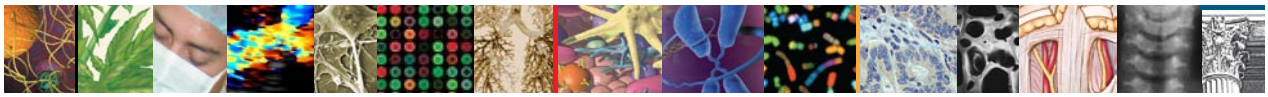

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Perspective

Poor Substitutes — Why Cooperatives and Triggers Can't Achieve the Goals of a Public Option

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According to a recent survey, a majority of U.S. physicians support health care reform that includes a new national public health insurance plan, which would compete with private plans.[1] Polls have shown that a substantial majority of Americans support the public option as well.

Yet the idea has occasioned considerable controversy on Capitol Hill. Senate Finance Committee chairman Max Baucus (D-MT) recently unveiled his draft bill (the chairman's "mark"), which contains no competing public plan. Instead, it substitutes the largely untested idea of providing federal loans and start-up funds to encourage the creation of decentralized, member-run health care "cooperatives." Another prominent senator on the Finance Committee, Olympia Snowe (R-ME), has indicated that she would support a public plan only in the event that private health plans failed to offer affordable coverage in a particular region, "triggering" the creation of a public option. President Barack Obama — while reiterating his support for a public plan — has said that he could support both these alternatives if they could create accountability and competition for private insurance.

Could they? Both proposals lack adequate specificity to make the answer clear — Baucus's plan remains a blueprint in key respects, and Snowe's proposed amendment is just two paragraphs long (http://finance.senate.gov/sitepages/legislation.htm). But analysis of existing outlines of both ideas and similar initiatives in prior legislation suggest that they could not.

The "public option" is meant to bring greater competition, choice, accountability, and cost restraint to U.S. health insurance. It would do so by offering the choice of a new national, public, nonprofit insurance plan modeled after Medicare to those who lack employer-sponsored coverage or work for very small firms that decide to buy coverage through a proposed national insurance "exchange." This plan would be subject to the same rules as private health plans and would be wholly self-financing, with revenues derived entirely from premiums, employer contributions, and the same government subsidy payments for lower-income Americans that would be available to private plans.

Today, most local insurance markets are dominated by one or a few insurers and one or two

hospitals. To ensure the participation of the dominant providers in such markets, many insurers pay them far more than their costs — which tend to be excessive anyway, owing to inefficiency and excess volume. In this context, giving enrollees in an exchange the choice of a new federally administered, national public plan would achieve three aims: it would provide a backup option for people and small employers without good insurance options today; it would create a benchmark for private insurers, challenging them to improve the value of their product and bargain more aggressively with dominant providers; and, through innovative methods of payment and care delivery that build on approaches used by successful public programs, it would reduce costs over time.[2]

Could cooperatives achieve these goals? Baucus's draft bill offers a brief description of cooperatives as new decentralized "non-profit, member-run health insurance companies that serve individuals in one or more states" by issuing "qualified health benefit plans in the individual and small group markets."[3] Federal support would consist of $6 billion in start-up loans and grants to meet state insurance solvency requirements.

As envisioned, cooperatives almost certainly could not achieve the key aims of the public plan. Although they might offer a backup option in some regions, they would have little chance of offering the broad choice of providers and portable, standardized, nation-spanning coverage that a national public plan offers. Moreover, as is the case with any private health plan entering a local market, decentralized cooperatives would find it difficult to get off the ground and expand, much less attain the reach or authority required to drive widespread delivery and payment reforms or compete strongly with private insurers.

The history of consumer health cooperatives supports this pessimism. During the Great Depression, the Farm Security Administration encouraged the development of cooperatives to provide health coverage to residents of rural areas. But physicians perceived the cooperatives as constraining their autonomy, the plans had trouble maintaining sufficient enrollment to stay afloat, and government support was eventually withdrawn.[4] Today, the experiment's only survivor is Group Health Cooperative of Puget Sound, a nonprofit health maintenance organization with about half a million members — as compared with the 33 million members of WellPoint, the largest U.S. insurer. None of the handful of other existing cooperatives has anything like the reach of the biggest private plans, and all operate pretty much the same way other nonprofit health plans do.

Any new federally authorized health plan must be able to counterbalance the leverage of dominant insurers and providers, in part by constructing its own competitive provider networks. Otherwise, it will have neither the market share nor the bargaining power necessary to become established and serve as a check on those entities. Alas, cooperatives have no real prospect of garnering the requisite market power. The Congressional Budget Office, which has said that the competing public plan could achieve substantial savings if it paid rates linked to Medicare's payment schedule, has concluded that cooperatives would have "very little effect" on health care spending.[5]

The other proposed alternative is to allow the private insurance system to attempt to achieve reform's key goals, with the understanding that its failure to do so would trigger the creation of a public plan. But if constructed as currently discussed, a trigger would probably not be "pulled." And even if it were, it would be hard-pressed to foster the necessary competitive pressure that the immediate creation of a national public plan would.

Experience indicates that legislative triggers are designed primarily to provide political cover and thus are made nearly impossible to pull. For example, the Medicare prescription-drug benefit passed in 2003 included a trigger for the creation of a federally insured benchmark plan in regions where two or fewer private plans operated. This criterion was so lenient that the trigger was never pulled. Furthermore, the standard had little to do with the drug benefit's goal of providing affordable drug coverage. A trigger that was based on a plan's performance in controlling costs and providing good service might well have led to federal intervention. But since avoiding such intervention while minimizing political opposition was the whole point, it is not surprising that a more relevant metric was not chosen.

It is difficult to know whether Snowe's trigger would face a similar fate. The senator would support the introduction of a public "safety net" plan if 95%

of residents in a particular state lacked access to "affordable coverage," which her proposal defines as the availability of two or more plans whose direct individual premium costs do not exceed a level ranging from 3% of adjusted gross income at 133% of the federal poverty level (around $29,000 for a family of four) to 13% at or above 300% of the poverty level (around $66,000 for a family of four). These are high thresholds, given that most people pay only a relatively small share of insurance premiums directly and that insurers can design plans with low premiums and very high out-of-pocket costs under Baucus's proposal. Indeed, such a trigger is meaningless unless what counts as "coverage" is defined precisely, so that insurance plans could not simply cover less care (for example, through higher cost sharing) in order to bring premiums down. A better standard would focus on the annual rate of growth of premiums for a set package of benefits with defined cost sharing.

In addition, even if the trigger were based on a reasonable standard, Snowe's proposal stipulates that a public plan be created only in regions where the standard was met. This approach would be administratively cumbersome and would forfeit two primary advantages of the public plan: its ability to provide broad coverage on similar terms nationwide and its ability to leverage a large subscriber base to obtain lower-cost, higher-quality care. And, of course, a trigger would mean delaying the implementation of a new public plan even longer — despite the fact that any reasonable trigger based on the failure of private insurance to provide affordable coverage should have been pulled decades ago.

In short, neither the cooperative nor the trigger represents an acceptable substitute for the immediate creation of a national public plan. Rather than developing fig leaves to provide political cover, congressional leaders and the President should push for a national public plan that competes on a level playing field with private insurance to provide coverage to people who are uninsured and workers in the smallest firms. Such competition is the key to creating greater choice and accountability in increasingly consolidated insurance markets.

Dr. Hacker reports receiving advisory-board fees from Pfizer and speaking fees from America's Health Insurance Plans, all of which he reports donating to charity. No other potential conflict of interest relevant to this article was reported.

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