

CRITICAL ISSUES IN HEALTH REFORM

Health Insurance Cooperatives

October 2009

AMERICAN ACADEMY of ACTUARIES



As the debate surrounding health care reform continues, the concept of a health insurance cooperative (or series of cooperatives) has been proposed. Similar to a public plan option, it is crucial that a level playing field be established between the co-op(s) and private plans in order to mitigate the potential for adverse selection.

As the debate surrounding health care reform continues, the concept of a health insurance cooperative (or series of cooperatives) has been proposed. In general these cooperatives would be non-profit and membership-directed. Similar to a public plan option, the American Academy of Actuaries neither advocates for nor opposes the concept of a health insurance cooperative (co-op). Nevertheless, if a co-op is included, there are certain issues that need to be considered.

There are three potential models for such co-operatives:

1. A co-op that acts as a purchasing cooperative, sponsoring one or more insurers. Examples of this type of co-op include the Connector model in Massachusetts¹ and the Connecticut Business and Industry Association purchasing cooperative;
2. A co-op that acts as an insurer, providing its own administration and contracting its own network. Alternatively, it could act as a marketing organization and contract out these services;
3. A co-op that is based on a captive network,² such as the provider-owned plans that were prevalent in the 1990s, or the Group Health Cooperative in Seattle, which is often cited as an example of a successful co-op.

Proponents of a co-op model suggest that it could lower health insurance premiums, which could be achieved if a co-op has a lower

cost structure (i.e., administrative costs or claims management) than existing insurers or if the co-op is not subject to the same rules as insurers (e.g., exemption from regulation or access to favorable pricing). The existence of competing benefit plan designs or regulatory models in the same market has the potential for destabilizing the entire market by creating an environment that encourages adverse selection on the part of consumers who choose the most favorable alternative from among differently situated insurers.

Similar to a public plan option, it is crucial that a level playing field be established between the co-op(s) and private plans in order to mitigate the potential for adverse selection. Regardless of which method is used, there are other issues that must be considered: capital requirements, administrative costs, provider rates, state mandates, state assessments and taxes, and regulatory authority.

To mitigate adverse selection all plan options must operate under the same rules.

Implementing the same issue and rating rules, as well as benefit package requirements, for all health plans would help mitigate inequities regarding adverse selection among plans. Adverse selection, which can be exacerbated by certain rules, occurs when individuals with high health spending choose those plans that best align with their health care needs. Guar-

ADDITIONAL RESOURCES

Public Plan Option

http://www.actuary.org/pdf/health/public_plans_june09.pdf

Administrative Expenses

http://www.actuary.org/pdf/health/admin_expenses_sept09.pdf

Minimum Loss Ratios

http://www.actuary.org/pdf/health/loss_july09.pdf

Market Reform Principles

http://www.actuary.org/pdf/health/market_reform_may09.pdf

¹ The Connector is an independent agency that facilitates the purchase of insurance via a central website. The Connector was created when the Massachusetts health care reform act was passed in 2006.

² In a captive model, an HMO typically forms a large multi-specialty group of physicians that then provides services to the HMO membership.



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anteed issue and prohibiting premium variations by health status can be advantageous to higher-risk individuals, while underwriting and premium variations by health status can be more advantageous to lower-risk individuals. If underwriting and premium variation by health status were permitted in the co-ops, but not other private plans, lower-risk individuals would move to the co-op, resulting in lower average costs relative to other private plans.

Similarly, if the benefit package requirements differ between the co-ops and other private plans, individuals will be attracted to the plan that offers the benefits most advantageous for their personal medical needs. For example, higher-risk individuals may opt for more generous plans and those plans with the most comprehensive network. Alternatively, lower-risk individuals may prefer less comprehensive coverage or a more limited provider network. Holding plans to the same issue and rating rules, as well as benefits and premium-subsidy requirements, would help ensure that competition is based on efficiencies and quality of care.

To provide consumers with protection against plan insolvency, co-ops would need to be subject to the same capital requirements as insurers.

Since state regulations and solvency standards reflect experience with the costs of doing health insurance business, risk-based capital (RBC) regulatory requirements may provide a basic measure of the capital needs for stable

health insurance entities. Health insurers are subject to minimum RBC requirements—that is a risk-based measure of capital (an excess of viable assets over liabilities)—as developed by the National Association of Insurance Commissioners (NAIC). This capital is often referred to as “surplus” or “contingency reserves” for not-for-profit insurers.

To protect their policyholders, the rules governing solvency standards for co-ops should include requirements that are similar to the minimum requirements established for health RBC. In order to be licensed to write business, a company needs minimum capital of 200 percent of the NAIC RBC formula (which is equivalent to 8 percent to 10 percent of anticipated annual premium). To avoid regulatory intervention and to operate a financially sound health insurer, many prudent companies aim at carrying 500 percent to 1000 percent of the RBC formula. Some states apply their own standards. New York, for instance, requires minimum capital of 25 percent of premiums. In order to maintain a constant capital level, companies must earn a margin of between 1 percent and 6 percent of premium every year.

Non-profit status may or may not lead to lower premiums.

Proponents of a co-op model suggest that by eliminating the profit element from health insurance, co-ops could reduce rates. Many insurance companies in the market are already not-for-profit,³ so eliminating profit

The American Academy of Actuaries is a professional association with over 16,000 members. The Academy’s mission is to assist policymakers by providing leadership, objective expertise and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice and professionalism standards for actuaries in the United States.

³ Alliance for Advancing Nonprofit Health Care. *Basic Facts and Figures: Nonprofit Health Plans*.

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will not necessarily reduce rates. To the extent that co-ops are subject to current capital requirements, they will need to generate contributions to surplus in order to service and replenish their capital base. According to PricewaterhouseCoopers, the average profit margin for health insurers is 3 percent.⁴ As such the amount of premium reduction attributable to “profit” may be overstated.

The type of co-op will determine its ability to lower premiums through negotiated provider rates.

Since the most significant component of premiums is medical costs, a co-op will have to reduce medical costs if it wants to reduce premiums significantly.

In Model 1 the co-op acts as a purchasing cooperative and does not assume any risk for the insurance operations. The co-op could try to negotiate with several insurers on premium rates to be offered to groups/individuals within the co-op; however, there is little evidence that these types of co-ops would have success negotiating lower premium rates from the various insurers without some form of government intervention. If the co-op has a relatively small membership and the same insurers are able to participate in the small group and individual market outside a co-op environment, then there would be few incentives for insurers to offer lower premium rates to a co-op (other than possibly to reflect lower distribution costs through the co-op⁵).

In Model 2, the co-op is an insurer and is responsible for administrative functions such as marketing, enrollment, billing, policy

issue, etc. The co-op would also need to be able to offer a provider network—its own network or one rented from another insurer.⁶ If the latter, the co-op would be subject to the same provider reimbursement levels that the insurer has negotiated for all of their other policyholders. For a co-op to offer lower premium rates, it would either have to negotiate its own lower reimbursement rates or sponsor an insurer network that is not offered outside the co-op.

Co-ops may also be based on provider groups (Model 3) such as the Group Health Cooperative in Washington. These models are generally considered staff model HMOs⁷ or group model HMOs⁸ and are risk-assuming entities. These co-ops would need to ensure that they have providers representing the various mix of specialties required and/or have agreements with non-affiliated providers to meet the needs of their members. There is evidence that a staff model HMO could deliver care at lower premiums than other types of insurance. However, currently the public as a whole has resisted forfeiting the ability to access providers that are outside the HMO. In addition, there may be many geographic areas where the limited availability of medical providers makes setting up this type of model impractical or impossible.

Co-ops and insurers would have similar administrative expenses.

If implemented, the basic administrative functions for a co-op would likely be similar to those of a private not-for-profit or for-profit insurance company.⁹ These functions would still need to be performed by the co-op or

⁴ PricewaterhouseCoopers, *The Factors Fueling Rising Health Care Costs 2008*, December 2008. <http://www.ahip.org/content/default.aspx?docid=25123>

⁵ “Distribution costs” in this context refers to the costs associated with marketing and enrolling members and groups in insurance programs. Distribution costs include but are not limited to commissions, advertisement, salaried sales representatives, etc.

⁶ Many large self-insured groups, health plans, and third party administrators rent networks from existing insurance companies. The term “rented” means that these groups, or in this case the co-op, would have access to the discounts that an existing insurance company has already negotiated. The insurance company will rent this access to self-insured entities for a fee.

⁷ In a staff model HMO, physicians are generally salaried and treat only HMO patients/beneficiaries.

⁸ In a group model HMO, an HMO could form a multi-specialty group to provide services to its patients. Alternatively, the HMO could contract with an existing group to provide those services to its patients.

⁹ For a more complete discussion of administrative expenses, please see the American Academy of Actuaries’ *Critical Issues in Health Reform: Administrative Expenses* (http://www.actuary.org/pdf/health/admin_expenses_sept09.pdf).

its administrator. The larger the co-op, the broader the population over which it can spread the administrative costs. However, it is unclear whether these administrative services could be provided at lower costs for co-ops relative to insurance companies that may already enjoy economies of scale.

If a co-op operates within an insurance exchange or connector, the incentive for the co-op to provide individual marketing (through an agent or broker) may be eliminated or reduced. However, this does not eliminate the need for a mechanism to distribute insurance to consumers. The reduction in marketing costs could mean lower premiums for insureds. However, the experience in Massachusetts indicates that distribution costs through the Connector are comparable to the costs associated with brokerage distribution. This indicates that any type of mechanism would need to incur distribution expenses, whether through brokers or other channels.

Various legislative proposals would allow for distribution via “navigators” that would replace brokers. One example of this type of model is the Massachusetts Connector, which has incurred similar marketing costs as its pre-reform external market. Another model is the small group health insurance purchasing cooperative (HIPCC) created in California in the mid 1990s. This co-op initially varied premium rates depending on whether an agent/broker was used. However, it subsequently dropped this two-tiered approach because the vast majority of small employers were relying on agents to help them with health care purchasing decisions and explain the various options available to their employees. Unless these proposed navigators are subsidized from an outside source that is independent of premium, it is unlikely that the cost of distribution via a navigator would be significantly less than cost associated with the use of brokers in the current market.

If state requirements do not apply equally to co-ops and insured plans, certain plans will be disadvantaged.

States place a variety of additional requirements on private health plans, and these would need to also apply to a co-op for the playing field to remain level. For example, many states assess health plans to fund high-risk mechanisms, uncompensated care pools, graduate medical education, state insurance departments, regulatory activities, and guarantee funds. If the co-op is regulated in a way that it is not subject to state premium taxes, licenses, fees and assessments, the co-op may not have to pay fees/assessments of 2 percent to 5 percent of premiums in many states.¹⁰ This would give them a premium advantage, but reduce income for the state or fund.

Additionally, the co-op may or may not be subject to state and federal income taxes on net income. To the extent that a co-op is exempt, it would receive an advantage relative to other insurers of about 1 percent to 3 percent of premiums. However, as the co-op grows this exemption could create a significant revenue problem for state (and to a lesser degree federal) treasuries.

States also require a variety of non-benefit requirements on health plans, including consumer protections, market conduct examinations and financial reporting of audit and actuarial certification requirements. For consumers to receive the same level of protection, these requirements would need to apply to all participating health plans and co-ops.

Regulatory requirements and oversight should be the same for co-ops and insurers in order for consumers to have the same protections under both models.

To have a level playing field, co-ops acting in the same capacity as insurers would need to have the same regulatory requirements and oversight as insurers (both state and federal). They would need to be subject to

¹⁰ U.S. General Accounting Office (now the U.S. Government Accountability Office). *Varying State Requirements Affect Cost of Insurance*. August 1996. <http://www.gao.gov/archive/1996/he96161.pdf>.

the same reporting requirements, market conduct reviews, and be accountable to the state commissioner of insurance. Without these requirements, ambiguity in regulatory oversight could exist. Such ambiguity in regulatory authority can result in the absence of all oversight. This was the case for multiple employer trusts (METs) in the 1970s and multiple employer welfare associations (MEWAs) in the 1990s, which resulted in many of these entities becoming insolvent and some consumer claims going unpaid. Even for those self-funded MEWAs that were solvent, the ambiguity of regulatory authority resulted in consumers/members having little recourse in the event of claim or coverage disputes. This uncertainty should be avoided to ensure that consumers receive appropriate regulatory protections.