Backgrounder

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Health Insurance Co-ops: How Congress Could Adopt the Right Design

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It is becoming increasingly clear that the congressional creation of a public health plan to "compete" with private health insurance plans is a roadblock to serious, bipartisan reform of the American health care system. Such a plan would likely result in the massive erosion of private health insurance options for individuals and families, restricting personal choice and competition.

All attempts at federal health reform inevitably end in a search for a compromise that will be passed by the U.S. Senate. The current efforts are no exception. Recently, Senator Kent Conrad (D–ND) suggested that maybe some form of "consumer cooperative" might be a politically acceptable alternative to the "competing public plan."[1]

It is important to clarify exactly what is being proposed and exactly how it would work.

A Familiar Concept. As Senator Conrad and others have noted, cooperatives—often called "co-ops"—have a long and rich history. Farmers established co-ops in order to market and distribute their produce, workers in some industries organized financial co-ops called "credit unions," and when the term "co-op" is used in New York City, the speaker most likely means an apartment building collectively owned by its residents.

Defined by Merriam-Webster as "an enterprise or organization owned and operated for the benefit of those using its services," the cooperative is also long-standing and widespread in the insurance sector, where it is known as a "mutual" insurance company.

Talking Points

- If structured correctly, consumer-owned cooperative, or mutual, health insurers could increase consumer control and choice in health insurance.
- Member-owned mutual health insurers would return any profits or surplus to their policyholder-owners in the form of lower premiums or enhanced coverage benefits.
- In any design for cooperative health insurers, Congress must avoid including any provisions that give those organizations special subsidies, financial guarantees, or regulations that limit true member ownership, or disadvantage competing insurers in the marketplace.
- Congress can amend tax law to authorize non-profit, member-owned cooperative health insurers based on applying the successful model of non-profit, member-owned cooperative credit unions. Hundreds of existing philanthropic health care foundations with billions of dollars in assets could provide any start-up funding needed for new cooperative health insurers.
- Existing non-profit health insurers could convert to member-owned mutual insurers and still remain tax-exempt.

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Thus, such large well-known companies as Mutual of Omaha or Northwestern Mutual Life, are, in fact, cooperatives. There are also successful, smaller niche-market mutual insurers, such as Church Mutual, which offers lines of property, casualty, and liability coverage for member religious institutions, or Jewelers Mutual, which offers similar coverage lines for members engaged in making or selling jewelry.

If Congress were to adopt such an approach, it would have to ensure that the co-op was a genuine competitor in the insurance market, not another government-sponsored enterprise (GSE) designed to undercut choice and competition. Moreover, as with any other entity in the marketplace, it would need to compete on a level playing field with no special advantages, including special taxpayer subsidies or government financial guarantees.

How Health Insurance Co-ops Might Work

In any field, there are two key features that distinguish "co-ops" from alternative arrangements designed to perform the same function:

1. **Co-ops are "consumer-owned."** This is also why co-ops are often referred to—somewhat redundantly—as "consumer cooperatives." One characteristic of a co-op is that its customers are its owners, and its owners are its principal customers. For example, a credit union operates like a bank, but offers banking services only to its member-shareholders. Non-members cannot open a savings or checking account or obtain a loan from a credit union. In the case of a dairy cooperative, the purpose might seem to be selling milk to the public, but what it really does is provide marketing and distribution services for its members—dairy farmers—who are also its owners. After all, there are any number of other arrangements and middlemen who could buy the milk from farmers, and then package and distribute it to retail stores. The difference with the cooperative is that the farmer-owners provide that service to themselves through the co-op.
2. **Co-ops limit the ability of members to exercise their ownership rights individually.** A member of a co-op cannot, individually, sell or transfer his or her ownership rights to a non-member. Thus, while someone who owns a condominium can sell his unit at any time to anyone, in a co-op building, the co-op board must approve the sale. The reason is that in the co-op, the member does not actually own the specific unit in which he lives. Rather, he owns a share in the cooperative that owns the entire building. In the same manner, a shareholder in a credit union has essentially the same ownership and governance rights as the shareholder in a stockholder-owned bank. But the shareholder in a credit union cannot sell his shares to a non-member. The credit union can be sold, say to a commercial bank, only as a whole and only by vote of its membership.

In the case of health insurance markets, there are two areas where the co-op model could conceivably be applied.

The first is with respect to entities that might organize the buying and selling of health insurance, such as employer purchasing groups or state health insurance exchanges. The second is applying the cooperative concept to one or more of the insurers selling coverage in the market.

Neither of these concepts is novel. Existing and previous multi-employer health insurance purchasing arrangements have usually been established under the auspices of a business association. The Cleveland Council of Smaller Enterprises and the Lubbock Chamber of Commerce, to name two examples, currently sponsor such arrangements. Doing the same through a special-purpose, member-owned cooperative wouldn't be that different. Similarly, when it comes to insurance companies, the very definition of a "mutual" insurance company is an insurance company that is organized as a cooperative with its policyholders as the owners.

Cooperative Purchasing Arrangements. The cooperative approach is certainly one, but not the only, reasonable and plausible model for health insurance purchasing groups or state health insurance exchanges. Basically, those entities provide

1. Ezra Klein, "Has Kent Conrad Solved the Public Plan Problem? An Interview," *The Washington Post*, June 11, 2009, at *http://voices.washingtonpost.com/ezra-klein/2009/06/has_kent_conrad_solved_the_pub.html* (June 22, 2009).

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standardized administrative and human resource services for participating businesses. While the administrative tasks involved in offering each employee the choice of, say, 15 different health plans at an annual open enrollment season is beyond the capabilities of the 10-employee auto repair business, it is quite feasible to standardize those functions through a single entity for not only that employer, but for hundreds of others as well. Organizing such an entity as a cooperative owned by its customers would be quite similar to the way agricultural cooperatives work.

In the case of a state health insurance exchange, a state government could decide that it wants to give all businesses in the state the option to offer health insurance coverage though an arrangement under which each employee is free to choose the coverage he or she prefers from a menu of competing plans. Of course, making that work will require some kind of administrative mechanism to handle tasks such as: employers electing to participate; offering all the participating individuals a menu of price and coverage information on the competing plans; the process for workers making individual plan choices; and transferring payments from different employers and workers to the various insurers based on who picked which plan.

In the case of Massachusetts, which authorized this new kind of health insurance coverage option as part of its 2006 reform law, the state created an independent entity called the Commonwealth Health Insurance Connector to perform those administrative tasks, along with other responsibilities. In contrast, Utah enacted reforms this year authorizing the creation of a similar coverage option for employers and their workers, but the state is implementing a decentralized design that will form contracts with private vendors to provide the necessary administrative services.

These are by no means the only approaches. Yet another state pursuing the same coverage option, could, for instance, charter a member-owned cooperative entity to perform the necessary administrative functions—in short, a co-op solution.

None of this requires federal action, nor does it seem to be what Senator Conrad has suggested. Rather, and somewhat more interestingly, the Senator appears to be suggesting that health insurers who are organized as cooperatives and competing against other types of insurers—on the same terms and under the same rules—could be an alternative to the liberal proposal of a government-sponsored "competing public plan."

Cooperative Health Insurers. In essence, what Senator Conrad seems to be proposing is the authorization of health insurers that are member-owned mutual insurance companies. That suggestion is intriguing for two reasons—one political, and one that relates to the market.

The political aspect is the possibility that the option to buy health insurance from a member-owned mutual insurer could give lawmakers a way to address voter interest in more options and more consumer control when it comes to health insurance.

From the market perspective, the idea is intriguing because while member-owned mutual insurers are a longstanding feature in most other insurance markets, they are not found in today's health insurance market. Instead, current health insurers are organized either as stockholder-owned companies, or as non-profits (operated, at least in part and at least in theory, charitably, and beyond simply selling health insurance). Even the Group Health Cooperative of Puget Sound, cited by Senator Conrad as an example of a cooperative insurer, is actually organized as a non-profit, the same as a charity, and is not, in fact, a mutual insurer. The one difference between Group Health Cooperative and other non-profit health insurers, such as Kaiser Permanente, is that Group Health Cooperative includes in its bylaws provisions allowing policyholders to apply to become members and then grants those "members" voting rights on certain governance issues, such as the election of directors. However, Group Health Cooperative's policyholders do not have ownership rights in the company as in the way the policyholder owners of, say, Northwestern Mutual Life.

Of course, while the idea of member-owned mutual health insurers might be intriguing from both a political and market perspective, as with so much in health policy, the devil is in the details.

A Level Playing Field. To begin, any health insurer that is subject to any special government

control or receives any type of special government subsidy or financial guarantee would not be a truly "private" entity, nor in most such designs would it be truly "member-owned," regardless of what Congress chooses to call it.[2] In order to be a true "cooperative," or mutual insurer, the entity would have to be subject to the same insurance regulations as other health insurers, be independent and self-governing, and not benefit from any direct taxpayer subsidies or financial guarantees. Of course, like any other health insurer, they could still indirectly benefit from, say, a government program that subsidizes low-income individuals to help them buy coverage.

If those conditions are not met, then any proposed "co-op plan" simply becomes an unacceptable exercise in attempting to disguise the true nature of a government-controlled or -funded "public plan."

That said, assuming that those conditions apply, there does exist room for good-faith efforts to try to make the option of member-owned mutual insurance companies offering health care coverage available to consumers.

So, the question then becomes, what, if anything, might Congress do to make the mutual insurer option available in health insurance markets? Given that mutual insurers already exist, and that they are regulated like other insurers by state insurance departments, there does not appear to be any need to modify existing laws in the areas of either corporate form and governance or insurance regulation.

The one change that Congress might explore is the possibility of granting an exemption from corporate income taxes to mutual insurers offering health insurance. In other words, Congress could consider authorizing *non-profit* mutual insurers.

Under current tax law, in order for a health plan to qualify as "non-profit," it must meet the "community benefit" test along with the requirement that "no part of its net earnings inures to the benefit of any private shareholder or individual."[3] Those are the same tests applied in granting tax-exempt status to any other type of charitable organization. However, those restrictions also effectively make it impossible for a non-profit health insurer to be a true policyholder-owned mutual insurer without losing its tax-exempt status in the process.

Indeed, the structure of Group Health Cooperative of Puget Sound seems to be about as far as a non-profit health insurer can go under current law in providing for some limited "member governance" of a non-profit organization without crossing the line into "member ownership" and triggering the loss of its tax-exempt status.

That said, the tax code does provide precedents for Congress granting tax-exempt status to certain truly member-owned cooperative entities, such as "mutual or cooperative" telephone or electric companies.[4] The most directly relevant and comparable precedent is the tax-exempt status explicitly granted to member-owned credit unions.[5]

Credit unions are able to retain their tax-exempt status by distributing any "profits" or "surpluses" to their members in the form of dividends, lower interest rates charged on loans, or expenditures to improve the services offered to their members—and may do so in any combination. Each credit union is also free to make those decisions in accordance with the specific self-governance provisions adopted in its articles of incorporation or bylaws. So, one credit union might specify that whether to distribute a surplus to its members in the form of increased interest rates on deposits versus decreased interest rates on loans requires a shareholder vote, while

2. For example, Senator Charles Schumer (D–NY), a supporter of a public plan, offered principles for co-ops that would result in a federally run public plan in all but name. He states that a co-op must be national in scope, must secure significant federal start-up funding, and must be run by federal officials appointed by the President. See Anna Edney, "Baucus Expects CBO Score by Monday," *National Journal*, June 11, 2009.
3. 26 U.S. Code § 501(c)3. The same standards are also applied to Blue Cross and Blue Shield health plans in 26 U.S. Code § 833.
4. 26 U.S. Code § 501(c)13.
5. 26 U.S. Code § 501(c)14(A).

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another credit union may delegate such decisions to its board, and yet another credit union might delegate those decisions to management.

How Tax Changes Can Make True Co-ops Available

It is possible for Congress to create a legal framework that authorizes the creation of non-profit mutual insurers in the health insurance sector. Furthermore, the explicit granting of tax-exempt status to credit unions offers both a relevant precedent and a good model for how that might be accomplished. However, the central issue involves changes to tax law—not changes to insurance law or incorporation law, both of which already contain long-standing, well-established provisions governing mutual insurance companies.

That said, the possibility of amending the tax code to allow for non-profit mutual health insurers does raise a number of key issues:

1. **Should a tax-exemption for mutual health insurers be conditioned on meeting unique requirements with respect to how they conduct their business?**

   The answer is no. In order to have a well-functioning insurance market, all competitors must be subject to the same set of insurance (i.e., business practice) regulations, regardless of any other differences among them in tax status or corporate form. Questions about what, if any, changes should be made to existing insurance law, and whether those changes should be made at the state or federal level, are entirely separate and independent issues. Furthermore, if there are to be any such changes, they must be applied equally to all competing plans. Judging by his public comments, Senator Conrad seems to understand and accept this principle; his colleagues should as well.[6]

2. **Would combining tax-exemption with mutual status create an unacceptable, or even significant, market imbalance between tax-exempt mutual insurers and for-profit stockholder competitors?**

   This is an important question and one likely to engender debate, but there are some good reasons to think that the answer is no. While some argue that the avoidance of corporate taxation gives existing non-profit health insurers an inherent advantage over for-profit competitors, what is often overlooked is that their non-profit status also imposes countervailing competitive disadvantages on those organizations. The most significant disadvantage is lack of access to capital markets—which is particularly relevant if the entities in question offer financial services, such as insurance.

   The cheapest and easiest way for a stock company to raise capital is through stock offerings, either by public or private placement. While issuing more stock initially dilutes the ownership interest of existing shareholders, if the funds raised are put to good use, the shareholders will benefit from subsequent growth in the company's profits.

   However, that option is not available to non-profits or mutual companies because it is not possible under their ownership structures. The same would hold true for a non-profit mutual insurer.

   It was this inherent limitation on access to capital markets that in the recent past led some mutual insurers who offer other lines of coverage to convert themselves into for-profit, stockholder-owned companies. That process is called "demutualization." A prominent example was the demutualization of the Prudential Life Insurance Company in 2001. A crucial aspect of that demutualization process was that Prudential's policyholders' existing ownership rights in the company were monetized in the form of being converted into shares of stock in the new, stockholder-owned incarnation of the company. Once that change took effect, those policyholders were free to sell their stock on the stock

6. "These cooperative entities would provide their contracts through the exchange just like everyone else, be subject to the same rules as everyone else, in terms of reserve requirements, in terms of what kind of contracts they could offer." Senator Kent Conrad as quoted in Ezra Klein, "Has Kent Conrad Solved the Public Plan Problem? An Interview."

exchange or to enter into private transactions to sell or give their shares to others.

The inherent limitation on access to capital markets also helps to explain why for-profit, stockholder-owned health insurers have successfully competed for years against their non-profit rivals.

However, this does raise the next important question that will need to be addressed in the design.

3. **What limits should be placed on the ability of such tax-exempt mutual health insurers to retain earnings on a tax-free basis in order to organically fund growth through acquisitions or capacity build-outs?**

   Almost certainly, some allowance will need to be made in order to give non-profit mutual companies the ability to accumulate some discretionary capital for expansion purposes. However, if the allowance is too generous, it could tip the competitive balance described earlier decisively in favor of the non-profit mutual companies vis-à-vis both their for-profit and traditional non-profit competitors.

   A good solution would be to include in the provisions that grant tax-exempt status to mutual health insurers some reasonable limits on their ability to accumulate capital on a tax-free basis. For example, the statute could specify that the organization could accumulate capital tax-free in order to meet its working capital needs (defined, say, as a maximum allowable percentage of the premium income it received) and to fund reserves against claims as required by insurer solvency laws.

   Congress could then allow further tax-free accumulations up to a set ratio of minimum reserve requirements. That way, the company would not be penalized if it acted prudently by setting aside larger reserves than the minimum required by law. Beyond that, any further capital accumulation would be taxed annually at a low rate, for example, 1 or 2 percent, applied to the total excess balance. The idea is to allow the organization to accumulate reasonable excess capital to fund future growth plans while simultaneously giving it incentives to be practical and concrete about any such plans and act on them expeditiously by imposing a "carrying charge" on any excess funds it holds.

   This approach is similar to existing requirements that a charitable trust disburse a minimum percentage of its assets each year, or that an IRA beneficiary over age 74 withdraw each year a minimum percentage of the IRA balance and add that amount to his or her taxable income. These kinds of provisions are designed to limit the accumulation and preservation of tax-free income beyond the amounts and timeframes that are reasonable for effecting the purpose for which the assets or income was granted a tax-exemption.

4. **How could Congress ensure that tax-exempt mutual health insurers do not deviate from their intended purpose?**

   Once again, there is a well-established tax law precedent that can be applied to keep tax-exempt organizations properly focused. Tax-exempt organizations are subject to the "unrelated business income" (UBI) tax on any income they receive from operating businesses that are not related to their tax-exempt purpose. Thus, in authorizing tax-exempt mutual health insurers, Congress could specify that offering major medical health insurance to its members would be the only tax-exempt activity. Any other coverage offerings or business activities would be subject to the UBI tax, though Congress should consider whether UBI tax provisions need to be further modified to ensure that income from other lines of coverage is appropriately taxed. That way, if say, an existing non-profit health insurer that also offers supplemental coverage, such as Medigap or dental plans, decided to convert to mutual status, it could still offer those other policies, but its income from them would be subject to normal taxation.

5. **Might there be some new benefits from introducing this concept into the existing market?**

   Indeed, there would be some added benefits. A mutual health insurer would be able to offer "policyholder-owned" as a clear, easily understood differentiation in the marketplace and

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would likely attract some segment of customers on the appeal of that proposition alone. The practical significance is that those policyholder-owners could ensure that any profits or surpluses are returned to them in the form of either lower premiums or enhanced coverage—just as credit unions distribute surpluses to their members in the form or either higher interest rates paid on deposits or lower interest rates charged on loans.

For anyone who complains that existing for-profit and non-profit insurers are too self-interested, make too high a profit, or spend too much on administrative overhead, the option of obtaining coverage through a non-profit mutual insurer offers a practical and personal solution. With policyholder-owners controlling the company, the incentives will be to find ways to lower costs while also expanding coverage and benefits. Furthermore, those policyholder-owners are not likely to favor cost control strategies that mainly rely on denying claims or limiting access to providers. What they will want to see is that their premiums are kept in check, but that they can still receive timely access to quality care. Thus, the managers they hire to run their company will need to work with—not against—health care providers to find ways to deliver better value to their company's policyholder-owners. That result would be a very positive, pro-consumer development and any demonstrated successes of cooperative mutual health insurers would also generate indirect pressure on competing insurers with different corporate structures (whether for-profit or non-profit) to adopt more "consumer-friendly" business practices.

6. **Should existing health insurers be permitted to convert to the new non-profit mutual structure?**

There are some good arguments in favor of an answer of yes. First, capital considerations, provider-contracting considerations, and capacity build-out considerations all mean that conversions by existing insurers will be, by far, the fastest way for the new model to enter the market—in terms of scale as well as geographic coverage. In contrast, start-ups inherently face a long, slow path to achieving any significant scale or geographic dispersion. Indeed, building sales channels, constructing back-office billing and claims-processing operations, negotiating provider contracts, marketing a new company with new products, and so on, all require significant time, even with adequate start-up capital.

The second point is given that the most promising path would be conversion to mutual status by existing insurers, the insurers most likely to pursue that conversion path are the existing non-profit ones.

In the case of for-profit carriers, the major obstacle to conversion would not be the mutual aspect (that is, moving from stockholder-owned to policyholder-owned), but the significant change in corporate culture entailed in moving from for-profit to non-profit status.

In contrast, in the case of existing non-profit insurers, the conversion would mainly involve a change in governance, with little initial change to existing business models or corporate culture, though the ownership change would likely produce the positive effect of an increasingly policyholder-focused corporate culture.

Furthermore, such conversions might well be attractive to existing non-profit health insurers for another reason: It would allow them to retain their non-profit status by meeting the "member benefit" test applied to credit unions instead of having to meet the "community benefit" test applied to charities. Given the increasing difficulty that non-profit health insurers face at both the federal and state levels in defending their current business practices under the "community benefit" test, they might find this new option quite attractive. Indeed, one implicit effect of federal or state lawmakers enacting health reform measures designed to cover the uninsured will be the further erosion of the few remaining justifications offered by non-profit health insurers for preserving their tax-exempt status as "charities" that provide "community benefit."

7. **While existing non-profit health insurers might be able to convert to cooperative mutual status, would not federal government "start-up" funding be necessary to create new ones**

in states where people believe there is a need for more health insurance competition?

The answer is no. Furthermore, there are very good reasons for Congress to avoid including any federal government "start-up" funding in a proposal to create cooperative, non-profit mutual health insurers. First, even start-up funding by the federal government would inevitably entail some level of federal government control—on the grounds that federal officials need to be "stewards" of the taxpayers' "investments." This is precisely what has occurred with the federal government's recent bailouts of the banking and auto industries. Second, once federal lawmakers have "invested" taxpayer dollars in a business, they have a natural incentive to ensure that their investment succeeds.

But a truly free market offers both the opportunity to succeed and the opportunity to fail. Thus, even if lawmakers could devise some kind of "arms-length" structure for providing start-up capital (a questionable "if"), the temptation would be for Congress to treat the recipient organizations as "too important to fail"—leading to later, further interventions on their behalf. Indeed, the health care delivery system is already distorted by these kinds of policies, most notably federal, state, and local regulations and subsidies designed to protect or prop up hospitals that are deemed too important to their communities to be allowed to fail—despite inefficiencies or substandard care.

More important, with the right policies, federal start-up funding would not be needed at all. There is currently more than enough private, philanthropic funding available to provide start-up grants for new cooperative insurers. A newly released report by Grantmakers in Health, for example, "identified 197 health foundations created in the wake of transactions involving the sale, merger, or transfer of assets of nonprofit health organizations," mostly hospitals and insurers.[7] In March, 155 of those organizations responded to a GIH survey: Of those, 146 reported the value of their assets as of December 2008. The assets reported by those 146 foundations ranged from "approximately $2.4 million to $3.5 billion."[8]

Indeed, those 146 health care foundations collectively hold more than $18.3 billion in assets. Not counted are the further 51 conversion foundations that either did not respond to the GIH survey or did not provide asset figures. In addition, there are numerous other foundations, both large and small, with a special focus on health care charitable giving that were not included in the GIH survey because their endowments were derived from sources other than the conversion of a previously non-profit health care organization. The Robert Wood Johnson Foundation, originally endowed by its namesake who created the Johnson & Johnson company, has long been a major funder of health care causes and lists in its 2008 annual report assets of $7.3 billion and disbursements of over $523 million in grants.[9]

Thus, there are likely tens of billions of dollars of health care philanthropy available to meet the start-up capital needs of new, cooperative health insurers. All that Congress needs to do to unlock that potential funding is to amend non-profit tax law to allow those foundations to make the necessary grants. The reason a tax-policy clarification is required is that current law prohibits those foundations from distributing their funds for the benefit of private shareholders or individuals—which could be interpreted as applying to grants made to member-owned cooperative health insurers.

Of course, it would also be possible for state governments to provide start-up funding for new health insurance cooperatives through special

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7. Grantmakers in Health, "A Profile of Foundations Created from Health Care Conversions," June 2009, at *http://www.gih.org/usr_doc/2009_Conversion_Report.pdf* (June 23, 2009).

8. *Ibid.*

9. *The Road to Reform*, Robert Wood Johnson Foundation, 2008 Annual Report, at *http://www.rwjf.org/files/publications/annual/2008/index.html* (June 23, 2009).

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purpose bond issues. While that does entail risks similar to the ones that would accompany federal start-up funding, those risks would be limited to only the state in question. In any event, given the substantial amount of available private philanthropic funding, state lawmakers should only consider such state funding as a fallback.

Finally, Congress could provide for proper oversight for the start-up of new cooperative mutual health insurers by asking the National Association of Insurance Commissioners (NAIC) to develop model rules for special supervision of start-up companies by state insurance departments. The model would specify standards and procedures to be applied by a state insurance department during the start-up phase of a new entity. Specifically, the state insurance department would ensure that initial capitalization funding was properly accounted for and that the entity was executing an appropriate plan to become a licensed insurer under the laws of the state, and to obtain tax-exempt status under federal law. Once the organization met all licensure standards and became a licensed insurer, the special rules and oversight would end. From that point on, the company would be subject to normal state insurance laws and regulations (both in that state and in any other in which it seeks to do business), the same as any other insurer.

Furthermore, it would only be necessary for one state to adopt these rules. Once that happened, new cooperatives could be incorporated in that state. Then, once a cooperative attained licensure in that state, it could apply for licensure in any other state under the existing laws of the states in which it seeks to do business.

Conclusion

The concept of a health insurance co-operative, if structured as a non-profit mutual insurer, is an intriguing one. However, the design issues that will need to be addressed are ones of tax policy—not of health care policy or insurance regulation.

Most important, the entire basis for lawmakers even pursuing further discussions of the cooperative insurer concept must rest on a firm agreement that the objective is to give consumers more options and control within the context of a "level playing field"—with all insurers subject to the same market rules.

Simply calling some form of government-sponsored enterprise a "cooperative" is worse than false advertising. Not only would a health insurance GSE tilt the market playing field and open the door to political manipulations—both of which would ultimately harm consumers—it would also create unjustifiable and unaffordable taxpayer exposure to financial risk.

As an object lesson, Congress need look no further than the experience of the mortgage market—at the GSEs Fannie Mae and Freddie Mac that it created. Decades of market distortions generated by their implicit government backing, compounded by the effects of repeated political meddling by Congress, put those GSEs at the very epicenter of the mortgage market collapse that triggered the current financial crisis and recession. Furthermore, that GSE approach has now saddled American taxpayers with hundreds of billions of dollars in liabilities for just Fannie and Freddie alone—not counting the additional costs of the follow-on effects that their market-distorting practices produced in the rest of the financial system.

Furthermore, subsidizing private cooperatives in health care directly, as the federal government has done with rural electric cooperatives since their inception in the 1930s, would create similar unjustifiable distortions and taxpayer risks.

In short, the idea of cooperative health insurers merits further discussion only if it is based on expanding consumer choice in a market that provides a true "level playing field."

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