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Health Insurance Co-Ops:

More Form Than Reform

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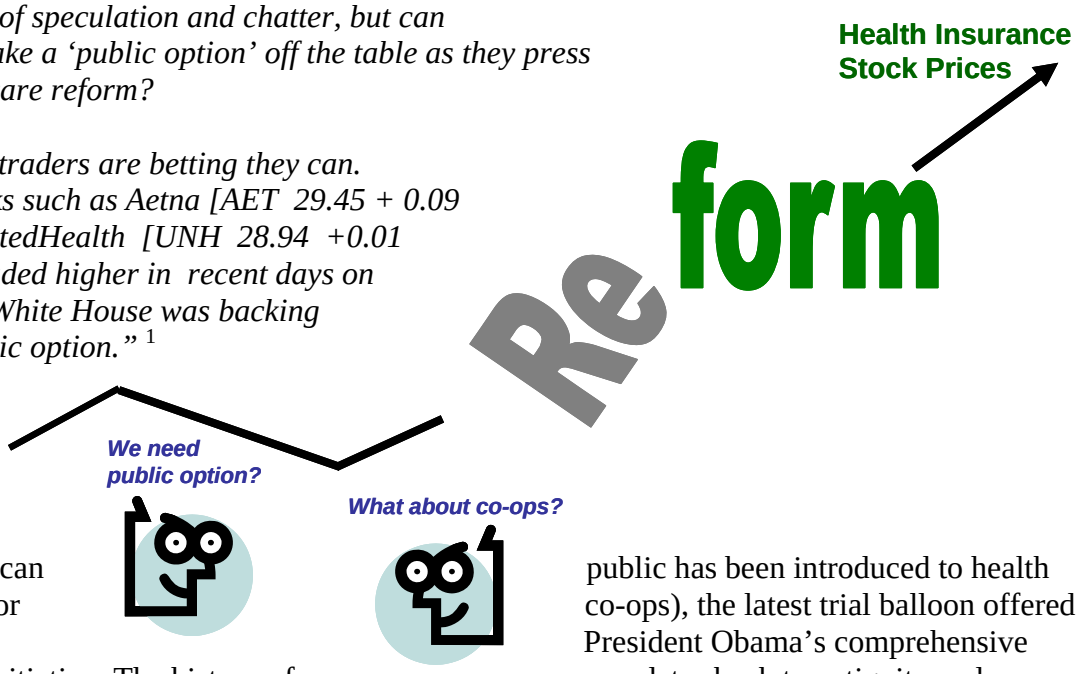
"There's been a lot of speculation and chatter, but can Democrats really take a 'public option' off the table as they press ahead with health care reform?

Right now it seems traders are betting they can. In fact HMO stocks such as Aetna [AET 29.45 + 0.09 (+0.31%)] and UnitedHealth [UNH 28.94 +0.01 (+0.03%)] have traded higher in recent days on the belief that the White House was backing down from the public option." [1]



SUMMARY

Recently, the American public has been introduced to health care co-operatives (or co-ops), the latest trial balloon offered by opponents of President Obama's comprehensive health care reform initiative. The history of co-ops dates back to antiquity and more recently, to 19th century Europe. The member-based economic units exist in financial services, food, tourism, and various other industries. This paper cites various commonalities between depository co-ops (i.e., credit unions) and health insurance co-ops. Given these parallels, this paper makes extensive use of the former as a model for the economic impact of the latter.

While co-ops evolve out of regulatory changes, economies facing severe instability, and/or the peculiar needs of a niche market segment, they are typically limited in their role as a market leader in highly functional and efficient economies. Co-ops generally lack the size to mount a serious competition against larger organizations that operate in market economies. Increasing trends of industry consolidation, where highly capitalized firms absorb smaller and/or troubled firms, further expands scale differences between commercial and co-op units. Co-ops generally lack capital reserves to introduce the kinds of process and technology innovations needed to improve efficiency in our nation's complex health care system. Economic units that form under a co-op model require underwriting and sometime

[1] CNBC, *Is Public Option 'Really' Off The Table?*, August 25, 2009. See http://www.cnbc.com/id/32553383.

lengthy timeframes to establish sufficient membership enrollment levels. Health insurance co-ops would not offer health care providers sufficiently large plan enrollments as an alternative to maintaining contractual relationships with large poorly performing insurers. Size differences between commercial and co-op health insurers would maintain the power position that exists in private insurer-provider channel relationships. Finally, co-ops formed to serve niche (high-risk) demographic groups face considerable difficulty in maintaining solvency. Avoiding these dangers often requires co-ops to highly scrutinize their members and design product/service offerings in a way that reduce risks. The resulting effects are unintended outcomes for the vulnerable populations many co-ops are formed to serve.

Co-ops will little accomplish the objectives of the forerunner proposal - ***public option***. Substituting the more substantial intervention for a less meaningful measure will leave the American public tomorrow in the mess it is living today. Consequently, this paper strongly rejects proposals that call for co-ops as an alternative to a public option health insurance program.

INTRODUCTION

Noted experts with healthcare and public administration experience understand the need for the proposed public option. Dr. Howard Dean, former Governor of Vermont and Democratic National Convention Chairman, consistently cites the essential nature of a government-sponsored health insurance program if real reforms are to emerge from the current legislative processes. Fundamentally, without the entrance of a formidable competitor to the health insurance marketplace, big insurance companies will continue to fulfill their principle mission – maximize shareholder value. Likewise, Americans will further witness policyholders held hostage to profit-taking companies that operate in ways that sometimes disconnect them from the needs of consumers – as is the case with premiums that translate into excessive executive compensation packages, marketing, and other non-patient care activities.

BACKGROUND

In an effort to slow the momentum around President Obama's health care reform initiative, opponents on Capital Hill, pundits, and other stakeholders are now suggesting co-operative insurance plans (co-ops) would be an equitable and effective alternative to a public option. Supporters of this alternative promote the formation of co-ops that expressly serve the needs of distinct population groups such as un- and under-insured, those struggling with pre-existing conditions, and/or individuals plagued by other circumstances that impose high-cost insurance problems.

ORIGINS AND ROLE OF CO-OPS

The term co-op applies to myriad economic arrangements where individuals organize transactions that yield mutual social benefits. The International Co-operative Alliance's [ICA] Statement on the Co-operative Identity as *an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically-controlled enterprise*.[2] In contrast to purely market relationships, co-ops balance sustainability with intrinsic interests to enhance the economic position of co-op participants; as such, co-ops are not

[2] http://www.ica.coop/coop/principles.html.

structured with a primary focus on profits.

The earliest forms of co-ops can be traced to ancient Greece, Egypt, Rome and Babylon, as well as among Native American tribes, African villages, other groups throughout the world. A model of co-ops operating in antiquity is found in the Book of Ruth and the biblical account of the well-established practice of gleaning where farmers would leave a portion of their harvest for the poor. Modern co-ops emerged during the 18th and 19th century as functioning units within both agricultural and industrial economies. The Fenwick Weavers' Society (1761) formed in Fenwick, East Ayrshire, Scotland with the idea of selling discounted oatmeal to local workers. Another co-op, the Rochdale Equitable Pioneers Society (1844) formed after Rochdale, England textile workers, who waged an unsuccessful strike during the previous year, sought alternative means to improve their standard of living.

Cop-ops operate in sectors health care, financial, tourism, housing, etc. While these organizations exist in developed nations, they are more prevalent in lesser developed nations that lack structure or systems, stable currencies and/or socioeconomic conditions, sufficient infrastructure, sustaining and sustainable resources needed to support open/market economies. Their expansion is known by membership numbers and activity. For instance, co-op membership exceeds 239 million in India.[3]

CURRENT MODELS

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We have considerable experience with co-ops, whether called by this term or another. Some of the many examples of co-ops include:

Housing Co-Ops extend owner-occupant opportunities to seniors, low-income families, and physically disabled individuals. Other examples arise as a solution to problematic residential housing districts (e.g., New York City) and within college communities for attending students. The New York Cooperative formed following complex rent control laws that led to landlords leaving the rental property market.

Produce Co-Ops form with members sharing some common set of goals, whether related to land ownership, environmental sustainability, or economic localization (i.e., in-sourcing). The Movement Dallas Organic Produce Co-Op formed to provide its members a source of affordable healthy foods.

Utility Co-Ops concentrate on delivering telecommunications, water, gas, electricity, or some other public resource to its members. The Utility Connection boasts a repository of 188 electric co-ops that serve over 15,000 customers. Utility co-ops form for myriad reasons. In recent years, gasoline co-ops sprouted up across the country, offering members forward contracts that locked into low fuel prices.

Depository Co-Ops, commonly referred to as credit unions**,** date back to 19th England**.** America's form of credit unions that emphasize democratic processes (e.g., one vote per member, member election of boards) can be traced to institutions that sprung up in Germany during the mid-1800s. Whether federally- or state-chartered, America's credit unions function as financial services co-ops. Here, member-owned institutions offer financial services with a focus on more of an emphasis on sustainability and providing value. At credit unions, members are the shareholders. Hence, non-time deposit accounts - saving accounts and checking accounts – are referred to as shares and share drafts, respectively.

[3] Data extracted from a presentation given by Iain Macdonald, Director General ICA, at the ICA Regional Youth Seminar Malaysia on September 7, 2004 – see http://www.ica.coop/directorpage/presentations/youth04.pdf

It is not uncommon for co-ops to emerge out of societal crises, to a greater or lesser extent. In the above, co-ops emerged as practical solutions to general economic downturns, industry responses to government regulations (e.g., landlord, hostilities between economic units (e.g., management/worker, business/ consumer). It is thus plausible that *some* who argue for health insurance co-ops do so with genuine interests in applying the co-op model to our nation's health care crisis.

CREDIT UNIONS OFFER INSIGHTS INTO HEALTH INSURANCE CO-OPS

Although a small number of health insurance co-ops currently operate in the US, reforms that substitute the proposed public option with co-ops would require a massive entry of these units to the marketplace.

What would be the economic impact of the growth in health insurance co-ops?

To answer that question, we can look at depository co-ops for insights given a number of factors in common with health insurance, including:

Structural Crisis. The history of credit union co-ops in America most resembles the concept of health insurance co-ops. Credit unions formed out of collapse of America's financial institutions. We are now considering a similar crisis, this time in the health care arena. At 17% of GDP, health care expenditures have risen to a national security problem.

Government Intervention. Unlike other forms, credit union co-ops came into existence by way of direct government intervention. In the aftermath Wall Street crash and Great Depression, President Roosevelt signed the Federal Credit Union Act of 1934 to facilitate a system of not-for-profit cooperatives that promotes thrift and frees the American public from usury practices. For the following 30 years, 10,000 credit unions launched, accounting for 6 million members by 1960. In 1970, the Bureau of Federal Credit Unions moved away from the Farm Credit Administration to an independent federal agency – National Credit Union Administration [NCUA] – to centralize federal chartering, supervision, and depository insurance activities. Deregulation further spiked the credit union movement during the 1980s. Today, America's 7,550 federally-chartered credits unions account for nearly 90 million members, deposits exceeding $679 billion, and loans surpassing $355 billion.[4]

Regulated Industry. Both sectors, financial and health care, are highly regulated. Regulations such as minimum capital reserve requirements impact key operational and financial management aspects of companies in both industries. Such restrictions pose considerable challenges for (newly-formed) co-ops.

Market Penetration. Credit unions are among the advanced forms of co-ops in terms of embedded base of member-consumers. They enjoy a cult-like following that defines credit unions in terms of a "movement". It is improbable that proposed health care insurers would exceed this level of market success in the foreseeable future. The Congressional Budget Office estimates that between 10 million and 11 million individuals would move to the public option over the next decade.[5] If we assume this group would participate in the alternative health insurance co-op system, the membership ranks would account for less than 4% of the population.

[4] National Credit Union Administration [NCUA]. See http://www.ncua.gov.

[5] The CBO study projecting public option participants refutes a Lewin Group study that estimated as many as 103 million Americans would participate in the public option. It is important to note that Lewin Group is a part of a large organization owned by an insurance company.

Given these and other similarities, the financial sector provides plausible indicators as to what American citizens might expect after the introduction of health insurance co-ops as a pillar of health care reform.

WHY CO-OPS WON'T SOLVE AMERICA'S HEALTH CARE SYSTEM CRISIS

This concludes ***co-op health insurers are no substitute for a more substantial public option framework for several reasons:***

1) Scale Differentials Limit Competition

The public option is intended to increase competition. This provides incentives for private insurers to offer a higher value proposition. However, co-ops rarely (if ever) capture a critical mass in functioning economies to effectively shift the competitive landscape. This is not to suggest that co-ops don't have their place. Obviously, they do and particularly in lesser developed countries. However, America's mature market economy pits potential co-ops against well-established firms. Consider for a moment the aforementioned credit union co-op. According to the Credit Union National Association [CUNA]: "*Credit unions are a small, but constant presence in the financial services industry. Credit unions held 1.8 percent of household financial assets as of December 2004, according to Federal Reserve data, and have held a share below 2 percent since 1980.*"[6]

As we celebrate the 65th anniversary of the Federal Credit Union Act of 1934, credit union deposits represent only 8.4% of $8.077 trillion in commercial bank deposits.[7] Further, credit union lending is 5.29% of $6.717 trillion in loans and leases at commercial banks.[8] The Federal Reserve Bank tracks 1,750 large commercial banks that exceed $300 million in consolidated assets. Of these, six institutions alone - Bank Of America, JP Morgan Chase, Wells Fargo, Suntrust, Citibank, and Wachovia – account for $5.57 trillion in assets.[9] Large commercial banks tower over the relatively small number of CUs that approach or match this asset level.

Scale differentials between commercial and co-op depositories guarantee the relative market positions of both. This is not only true during periods of economic expansion, but as we have witnessed, during periods of economic decline. Stated differently, in the wake of the recent collapse of America's financial sector, legislators readily accepted a premise that commercial banks must be restored at all cost.

Scale variances that define units in the financial sector will also confront any health insurance reform that rests on formation of health insurance co-ops. As noted in GraniteRG.com's report entitled *Big Six Health Insurance Company Profits 2006-2008*, market leaders Unitedhealth Group, Humana, Coventry Health Care, AETNA, Cigna, Wellpoint, garnered $233.3 billion in revenues in 2008.[10] These and a number of mature health insurers command large assets and capital reserves.

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[6] CUNA website - http://www.cuna.org/press/basicinfo.html.
[7] Federal Deposit Insurance Corporation [FDIC]. *Quarterly Banking Profile TABLE III-A. First-Half 2009, FDIC-Insured Commercial Banks*. See http://www2.fdic.gov/qbp/2009jun/cb3.html.
[8] Federal Deposit Insurance Corporation [FDIC]. *Quarterly Banking Profile TABLE V-A. Loan Performance, FDIC-Insured Commercial Banks*. See http://www2.fdic.gov/qbp/2009jun/cb5.html.
[9] Federal Reserve Bank. *INSURED U.S.-CHARTERED COMMERCIAL BANKS THAT HAVE CONSOLIDATED ASSETS of $300 MILLION or MORE, RANKED by CONSOLIDATED ASSETS As of March 31, 2009*. See http://www.federalreserve.gov/releases/lbr/current/default.htm.
[10] GraniteRG.com, *Big Six Health Insurance Company Profits*. See http://graniterg.com/uploads/HCR-Big_Six_Health_Insurance_Profits_2006-2008.pdf.

2) Consolidations Effects on State Quasi-Monopolies of Health Insurance

The health insurance industry is highly centralized around individual companies that dominate various states. Consolidation is a key determinant in market share as opposed to "natural selection" of high performing organizations. In November 2004, a merger between Anthem and Wellpoint valued at $16.5 billion overcame objections by insurance commissions.

Large health insurers maintain profit positions by unwritten agreements to carve out geographic territories. This effectively positions insurers to grow profits by increasing revenues (premiums) as opposed to fighting for greater market share. Monopolies concentrate a significant percentage of several state's enrollment with the largest health insurance plan. As of December 2004, these concentrations included: AL (71%), AR (56%), IA (66%), IL (47%), ME (70%), MT (59%), NC (50%), NE (54%).[11]

Senator Kent Conrad (D-ND), the proponent of health insurance co-ops, serves a state where the largest health care insurer controls 51% of the market. Further, commercial health insurance enrollment in North Dakota is 395,000 – the lowest in the nation. This might explain Conrad's opposition to the public option and his orientation to a co-op model.

Unlike natural selection dynamics – where firms legally gain monopoly position as a result of their highly-valued offerings - implicit territorial agreements coupled with consolidation rise to a high level of concern for anti-trust regulators. Essentially, consumers with few legitimate options are held captive to these excessive price hikes. In addition, health insurance companies can selectively qualify and disqualify potential policyholders and make profit-driven decisions around coverage. Consolidation favors insurers that operate as the de facto "only game in town".

Health insurance companies argue against anti-trust claims by citing that market share is an inconclusive indicator of structural monopolies. Insurers further note that certain pricing behaviors are more insightful in making such assessments. Given that criteria, one might argue that monopolies are indeed entrenched in states around the country in light of escalating premiums, which in recent years grew 10% to 15% - outpacing health care costs. The absence of transparency further complicates the pricing-oriented anti-trust analyses of monopolies. Insurers tightly guard their proprietary pricing data, which requires legal intervention for third-party analysis. Historically however, the Department of Justice has brought relative few anti-trust cases against large insurers. Barring more aggressive investigations, little exists today in both private and government arenas to retard industry the pace and scale of consolidation.

Health insurance co-ops pose no more threat to these arrangements than one or a group of credit unions to a larger commercial bank. As deregulation opened the door to consolidation in the financial sector, it is conceivable that market arrangements which threaten leadership positions in the health insurance sector would accelerate the pace of similar responses. Namely, larger and more capitalized firms will pursue measures to maintain scale differentials over small health insurance co-ops. Substantial competitive threats will only emerge with a large entrant into the health insurance arena that operates outside of unwritten territorial agreements. That role is well suited for a government-sponsored insurer – hence the public option.

3) Co-Ops Would Forfeit Scale Innovations

[11] James C. Robinson, PhD, *Consolidation And The Transformation Of Competition In Health Insurance*, HEALTH AFFAIRS ~Volume 12, Number 6, November/December 2004. See http://content.healthaffairs.org/cgi/reprint/23/6/11.pdf.

Process innovation, aided by information technology, is a key component to reforms that yield greater value for a wider population. With the exception of exceptional new ventures, the history of technological innovation overwhelmingly points to well-more capitalized organizations. In pharmaceutical R&D, the use of robots exponentially improved compound discovery and high throughput screening [HTS].[12] Larger firms such as Pfizer led the integration of robotics to speed up drug development over manual processes. Various introductions of the automated teller machine [ATM] debuted at City Bank of New York (1939), Barclays Bank (UK/1967), and Lloyds Bank (UK/1973). Just-in-time inventory [JIT] management took root at Ford Motor Company, and later at companies such as Piggly Wiggly and Toyota Motor Corporation of Japan; each armed with resources to implement and/or overhaul their physical plant and/or administrative office.

Innovation and the pace of diffusion play a major role in structural cost reductions that ultimately benefit a broader consumer base. For example, self-service gas stations originated in Omaha, NE in 1958. One might imagine what recent high gas prices would have been had this process innovation not migrated to our nation's 120,000 gas stations, most of which are connected to large networks (e.g., Shell). In the case of pharmaceuticals R&D, prior to the 1980s, screening of compounds for absorption, distribution, metabolism, excretion and toxicity [ADME] was manual, with scientists capable of testing 30 candidate compounds per week. Robotics-oriented HTS gives scientists the capability to screen 100,000 compounds in a day. Scale innovations shift marginal cost curves that reposition pricing throughout an industry's channel.

Co-ops often lack the reserves to lead process and technological innovation. This is particularly difficult in highly-regulated industries that set minimum reserve requirements. These initiatives often require considerable investment to research, develop, prototype, and diffuse innovation. Health insurance co-ops are less likely to deliver the myriad improvements necessary to drive cost reduction and efficiency. To the extent that co-ops desire such innovations, scale economies prohibit the reach of these improvements. Further, disincentives exist for co-ops to lead innovations that are quickly replicated by larger firms, nullifying the competitive advantage sought by smaller organizations.

Relying on co-ops to advance cost-savings slows the very pace of innovation. The public option has a potential to introduce a sufficiently larger competitor to diffuse innovations across a scale operation in a way that is both feasible and competitively sustainable.

4) Co-Ops Represent Costly and Expensive Membership Start-Up

Organized co-ops start with the signing of membership documents. In the case of credit unions, a "Field of Membership [FOM]" defines the population segment served whether employee-based, associational, or community development. Founding members sign-up for participation in a credit union during initial chartering and this signing process continues through the life of the institutions. FOM effectively limits membership. Ardent supporters of credit unions often cite that this requirement places financial services co-ops at a disadvantage relative to commercial institutions.

Similar problems exist with proposed health insurance co-ops. Their start would require signing of large enough membership pools to provide sufficient capital. Further, the federal government would be

[12] Bennett Brumson , Contributing Editor, *Pharmaceutical Robotic Applications*, Robotic Industries Association, posted on Robotics Online, 04/01/2002. See http://www.robotics.org/content-detail.cfm/Industrial-Robotics-News/Pharmaceutical-Robotic-Applications/content_id/1156.

required to underwrite these startups at a significant cost – again for an outcome (i.e., small co-ops) that facilitates competition in a limited sense.

5) Co-Ops Maintain Private Insurer Channel Influence

The top eight private health insurers account for a combined enrollment of 133.1 million.[13] Territorial monopolies afford large health insurance companies a powerful position when negotiating with physicians, hospitals, and managed care organizations. Size variances between commercial and co-ops will effectively maintain large insurer dominance. Founded in 1947, Tennessee Rural Health Plan [TRHP], the largest health insurance co-op in the US represents 186,000 policyholders.[14] TRHP competes in a state where enrollment exceeds 3.4 million, with three insurers controlling over 60% of plans.

While small health insurance co-ops exist today in niche market, they lack the critical mass of members to *command* their preferred terms and conditions available to top-tier private insurance. Conversely, our largest private insurers have the ability to negotiate contracts even in situations where health care providers are not particularly satisfied with the business relationship. A recent survey by public affairs firm, Davies, rated health insurance partners based on trust, honesty, good faith negotiations, claims processing, claims acceptance/denials, and other business practices. The survey, that included 18% of our nation's hospitals, polled CEOs, CFOs and managed care Directors. Eighty-two percent of survey respondents indicated an unfavorable opinion of the lowest rated insurer - UnitedHealthcare. According to Nathan Kaufman, a national healthcare strategy consultant and managing director of Kaufman Strategic Advisors:

> *"UnitedHealthcare is paying as much or more than other insurance companies for healthcare services but they are viewed as the worst performer by a large margin."*
>
> Source: NewsRX.com

> *"Three years in a row shows a clear trend. United's bad reputation seems to be an outcome of a deliberate business strategy, approach to negotiations and set of business practices. Most negotiations between health plans and providers take place behind closed doors. These results reveal payors through the eyes of people who know how they act when no one is watching – the hospitals that deal with them every day."* [15]

However, problematic large insurers have the power to force providers out-of-network, creating instability for group plans and policyholders. Health care providers find themselves in a vulnerable position. Walking away from a under-performing insurer that covers a niche membership segment might be plausible. Jettisoning a relationship with an insurer that controls 30%-to-60% of the market has seriously adverse financial implications. Hence, consumers ultimately feel the brunt of troubled insurer-provider relationship.

Smaller sized co-ops would not be in position to offer providers large enough plan participant pools to

[13] Debra A. Donahue, *Top Plans Experience Enrollment Declines During 1Q09*, Mark Farrah Associates, July 24, 2009. See http://www.markfarrah.com/healthcarebs.asp?article=65
[14] Source: http://www.trh.com/ as posted on August 27, 2009.
[15] NewsRX.com, *New Survey Reveals Best and Worst Health Insurance Companies*, March 16th, 2009. See http://www.newsrx.com/health-alert/3586.html.

substitute the loss of a large insurance partner. Also, co-op entrants would be at a disadvantage when competing against large insurers that fragile insurer-provider relationships notwithstanding, can consummate more attractive agreements. A policy shift from a public option insurer to health insurance co-ops forfeits the market influence a government-sponsored insurance program would to cultivate sound partnerships with providers. The potential size of government-sponsored plans would offer providers large policyholder pools, where it becomes necessary to terminate relationships with a subpar insurer and strengthen providers' channel position with insurers.

6) Unintended Negative Outcomes for Targeted Consumers

Another concern of relying on health insurance co-ops is the *availability* of affordable services. As noted, the Federal Credit Union Act sought to promote low-cost credit and thriftiness. Credit unions however, are chartered under and governed by a number of regulations that require similar processes such as credit analysis on loan applications. The rigor credit unions must apply to lending is most problematic for community development credit unions, chartered to serve lower-income population segments. When coupled with usury laws that place ceilings on loan rates, federal-chartered credit unions that are principally (and appropriately) concerned with solvency adopt polices and practices which limit lending to the very groups they were chartered to serve.[16]

Credit unions then, cherry-pick lending to some extent – albeit not to the magnitude of commercial banks. Similarly, health insurance co-ops that form to serve the un- and under-insured will be forced to adopt policies and practices that promote their long-term solvency. Licensing does not impose upon co-ops regulations that endanger their existence. Consequently, the real potential exists that health insurance co-ops will leave some of our most vulnerable confronted with expensive premiums under a reformed legal regime that mandates coverage.

POLICY RECOMMENDATION

Given the limitations of health insurance co-ops, this recommends policymakers to proceed with the public option as an essential component to comprehensive health care reform. Considerations of a co-op model erode the potential impact of comprehensive reforms, and forfeit any substantial benefits that reforming our nation's health care system offers the American public.

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[16] John D. Wolken and Frank Navaratil, *The Economic Impact of the Federal Credit Union Usury Ceiling*, The Journal of Finance, Vol. XXXXVI, No. 5, December 1981.