

A Co-op is Not a Public Option

A Wall Street health industry analyst sums it up: “As the co-ops are currently described, we think they would be a **big positive for the managed care groups** [publicly traded insurance companies], but it seems to us that they would be **destined to fail** from the moment of creation.” -- Carl McDonald, Oppenheimer and Co., June 13, 2009.

A proposal being discussed in the Senate would allow for the creation of health care co-ops instead of establishing a new public health insurance plan option. Many important details about this plan are still up in the air. Experience with co-ops suggests they would have no more ability than a good non-profit health plan to enter most local markets, rein in costs, or “compete,” other than through mimicking the behavior of profit-driven plans.

A co-op is not a substitute for a public health insurance plan that is:

- Available to everyone nationwide, with the government bearing risk
- Big enough to compete with insurers
- Powerful enough to get good rates from providers but with fair payment that attracts broad participation
- Innovative enough to change care delivery and put the right incentives in the system
- Transparent and accountable
- Playing on a level playing field with other plans in the exchange
- Able to remedy disparities in access to care for underserved communities

Co-ops Can't Compete to Lower Costs

- State-based or regional co-ops, run by their members, would be too weak to stand up against the insurance industry conglomerates, unlike a single public health insurance plan, available nationwide.
- Today, 94% of insurance markets in America are “highly concentrated” and controlled by a handful of powerful companies.
- Co-ops would be too small to attract provider participation or to strike bargains with providers, unlike insurers with established networks strengthened by backroom deals with providers.¹ In fact, according to one Wall Street analyst, “providers would have very little reason to deal with them, since the co-ops have no volume or leverage.”²

¹ Globe Spotlight Team, “A handshake that made healthcare history,” The Boston Globe, December, 2008. Accessed at http://www.boston.com/news/health/articles/2008/12/28/a_handshake_that_made_healthcare_history/.

² Oppenheimer Equity Research Industry Update, Managed Care Weekend Update, 6/13/09.

- According to Saint Louis University law professor Thomas Greaney, “it is hard to envision numerous regional co-ops gathering the necessary data, experience and reputation to serve as a benchmark or counterweight to dominant hospitals and provider groups across the country.”

Co-ops Won't be Ready for Prime Time

- Forming 50 state co-ops would take an enormous investment of time and federal capital: filing to become a co-op, applying for and winning federal seed money, establishing boards of directors, recruiting enrollees, forming provider networks, designing plans that comply with 50 state and new federal laws, setting up all plan administration – and so on.
- In an environment where one person goes bankrupt due to medical costs every 30 seconds, even if all barriers to their success could be overcome, we cannot afford to wait for co-ops to spring up in every state across the country. We need a solution that's available everywhere on day one.
- What happens when a co-op fizzles? New market entrants face a host of obstacles, according to Greaney, and even established plans can find it impossible to break into a new market. For instance, in Pennsylvania, the dominance of two non-profit insurers in distinct parts of the state has thwarted the entry of other regional and national competitors for years.³
- Co-ops have been tried and failed before. Rural health cooperatives started after the Great Depression “crumbled in the face of physician resistance (including boycotts), the lack of financial wherewithal of the cooperatives themselves, and the eventual withdrawal of government support.”⁴

Co-ops Can't Change Care Delivery

- Democrats and Republicans have agreed that delivery system reform is key to the success of health care reform and the sustainability of our American health care system. A weak co-op structure won't have the weight or the know-how to accomplish these goals.
- As Jacob Hacker noted: “Cooperatives might be able to provide some backup in some parts of the nation, but they are not going to have the ability to be a cost-control backstop, much less a benchmark for private plans, because they are not going to have the reach or authority to implement innovative delivery and payment reforms.”⁵
- Private health plans, both for-profit and non-profit, consider the data necessary to understand plan coverage, innovations and provider incentives to be business trade secrets – making it impossible to understand or improve quality overall.

Co-ops are a Gift to the Insurance Industry

- Because co-ops would start entirely from scratch, they would likely need to outsource most core operations. That means 50 state co-ops handing over their federal seed money in big contracts with insurance companies.

³ David Balto, Testimony to the Pennsylvania Senate Banking and Insurance Committee, Sept 23, 2008.
http://www.americanprogressaction.org/issues/2008/pdf/balto_pa_testimony.pdf

⁴ Jacob Hacker, “Un-Cooperative: The Trouble with Conrad’s Compromise,” The New Republic, June 14, 2009.

⁵ Jacob Hacker, “Un-Cooperative: The Trouble with Conrad’s Compromise,” The New Republic, June 14, 2009.

- A co-op model is a handout to the industry in two ways: it deprives Americans a true competitor – a strong public health insurance option – and allows lucrative new third-party administrator contracts to operate without government oversight.

Non-Profits Have Failed to Act in the Public Good

- Co-ops would be indistinguishable from today's non-profit plans, which generally are compelled to act in ways that do not serve the public's interest in order to "compete" with for-profit plans. Today, nearly half of privately insured people are enrolled in non-profit health plans and yet costs have skyrocketed.
- The Blue Cross Blue Shield health plans were originally started as co-ops. Those that retain their non-profit status have done no better than their for-profit counterparts in controlling costs. For instance, Blue Cross Blue Shield of Alabama controls 83 percent of the insurance market but allowed costs to increase 79 percent between 2000 and 2007, with premiums increasing nearly 5 times faster than wages in the state.⁶
- Non-profit status doesn't guarantee good behavior. According to Senator Barbara Mikulski, Maryland's Blue Cross Blue Shield plan went from "non-profit to profiteering."⁷ According to a report in Health Affairs, "Blue Cross Blue Shield of Maryland and its sister plan in the District of Columbia were poster children of nonprofit corruption and incompetence, squandering their assets on ego-building but money-losing diversification initiatives and on lavish executive lifestyles that devoted more days per year to jetting around the globe than to paying insurance claims back home."⁸
- Held to the same level of scrutiny, non-profit insurers would exhibit the same greed and lack of public accountability Senator Charles Grassley has found in repeated investigations of non-profit hospitals.

⁶ www.HealthCareforAmericaNow.org/competition

⁷ Statement of Senator Mikulski, HELP Mark-Up, June 17, 2009.

⁸ James C. Robinson, *Health Affairs*, "For-Profit Non-Conversion And Regulatory Firestorm At CareFirst BlueCross BlueShield," 2004 (<http://content.healthaffairs.org/cgi/content/abstract/23/4/68>)