rural counties in each year.

The Presence of a CO-OP was Associated with Greater Product Availability

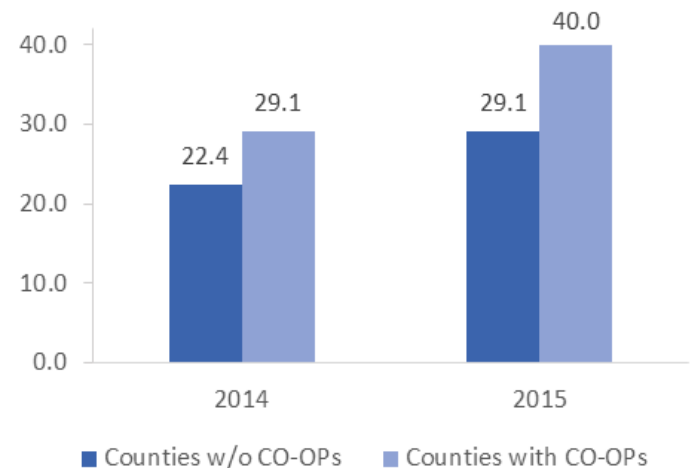
The total number of CO-OP products offered nationally grew from 8,698 in 2014 to 13,118 in 2015 (data not shown). In their first year of operation, CO-OPs offered as many products on average in rural counties as in urban counties (Figure 2). In 2015, CO-OPs expanded their product offerings in both rural and urban counties, though urban counties saw the larger increase, on average (3.6 percentage points versus 1.4 percentage points in rural counties).

Figure 2. Average Number of CO-OP Products in Rural and Urban Counties with a CO-OP Presence, 2014 and 2015



We also examined the relationship between CO-OP presence and the average number of total Marketplace insurance product options available to rural consumers. As indicated in Figure 3, in 2014, there were an average of seven more products available in rural counties with a CO-OP presence than without. In 2015, an average of 11 more products were available in rural counties that had a CO-OP. This association held in urban counties with a CO-OP presence as well, where there were an average of 11 more products available in 2014 and 23 more products available in 2015 (data not shown).

Figure 3. Average Number of Total Products in Rural Counties, 2014 and 2015



Although a greater average number of products were available for purchase in counties with a CO-OP presence in both years, we cannot assume a causal relationship. CO-OPs may have established themselves in markets that had high participation from other insurance carriers, rather than driving these higher numbers through their presence.

CO-OPs Offer Greater Proportion of Lowest Cost Silver Products in Rural Counties

Comparing absolute premium differences across rural and urban counties, or between counties with or without CO-OP plans, is challenging because other county-level differences may account for an unknown degree of observed variation. To address this, we opted to examine CO-OP product pricing relative to other products in the same counties, and then made rural-urban comparisons of these trends. Specifically, we identified the lowest cost silver product in each county for 27 year old individuals and calculated the proportion of counties in which the lowest cost product was offered by a CO-OP. Overall in 2014, CO-OPs offered the lowest cost silver product for 27 year olds in 34.8 percent of the counties where CO-OP products were sold. This proportion increased substantially in 2015, to approximately 51.0 percent (data not shown).

Importantly, among counties with CO-OP plans, a CO-OP product was even more likely to be the lowest cost silver product in rural than in urban counties in both years. In 2014, CO-OPs offered the lowest cost silver product for 27 year olds in 40.4 percent of rural counties where CO-OPs were sold, versus just 25.3 percent of urban counties. In 2015, CO-OPs offered the lowest cost silver products for 27 year olds in 56.0 percent of rural counties and

41.6 percent of urban counties where they operated. (data not shown).***

Impact of CO-OP Closures on Rural Counties

Our findings that CO-OPs represented a somewhat larger share of the rural versus urban products available in the Marketplace raises the question of what impact the closure in late 2015 of 12 CO-OPs serving 13 states may have had on rural residents. To examine this question, we removed the CO-OP plans facing closure at the end of 2015 from the data set and re-ran our analyses to project the rural-urban distribution of counties that had a CO-OP presence as of spring 2016. Because these analyses do not account for the 6 CO-OPs that closed during 2016, our findings may underestimate the impact of CO-OP closures on product availability in 2016.

Using this approach, we estimated that only 464 counties had a CO-OP presence in early 2016 (data not shown). This compares with 1,004 and 1,207 counties that had a CO-OP presence in 2014 and 2015. Notably, among counties that had a CO-OP plan in 2015, a somewhat greater proportion of rural than urban counties lost their CO-OPs by the start of 2016 (63.8 versus 57.7 percent). While nearly 63 percent of all counties with a CO-OP plan option were rural in 2014 and 2015 (hewing closely to the national distribution of rural counties), 58.8 percent of all counties with a CO-OP were rural as of spring 2016.

As noted previously, CO-OPs represented 10.2 and 10.7 percent of the products offered in rural counties and 8.0 and 8.9 percent of all products offered in urban counties in 2014 and 2015, respectively. If the volume of other products remained the same as in 2015, CO-OPs would have represented just 2.7 percent of the products offered in rural counties and 3.2 percent of the products offered in urban counties in early 2016. While CO-OP prevalence was greater in rural counties in both 2014 and 2015, it appears that CO-OPs represented a greater share of product offerings in urban than in rural areas in the spring of 2016.

Using the same approach, we projected the total availability of product offerings in the spring of 2016. While this approach cannot account for new entrants to the market or expanded offerings by existing insurers, it suggests that the average number of products available to consumers in counties facing CO-OP closures dropped considerably, from 38 to 27 in rural areas and from 61 to 48 in urban areas (data not shown). The average overall number of CO-OP products

available for purchase in spring of 2016 was 4.2 in urban counties and 2.9 in rural counties, down from 12.3 and 10.0, respectively, in 2015 (data not shown).

DISCUSSION AND POLICY IMPLICATIONS

Research indicates that, prior to the ACA, rural residents with private health insurance had fewer health plan choices than their urban counterparts and that plans offered in rural areas provide fewer benefits for the same or higher cost.^{27,28} This is partly explained by the concentration of the rural workforce among small employers and self-employed individuals, who are more likely to have deductibles, and higher deductibles, than employees of larger firms. Moreover, urban markets tend to be more attractive to insurers given the larger pool of potential subscribers and the greater supply of health care providers with whom to contract.⁷

Given the many longstanding barriers to competition in rural health insurance markets, there has been great interest in the potential for the CO-OP program to expand and improve health insurance options for rural residents.

Through 2015, CO-OPs appear to have been an important, if relatively small, new player in the post-ACA health insurance landscape for rural residents. The distribution of CO-OPs across rural and urban counties mirrors the rural-urban distribution of counties generally (63 percent rural, 37 percent urban), suggesting that CO-OPs were equally likely to sell in rural as urban markets. Yet, CO-OPs represented a greater proportion of all products available in rural versus urban counties and may have played a somewhat greater role in increasing product availability in rural areas. In both rural and urban counties, the presence of a CO-OP was associated with a greater number of products sold in the Marketplaces. However, it is not clear whether CO-OPs increased the product availability or whether they chose to operate in more established markets.

Our findings also suggest that CO-OP products were priced lower compared to other products in the Marketplaces, particularly in rural areas. In 2015, CO-OP plans offered the lowest cost silver product available for purchase by 27 year olds in more than half of counties where they operated, and more often offered the lowest cost silver product for 27 year olds in rural than in urban areas in both years. These findings support a 2016 GAO report that found that average premiums for CO-OP products at all metal levels were lower than other issuers in more than 75 percent of rating areas where they

***Age is one of the limited factors insurers are permitted to use when calculating premiums, but pricing cannot vary by more than 3:1 for like individuals of a different age. To understand whether results varied by age we also examined the lowest cost silver plans for 55 year olds. CO-OPs offered a similar proportion of lowest cost silver plans for 55 year olds in rural and urban counties in both years.

operated in 2015, and that average silver level premiums were lower for CO-OPs than other issuers in 31 to 100 percent of rating areas.²⁹ Although it is unclear from our analyses whether premiums may rise as a result of CO-OPs exiting the Marketplaces, the provision of Advanced Premium Tax Credits (APTC) will help offset any cost increases for a vast majority of consumers. Indeed, 85 percent of all Marketplace enrollees qualified for an APTC in 2015.³⁰

A recent ASPE issue brief found that health insurance coverage increased by 8.0 percent in rural areas between 2014 and 2015 and the share of rural residents unable to afford needed care dropped by 5.9 percent.³¹ However, combined with other emerging reports, our study suggests that the loss of CO-OP plans in 2016 may have particularly affected rural areas and exacerbated problems of plan choice for rural residents. CO-OPs represented a larger share of all rural products, and a greater proportion of rural than urban counties lost their CO-OP plans by early spring of 2016. Likely reflecting this fact and other market trends, the Kaiser Family Foundation found that rural populations are overrepresented in counties with only one insurer in 2016.⁷ Compounding this, an analysis of UnitedHealth's anticipated 2017 exit from the Marketplaces revealed that a disproportionate share of rural areas will experience a drop from three to two insurers, or be left with just one insurer.³²

CO-OPs have faced multiple policy and market challenges since their inception. In addition to instituting a loan program in lieu of grants for startup costs, Congress cut the appropriation for CO-OPs from approximately \$6 billion to \$3.4 billion, and on January 1, 2013 further rescinded all but 10 percent of the remaining uncommitted funds.² Also, because CO-OPs were restricted from using federal loans for marketing and outreach, they have needed to explore alternative pathways to fund and carry out member education efforts.³³ CO-OPs face additional challenges having to do with brand awareness, absence of existing revenue streams,³⁴ and lack of high patient volumes to leverage hospital and provider discounts.^{16,33} CO-OPs also lack economies of scale in core insurance operations such as claims processing, software system design, and setting up and maintaining compliance regimes.³ Finally, to validate their receipt of federal funding, CO-OPs are expected to navigate additional federal regulations to demonstrate financial and operational stability, imposing a significant administrative burden on fledgling organizations.

The National Alliance of State Health CO-OPs (NASHCO) and other program supporters observed that changes to the ACA's risk adjustment and risk corridor programs have contributed to CO-OPs'

financial problems. The risk corridor program was intended to offset the unpredictability of insurance risk and adverse selection. Over the course of the three year program, health plans must submit risk adjustment payments to the federal government if their premiums exceed claims costs by a certain amount, and receive payments if premiums fall short of costs.³⁵ However, CMS announced in October 2015 that only 12.6% of all requested 2014 risk corridor payments would be paid out by the end of 2015.³⁵ At the same time, CO-OPs had no prior experience to assess risk, had a more limited capital base, and had less diverse revenue streams, making them more affected by the risk corridor program. This combination of conditions has reportedly left some CO-OPs required to pay risk adjustment payments, while others serving higher risk enrollees received lower than anticipated payments.^{33,36,37}

Importantly, low pricing and enrollment may have also contributed to CO-OPs' challenges. As noted previously, the OIG found that 13 CO-OPs failed to meet enrollment projections and 21 incurred net income losses in 2014.¹⁸ Among those with net losses, 19 reported claims expenses that exceeded premium revenues, suggesting these insurers may have attracted sicker than expected enrollees, failed to attract healthy enrollees, and/or inaccurately priced premiums.¹⁸ Additionally, state decisions regarding Medicaid expansion may have affected risk pools and contributed to overall market volatility in states both with and without CO-OP products.

As noted previously, due to data limitations we could not explore the relationship between CO-OP premium pricing, enrollee health status, and CO-OP viability. While further research on premium pricing, enrollment, and Marketplace competition is needed to better understand the implementation experience of CO-OPs and the challenges they continue to face, observers have noted that without additional support from state and federal policymakers, it is likely that many of the remaining CO-OPs will struggle to remain viable in the long run.^{33,38,39} Recognizing this, in 2016 CMS released guidance clarifying that while two-thirds of a CO-OP's business must comprise sales of qualified health plans in the state and federal Marketplaces, this does not preclude the sale of large group policies, Medicaid Managed Care products, Medicare Advantage products, or ancillary products such as dental or vision plans outside the Marketplaces.⁴⁰

Depending on local market conditions and internal capacity, CO-OPs may be able to increase revenue or strengthen their market position by offering such products; more CO-OP executives are considering

expansion into the group market and potentially across state lines.³³ A May 2016 interim final rule further clarifies that if a CO-OP fails to meet the two-thirds requirement in a given year, CMS may allow it to develop a plan and timetable to come back into compliance with the two-thirds requirement in future years.⁴¹ The rule also grants greater flexibility for CO-OPs to include qualified individuals from government agencies, outside entities offering loans, investments and services, and insurers that existed prior to the ACA on their boards of directors.⁴¹ Finally, CMS acknowledges problems with the risk adjustment program and indicates that it will seek ways to improve the methodology, including support for states to explore localized approaches.⁴¹

Also, beginning in 2015, CMS agreed to convert start-up loans to surplus notes on a case-by-case basis. Conversion allows CO-OPs to delay loan repayment until their state insurance department determines it will not have an adverse impact on the plan's operations, granting greater flexibility to leverage private financial markets.³⁸ While CO-OPs will continue to have their capital reserves and projected risk strictly monitored, CMS has also clarified that it will determine on a case-by-case basis whether CO-OPs that dip below the capital thresholds specified in their loan agreements should be placed on a corrective action plan or notified of an event of default. CMS contends that granting CO-OPs the flexibility to operate with lower than optimal reserves for a period of time will aid consumers by allowing CO-OPs to more easily manage changes in business operations.⁴⁰

In addition to these regulatory changes, some CO-OPs reportedly adopted their own strategies to adjust to various operational challenges and market conditions in 2014 and 2015 including: re-negotiation of out-sourced contracts for administrative services (e.g. network design and claims processing); building provider networks and negotiating better provider rates; developing stronger relationships with insurance brokers who can help steer consumers and businesses to their products; and, eliminating unprofitable platinum level products.³³ Going forward, the remaining CO-OPs will benefit from greater regulatory flexibility, but should also draw on the lessons of their peers and learn from their own rating experiences to ensure their future viability.

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Appendix. CO-OP Characteristics, 2014 and 2015

CO-OP Name(s)	State(s) Served	2014 Counties Served		2015 Counties Served		Date of State Regulatory Action
		Rural	Urban	Rural	Urban	
Meritus Health Partners	Arizona	7	8	7	8	October 30, 2015
Colorado HealthOP	Colorado	47	17	47	17	October 16, 2015
HealthyCT	Connecticut	1	7	1	7	July 1, 2016
Land of Lincoln Health	Illinois	62	40	62	40	July 14, 2016
CoOpportunity Health	Iowa (Nebraska)	158	34	158	34	December 23, 2014
Kentucky Health Cooperative, Inc.	Kentucky	85	35	85	35	October 29, 2015
Louisiana Health Cooperative, Inc.	Louisiana	29	35	29	35	September 1, 2015
Community Health Options	Maine (New Hampshire)	11	5	18	8	NA
Evergreen Health Cooperative, Inc.	Maryland	5	19	5	19	NA
Minuteman Health, Inc.	Massachusetts (New Hampshire)	0	7	7	10	NA
Consumers Mutual Insurance of Michigan	Michigan	28	19	48	20	November 13, 2015
Montana Health CO-OP (Mountain Health CO-OP)	Montana (Idaho)	51	5	83	17	NA
Nevada Health CO-OP	Nevada	13	4	3	4	October 1, 2015
Health Republic Insurance of New Jersey	New Jersey	0	21	0	21	September 12, 2016
New Mexico Health Connections	New Mexico	26	7	26	7	NA
Health Republic Insurance of New York	New York	6	20	13	30	November 30, 2015
InHealth Mutual	Ohio	NA	NA	50	38	May 26, 2016
Health Republic Insurance of Oregon	Oregon	22	11	23	13	October 16, 2015
Oregon's Health Co-Op	Oregon	23	13	23	13	July 31, 2016
Consumers' Choice Health Plan	South Carolina	20	26	20	26	November 10, 2015
Community Health Alliance	Tennessee	33	29	53	42	October 14, 2015
Arches Health Plan	Utah	19	10	19	10	November 2, 2015
Common Ground Healthcare Cooperative	Wisconsin	5	14	5	14	NA

Notes: In 2015, Community Health Options of Maine and Minuteman Health, Inc. of Massachusetts expanded into New Hampshire; Montana Health CO-OP expanded into Idaho under the name Mountain Health CO-OP, and InHealth Mutual of Ohio entered the Marketplace. Health Republic Insurance of Oregon and Community Health Alliance of Tennessee announced their voluntary withdrawal from the Marketplace on the dates reported above.



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