Public Plan or Cooperative: Does it Make a Difference?

Timothy Stoltzfus Jost

Why Public Plan Choice?

- To drive cost control by controlling administrative costs, introducing plan competition, and bargaining with providers.
- To offer Americans a choice of insurers.
- To encourage delivery system reform.
- To bring transparency and accountability to health care financing and delivery.
- To provide a national strategy for a national problem.

Are cooperatives a reasonable alternative?

- Health care cooperatives existed in the 1930s and 1940s, encouraged by the Farm Security Administration. At one time they covered 600,000 Americans. They were small and unable to compete, and died out.
- The Blue Cross and Blue Shield plans began as community-service oriented, nonprofit plans. They lost their way, however, and have become indistinguishable from commercial insurers. Indeed, some of our nation's largest for-profit insurers are former Blue plans.

What can we learn from this history?

- A realistic strategy is needed to get cooperative plans off to a strong start. Senator Conrad's proposal has serious chicken and egg problems: boards will be elected by the members, but organizations will not be able to attract members until they get underway, which will take a board. The national board will be chosen by the state boards, but the state cooperatives will be established under national cooperative guidelines.
- Small, state-run cooperatives cannot compete and are destined to fail.
- If state-run cooperatives succeed, what is to keep them from becoming just like their commercial competitors, like the Blues did?
- State-run cooperatives are not a national solution for a national problem.

Is a cooperative a viable alternative to a public plan?

- Yes, but only if it is formed under Senator Conrad's second option, a national cooperative, independent and not run by the government, competing on a level playing field with private insurers, but under Congressional guidance.
- We need a national solution to a national problem, be it a public plan or a cooperative.

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Why Public Plan Choice?

One of the most significant and innovative proposals of the 2009 health-reform debate has been the concept of public plan choice. Although the exact features of a public plan have not been specified, the public plan concept offers several significant benefits:

Cost control. Health reform cannot happen unless we can control the continual upwards spiral of health care costs. The public plan would control costs in three ways. First, it would be able to keep its costs down by not having to make a profit and by avoiding many of the administrative costs incurred by private insurers. Second, it would introduce competition into the health insurance industry. Although there may be, as Karl Rove asserted yesterday, 1300 health insurers in the United States, health insurance markets are segmented into the large group, small group, and nongroup markets and within each of those categories competition is exceedingly local. In 36 states, 65% of the small group market is controlled by 3 insurers; in 16 states one insurer controls half of the market. In any one locality, moreover, the market is even more concentrated. In my home town of Harrisonburg, Va., one insurer controls 86% of the market. Private insurers simply do not compete; they simply take prices from providers and pass them on to consumers, driving the health care price spiral. A national public plan would introduce vigorous competition into every part of the country, forcing private insurers to compete for business and to bring down their premiums. Third, a national public plan would also have the bargaining clout to make providers moderate the increase in their prices, bringing down the cost of health care itself.

Choice. Right now the only choice available to most Americans is private insurance and, in many markets, small businesses have only a choice of one or two insurers. Americans want to have alternatives to choose among to best meet their needs. A public plan offers this.

Delivery System Reform. A national public plan could drive delivery system reform and improve the quality of care, as Medicare has been doing through its demonstration projects, payment reforms, and consumer information initiatives.

Transparency and Accountability. One of the most important developments in the health care reform debate over the past decade has been the data that has emerged from the Dartmouth research group on variations in health care spending. This data, discussed by Atul Gawande in his widely noted recent article on health care costs and the President in his speech at Green Bay, could only be collected because Medicare data are available to researchers. No comparable research can be done on the under 65 population because private insurers regard whatever data they have to be proprietary. Private insurers are also much more secretive about their coverage and utilization review policies. A public plan could make anonymized data available to researchers and be open with its subscribers about coverage and utilization policies.

***A National Strategy*.** We have waited for decades for the states to make affordable health care available to Americans. A few have tried, most have failed. None have developed an effective alternative to private insurance. All Americans are experiencing the same problems with health care–lack of access, high costs, and uneven quality. We need a national strategy for health care reform that will help all Americans, not just some. We also need a national public plan that offers uniform benefits to all Americans and national bargaining power.

Are Cooperatives a Reasonable Alternative?

First, a word about history. We have tried cooperatives before. During the 1930s and 1940s, the heyday of the cooperative movement in the United States, the Farm Security Administration encouraged the development of health cooperatives. At one point, 600,000 mainly low-income rural Americans belonged to health cooperatives. The movement failed. The cooperatives were small and undercapitalized. Physicians opposed the cooperative movement and boycotted cooperatives. When the FSA removed support in 1947, the movement collapsed. Only the Group Health Cooperative of Puget Sound survived. Over time, moreover, even Group Health, though nominally a cooperative, has become indistinguishable from commercial insurers–it underwrites based on health status, pays high executive salaries, and accumulates large surpluses rather than lower its rates.

The Blue Cross/Blue Shield movement, which also began in the 1930s, shared some of the characteristics of cooperatives. Although the Blue Cross plans were initiated and long-dominated by the hospitals and the Blue Shield plans by physicians, they did have a goal of community service. The plans were established under special state legislation independent from commercial plans. They were non-profit and, in many states, exempt from premium taxes. They were exempt from reserve requirements in some states because they were service-benefit rather than indemnity plans and because the hospitals and physicians stood behind the plans. They were exempt from federal income tax until the 1980s. In turn, they initially offered community-rated plans and offered services to the community, such as health fairs. In some states their premiums were regulated and they were generally regarded as the insurer of last resort for the individual market.

Over time, however, the Blues lost their focus on community service and began to look more and more like their competitors. They abandoned community rating (which, realistically, they could not maintain when faced with competition from experience-rated commercial plans) and began to impose underwriting and cost-sharing requirements indistinguishable from the private plans. Although providers lost control of the Blue plans, the plans never took a leadership role in bargaining aggressively with providers, despite their market dominance in many states. Many of the largest Blue plans became for-profit, and those that remain non-profit are largely indistinguishable from commercial insurers. Although the national Blue Cross/Blue Shield association offers some coordination services to local plans, it has not resisted the move of Blue plans away from a community-service toward a for-profit orientation. Lacking a national focus on public service, state and regional plans have become indistinguishable from their commercial competitors.

Blue plans are not the only non-profit insurers that survive. Many church and fraternal organizations have their own non-profit plans. Although these plans often try to serve their communities, they usually have a small presence and little bargaining power in most communities in which they operate; tend to insure individuals and small groups, the most costly market; are often the victims of adverse selection; usually underwrite much like commercial plans; and tend to offer low value, high cost-sharing policies. They are not a model on which to build national reform. Mutual insurers are also in theory owned by their members. They also, however, are indistinguishable from for-profit insurers in most states.

What can we learn from this history? First, health care cooperatives are, in fact, an American response to health care reform. Cooperatives and non-profit insurers were there before for-profit commercial insurers entered the health insurance business, and we could try to revive the idea again.

But why would state or locally-run cooperatives be any more successful now than they were when we tried them before?

First, it is hard to imagine how they would get underway. Capitalization and critical size were problems before and would likely be problems again. Senator Conrad's recent draft suggests that members of the coops would elect their boards, and that the coops would then obtain state licensure as mutual insurers, meeting state standards for solvency and reinsurance (with the help of federal seed money). But there is a chicken and egg problem here. Until the coops had members they could not have a board. Until they had a board, how would they meet licensure requirements? The state coops, moreover, would, under Conrad's, proposal be supervised by a national board, but the national board would be elected by the state coops. Again, the state coops would presumably not be able to get underway until the national board provided policy guidance, but the national board could not get underway until the state coops were formed to elect it. None of this makes sense.

Second, there is every reason to believe that small, state run coops would fail like their predecessors did in the 1930s and 1940s. Unless they reached the critical mass necessary to bargain effectively with providers, to accumulate reserves, and to compete with national private insurance plans, they would be doomed to failure. Even if they managed to succeed here and there, they would contribute nothing to a national effort to control costs, drive value, and make affordable care accessible.

Third, if state-run coops in fact, against all odds, became large, successful competitors for insurance business, what would keep them from following the course of the Blue and mutual plans before them? Without strong Congressional direction and a unifying national leadership, what could keep them focused on cost control, quality improvement, transparency, and service rather than simply becoming indistinguishable from their commercial competitors? How would they drive the delivery system change we need?

Fourth, how does setting up cooperatives on a state-by-state basis drive national health care reform? Each state currently can set up cooperatives if it wishes to, but none have done so. Why would states suddenly embrace this concept? And what assurance do we have that they would

pursue anything like a common strategy? To approach this issue on a state-by-state basis is simply to surrender on national health care reform. A federal fallback plan to be implemented in the future is also unlikely to work. HIPAA contained a federal fallback plan for states that failed to implement reforms in the individual market, but it was poorly implemented and eventually abandoned. To revert to a state-by-state approach is to surrender on national health care reform.

What Would Make the Cooperative Concept Work?

In fact the cooperative idea in itself is promising. The proposed cooperatives look much like the social insurance funds of Germany and of other central European states. Those funds are governed by their members and do a comparatively good job of keeping health care costs in check. But they operate in a strong framework of national laws and under the guidance of national leadership.

The only viable strategy is Senator Conrad's Option 2–a federal charter to license and regulate a national non-profit coop, with coop governance prescribed by Congress. Leadership could initially be appointed as directed by Congress to represent consumer, labor, and small business interests, and thereafter be elected by the membership. The federal government could provide seed funding to assure initial solvency, but thereafter the coop could be self-supporting. It would be financed through premiums, and compete on a level playing field with private insurers (although some account would have to be taken of the fact that private insurers, no matter what underwriting rules were imposed, would still dump high-risk insureds into the coop). Some administrative functions could be delegated to the regional level, much as Medicare Advantage or drug plans are administered at the regional level. Regional councils could also be elected by members, who could have a role in selecting the national board and an influence on national policy.

A national cooperative could perhaps compete effectively with national private insurers. It could perhaps bargain effectively with providers, including global pharmaceutical firms and national hospital chains. It is possible that it could drive creative national quality initiatives and provide national data on health care use. It would not be government-run insurance, the great fear of the American right. But it could perhaps provide a national solution for a national problem. It will not happen on its own, however. It will only work with concerted and probably long-lasting support from the federal government.