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Behind The Scenes of the Affordable Care Act: The Making of a Health Care Co-Op

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A primary aim of the Affordable Care Act (ACA) is to expand access to health insurance to small businesses and individuals. These groups experience significant barriers to obtaining affordable insurance because they are subject to discriminatory practices by insurers and lack the necessary market power to negotiate reasonable premiums. While much attention has been paid to the ACA's requirement for state exchanges through which these groups will shop for insurance, and reforms of insurers' practices, less is known about the ACA's provision for nonprofit, member-owned health insurance cooperatives (or co-ops) that will operate inside these exchanges. Cooperatives are limited in scope, but they have the potential to strengthen the position and control of small firms and individuals in the health insurance decisions.

In this article, I briefly sketch the insertion of cooperative provision in the ACA, and note how this represented a compromise between progressive and conservative Democrats in Congress. I then use Common Ground Healthcare Cooperative (CGHC) as a case study to explore the political and technical challenges facing the creation and implementation of cooperatives at state level. Located in Wisconsin, CGHC is one of the first wave of co-ops to receive federal funding under the ACA. I conclude with an assessment of the possible impact that co-ops may have on the US health care system.

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Problems of Affordability in the Small Group and Individual Insurance Markets

Small firms and individuals face specific obstacles to finding affordable health insurance that large employers do not. First, small employers and individuals are subject to medical underwriting practices that place insurance out of reach. These include the use of experience rating to calculate premiums according to the expected or actual health use of the customer, and exclusion waivers that specify certain common health conditions from coverage. Perhaps the most insidious practice is the preexisting condition clause, which absolves insurers from current coverage of any medical condition that a client had — even if it went untreated or undetected — in the year prior to the start of the insurance policy (Stone 1993). Second and related to medical underwriting, the administrative costs are much higher than for a single policy that covers a large employer, and the premiums in the small group and individual markets reflect such costs (Sered and Femandopulle 2007: 114). Lastly, unlike a large firm, small businesses and individuals seeking to purchase health insurance are too atomized and too small to exert the necessary market power in negotiations with a few large insurers.

Coverage figures attest to the difficulties that small firms and individuals face. In 2012, only 35.7% of firms with fewer than 50 employees offered insurance, while 95.7% of firms with 50 or more workers did so (Kaiser Family Foundation 2012a). Between 1999 and 2012, premiums for employer-based insurance rose from $5,791 to $15,745 for family coverage (Employer Health Benefits 2012). Whereas large firms must absorb single-digit annual increases in premiums, small firms and individuals routinely face double-digit annual rate hikes of 30% or more (Jacobs and Skocpol 2010: 111; Jagler 2012: 21).

Cooperatives under the ACA

To rectify these problems, the ACA requires that each state create a health insurance marketplace, or exchange, through which small businesses with fewer than 100 employees and individuals can choose among competing insurers. All insurance companies must offer minimum levels of coverage and must market their products in easily

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comparable and understandable formats. The law also provides subsidies for persons with incomes up to 400 percent of the federal poverty line and tax credits for firms with fewer than 25 full-time employees that opt to offer insurance. The ACA also requires insurers in the exchanges to use modified community rating instead of experience rating. All insurers will have to accept any client regardless of health status. The ACA also inserted a provision for the creation of a nonprofit insurance cooperative in each exchange (www.healthcare.gov; Kaiser Family Foundation 2012b).

A cooperative is a mutual self-help organization whose members join together to enhance their market power. They are member-governed, and if nonprofit, must invest surpluses into the services and operations of the organization (Richardson 2011). Rural health care cooperatives sprang up during the New Deal, but most were short-lived (Jost 2011; Richardson 2011).

The ACA gave cooperatives a new lease on life and constituted a compromise between progressive and conservative Democrats in Congress on the terms of health care reform. Many progressives advocated a single-payer health insurance system like Canada's, or "Medicare for all." But moderates saw it as politically infeasible, as a government takeover of health care that would vastly expand federal and state budgets obligations. Other reformers proposed a public option as a middle way. The public option would have preserved existing employment-based insurance while permitting a government health plan to compete alongside private insurers in the small group and individual exchanges (Hacker 2008). House Democrats inserted a watered-down public option in their reform bill, but Senate Democrats refused to follow suit. Conservatives within the Democratic caucus in the Senate had more leverage than their House counterparts, and the rules of debate posed a real possibility that reform bill might not reach a vote on the Senate floor. For conservative Senate Democrats and private insurers, the public option was still too much government (Jacobs and Skocpol 2010: 59-64).[2] Senator Kent Conrad (D-ND) offered a way forward with his proposal for cooperatives as a bipartisan solution (Conrad 2009; Gardner 2009; Weisman 2009). Conrad maintained that nonprofit, member-governed co-ops with a strong consumer focus could appease advocates of a public option, while co-ops run by and for small businesses and operating at state level could assuage the fears of those concerned with a government

takeover of health care (Weisman 2009). While failing to achieve bipartisan agreement, cooperatives became part of the Senate bill and the final ACA.

Section 1322 of the Affordable Care Act created the Consumer Operated and Oriented Plan (CO-OP) program, and provides up to $3.8 billion in federal loans to help cover the start-up costs of nonprofit, member-owned and operated health insurance companies in each state exchange. According to the law, each cooperative must be governed by its members, have a strong consumer focus, and reinvest any profits into the organization in order to improve benefits or health care delivery, or lower premiums. To ensure that co-ops are truly representative of small businesses and individuals, the ACA bars existing health insurance companies and state or local governments from creating such entities (Kaiser Family Foundation 2012b: 4).

The Common Ground Healthcare Cooperative (CGHC)

Common Ground Healthcare Cooperative (CGHC) was among the first wave of co-ops to receive federal funding in February 2012. It was established by Common Ground, an organization of religious congregations, neighborhood associations, and schools working to achieve positive social change in southeastern Wisconsin. Common Ground, in tum, is an affiliate of the Industrial Areas Foundation (IAF) community organizing network. Though established by Common Ground, the co-op is a separate legal entity with its own management and board of directors (Common Ground; CGHC 2012).

The creation of CGHC is a story of perseverance and a willingness to adjust to new circumstances. The effort began in 2007 when Common Ground leaders consulted their member organizations and learned that affordable health insurance was one of their chief concerns. Next, the leadership formed a health care team of Common Ground members to research the issue and consider possible solutions. In 2008, well before the election of Barack Obama, Common Ground's membership decided to create a health insurance purchasing cooperative for small businesses, self-employed individuals, and nonprofits. During the next three years, the health care team conducted informational meetings with over 200 small businesses and individuals to gauge their interest in the idea and met with state

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officials and health care stakeholders to seek their support. The team also sought state and federal seed money for the co-op, but the fiscal strains associated with the 2008 recession closed off such possibilities.

The passage of the ACA opened a new door, however. The type of co-op under the law was a nonprofit, member-owned insurance company to be offered in the state exchanges for small businesses and individuals. Accordingly, Common Ground abandoned its plans for an insurance purchasing cooperative and instead worked to establish a nonprofit health insurance company and seek federal funding under the ACA. The CGHC submitted a loan application to the Department of Health and Human Services (DHHS) in the fall of2011 and was one of seven co-ops to receive development loans from the federal government in February 2012. The federal loans of up to $56.4 million represent crucial assistance to CGHC to address the start-up costs it faces in a mature health insurance market (Boulton 2012b). Following the ACA's timetable, CGHC will begin enrolling members in October 2013, with coverage commencing on January 1, 2014. CGHC will offer insurance to small businesses of 50 or fewer employees, nonprofits, and individuals in seven southeastern Wisconsin counties (CGHC 2012; Jagler 2012: 21).

Challenges to the CGHC

To succeed, co-ops must overcome political and technical challenges. The political tasks include garnering federal funding and designation, while winning support from policymakers at state level. In Wisconsin, the political climate was initially favorable to Common Ground's efforts to create a co-op. For most of 2008, the administration of Democratic Governor Jim Doyle worked on its own plan for an exchange, BadgerChoice, modeled on the Massachusetts exchange. But the state's fiscal difficulties the following year required Doyle to put the plan on hold *(Business Journal* 2008; Hess 2009; Common Ground n.d.). Following the enactment of the ACA, the federal government designated Wisconsin an early leader in developing an exchange, and awarded the state $38 million to resume its work.

The political climate abruptly shifted following the midterm elections in 2010. Republicans wrested majority control of the US House of Representatives and vowed to block the implementation of the ACA. In Wisconsin, Republicans swept both houses of the state

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legislature and the governorship from the Democrats. The new governor, Scott Walker, championed the Tea Party ideology of small government and low taxes. Health policy in Wisconsin was also subsumed in the ferocious struggle over public employees' collective bargaining rights in 2011-12. Walker prevailed in that battle, but the matter poisoned the political climate and halted any meaningful legislative activity until after the 2012 elections.

Governor Walker initially gave mixed signals on the direction of his administration toward the ACA. In the name of small government and state's rights, Wisconsin became one of26 states to file a lawsuit challenging the constitutionality of the ACA before the US Supreme Court. At the same time, however, Walker directed his administration to continue work on the exchange under the aegis of the newly created Office of Free Market Health Care (OFMHC 2011). In late December 2011, however, the governor reversed course, halting work on the exchange pending the Supreme Court ruling (Boulton 2012a), and subsequently returning the $38 million in federal money that Doyle had received for the exchange. According to Walker, '"Stopping the encroachment of ObamaCare in our state, which has the potential to have a devastating impact on Wisconsin's economy, is a top priority"' (Stein 2012a). While Democratic legislators were more receptive to Common Ground's bid for federal funding of the coop, Republicans adopted a stance of calculated indifference and Walker remained silent on the news that CGHC had secured the federal loan.[3]

The political climate has since become more settled in 2012. The ACA's survival is assured with the Supreme Court's decision upholding most of the ACA's provisions and President Obama's reelection in November, and the Walker administration has since clarified its position. On November 15, the governor announced that he would let the federal government set up the exchange in Wisconsin. He justified his decision by citing the potential cost to Wisconsin taxpayers to run a state exchange and arguing that the state would have had little power in setting its parameters. His stance sat well with the 20 Tea Party organizations that had urged this course of action, but less so with the state's business community and health care providers who had pushed for a state-created exchange (Durhams et al. 2012; Stein and Boulton 2012).

Throughout the unsettled political climate, Common Ground remained undaunted. The organization continued its work on the co-

op, and maintained that it could operate with or without an exchange. For CGHC, the political saga had a positive outcome for its future operations, since the insurance reforms will go forward and Wisconsin will get an exchange.

There are still a number of significant technical challenges that CGHC must confront. First, the co-op needs management and administrative expertise in order to design benefit packages and negotiate contracts with providers. CGHC is well positioned in this regard, having hired a senior management team and administrative staff with strong backgrounds in the health care industry. Its board of directors includes experts in health care management alongside consumer representatives. CGHC also got an early start by partnering with firms with expertise in actuarial, benefits, and legal matters when developing its loan application, and these entities continue to provide assistance.[4]

Second, co-ops like CGHC face formidable barriers to market entry (Gray 2011). They will be up against well-established, large national insurers to offer products that are competitive on price and quality. In addition, the ACA's prohibition on using federal loan money for marketing purposes may place cooperatives at a disadvantage relative to established insurers. This requires co-ops to be creative in devising ways to get information on its products out to potential members. For CGHC, this might include using foundation money for marketing purposes and contracting with existing insurance brokers to sell its products. The co-op might also find Common Ground member organizations, and the small businesses and individuals that the health care team has contacted in the past three years, to make up an important source of its initial enrollment.

Adverse selection poses a significant challenge to the co-op's survival, though the ACA might diminish this threat somewhat. The ACA requires that two-thirds of co-op insurance policies be written for the small businesses and individuals, which could mean the enrollment of people who had previously been shut out of the insurance market because of preexisting medical conditions. If CGHC fails to attract enough healthy members to pool risks with sicker enrollees, it could go bankrupt.[5] However, the ACA contains important provisions to mitigate this danger. The individual mandate should bring healthier members into the exchange, and presumably the co-op will benefit from this. The law's provisions for modified community rating and risk-adjusted

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payments among insurers in the exchanges should also moderate premiums differences among insurance companies and compensate the co-op if it enrolls less healthy members. Moreover, the bulk of the federal loan money that CGHC received must go into its reserves to pay out insurance claims, which could tide the co-op over during its perilous formative period.

The co-op's size will also be critical to its success in negotiating contracts with large, established provider systems. One estimate is that insurers need 500,000 members to exert such leverage (Pear and Harris 2009; Weisman 2009), something that small startups like CGHC may not possess. But the ACA prohibits some forms of collaboration among co-ops that could undermine their market power relative to providers. While coops may form "private councils" with each other to purchase and share claims processing and administrative services, the ACA bars them from coordinating fee negotiations with providers in order to avoid running afoul of antitrust law (Gray 2011: 3). This ban rules out an "all-payer system" that would have given co-ops the ability to negotiate lower uniform fee schedules with providers.

Still, co-ops like CGHC may be able to collaborate with providers to promote affordable quality care. Providers are consolidating into integrated delivery systems (IDSs) to survive and bolster their marketing position relative to insurers (Devers et al. 2003). At the same time, IDSs and their use of electronic medical records are an opportunity for co-ops to negotiate new forms of coordinated care and reimbursement, such as accountable care organizations and medical homes, which could meet both cost and clinical effectiveness.

But if other insurers offer similar products, what might set co-ops apart from their rivals? In the end, cooperatives' distinctive rules and governance structure could prove critical competitive advantages. First, as a nonprofit, a co-op like CGHC must invest any surplus into the organization to improve benefits and health care delivery, or to lower premiums and expand enrollment. This means that unlike their for-profit rivals, co-ops are unencumbered by the need to distribute its profits to shareholders as dividends or pay exorbitant salaries to CEOs.[6] This gives co-ops like CGHC a longer time horizon in which to operate, particularly if it can enroll members for three years rather than one. The co-op model is one based mutual assistance, trust, and shared commitment. Such "social capital" (Putnam 2000) is lacking in faceless national insurers. Moreover, because it is member-owned and

governed, CGHC can offer clients transparency, accountability, and responsiveness that a national commercial insurer cannot. CGHC members will have a direct say on its strategic decisions through their presence on the board of directors, and will have access to its financial records. Since the co-op is "us" and not "them, it should be expected to tailor insurance products that meet the needs of small businesses and offer personalized service that a distant insurance carrier may not be able to provide.[7]

Most important, the co-op offers small firms and individuals the possibility of exerting genuine market power in the market for health insurance and health care for the first time. By banding together as a single insurance company, previously powerless individuals and small businesses may finally have the clout to negotiate competitive contracts with providers directly. There is no assurance that exchanges in and of themselves will provide this. To be sure, exchanges will structure the competition and set rules so that insurers will have to compete fairly and transparently for customers. But if those customers remain puny and atomized, insurers might still treat them with disdain. But if individuals and small firms become the insurance company-and become a large enough one-they will be able to free themselves from servitude to insurance middlemen and be a size that providers will have to reckon with.

Conclusion

Given their restrictive design under the ACA, co-operatives are unlikely to fundamentally transform the US health care system in ways that progressive forces had hoped. Nevertheless, co-ops could reshape the local or regional markets in which they will operate. If successful, they will empower small businesses and individuals and offer them democratic, responsive health care experiences. For these groups too long disdained by commercial insurers, this would represent meaningful, positive change.

Notes:

[1] The author is a member of the Common Ground health care team and previously served on the board of directors of CGHC.

[2] A filibuster allows unlimited debate on a bill on the Senate floor, unless at least 60 senators move to end debate and take a vote on a bill.

Democratic leaders in the Senate did not believe they had the requisite supermajority to overcome such a filibuster.

[3] Common Ground failed to secure letters of support from politicians of either party to include with its loan application for the co-op. Staffers of Democratic Congresswoman Gwen Moore, Senator Herb Kohl, and state Senator Jon Richards met with Common Ground and expressed their support for the co-op, but Republican Senator Ron Johnson, Representatives Paul Ryan and Jim Sensenbrenner, and state Senator Leah Vukmir rebuffed requests by Common Ground for meetings in 2011.

[4] These included Milliman, Benefits Services Group, Quarles and Brady law firm, and assistance and advice from the National Association of State Health Co-Ops (NASHCO).

[5] According to expert testimony before the Consumer Operated and Oriented Health Plans advisory board and from a consultant who assisted Senate staff in drafting the ACA, an insurer needs 25,000 members or 5% of the market to effectively counter adverse selection (Gray 20 II: 6, 8, n. I 7; Pear and Harris 2009; Weisman 2009).

[6] Most for-profit insurers spend only 80% or 85% of premiums on direct medical care, with the rest going to administrative costs, marketing, and salaries (Reid 2009, 20 I 0: 37). Bob Connolly, CGHC's president, admits that the CEO will be paid a competitive salary, but says it will be below the $50 million remuneration typical ofCEOs offor-profit insurers (Jagler, 2012: 21).

[7] CGHC CEO Cathy Mahaffey notes that most small employers do not have the resources to create their own health promotion and prevention programs for their workers, but that the co-op could involve its members in decisions on benefits designs that meet their particular needs (Jagler 2012: 22).

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