

# Nonprofit Health Co-ops:

## *Designed to Compete for the Public Good*

by Rick Cohen

Although shackled by the competition of large, well-established insurance companies, the unexpected provision for early renewal of policies not in accordance with ACA standards, and the prohibition on using federal funds for the purpose of marketing, nonprofit health co-ops are doing surprisingly well.

IT DIDN'T EXIST UNTIL A FEW YEARS AGO, BUT THE consumer-owned nonprofit health insurer Kentucky Health Cooperative sold as much as 75 percent of the private insurance policies purchased during the state's health exchange's first year of operations under the newly implemented Affordable Care Act (ACA). (Massive commercial provider Anthem Blue Cross and Blue Shield sold just 12 percent of its policies on the exchange.)<sup>1</sup> Nonprofit cooperatives reporting robust sales also include Maine Community Health Options and New Mexico Health Connections. Others did not fare so well. But, launched to compete with such mammoth insurance companies as UnitedHealthcare, WellPoint, Humana, Aetna, Cigna, and the abovementioned Blue Cross and Blue

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Shield (to name just a few), what all these brand-new entities share is the David versus Goliath challenge that they represent. They are not only small and untested but also structured as consumer-owned nonprofit cooperatives—and, if that weren't enough of a competitive challenge, they inhabit a market that includes large insurers that, in many states, have in the past operated in near monopolistic fashion.<sup>2</sup>

The as yet untold story is that, for all of the obvious competitive challenges facing these nonprofit start-ups, they had to overcome unexpected obstacles in the ACA federal legislation and regulations that seemed all but designed to minimize the cooperatives' chances of success. Some, like Kentucky's, succeeded—at least in ACA year one—despite those obstacles, and their strategies for overcoming them constitute a textbook of creative nonprofit approaches to competitive hurdles.

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### Origins of Nonprofit CO-OPs in the ACA

One of the core functions of the Affordable Care Act was to create competition for the big health insurers and, through that competition, compel them to improve their services and lower their costs. The intended mechanism was the “public option”—a health-insurance plan that would have been offered by the federal government, challenging the near-monopoly insurance environments in some states by providing an alternative operated and funded by government.

Although the public option was meant to be insurance, not government-provided healthcare, the idea caused a commotion among political

conservatives. Fearing that this was the slippery slope to surreptitiously transforming the American healthcare system into something more like the UK's or Canada's, Republicans organized to ensure that a public option was excluded from the legislation, abetted by President Obama's lukewarm support for a government-funded insurer.

As the public option collapsed, health reform advocates in Congress scrambled to come up with some mechanism that could effectively create competition for the big insurance companies. Kent Conrad, the Democratic senator from North Dakota at the time, stepped into the breach and suggested the creation of consumer-owned health insurance cooperatives that would provide an “affordable, accountable, transparent alternative to private insurance.”<sup>3</sup> Would nonprofit health insurance cooperatives be able to provide sufficient and effective competition for the big private insurers? Would the very limited number of existing models of reasonably successful and sustainable health insurance cooperatives (notably, the Group Health Cooperative in Seattle, established in the late 1940s, and Minnesota's HealthPartners, dating from the late 1950s) be replicable in the context of the new health insurance law?

As Consumers Union's Chuck Bell told the *Nonprofit Quarterly*, the consumer cooperatives were not meant to be “a robust substitute for the public option.”<sup>4</sup> Nonetheless, in the absence of the public option, the cooperatives that emerge from the Affordable Care Act—established as the Consumer Operated and Oriented Plan (CO-OP) Program—to offer insurance on the individual and small-group markets could become the official ACA mechanism for calling out the big insurers and providing alternatives that consumers might want. In the words of Jesse Thomas, CEO of InHealth Mutual Ohio, in an interview with *NPQ*, “the CO-OPs [as they became known] were [supposed to be] *an* alternative to the public option, but we have become *the* alternative to the public option.”

The ACA's provisions for nonprofit cooperatives (Section 1322) were a tiny part of the law—taking up only six pages of the one-thousand-page (condensed version) legislation.<sup>5</sup> The law

authorized the creation of nonprofit health cooperatives that could begin selling insurance in 2014. CO-OPs could apply for low-interest start-up and solvency loans—the latter to help the new entities meet state insurance reserve requirements. Previously licensed insurers or new entities that received a quarter or more of their funding from licensed insurers could not become CO-OPs and access the federal loan funds. CO-OPs were prohibited, unlike other nonprofit insurers like Blue Cross and Blue Shield, from ever converting from nonprofit to for-profit status.

For the new cooperatives willing to enter the fray and do battle against the Anthems and Humanas of the industry, those were the rules—and they could craft strategies to try to function in this arena, just like nonprofits do within the framework of any other industry governed by federal regulations, except in this case, the “long knives” and “poison pills” (as characterized by Conrad<sup>6</sup>) of ACA opponents served to make an onerous challenge appear next to impossible. In Congress, former Nebraska senator (and former insurance company lawyer) Ben Nelson opposed the idea of there being start-up grants, instead of (or in addition to) loans for the CO-OPs, and supported sharp restrictions on what the CO-OPs might be able to do with their loan funds and which markets they might enter. Critics of the CO-OPs deemed the loan funds “a gift, a federal handout.”<sup>7</sup> The nation’s “fiscal cliff” deal in 2013 further hit the CO-OPs by halting loans to any cooperatives that hadn’t already been approved for their funding—freezing the funding for cooperatives in twenty-four states and ruling out plans that might have been in the works for cooperatives in any other states.<sup>8</sup>

How could the Kentucky Health Cooperative and other CO-OPs possibly function, compete, and survive—and deliver improved health insurance coverage to consumers—in this environment hostile to the Affordable Care Act, beset with numerous well-publicized problems plaguing the operation of the federal and some state health insurance exchanges, and unsupportive of new, nonprofit entrants challenging the commercial health insurers? Some did—a few even thrived—by adopting a panoply of strategies that nonprofits

use to compete against much-better-capitalized organizations. Their stories about what worked well, what perhaps worked less well, and what the future portends follow.

### Coming from Different Starting Points

The diversity of the nonprofit health insurance cooperatives’ origins is remarkable. Consumers Mutual Insurance of Michigan’s CEO Dennis Litos explained that his CO-OP emerged from discussions by county health plan providers concerned about the number of uninsured and underserved consumers. Colorado HealthOP, run by Julia Hutchins, emerged from the Rocky Mountain Farmers Union, representing small family farmers and ranchers; RMFU saw the CO-OP provisions of the ACA as a program to which “they felt like they had something to offer.” According to CEO Janie Miller, the Kentucky Health Cooperative was developed by a coalition of businesses and healthcare providers. HealthyCT, reported CEO Ken Lalime, was created by two large doctors associations in Connecticut. Oregon’s came from the state’s largest Medicaid plan.

So many of the stories sound like fairly typical nonprofit start-ups, except, of course, that they were responding to the opportunity provided by a massive structural change in the financing and content of health insurance in the United States. The cooperative serving Nebraska and Iowa, CoOpportunity Health, as recounted by then COO (now CEO) Cliff Gold, started “with three of us who didn’t know each other: Dave Lyons—the common thread—former insurance commissioner for Iowa and then head of economic development [who later became the CEO of CoOpportunity but has since stepped down]; Steve Ringlee, a venture capitalist; and me, a senior executive at Wellmark Blue Cross and Blue Shield. Dave put us all together, we began talking about starting a co-op, and we decided to put in an application.”

A number of people involved in these ventures came with health insurance experience: Cynthia Jay, CMO of Health Republic Insurance of New Jersey, had been the executive director of a health literacy coalition; InHealth Mutual Ohio’s vice

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president of community relations, Jen Patterson, used to work on housing and homelessness issues at the Columbus Housing Partnership; and Kentucky's Miller, who was also the state's former insurance commissioner, had dealt with the issue of health insurance coverage "from all sides." They also came with health insurance frustrations and critiques. Miller, for instance, told *NPQ*, "I think the country is better off [as a result of the ACA]. How can we as a country ever understand our costs and quality unless you have everyone with access and coverage and then hold providers and insurers accountable?" She described the reason for joining the Kentucky Health Cooperative as a "lifelong passion for getting coverage and access for people."

Former primary care provider Martin Hickey also said that he had seen the issue from multiple perspectives. One of the founders of New Mexico Health Connections (and friend and fellow physician of Hickey's) called to ask if he wanted to "come home" and attend one of their organizing meetings. Hickey admitted to *NPQ* that initially he "wasn't sure that the concept [of a nonprofit health insurance cooperative] was going to fly [because] everyone and their mother are starting health plans now"—but in the end he did come home to join the cause, and became the organization's CEO. Like Miller, the mission drove him. "I've been a primary-care provider. I've lived on every side of the equation, and I know how the money works. It's an unregulated system of infinite demand, and it will never stop until there are incentives to purchase wisely." Hickey described New Mexico as a "perfect place" to test the idea of a new way of providing health insurance coverage to people in need.

The notion of incentivizing people to protect their health and to purchase health services wisely is consistent throughout the plans. For instance, Colorado HealthOP consumers qualify for debit cards if they follow some useful preventative health steps, and CoOpportunity Health offers hundred-dollar gift cards for customers completing online health assessments.

### The Big Work-Around: Marketing

When a typical corporation seeks start-up capital, the funds are not quite as constrained as they were

in the case of the CO-OPs. Federal regulations prohibited the CO-OPs from using federal funds for the purpose of marketing. It may be difficult to imagine, but new entities without brand identities or histories of delivering insurance products were not allowed to use their federal start-up funds to market. According to Litos of Michigan's Consumers Mutual, "We had these funds for education, but we couldn't talk about products and prices. [But] the brand is the product, so how do you do this?"

In almost every instance, the cooperatives chose the route of educating consumers—not about their products, which they couldn't do, but about healthcare, health insurance, and the Affordable Care Act itself. In many cases, it was with and through partners, particularly nonprofit ones. Consumers Mutual accessed the patients being served by federally qualified health centers and developed mailings about the ins and outs of the ACA, which, according to Litos, ensured that "our name was getting out there." Many of the cooperatives turned to the tried-and-true techniques of nonprofit outreach and marketing, working with other nonprofits at the community level (in Colorado), with the federally qualified health centers and local advocacy groups, and, according to Hutchins, "anyone who was talking about healthcare, to make sure we were part of that conversation."

In other cases, the cooperatives sought non-federal money to fund their marketing. Hutchins reported that the Colorado CO-OP got marketing funds from a health foundation. New Mexico's Hickey explained, "We couldn't market a specific plan to an individual, but we borrowed \$500,000 for a pamphlet that did concept marketing. People liked the fact that we were New Mexicans—a New Mexican health plan built by New Mexicans. No one trusted the health plans but they did trust doctors, so we just informed the public that we're physician-led, we're not corporate, and the money stays in New Mexico."

Borrowing for an entirely new organization requires, on the part of the lender, an appetite for risk. Consider that the cooperatives, while armed with business plans developed by experts in the field, were operating in a policy environment of exceptional turbulence—with the Affordable Care

Act facing an unending series of congressional votes to end the program and implementation problems highlighted by the federal government's troubled rollout of the federal health exchange website. Anticipating revenues that could be pledged against loans for marketing purposes in this environment meant that lenders might have to have as much belief in the cooperatives' missions as the cooperatives themselves.

Gold of CoOpportunity described the prohibition on using government funds for marketing as the "biggest poison pill" the CO-OPs faced—not just because they couldn't guarantee revenues that could be used to pay back loans but also because government loans were their only asset. But, according to Gold, in the case of the health-care cooperative serving Nebraska and Iowa, the Iowa credit union league gave CoOpportunity money for a feasibility study followed by a \$650,000 unsecured loan for marketing and education. CEO Kevin Lewis of Maine Community Health Options was able to get a \$300,000 grant specifically for marketing from the Maine Health Access Foundation, a vote of confidence that led to a \$500,000 grant from Coastal Enterprises, a Wiscasset-based community development financial institution (CDFI) that invested in the CO-OP based on the strength of its business plan—notwithstanding its inability to use its federal moneys for repayment.

In the end, as Gold noted, the marketing prohibition "was a huge hurdle that existed between the Affordable Care Act and the cooperatives, promoted by the health insurers to keep their advantage over the cooperatives." Gold may be speaking from the perspective of a hard-pressed CO-OP trying to get off the ground, but the restriction makes no sense other than as a means of limiting what the cooperatives can do to get started. Just as they cannot use the federal money for marketing, the CO-OPs are also prohibited from using any of the federal money for lobbying—even if the lobbying were simply to make some of the regulations on cooperatives less onerous.

Going forward, while the cooperatives may not be able to do much in the way of lobbying, it would seem logical that nonprofit healthcare

advocates step up their game to promote a more rational regulatory framework for the use of government dollars by the cooperatives.

## Changing the Rules of the Game Midstream

It was a thunderous, business-plan-altering shock for the cooperatives to hear President Obama's unexpected announcement that people with existing insurance plans would be allowed to keep those plans, even if the plans were not compliant with ACA standards. The cooperatives' business plans all contained the assumption that some portion of consumers with existing plans would be in the market for new insurance coverage in order to meet the ACA's requirements.

"We don't whine or bellyache about it—we determine how we pivot and turn on the dime in response to the challenges," said Thomas of InHealth Mutual Ohio. As he described it, when the administration announced that "if you like your policy, you can keep it . . . our universe literally shrank from 800,000 eligible small businesses down to 80,000." Maine's Lewis noted that many people "early renewed" at the president's announcement, taking a substantial amount of potential business "off the table." It probably doesn't need to be pointed out that the beneficiaries of the early renewals of ACA noncompliant policies were often the big insurance companies with which the cooperatives were competing.

Making midstream business-plan modifications in the critical first year of ACA operations was hardly optimal for the cooperatives. Litos noted that the early renewals of noncompliant policies "required us to move into the small-group market," but that there were pricing and other competitive issues to address. For HealthyCT, the off-exchange small-group market didn't materialize to the degree that they had hoped, perhaps due in part to the aggressiveness of existing insurers pushing for early renewals and in part because of the tendency of many people to stick to the policies they have—even if of demonstrably higher cost and lower quality than others in the marketplace.

The president's surprise pronouncement sent a mixed message that caught the CO-OPs by surprise and limited their ability to recover during the first year of the ACA. HealthyCT's Lalime said

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that the CO-OP is still “plugging away” at this end of the market. “The early renewal piece, I’m not going to whine about it,” Lalime said. “It is the marketplace.” Unfortunately, in this case it was the marketplace twisted by an early, unthinking commitment of the president’s, who then had to live up to the statement due to political pressures even though the decision was bad for consumers (with plans not in compliance with the ACA), bad for the cooperatives (unable to market to tens of thousands of potential customers), and good only for the big insurers (who got to hold on to most of that segment of the market).

### Avoiding Excessive Fixed-Cost Investments

With a constantly shifting environment and threats on every front, the smarter cooperatives chose wherever possible to avoid sinking their assets into building in-house functions. Rather, they outsourced a number of activities, which meant an upfront cost savings and, given the time constraints of getting ready to sell products on the state exchanges by October of 2013, increased the speed of operations.

For some, as in Michigan, it meant working with existing networks of insurance agents that were not associated with or owned by Blue Cross and Blue Shield. In working with the agents who were looking for better products for their customers, Litos explained, they built a network of agents capable of reaching areas where the competition might not be marketing quite as much—such as, for example, in the largely rural Upper Peninsula of Michigan. Litos reported that because the agents were looking for products that would be particularly beneficial to their customers, he and his colleagues had learned from their outside brokers that the CO-OP’s plans for its extensive chronic disease program would be a “game changer” or “tipping point.” Not investing in in-house brokers and agents but instead using existing networks gave CO-OPs like Consumers Mutual access to off-exchange customers they might not have reached otherwise and to new product ideas that were not being picked up by the competition. As the CO-OPs start to edge into large-group policies—particularly as the definition of “small group” gets changed from

fifty to one hundred members—the CO-OPs are linking up with existing networks. HealthyCT, for example, linked up with The Alliance for Non-Profit Growth and Opportunity (TANGO), representing some four hundred nonprofit groups that constitute a new network of brokers and sales for the CO-OP.

Several interviewees noted that, as new entries in the marketplace, the health insurance cooperatives were not bogged down by having to maintain and operate “legacy” systems and a built-up infrastructure that wasn’t up to the market’s demand for flexibility and speed. Apologizing for sounding very “co-op-y,” Colorado’s Hutchins sees the long-term competitive need for CO-OPs like hers to be nimble and accountable. She wants consumers and members to have a “wow experience” when they are on the CO-OP’s web portal. In New Mexico, Hickey’s CO-OP has outsourced member services so that members who call get a person, not a recording, as well as the time they need to get help with any problems. For Hickey this may be a cost savings, but it is part of a CO-OP’s strategy of incorporating empathy for the consumer.

Ohio, too, “vended out” customer service, according to InHealth Mutual’s Thomas, and also recruited a network of more than 1,300 general brokers and agents to sell InHealth Mutual’s products, rather than investing in the cost of creating an in-house cadre of agents. CoOpportunity Health’s Gold said that the CO-OP outsourced its claims processing and provider oversight, and, like others, had decided to work with independent brokers and agents rather than hiring their own.

CoOpportunity Health, having its origins in Iowa, did exceptionally well in rural Nebraska, in part because of the independent brokers’ access to rural areas—much like other cooperatives servicing rural markets, such as Michigan’s and Maine’s. And one of the untold stories of the cooperatives may be that their most significant areas of success, like their forebears among rural electric cooperatives and agricultural cooperatives, have been their reach into rural America, whose access to health provision and health insurance historically has been limited.



## Odd and Sundry Competitive Challenges

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services approved two health insurance cooperatives for Oregon, the only instance of two CO-OPs in a single state: Oregon's Health CO-OP and Health Republic Insurance of Oregon—an affiliate of Health Republic Insurance of New York. Created by New York's Freelancers Union (which since 1995 has advocated for health insurance for independent workers), Health Republic Insurance of New York (which helped establish cooperative health insurers in New York, and New Jersey, as well) apparently aimed to provide insurance to Oregon's "creative class." According to Ralph Prows, CEO of Oregon's Health CO-OP, different business plans and target markets aside, the reality of the market constraints meant that the two cooperatives ended up competing head to head.

The competition was compounded by another problem: the state health insurance exchange, Cover Oregon, had, in Prows's words, "mega-failed." Oregon was one of the state exchange disasters that left consumers confused and angry. In the midst of trying to launch the exchange, the state government also attempted a complete overhaul of the structure and delivery of state Medicaid, with the result that everyone was pretty much overwhelmed by the complexity and chaos of the system. For Oregon's Health CO-OP, that meant having to switch from enrolling customers on the exchange to going off-exchange and doing direct enrollments and broker enrollments. In addition, consumers were faced with an eighty-two-page list of plans that they had to scroll through before finding one they might want to purchase. The result was a very low enrollment in the first year—not aided by the non-cooperative competitors trying to underprice the CO-OP.

Prows may be battered from how Cover Oregon did in healthcare reform in the first year of the ACA, but he doesn't seem dismayed. "I am inspired by the mission that we have, by the democratization that we have," he said, pointing to a board that has a majority of members elected by the consumers. "People are so engaged in the movement; people really want this." (Prows also

noted that the biggest private sector competitor in the state, which had enrolled the largest number of purchasers, had just spent \$40 million on rebranding a new sports arena, and that it was also asking for a 12 percent increase in the prices of its policies on the market—the implication being that this may have been causally related.)

And then there is the issue of structure. Those non-cooperative competitors are large corporate players structured as nonprofits. HealthyCT's Lalime noted that one of his cooperative's major competitors in the state (Connecticut) is Harvard Pilgrim, which is nominally a nonprofit. Many of the Blue Cross and Blue Shield entities are structured as nonprofits, too. For a nonprofit CO-OP, that means distinguishing how these large corporate players operate in the market (notwithstanding their nonprofit tax status) versus how a consumer-oriented, consumer- and provider-run cooperative operates.

Despite what often seems to have been a life-and-death political scrum over the Affordable Care Act in Congress, there was little indication that political bias was a huge competitive problem for cooperatives at the state level. New Jersey, however, did not have a state exchange, and there were some problems. Health Republic's Jay reported that the governor, Chris Christie, returned ACA education funds that the state had received back to the federal government. In addition, New Jersey didn't end up with many healthcare navigators, who played such an important role in other states in helping consumers understand how the state and federal exchanges work. The lack of those consumer guides may have helped hamper progress for New Jersey's cooperative simply because the cadre of grassroots organizations explaining and promoting the ACA wasn't quite up to snuff.

The political imbalance in New Jersey could also be seen differently. The existing insurers, some of them fifty or sixty years old, had longstanding relationships with the state insurance departments, and knew the ins and outs of what the states might look for and accept in licensing applications. For the new CO-OPs (except perhaps those like Kentucky's, where the CEO happened to be the former state insurance

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Essentially, long-term political and business dynamics between the large insurers and the state regulators meant that frequently the CO-OPs had to deal with competitors who had better inside information than they did about the likely decisions emanating from state agencies.

commissioner), it often felt like being behind the eight ball: a second slower than the big competition in knowing what the insurance departments were going to require and decide. Essentially, long-term political and business dynamics between the large insurers and the state regulators meant that frequently the CO-OPs had to deal with competitors who had better inside information than they did about the likely decisions emanating from state agencies. For some CO-OPs, it meant delayed approvals—some almost to the start of the October 2013 beginning of the ACA sign-up period—with several cooperatives unable to offer as many different policies as their big corporate competitors.

Some of the cooperatives have, however, gone beyond the Affordable Care Act to provide services that the ACA didn't call for (and that, perhaps, it should have). If consumers have frequent problems with health insurance, they probably have similar if not worse problems with dental care coverage. The ACA only included pediatric dental care as a requirement for ACA-qualified health plans for individual and small-group plans on and off the exchanges. Although the ACA excluded dental care for adults as a mandatory component of ACA-qualified insurance plans outside of Medicaid, Maine's CO-OP, according to CEO Lewis, created a partnership with Northeast Delta Dental to put oral health coverage into its plans.

### The CO-OPs' Mission and Nonprofit DNA

InHealth Mutual Ohio's Patterson made an observation about the core competitive advantage that the nonprofit CO-OPs used to their benefit in dealing with their competitive challenges. Of course, they had to deal with their positions in the health insurance marketplace from a business perspective, but InHealth Ohio, like the others, drew strength and competitive juice from their missions. Patterson explained that it was in the organization's "DNA to increase access to care." That mission commitment, superseding business concerns, turns into a competitive advantage for the CO-OPs if they remember and capitalize on it. "We kind of feel like we're in a space to ourselves," Patterson said—in part because she and

her colleagues spent much of their start-up time traveling around Ohio having conversations with communities "about what the insurance sector as a whole is missing."

Similarly, InHealth Ohio's Thomas said that the cooperative aimed to "make sure that we don't get wrapped around the axle around any one thing that takes our focus off from what our core commitment is . . . access, innovation, and competition." Barbara Freeman, InHealth Mutual Ohio's chief doctor, homed in on how their nonprofit consumer-oriented model was responding to what they were hearing from people on the ground. She pointed out that most insurance companies are narrowing their networks of providers, so InHealth Mutual is generating a "wide open network . . . [that] exceeds the requirements of what we were supposed to do." Freeman described InHealth's efforts to get supplies and products to consumers so that they could manage their health issues, including a "bronze" plan that offers two free office visits for primary health treatment and two free behavioral health visits, and noted that eliminating co-pays on a number of products for diabetes, asthma, and depression means that people covered by InHealth will never have to say, "I couldn't get my medicine because I couldn't afford it." Added Thomas, "It's listening to the public, creating incentives rather than disincentives [for effective patient management of their healthcare needs]. We are going to remove as many roadblocks as we can to critical access and improvement." Listening to the public—if the cooperatives are really listening—means responding differently in different environments.

Take Oregon's Health CO-OP, for instance. Prows reported that Oregonians directed the CO-OP to value what *they* valued in health care—and, to his surprise, that included support for "naturopathic" doctors and treatments. "This came up in every single session. I was compelled because of our mission to explore this." Prows, a physician himself, did not come from the naturopathic model, but upon learning that the naturopaths were licensed to provide primary care medical treatment, he concluded, "If they're licensed by the state to do this, why wouldn't I bring them on as primary

providers?" Simply put, "They wanted providers that speak to them and promote wellness on their terms." Consequently, the CO-OP credentialed over one hundred naturopathic physicians. "My orientation has shifted from a paternalistic health plan viewpoint," Prows concluded. "Now we have to listen to what people really want rather than what we think they want."

For Prows, that also meant simplicity. As he explained, consumers complained that under other providers "they would never know what their actual expense would look like. Consumers wanted us to simplify this so that they would know their actual costs." As a result, the Oregon CO-OP "got rid of coinsurance," which Prows described as a "mystery" for consumers, so that "members know exactly what it is going to cost [and] can make logical choices knowing what their costs will have to be." The simplification of health insurance is a consistent theme running through nearly all of the CO-OPs in terms of what they heard from potential purchasers.

In Colorado, the local issue was different. "Early on, we were asked by a number of nonprofit consumer advocacy groups about covering care for transgendered persons," Hutchins recalled. "Our board took a position of nondiscrimination in healthcare. We support what's medically necessary."

For Kentucky's Miller, the competitive theory is simple: "Treat the customers as well as you can, provide value for them, and help them understand why investing in themselves is so important." That simple theory led to a little nonprofit like Kentucky Health Cooperative's capturing three-fourths of the state's market—and since then being awarded access to West Virginia, as well. "We've hit a chord there," Miller modestly observed. It's a matter, she said, of "talking about why the CO-OPs were created and what value [they] bring to the insurance industry." New Mexico's Hickey saw it from another angle. Implicitly acknowledging that most people don't like dealing with health insurance, don't like thinking about it, and get confused by the offerings, Hickey said that the New Mexico frame on the various health plans could be described as "we suck less." But, given the problem of getting

people to change plans, even if there are cost-based reasons for doing so, "the differentiator would then be service."

Hickey's strategy in New Mexico is brazen. "Our model is to disrupt the wasted volume incentives, arm the primary care providers with information about quality, and let them make the referrals—because as primaries they take better care of their patients," he explained. "We have no co-pays on patients' chronic and behavioral meds. Keeping people on their meds will reduce unnecessary hospital visits and unnecessary hospital procedures, so it's clear where the money is to be saved." He added, "Our business model is like Robin Hood's: take it from the hospitals and take it from some of the overzealous specialists and return the savings to the providers and the members."

### Looking to the Future

Despite their modest expectations and, in some cases, modest results, the CO-OPs have had an outsized impact on the markets. The big providers are, of course, still ruining the competition from these relatively tiny start-ups, and suggesting that, as newcomers, their operations may not be sustainable. Our inquiries to a number of the CO-OPs' large, established competitors yielded the following statement sent in by Aetna spokesperson Cynthia Michener, who elected not to be interviewed:

A robust, competitive health care marketplace operating on a level playing field is necessary to assure that consumers receive improved quality, lowered costs, and the best value. New players like co-ops can be part of a fair and vibrant marketplace. However, it is critical for consumer protection and market stability that regulators take care that the special financial terms and assistance the ACA awarded to co-ops do not inadvertently lead to solvency vulnerabilities or to distorted pricing.

Nothing in the statement is inaccurate at face value, but it doesn't address the restrictions placed on the nonprofit health insurance cooperatives that made the marketplace in which they operated feel less than "fair and vibrant." Moreover, there is little question that while the CO-OPs tried to wring every

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The reality is that the big providers saw the pricing and products being offered by the cooperatives and in many cases adjusted theirs downward, sometimes to levels of “predatory pricing” ...

last dollar of cost out of the pricing that was offered to consumers, in several instances they found themselves facing distorted pricing practices from the large insurers themselves.

But there is no question that in many states the CO-OPs—to the advantage of the consumer but in some ways to the disadvantage of their own competitiveness—have had an impact on their competitors’ behavior. The reality is that the big providers saw the pricing and products being offered by the cooperatives and in many cases adjusted theirs downward, sometimes to levels of “predatory pricing,” as described by New Mexico’s Hickey—causing the state insurance commissioner to question their actuarial soundness and require all of the competitors on the state exchange to resubmit their plans and prices. Some state insurance commissioners, regardless of political party, were on the job in watching the pricing and products that were being offered—and, in fact, the interviewees from the cooperatives had generally positive things to say about the state insurance commissioners. Nevertheless, predatory pricing does seem to have seeped in and undercut the ability of some cooperatives to offer competitive rates.

If the role of the CO-OPs was to offer not just competitive pricing but also competitive quality in order to compel the large insurers to change, that happened too. Television advertisements by the likes of Humana abound, touting the simplicity and clarity of their offerings or promising consumers that they will not have to wait on hold for an eternity to speak over the phone with insurance company representatives. The large insurers are more than aware of commitments like the Health Republic of New Jersey’s, which, according to Jay, reports that a customer’s “call wait time is only fifteen seconds, 90 percent of problems [are] resolved on the first call, [and] the average time of the call is around five to six minutes.” Responsiveness to the customer becomes a competitive yardstick that the large insurers must try to meet—as they should—else they become even more unpopular with consumers than they already are.

In the end, all the cooperatives contacted by NPQ—those with strong performances as well as those that teetered in the first year—saw themselves as part of a grand effort to produce a

change in American healthcare that hasn’t been seen since the advent of Medicaid and Medicare, in 1965. As New Mexico’s Hickey said, “I am very grateful to the taxpayers for funding this experiment if it can inch us that much closer to a rational healthcare system.” The results of this experiment may well have surprised the White House, which was less than enthusiastic about the public option and not particularly assiduous in its support of the nonprofit health insurance cooperatives. Hickey believes that the administration didn’t expect to receive more than a handful of CO-OP applications at the outset, having agreed to the CO-OPs simply in order to placate the public option advocates, and was probably surprised by the more than two dozen that arrived in the first wave.

For all of the chaos and turbulence of the rollout of the Affordable Care Act—plus all of the obstacles that made the first year’s operations of the nonprofit cooperatives that much more difficult to pursue—the interviewees basically chose to follow the path of InHealth Mutual Ohio’s Freeman. “I’m not going to sit here and bad-mouth the Affordable Care Act,” Freeman declared—a position she acknowledges that her political party (Republican) tends not to support. “In my heart, I know that we have an underserved population . . . a population that could not get insurance because of adverse selection,” she explained. “The Affordable Care Act affords an opportunity for access to care . . . [and] the cooperatives were given a commission that allows them to create a competitive market for insurance companies and, most of all, to improve the quality of care that is provided.” Her summation is a powerful statement on behalf of the CO-OPs overall:

Our approach is not to focus on the barriers in the Affordable Care Act that give us problems, but to focus on solutions. You don’t do off-the-shelf products and off-the-shelf filings, but you create something specific to the needs of a defined population and make it specific to the individual. You take the cases one by one and deal with the barriers that the individuals have. You partner with the community, and you don’t drop the ball.

Thinking back to when she was in practice with her father and nicknamed “Little Doc,” Freeman

concluded, “Let’s get back to what medicine used to be.”

Health Republic Insurance of New Jersey’s CEO Jim Martin seemed moved by a telephone conference call for the CO-OPs in September of 2013, right before the opening of the ACA marketplace, arranged by CMS. Martin described how, on the call, President Obama “made reference to the fact that . . . this was clearly an historic moment and an historic time.” In that light, an evaluation of the cost reductions, improved care, and innovation that the CO-OPs are supposed to bring to the health insurance marketplace won’t be anytime soon. The year 2017 was most often quoted by the cooperatives as the right time to assess whether the cooperatives have been successful. As Martin concluded, “It’s a marathon, not a sprint.”

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Nonprofits may want to look at how the nonprofit health insurance cooperatives addressed and overcame the competitive obstacles confronting them, and reaffirm the competitive prowess that is in their missions and nonprofit DNA. If nonprofits go back to what nonprofits used to be—connected to communities, committed to serving people in need, and highlighting those distinctive roles and functions—they may discover that they can overcome many of the hurdles placed in their way by the corporate sector and governmental entities overly influenced by corporate lobbyists. By combining the services they deliver—for instance, to families and communities that are marginalized and mishandled by corporations in their commodification of social goods—nonprofits could deliver superior products and, by virtue of their track records, advocate for improved public policies that will redress inequities like the problems of health insurance coverage in the United States.

Hutchins concluded her interview with *NPQ* with the statement, “The CO-OPs are much more willing to bet on the success of healthcare reform [than are the large insurers with which they are competing],” many of which were reluctant about the national health insurance reform at best. Indeed, believing in the Affordable Care Act and wanting to see it succeed may very well turn out

to be the nonprofit health insurance cooperatives’ ultimate competitive tool.

## NOTES

1. To put this in perspective, the Robert Wood Johnson Foundation found that, just prior to the official start-up of the Affordable Care Act exchanges at the federal and state level, a sole insurer had sold more than half of the individually purchased health insurance policies in thirty states. See Rick Cohen, “Six Changes for Nonprofits as Results of the Affordable Care Act,” *NPQ*, April 3, 2014, [nonprofitquarterly.org/policy-social-context/23951-six-changes-for-nonprofits-as-results-of-the-affordable-care-act.html](http://nonprofitquarterly.org/policy-social-context/23951-six-changes-for-nonprofits-as-results-of-the-affordable-care-act.html), for more details.
2. Christine Vestal, “New Health Exchanges Unlikely to End Insurance Monopolies in Some States,” *Stateline*, April 25, 2013, [www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/04/25/new-health-exchanges-unlikely-to-end-insurance-monopolies-in-some-states](http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/04/25/new-health-exchanges-unlikely-to-end-insurance-monopolies-in-some-states).
3. Chuck Haga, “Wakefield, Conrad Talk Health Care,” *Grand Forks Herald*, July 2, 2009.
4. Cohen, “The Affordable Care Act, Three Years Later: Where Do Nonprofits Stand?,” *NPQ*, April 4, 2013, [nonprofitquarterly.org/policy-social-context/22077-the-affordable-care-act-three-years-later-where-do-nonprofits-stand.html](http://nonprofitquarterly.org/policy-social-context/22077-the-affordable-care-act-three-years-later-where-do-nonprofits-stand.html).
5. Office of the Legislative Counsel, *Compilation of Patient Protection and Affordable Care Act*, 111th Congress, 2d session (Washington, DC, May 2010).
6. Cohen, “Nonprofit Co-ops’ Role in Affordable Care Act in Trouble,” *NPQ*, October 28, 2013, [nonprofitquarterly.org/policy-social-context/23145-nonprofit-co-ops-role-in-affordable-care-act-in-trouble.html](http://nonprofitquarterly.org/policy-social-context/23145-nonprofit-co-ops-role-in-affordable-care-act-in-trouble.html).
7. Jerry Markon, “Health Co-ops, Created to Foster Competition and Lower Insurance Costs, Are Facing Danger,” *Washington Post*, October 22, 2013.
8. Cohen, “While You Were Sleeping, Fiscal Cliff Deal Whacked ‘Obamacare’ Nonprofit Co-ops,” *NPQ*, January 7, 2013, [nonprofitquarterly.org/policy-social-context/21586-while-you-were-sleeping-fiscal-cliff-deal-whacked-obamacare-nonprofit-co-ops.html](http://nonprofitquarterly.org/policy-social-context/21586-while-you-were-sleeping-fiscal-cliff-deal-whacked-obamacare-nonprofit-co-ops.html).

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