

HEALTH POLICY
BRIEF
SEPTEMBER 2009

Health Care Co-ops: Many Challenges

SUMMARY

The idea of state-based health care co-ops has emerged as one way to design provide new health insurance options for consumers. This brief examines the rationale for co-ops, highlights some existing examples, and summarizes expert opinion on the co-ops chances for success in today's health care markets. Based on the experience of health care co-ops to date, as well as the general difficulty of successfully entering today's health insurance markets, we find it unlikely that many state-based co-ops will form and endure, even with the proposed federal start up assistance. If this proves to be correct, a key opportunity will have been missed to provide consumers with a new, consumer-focused insurance option and meaningful price competition in today's highly concentrated insurance markets. Policymakers must be careful not to over promise the benefits of co-ops for consumers. Furthermore, they must ensure that the likely benefits are commensurate with the proposed taxpayer investment.

A Proposal For A New Type of Insurer

As part of the ongoing health care reform debate, the concept of Consumer-Owned and Oriented Plan, or co-ops, has emerged as a vehicle for controlling health care costs and improving health care delivery. Members of the Senate Finance Committee have proposed co-ops as an alternative to the public insurance plan option in an effort to reach bi-partisan agreement on the health care bill.¹

There are several underlying reasons why Americans might need a new type of insurer, to compete alongside today's private insurers. Today, one or two commercial insurers dominate the market in most geographic areas.² In many rural states, the two largest health insurance plans enroll more than 80 percent of the market.

Lack of vigorous competition contributes to a system whereby insurers do not negotiate aggressively with providers; instead annual cost increases are merely passed on to employers and individuals who pay the health insurance premiums.

Health insurance premiums increased by 119% in the past nine years – a time when wages increased by only 35%.³

Hence, it will be difficult to afford the proposed coverage initiatives unless we can also control the growth in health care costs. Many believe that at least part of the solution lies in introducing a new type of health insurance competitor. The goal for the competitor would be to re-energize local health insurance markets, creating real price competition and providing an insurance option with a vigorous consumer focus.

How Would The Health Care Co-op Work?

The proposed co-ops would provide health insurance for members and negotiate with doctors and hospitals for health care.⁴ Co-ops would operate within the proposed health insurance exchanges, subject to the same rules and regulations regarding minimum benefits, premium rating rules and reserve fund requirements.

The federal government would offer start-up funds through grants and loans. However, after receiving this seed money the co-op would need to be self-supporting. The costs of doing business would be paid out of premium revenues.

WHAT IS A CO-OP?

The National Cooperative Business Association defines cooperatives as member owned and controlled businesses that provide both social and economic benefits to the members – the people who use the services of the cooperative. Cooperatives distinguish themselves from other forms of business in the way their earnings are distributed and taxed. Cooperatives typically return any profits to their members in the form of lower prices or enhanced services. In contrast, in for-profit businesses excess profits accrue to the business owners, typically very different people from those using the goods or services produced by the business.

Co-ops in the U.S. operate many lines of business –ranging from grocery, to housing, to mutual insurance and utilities. Most fall into four categories:

- **Consumer-owned cooperatives.** For example, credit unions and rural electric co-ops. The proposed health care co-ops would take this form.
- **Purchasing cooperatives.** These co-ops allow businesses to join together to buy goods and services in bulk. Many hospitals join together to buy equipment.
- **Producer cooperatives.** These are farmer owned cooperatives like Land O'Lakes. These cooperatives transform member inputs (milk) into a marketable output (butter).
- **Worker-owned cooperatives.** Home-health care groups have started to form in this fashion to improve working conditions.

The co-ops would be self-governing by a board elected by the co-ops members. According to proponents, the member driven operation of co-ops could provide a strong consumer focus, encourage increased quality and appropriate utilization, and help foster care integration and other delivery system reforms. Because the co-ops would operate as non-profits, theoretically they could offer lower cost coverage when compared to traditional, for-profit insurance companies.

Few Health Care Co-Ops Exist Today

The overall number of consumer-owned health-care cooperatives has decreased markedly since their early years. In the 1930s and 1940s The Farm Security Administration (FSA) encouraged and subsidized the development of health cooperatives. At one point there were 600,000 mostly low-income rural Americans who joined health cooperatives. Ultimately, however, the movement failed. The cooperatives were small and undercapitalized and physicians opposed and boycotted them. When the FSA ended its support in 1947, the movement collapsed.⁵

According to the National Cooperative Business Association, five health insurance co-ops that use an HMO model exist today: Group Health Cooperative of Washington, HealthPartners in Minnesota, Group Health Cooperative of Eau Claire, Wisconsin, First Plan in Minnesota, and Group Health Cooperative of Southern Wisconsin. They have a collective membership of about two million people.

Group Health (Seattle) and Health Partners (Minneapolis and St. Paul), are nonprofit HMOs that have been held up as positive examples of the co-op concept.⁶ Both co-ops have solid reputations, generally offering high-quality care at costs lower than those on the commercial market. They are able to do so because they operate as both the insurer and the provider of care. Like HMOs elsewhere, these organizations have their own network of staff physicians, hospitals and clinics.

ARE RURAL ELECTRIC CO-OPS A GOOD COMPARISON?

Rural electrical cooperatives have been mentioned as example of a successful cooperative model. While popular, rural electric cooperatives differ in important ways from the proposed health care cooperatives. Rural electric coops began, with federal support, because commercial electric companies refused to serve unprofitable rural areas. As such, these co-ops do not face competition from large, for profit competitors the way health care co-ops would. Today, rural electrical co-ops serve about 14% of Americans, but after 75 years they still rely heavily on federal credit subsidies. Health care coops would not have an ongoing source of federal subsidies.

Mutual health insurance companies are another entity essentially identical to the proposed co-ops. Mutual companies are owned by their policyholders and any excess profit must be returned to the policyholders in terms of premium rebates or improved services. In contrast to the HMOs list above, mutual health insurers are often set up as a fee-for-service delivery system using preferred provider networks. Many Blue Cross Blue Shield (BCBS) plans were originally set up as mutuals but the need for greater access to operating capital led to a wave of “de-mutualizations” in the late 1990’s.⁷ When companies “de-mutualize”, they convert to a publicly-traded company allowing them to raise capital in the stock market. Several mutual BCBS companies still exist today, with HCSC (serving Oklahoma, Illinois, Texas and New Mexico) being the largest example.

Challenges Facing Health Care Co-ops

Consumers or private organizations can set up co-ops or mutual companies today using the laws on the books. However, there have been few new health insurance entrants in recent years.⁸ There are at least four key challenges facing new entrants of any type, whether co-op or other business forms. The main challenges include (1) acquiring sufficient market share, (2) adequate capitalization, (3) leadership expertise and (4) adverse selection.⁹

Four key challenges confront entities trying to enter health insurance markets.

GAINING MARKET SHARE

Sufficient scale is necessary to attract additional members and negotiate rates effectively with providers. Existing private companies insure millions of people and have pre-existing relationships with medical providers. Doctors and hospitals are often willing to offer their “best” rates when dealing with the big insurers because they’re guaranteed large numbers of patients.¹⁰ Similarly, to offer a competitive insurance product, a co-op would have to be able to offer significant patient volume. Proponents say that a health co-op would need at least 500,000 members to negotiate effectively with health care providers.¹¹ As co-ops grow large enough to become effective negotiators, they may become more disconnected from their members, undermining one of the key rationales for their formation.

ADEQUATE CAPITALIZATION

Starting a new health insurance enterprise takes a lot of money, with the exact amount depending on the market and the co-op’s business plan. These capital requirements are viewed as a tremendous barrier to market entry. Unanswered is the question of how co-ops would raise enough capital to meet state requirements for insurance reserve funds. If they organize using the integrated HMO model, the co-ops will also need capital to build or lease needed infrastructure, like clinic space, laboratories, etc.

FINDING LEADERSHIP EXPERTISE

The current proposal calls for up to 51 co-ops, although multi-state co-ops are permitted. In order to survive, the co-op leadership will require a daunting roster of expertise: understanding of the co-op business model; insurance expertise with respect to pricing premiums, reserve levels, building provider networks and medical cost trends; familiarity with new cost control techniques like bundled payment methods and chronic care management; and knowledge of how to compete effectively with large, sophisticated private insurers. This is a tall order and difficult to replicate across 50 new organizations.

ADVERSE SELECTION

While difficult to document, private insurers today are characterized as experts in avoiding less healthy enrollees. When successful, such practices allow insurers to offer insurance for lower premiums because their insured population is healthier than that of their competitors. In turn, lower premiums allow these insurers to attract the most desirable (healthiest) policyholders. From their competitors' perspective, it is a catch-22. If the competitor avoids such practices, their rates will climb, leaving their product unable to attract the best risks. When an insurer ends up with a population that is less healthy than average, it is called adverse selection.

In the comprehensive set of proposed health care reforms, some new consumer protections would be at work. No insurer (co-op, public or private) could reject applicants, nor could they charge more for poor health. However, the record of market practices used by the private plans that compete side-by-side with Medicare (our nation's insurance program for the elderly), suggests that insurers are very capable of attracting healthy enrollees even when such protections are in place.¹²

Small Business Purchasing Cooperatives Offer Other Lessons

Small business purchasing cooperatives, sometimes called purchasing pools, differ from the health care co-op proposal on the table. These entities are set up to "pool" the purchasing power of participating small businesses. They purchase insurance, as opposed to providing the insurance themselves (as a co-op would). The experience of these purchasing cooperatives offers some additional insights into the challenges facing health care co-ops.

In the 1990s, purchasing cooperatives were popular as a means of increasing health insurance options for small employers (2-50 employees). The goal was to provide small employers with some of the same advantages larger employers

have in offering health insurance, such as administrative simplicity, choice of multiple insurers and benefit packages, and leverage in negotiating lower premiums.

A review by the U.S. Government Accountability Office (GAO) found that purchasing co-ops were able to achieve some administrative simplicity and to offer a choice of multiple insurers.¹³ However, they were not effective in negotiating lower premiums. As a result, most eventually disbanded.

Policymakers must be careful not to over promise the benefits of health care co-ops to consumers. Further, they should ensure that the likely benefits are commensurate with the taxpayer investment.

The voluntary nature of the membership was highlighted as the underlying reason for their demise. The businesses comprising the purchasing pool could easily leave that arrangement if a better deal was found elsewhere. As a result, many businesses with healthy workers were able to find less expensive alternatives outside the purchasing co-op, leaving the co-op with the expensive sicker people which in turn drove up premium costs.

The fundamental problem is market share. Health Purchasing Cooperatives [HPC] could not attract and retain prestigious health plans, achieve significant economies of scale, and negotiate lower premiums without market share. Yet HPCs could not achieve large market share without attracting and retaining the best insurers, offering lower premiums and achieving economies of scale.¹⁴

As with these purchasing pools, membership in the proposed health care co-ops would be voluntary. Thus, they would be vulnerable to temporary under pricing by larger insurers.

What Consumers Would Need to See Under A Co-op Proposal

The experience of health care co-ops to date, as well as the general difficulty of successfully entering today's health insurance markets and remaining viable, suggests that policymakers should be cautious. Specifically, they should be careful not to over promise the likely benefits to consumers. Furthermore, they should put requirements in place that are protective of the initial taxpayer investment.

If Congress goes forward with the co-op option, Consumers Union recommends the following policy approach to make co-ops as strong as possible.

- Significant start-up assistance, in the form of both financial and technical assistance, so the newly formed co-ops can potentially compete with large, well-established insurers.
- The development of “competency” criteria used to qualify for the federal start up assistance, with the goal of ensuring that these outlays result in enterprises which achieve the legislation’s stated goals and endure over time.

A detailed, sound business plan would be one such criterion, but many others are possible.

- Co-ops must adhere meet state solvency requirements for insurers, as well as requirements with respect to consumer grievances and appeals.
- Ensure that there are no barriers to having the co-op grow large enough to negotiate effectively with providers.
- Include an effective risk adjustment mechanism to ensure that their large, sophisticated competitors don't shift all the bad risks to the co-ops. This mechanism will have to account for the possible shifting of risk into or out of the proposed health insurance exchange.

(Our list assumes that other proposed consumer protections such as guarantee issue, no medical underwriting, and coverage of pre-existing conditions are in place and applied to all insurers.)

Our final conclusion is that Consumers Union does not find Co-ops to be a real alternative to a Public Insurance Plan for creating meaningful competition with private insurers.

This Health Policy Brief was prepared by Lynn Quincy and Kathy Talkington.

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ENDNOTES

- ¹ For more information on the public plan option, please see our policy brief *Public Option vs. Co-ops: The Bottom Line for Consumers*, September 2009.
- ² American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2008 Update*.
- ³ Kaiser Family Foundation & Health Research and Educational Trust, Employer Health Benefits 2008 Annual Survey and U.S. Bureau of Labor Statistics, Employer Cost of Compensation data (Wages and Salaries component).
- ⁴ Our sources include the “Framework For Comprehensive Health Reform” released by the Senate Finance Committee September 9, 2009 (<http://finance.senate.gov/press/Bpress/2009press/prb090909.pdf>) and a description of the co-op proposal from Senator Conrad’s website (http://conrad.senate.gov/issues/statements/healthcare/090813_coop_QA.cfm)
- ⁵ Jost, Timothy Stolfus. *Local cooperatives will not work for rural America*. Professor of Law, Washington and Lee University.
- ⁶ The Group Health Cooperative of Puget Sound, is actually organized as a non-profit, and not strictly as a co-op. Group Health Cooperative includes in its bylaws provisions allowing policyholders to apply to become members and then grants those “members” voting rights on certain governance issues, such as the election of directors. However, Group Health Cooperative’s policyholders do not have ownership rights in the company as in the way the policyholder owners of, say, Northwestern Mutual Life. <http://www.heritage.org/Research/healthcare/bg2290.cfm>
- ⁷ Consumers Union, *Blue Cross and Blue Shield: A Historical Compilation*, November 30, 2007.
- ⁸ American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets: 2007 Update*.
- ⁹ See for example, the National Cooperative Business Associations August 5, 2009 letter to Senator Rockefeller (<http://www.ncba.coop/pdf/PublicPolicy/Senator%20Rockefeller%20Correspondence.pdf>) and this analysis by Carl McDonald of Oppenheimer (<http://blog.corporateresearchgroup.com/2009/06/15/>)
- ¹⁰ The largest insurers often have what are called “most favored nation” clauses which specify that the provider cannot offer a lower rate to other insurers than it does to the dominant insurer.
- ¹¹ See, for example, the description of the co-op proposal from Senator Conrad’s website (http://conrad.senate.gov/issues/statements/healthcare/090813_coop_QA.cfm)
- ¹² Ateev Mehrotra, Sonya Grier, and R. Adams Dudley. “The Relationship Between Health Plan Advertising And Market Incentives: Evidence Of Risk-Selective Behavior,” *Health Affairs*, Volume 25, Number 3.
- ¹³ GAO Report, “Private Health Insurance, Cooperatives Offer Small Employers Plan Choice and Market Prices. March 2000. GAO/HEHS-00-49.
- ¹⁴ Wicks, Elliot K, Hall, Mark A., and Meyer, Jack A. *Barriers to Small-Group Purchasing Cooperatives*. Economic and Social Research Institute. March 2000.