Making a Cooperative Work

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The problem:
• While the Cooperative is a possible alternative to the public health insurance plan and to private health insurance, it will face significant barriers at the outset to becoming operational.
• The Cooperative will find it hard to attract and keep a viable number of members with an acceptable risk profile.
• The Cooperative will face difficulties in becoming big enough to credibly bargain with providers to bring down costs and effect delivery reform.

Getting started
• A national Cooperative board representing consumer, business, and labor interests should be appointed initially by HHS to get the Cooperative underway.
• This board would establish national rules for running the Cooperative in accordance with legislation equally applicable to all insurers.
• Congress would need to provide substantial start-up money to fund the establishment of Cooperative administrative functions, policy terms, and payment protocols; recruiting of provider networks; and marketing the Cooperative on a national, regional, and local basis. It would also need to provide initial reserves to assure solvency. (see below) Over time the Cooperative would become self-funding.

National leadership, regional administration
• The Cooperative would be federally-chartered. It would be administered on a regional basis, like the Medicare Advantage or Part D drug programs. Regional boards would initially be appointed by the national board.
• Like Medicare Advantage plans, the Cooperative would not be subject to state regulation (other than for solvency). This is necessary to promote the development of a uniform national program driven by national policy.

Cooperative operations
• Once the Cooperative was operational, regional members would be elected by their members and the national board by the regional cooperatives. Funding would flow from the regional cooperatives to the national Cooperative.
• All insurance exchanges would be required to include the Cooperative, which could market its products both to individuals and groups.

Dealing with adverse selection
• It should be presumed that the Cooperative will be the victim of adverse selection by members and of risk selection by private insurers.
• The Cooperative should be freed from the burden of federal income tax and state premium taxes to the extent necessary to compensate it for the burden of a substandard risk pool.
• Risk adjustment of premiums and strict enforcement of underwriting requirements will also be necessary to protect the Cooperative.
Bargaining with providers
• At least initially, dominant providers in any market should be required to bargain with cooperatives and to face binding arbitration if provider agreements cannot be reached.
• The antitrust laws should be strictly enforced to deter provider boycotts of the Cooperative (as well as anticompetitive actions by insurers directed at the Cooperative).

What investment will be needed to make the Cooperative viable?
• Realistically, a massive federal investment will be needed to get the Cooperative underway. The Cooperative will need to compete with huge private insurers and will not be self-funding for some time.
• The Cooperative will need federal funds to establish administrative functions, claims processing, membership capacity, and provider networks.
• The Cooperative will need significant funds to establish reserves and to fund a nationwide marketing campaign to establish a credible presence in every part of the country.

What if it doesn’t work?
• The initial legislation should stipulate that if any regional cooperative fails to meet a specific membership goal by the end of 2013 (say 1 million members); the national Cooperative would either take over management of the region or provide special oversight of it.
• The legislation should also require that if the Cooperatives has failed to provide a viable alternative to private insurance and bring down health care costs (as specified by law) by 2015, the Secretary of Health and Human Services should be directed to implement a national public health insurance plan modeled on Medicare without the need for further legislation. Only a supermajority vote by Congress could reverse this determination.

Transition issues
• It will take some time to get the Cooperative operational. In the interim, Congress should consider temporary measures, like extending Medicaid to the low-income unemployed and opening up Medicare on a full-premium basis to span the immediate economic crisis facing Americans.
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The problem

While a health insurance cooperative is an intriguing idea, it is hard to see how it would operate in practice. No detailed description of how the Cooperative would operate has yet been released to the public. It is particularly difficult to imagine how the Cooperative would get underway. The goal would be to have the Cooperative eventually become a self-governing membership organization that competes with private insurers to bring down health care costs and to promote quality of care. At the outset, however, it would need to be constituted by the government, before it could begin to solicit members. Once the Cooperative was formed, it would need to enrol enough members to become a player in health care markets throughout the country. This would not be an easy task. Even large, national, insurers have found it difficult to break into local markets. If the Cooperative needed to spend large sums of its own money on establishing administrative policies and procedures, including coverage policies, and on marketing, it could not become financially competitive with existing insurers.

Assembling a network of contracted providers might prove an even greater barrier to entry. Providers would be unfamiliar with the Cooperative and would be reluctant to give it favourable rates until it could prove its market power. Unless the Cooperative was able to hold down increases in provider payments, it would not offer the cost-control benefits promised by a public health insurance plan. A large network of cooperating providers would also be necessary for the Cooperative to begin to address issues of delivery system reform. Even once willing providers were located, negotiating contracts with them would be a major, time-consuming, and costly task. All of these issues must be thought through before the concept can be operationalized.

Getting started

An approach to reform based on cooperatives and aimed at bending the cost curve and driving quality system-wide could not succeed without a strong national organization. The Cooperative would be federally chartered by Congress. It would not be subject to state corporation laws and would be barred from ever under any circumstances being converted into a for-profit corporation. A Cooperative board should be appointed at the national level. It could consist of 12-18 members, representing consumer groups, small businesses, labor organizations, and health policy experts. The board would be appointed for staggered terms of up to 6 years by some government agency, most likely HHS, but possibly the DOL.

To establish a level playing field and ground rules for competition, Congress would have to adopt a law governing private insurers and cooperatives that would require (at least):

1. Guaranteed issue, no pre-existing conditions clauses, community rating (modified for family size, geographic area, and richness of benefit package),
2. A minimum benefit package (which will be necessary in any event to define creditable coverage if health care reform includes a mandate),
3. Income-related limits on cost-sharing,
4. An internal and external appeal process,
5. A marketing code,
6. Transparency as to coverage, utilization review, and administrative costs (including executive pay), and
7. Availability of anonymized data for health services research so that we can understand cost drivers and quality improvement levers in the under-65 market.

The national board would be given until mid-2010 to develop national policies to implement the law establishing the Cooperative and these ground rules as they applied to the Cooperative.

Congress would provide seed money to fund start-up costs and for a marketing campaign. The funding available for this would at the outset have to equal or exceed the amount dominant private insurers spend on administrative functions, maintaining provider networks, payment protocols, and marketing, since the Cooperative would be trying to establish itself as a whole new player in the insurance market. Over time, the Cooperative could take over these expenses itself. Congress would also lend the Cooperative money to establish reserves, which would be paid back gradually as the Cooperative became established. The federal government would not be at risk for the Cooperative, and thus, under CBO’s announced scoring rules, the revenues and expenses of the Cooperative would be off-budget.

**National leadership; regional administration**

The national board would also appoint regional boards during the first half of 2010 for staggered terms of up to 6 years. There could be 26 regions like Medicare Advantage or 34 like the Part D plans, but they should not be based strictly on state boundaries. This is true for at least two reasons—first, some states are too small to house viable cooperatives and, second, state-based cooperatives would get tied up in state politics. Provider groups have powerful state-level lobbies and could easily squelch the cooperative movement if cooperatives were state regulated and began to threaten their interests by actually holding down cost increases.

Like Medicare Advantage plans, the regional cooperatives should be subject only to state licensure and solvency and reserve requirements, but otherwise should be subject to the national Cooperative law and rules and not to state mandates and requirements. This would be consistent with our current national policy on ERISA, which has freed self-insured employee benefits plans in order to promote national uniformity. The cooperative would also comply with any rules established by the health insurance purchasing exchanges, which would presumably apply equally to private insurers and cooperatives. Complaints about a level playing field from private insurers should be dismissed out of hand. From the outset, the playing field will be steeply tilted against the Cooperative, which will be trying to break into markets long dominated by private insurers. Absolute equality in regulations applying to both would doom the cooperative movement before it was even born.

**Cooperative operations**
After initial appointment, Cooperative board members would be elected by the members of the Cooperative. The Cooperative would be open to all individual uninsured persons and to employee groups. Allowing both individuals and groups to join would give the Cooperative a chance at a reasonable risk pool to work with. All insurance exchanges would be required to offer the regional cooperative as an option within the exchange. The national Cooperative would undertake a national advertising campaign at the outset to develop brand identity, supplemented by regional advertising campaigns.

As is customary with cooperatives, members would join by paying a small fee ($25 to $50). Those who paid the fee would thereafter be considered to be owners of the cooperative. The regional cooperatives would elect board members every other year. Board members could not be persons who had any interests that conflicted with their fidelity to the Cooperative, and in particular could not be persons who worked in or had a significant financial interest in the health care industry. The regional boards would in turn elect the national board, subject to the same conflict-of-interest restrictions. As ample experience from the nonprofit hospital and insurer sector demonstrates, we cannot assume that nonprofits will automatically maximize community benefit, and controls will be needed to keep the Cooperative on track. Cooperatives should be barred from using private insurers as third party administrators or from renting insurer networks to retain a clear distinction between the Cooperative and private insurance.

Cooperative premiums would be determined on a regional basis, but within strict guidelines established by the national cooperative. Funding from premium revenues would flow from the regional to the national Cooperative to finance its functions. Regional cooperatives would be responsible for claims processing, but procedures for claims processing would be uniform throughout the country. Any member of a region could receive care elsewhere in the country (or world), and have it paid for by his or her cooperative (as is true with the Blues now).

**Dealing with adverse selection**

Cooperatives would undoubtedly be subject to adverse selection by members and dumping by private insurers. They would need to be protected from this in some way. The Cooperative could be 501(c)(4) organizations, exempt from 501(m) and not subject to federal tax. They would also be exempt from state premium taxes. Each year their claims experience would be reviewed and would be compared to national insurers competing in the same markets. If they were in fact victims of adverse selection, they would be exempt from the tax costs incurred by private insurers to the extent of their additional burden. If, on the other hand, they had a similar risk pool to the private insurers, they would either pay a fee to the federal government equivalent to the tax burden borne by private insurers or would have to provide additional public health services to the extent of that cost. Risk adjustment of premium support paid by the federal government will probably also be necessary to combat risk selection. Finally, overt risk selection would be prohibited by the underwriting rules discussed above, and subject to penalty.

**Bargaining with providers**

The national Cooperative would bargain with drug and device companies and multi-state provider chains for all of the cooperatives. Regional cooperatives would bargain with local
providers and professionals. The Cooperative would be charged with lowering costs and with driving health care delivery reform. Cooperatives would be permitted to contract selectively, particularly with integrated health systems, but each regional cooperative would decide how best to deal with its local providers. Any provider or supplier controlling more than a specified share (for example, 40 percent or more) of the market of any particular medical product or service in the nation as a whole or in any particular county or city in the country (as determined by the federal government) would be required to bargain with the Cooperative. If the Cooperative and provider failed to reach an agreement, provider and supplier fees would be set by binding arbitration. Some percentage of Medicare payments could perhaps be used as a benchmark. This requirement could be time-limited if it provider participation turned out not to be a problem. The Federal Trade Commission would be specifically tasked to challenge any provider combination that refused to deal with the Cooperative. Anticompetitive conduct by private insurers directed at the Cooperative should also be dealt with severely. An alternative model to addressing provider fees, that should be considered in any event, would be an all-payer rate setting model like that used successfully in Maryland for many years, that could be used to insure a level playing field and to control costs for all insurers.

What investment will be necessary to make the Cooperative viable?

Surveys show that a significant majority of Americans want an alternative to private insurance. The Cooperative could provide an alternative that is not “government-run.” It cannot be done, however, on the cheap or it will not happen at all.

Getting the Cooperative underway will take significant federal funding up front, probably on the order of tens of billions of dollars. The Cooperative must rapidly be scaled up to become competitive with massive private insurers and will need the resources to do this. It is not realistic to believe that the Cooperative will be self-funding for some time. It will not be able to depend on private equity markets for funding. It is difficult to believe that it will initially have the capacity to borrow significant amounts of money, particularly if the full faith and credit of the federal government is not behind it (and the CBO will not allow it to be off-budget if the federal government guarantees its obligations). Federal funds will be needed to set up the administrative functions of the Cooperative, including establishing the boards, hiring staff, developing policies and procedures, writing policies, setting premiums, signing up members, establishing provider networks and payment protocols, and setting up claims processing functions. Significant funds will be necessary for marketing initially to establish a brand and a presence in every market in the country. Capital will be needed for reserves. It can be hoped that the Cooperative will become self-supporting over time, but it is simply not possible that it can get underway without a significant public investment. This investment, by the way, will probably have to be much greater than would be necessary for initiating a public plan, since a Medicare public plan would already be far more familiar to most America and could build on the Medicare infrastructure already in place and the vast experience HHS already has with providing public insurance. Also, considerable savings may be possible if the Cooperative piggy-backs on Medicare payment infrastructure, as, indeed, many private insurers already do.

What if it doesn’t work?
The initial legislation should provide that if any regional cooperative failed to reach some membership goal by the end of 2013 (say 1 million members), the national Cooperative would either take over management of the region or provide special oversight of it. An additional public investment may be necessary at this point.

The legislation should also stipulate that if the Cooperative had failed to provide a viable alternative to private insurance and bring down health care costs (as specified by law) by 2015, the Secretary of Health and Human Services would be directed to implement a national public health insurance plan modeled on Medicare without the need for further legislation. A super-majority vote of Congress would be necessary to repeal this trigger.

Transition issues

Realistically, it will take at least a year or two for the Cooperative to get up and running. Interim measures should be considered to assist those excluded from private insurance, such as extending Medicaid to all uninsured persons under 250% of poverty and permitting a full cost buy-in to Medicare on a temporary basis. As recognized by temporary measures adopted in the ARRA, we are currently in a national crisis that has caused millions of Americans to lose insurance coverage. The Cooperative may be a long-term solution, but in the short-term measures are desperately needed that can be implemented more rapidly.