Why Did the ACA Co-Op Program Fail? Lessons for the Health Reform Debate

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Abstract The ACA created a new type of nonprofit health insurance entity, the "Consumer Operated and Oriented Plan" ("co-op"). Most of the newly created co-ops soon lost money, and only 4 of the original 23 remain. We interviewed key stakeholders and conducted in-depth case studies of 3 of these co-ops. We discovered that politicians and regulators made it unlikely the program could succeed, that most of the co-ops did not have the management capacity to overcome these political obstacles, and that even those with good managers lacked the needed fiscal resilience. We also considered lessons suggested for those proposing a newly created "public option." The main one is that a successful public option requires a supportive political environment, strong management, and significant fiscal capacity, none of which comes easily. A better route may be a quasi-public option in which the government subcontracts the operation of its newly created plan to a private firm. Although it is uncertain whether federal regulators have the capacity to hold such private for-profit firms accountable, pragmatism suggests that a combination of public-sector regulation and private-sector implementation may be the most direct path toward a US version of affordable universal coverage.

Keywords ACA co-ops, private health insurance, public option, health reform

The current debate over the role of government in the US health insurance system is highly partisan. The Trump administration seeks to reduce the size of the nation's public insurance programs, while also scaling back regulatory oversight of the private insurance industry. One example is federal support for Medicaid work requirements. The administration also favors insurance products (such as Association Health Plans) that are exempt from regulatory requirements imposed by the Affordable Care Act

Journal of Health Politics, Policy and Law, Vol. 45, No. 5, October 2020
DOI 10.1215/03616878-8543274

(ACA). Democrats fiercely oppose such proposals and seek instead to expand public-sector coverage, either by permitting individuals to "buy into" Medicare or Medicaid, or more radically by expanding Medicare to the entire population.

As with much of US health politics, there is an element of déjà vu to the current debate. Prior to the enactment of the ACA, liberal Democrats argued that the law ought to include a "public option," modeled after (or part of) Medicare, for those purchasing coverage on the newly created health insurance exchanges. While that proposal failed to advance, the ACA included a consolation prize for public option advocates, the "Consumer Operated and Oriented Plan" (CO-OP) program (Patient Protection and Affordable Care Act of 2011, 111th Cong., Pub.L. 111–48, § 1322, 124 Stat. 163, 187–92). The goal was to catalyze the formation of new nonprofit insurance companies, making insurance markets more competitive by adding a consumer-oriented option.

The original plan was to have at least one co-op in every state, but cuts in federal funding shrunk the program by more than half, with the result that only 23 became operational (GAO 2016). Nonetheless, co-op enrollment grew from roughly 460,000 in 2014 to more than a million in mid-2015, prompting optimism that the initiative would succeed (Joseph and Adashi 2015). The optimism was short-lived, however, as it was soon clear that the co-ops were all losing money, and most had inadequate reserves to cover the losses. By the end of 2015, state regulators had closed a dozen of the plans, forcing hundreds of thousands of enrollees to shop for new coverage (and prompting lawsuits from providers seeking payment for services) (Norris 2018). The number of co-ops continued to decline over the next couple of years, and there now remain only four survivors.

In an effort to understand what went wrong with this part of the ACA, we interviewed key stakeholders, reviewed government documents and academic literature, and conducted in-depth case studies of three co-ops, one in Montana that posted a modest surplus in 2017 (Mountain Health Cooperative, or MHC), one in New Mexico that technically survives but does so under the umbrella of a for-profit partner (New Mexico Health Connections, or NMHC), and one in Maryland that has gone out of business (Evergreen). We focused on four plausible explanations for the program's disastrous performance: (1) it was doomed from the start by decisions made during the legislative process; (2) it was fatally undermined by a series of postenactment decisions (both legislative and regulatory) that discriminated against newer health plans; (3) most co-ops lacked adequate management expertise; and (4) most co-ops lacked sufficient fiscal resources.

We conclude that each of these hypotheses offers a useful lens through which to examine the co-op saga: the politicians and regulators made it unlikely the program could succeed, most of the co-ops did not have the management capacity to overcome these political obstacles, and even those with good managers generally lacked the needed fiscal resources. We also consider lessons suggested by the co-op program for liberals now proposing a newly created public option. The first and most obvious is that a successful public option would require a supportive political framework, strong management, and a large and well-regulated market. Equally important, however, is the recognition that it is extremely difficult to create a brand-new health insurance entity, be it public or private. For this reason, the argument here is that a *quasi-public option* (in which the government subcontracts the administration of its newly created plan to a private firm) is the best path forward. The recently enacted Cascade Care Program in Washington State is an example of such an approach.

The Politics of Enactment: Were CO-OPs Doomed from the Start?

Senator Kent Conrad (D-ND) proposed the idea of nonprofit insurance co-ops as a compromise between Democrats on the two sides of the public option debate (James 2014). The co-ops could presumably provide the benefits of the public option (a consumer-focused insurance alternative) without the baggage of a new government-run program. While the new entities would not be true "cooperatives" (organizations jointly owned and governed by dues-paying members), there would be a requirement that at least 50% of their governing boards be composed of co-op members. Conrad's proposal called for $10 billion in federal grants to be distributed to newly created co-ops.

Conrad's proposal drew a mixed response. The insurance industry was divided. Those insurers that operated primarily in the individual and small group markets worried about federally subsidized competitors, whereas those primarily in the large group market were less concerned. Liberal House Democrats, who viewed the co-ops as a sell-out, continued to push for a true public option. The White House and the Senate leadership were ambivalent, but willing to support an idea they could sell as an alternative to the public option.

By late 2009, with the public option blocked in the Senate, there was increased support for the co-op compromise, but also important limitations. Federal funding was cut from $10 billion to $6 billion (and later to

$2.4 billion) (Levinson 2015). Funding also was converted from grants to loans, a change that saddled the co-ops with debt rather than providing initial fiscal security. It also meant that federal regulators would later view their role more as protectors of fiscal investments than as collaborative partners, and the federal focus would be more on audits and compliance than on technical assistance and support.

Three other amendments also reduced the odds of success. First, the co-ops had to have "substantially all" of their business in the individual and small group markets, thus limiting access to the potentially more lucrative large-group market. Second, they could not use their federal loans on any marketing activity, a problem for start-ups trying to raise brand awareness. Third, the co-op board of directors could not include persons employed in the health insurance industry, thereby limiting their ability to access private capital.

The Politics of Implementation

Were CO-OPs Sabotaged by the Risk Stabilization Rules?

Prior to the ACA, there was relatively little competition in the individual and small-group health insurance markets. In 30 states, a single insurer (typically Blue Cross) controlled more than 50% of the individual market (Cox and Levitt 2011). These insurers charged enrollees based largely on their health status and often denied coverage altogether to persons with preexisting conditions. The ACA sought to restructure and improve these markets by requiring affordable coverage regardless of health status, a decent benefit package, and caps on administrative expenses. It also created new insurance exchanges, designed to provide information (and resources) to support sound coverage purchases.

The drafters of the ACA recognized that the new rules and the new markets would create a period of uncertainty and risk. What would be the health status and care utilization patterns of the new enrollees? How many health plans would compete for this business? What was the "right" price to charge as premiums?

In an effort to minimize instability, the law contained various programs designed to compensate insurers who enrolled unexpectedly costly individuals. Two became important parts of the co-op story. First, the "risk corridor" program provided supplemental funding to plans with costs 3% greater than a target amount, funded largely by assessments on firms with costs 3% lower than expected. Second, the "risk adjustment" program

transferred funds from insurers with a high proportion of low-risk enrollees to ones with a high proportion of high-risk enrollees.

Part D of the Medicare Modernization Act, enacted in late 2003, provided an important precedent. Although Congress required that Part D prescription drug coverage be delivered by private firms, lawmakers were uncertain whether enough of them would participate. There was particular concern about the viability of the *prescription drug plans* (PDPs), a new kind of health plan. By all accounts, the Part D risk stabilization programs worked well and nurtured what became a competitive insurance market. In contrast, the ACA's risk corridor and risk adjustment programs generated fierce political conflict, ongoing litigation, and a devastating impact on the ACA co-ops. Many observers consider these programs to be the most important reason that nearly all of the co-ops have failed. Are they right?

Risk Corridors

The ACA risk corridor program had a simple formula for determining whether plans should make or receive payments, but was less clear about the source of funding if it turned out that payments-owed exceeded payments-due. The funding issue became salient when it became clear that most insurers initially were going to lose money on their ACA line of business because health plans (especially start-ups) offered policies with extremely low premiums in an effort to gain market share, perhaps relying too optimistically on risk corridor protection. In addition, the administration's decision to allow states to permit insurers to continue selling non-ACA compliant plans enabled commercial plans to encourage healthy beneficiaries to stay in profitable temporary plans, with the result that their exchange plan was more likely to generate losses.

Federal officials initially gave assurances that the risk corridor program would be fully funded, declaring (in March 2013) that all payments would be made even if the payments-out to plans with losses exceeded the payments-in from plans with a surplus (HHS 2013). The GAO (in early 2014) provided additional assurance, noting that the US Department of Health and Human Services (HHS) could use general "program management" funds to supplement payments contributed by profitable health plans (GAO 2014).

Soon thereafter, however, conservative opponents of the ACA, led by Senator Marco Rubio (R-FL), began attacking the risk corridor program as a windfall for greedy insurers. In December 2014, Senator Rubio inserted a rider into the 2015 appropriations bill that prohibited HHS from using general program management funds to pay risk corridor claims.

The following fall, health plans (co-ops and others) submitted $2.87 billion in eligible risk corridor requests. There was, however, only $362 million paid in by more successful plans. While the HHS acknowledged its legal obligation to pay the full amount, it argued that it lacked the funds to do so, given the Rubio rider. The result was that health plans received 12.6 cents on the dollar (*Moda Health Plan, Inc. v. United States.* 892 F.3d 1311 [Fed Cir. 2018]). The shortfall was catastrophic, at least for start-up firms (including co-ops) that lacked significant fiscal reserves. Within months, eight co-ops were forced out of business. And while MHC, Evergreen, and NMHC were not among those eight, they too received far less than expected, in the amounts of $30 million, $16 million, and $5 million respectively. Despite howls from health plan officials, Republican leaders kept the Rubio rider in place for the next two years, resulting in a $12.3 billion shortfall in payments owed to dozens of insurers (Livingston 2017).

Numerous health plans, including NMHC, began litigation seeking full payment for their risk corridor claims. Several years later, the Supreme Court sided with the insurers, ordering the government to refund more than $12 billion to the nation's insurers, including the full amounts due to the co-ops (*Maine Community Health Options v. United States*. 590 U.S. [2020]). But the judicial verdict in their favor came far too late for those co-ops forced out of business nearly six years earlier.

Risk Adjustment

The battle over the ACA risk adjustment program was less explicitly political but equally problematic for most of the co-ops. The key here was the technocratic formula that determined the overall risk status of a particular group of enrollees. Individual enrollees were given a risk score based on their age, gender, and identified diagnostic codes. Regulators averaged all the individual risk scores to determine the score for the overall plan, then collected funds from plans whose risk score was below the statewide average and paid funds to those plans whose risk score was above that average.

Under this formula, all but one co-op lost money on risk adjustment in 2014, and co-ops continued to do poorly thereafter. NMHC, for example, paid $30 million in risk adjustment assessments between 2014 and 2016, Evergreen paid $24.2 million in 2015, and MHC paid $36 million in 2016. Even more striking is the gap between what the co-ops expected to pay (and baked into their premiums) and the amounts eventually charged. As Katherine Hempstead noted in her review of the 2015 risk adjustment

payments, the Centers for Medicare and Medicaid Services release of the risk adjustment figures came as "an unpleasant surprise" (Hempstead 2018).

One explanation is that federal regulators required the risk adjustment program to be budget neutral: plans whose enrolled actuarial risk is below the state average pay the health plans whose enrolled actuarial risk is above the state average. The Part D risk adjustment program works differently, requiring payments to any plan whose enrolled risk is above its average premium, with the result that there can be more winners than losers, with the additional funding coming from general revenues.

Start-ups also have a disadvantage under any risk adjustment formula, since more established plans have years of diagnostic data on their enrollees, while new plans must gather such data from scratch. Federal officials could have lessened this disparity by offering plans extra time to collect data, perhaps by giving them all of 2015 to collect data on their 2014 enrollees. This is the approach regulators used in Part D. Instead, 2014 risk scores were determined by data collected in that same year.

As a result, the co-ops faced the complicated management challenge of quickly gathering encounter data about their patient population. They did not respond well to the challenge, especially when compared to older health plans that have expertise in the coding game. For example, since federal officials did not include drug utilization as a diagnostic marker of high-risk status, health plans should have used such data to match drug utilizers to a medical record diagnosis. The co-ops were less likely to do this than were their competitors. Also, as noted earlier, older commercial plans were able to entice healthy enrollees to stay in low-cost, non-ACA-compliant health plans, thereby ensuring that enrollees in their ACA plans were sicker and more likely to generate risk adjustment collections.

Taken together, the risk corridor and risk adjustment programs as implemented significantly lowered the odds the co-ops could survive. But those obstacles could perhaps have been weathered if the plans had more experienced managers.

Management Matters

Coping with surprises in risk stabilization provisions was by no means the only managerial struggle the plans confronted. Other fundamental challenges included putting together an organizational infrastructure, a competitive analysis, a business model, a provider network, and a marketing strategy, all while meeting numerous state and federal regulatory requirements.

Most of the 147 applications for a co-op license emerged from collaborations of community-based activists, often working with former public-sector politicians and regulators. Most had little experience in commercial health insurance. The first CEO of Evergreen, for example, was Peter Beilenson, the former Health Commissioner of Baltimore, a public health expert but a commercial insurance novice. By the end of Evergreen's first year of operations, Beilenson realized that he did not have the right administrative staff or care management systems in place, sparking a major organizational reshuffling, always a difficult process and even more so for a brand-new nonprofit.

To be sure, the co-ops all hired consultants to help with initial tasks. For example, Milliman, a large actuarial and consulting firm, agreed to do co-op feasibility and actuarial work on a contingent deferred basis and to be paid only if the proposal was approved. Several co-ops took Milliman up on the offer. But consultants could not (or at least should not) make crucial strategic organizational decisions. It was critical that nonexpert founders put in place a management team with appropriate skills and expertise. The history of the MHC illustrates the point. Its founder and first board chair, John Morrison (a former State Health Insurance Commissioner), acknowledged that his colleagues initially were mainly activists who lacked insurance expertise, so he hired as the inaugural CEO Jerry Dworak, who had worked for more than 40 years in the insurance business, and who focused on keeping fixed costs low, growing enrollment slowly, and ensuring that the plan had the margin to meet its mission. NMHC followed a similar path: an activist founding board hired a long-time insurance industry leader, Martin Hickey, as its founding CEO.

Why was insurance expertise so important? Consider an important administrative choice every co-op had to resolve: which tasks to contract out and which to keep in-house. The balancing act is clear: there is more programmatic control when tasks are kept in-house but more cost predictability when tasks are contracted out (on a per-member-per-month basis). NMHC was one of eight co-ops that chose to develop its own network of providers, a decision its leadership counts as critical to its successful care management strategy. MHC, however, chose to "rent" its provider network and to contract out key administrative tasks to fix and limit its operating costs. Evergreen chose a middle ground, building and staffing its own health centers to accommodate a portion of its enrollees, but renting a provider network to serve the remainder.

Each of these strategies could work (or fail) depending on its implementation and management. For example, several co-ops paid far too much

when renting a provider network. Others hired third-party administrators that performed poorly. The central point is that significant prior insurance expertise improved the odds of success.

Health Republic Insurance of New York (hereafter Health Republic) illustrates how poor management derailed a newly created co-op. The Health Republic story began, ironically, with an effort to hire expert help: the plan used Milliman to calculate initial premiums, and chose Daniel McGowan, a former health plan leader, to be its first CEO. From that point on, however, the firm made one disastrous management decision after another. It charged premiums at rates well below those suggested by Milliman, presumably to spur enrollment. It rented one of New York's most expensive provider networks, thereby attracting high-cost enrollees, including five who were admitted to Memorial Sloan-Kettering for cancer treatment on their first day of coverage (Waldholz 2016). Meanwhile, McGowan was soon replaced by a new CEO, who began a wholesale management overhaul that further destabilized the company. Outside contractors hired to handle claims and customer service performed poorly. By late 2015, the plan had lost close to $500 million, state regulators had shut it down, 200,000 customers had to find a new plan, and the plan owed $209 million in unpaid provider claims (LaMantia 2016).

In Part D, by contrast, the problems created by inexperienced managers were less of an issue. Rather than limiting the involvement of traditional insurers, Part D relied heavily on such firms. For example, the largest prescription drug plan was created by a collaboration between AARP and United Health Care. Walmart and Humana combined to create another popular plan. These plans have very different target populations, and offer vastly different combinations of premiums, co-pays, and deductibles, but they are part of a competitive and well-functioning market that includes 23 PDPs and 17 Medicare-Advantage plans.

Money Matters

OSCAR health insurance provides an instructive contrast to the co-op start-up story. OSCAR is a for-profit insurer that began operations in New York in 2013, entering the ACA marketplace at the same time as the co-ops. OSCAR also fared poorly in risk adjustment, losing nearly one-third of its premium revenue under the program during 2014 and 2015, prompting CEO Mario Schlosser to complain that "risk adjustment promotes better risk coding as opposed to better risk management" (Goldberg 2016). OSCAR also is owed millions under the risk corridor program, funds tied

up in litigation for several years. Its leadership admits it made a number of mistakes during its early implementation, one of which was to rent the same expensive provider network used by Health Republic (Bartoni 2016). Having incurred more than $200 million in losses in its first four years, were OSCAR a co-op it would be out of business.

Instead of bankruptcy, however, OSCAR is expanding, now selling on the exchanges in more than a dozen states, with more than 350,000 enrollees. The company has developed a focused strategy of offering enrollees high deductible plans combined with low-cost primary care, access to free telemedicine, and a provider network comprised of one or two large health systems. In Ohio the provider network is the Cleveland Clinic. In New York it is Mount Sinai and Montefiore (Livingston 2018). OSCAR officials attribute their rising membership to their consumer-friendly website and their prestigious partners. But what has allowed OSCAR to get this far is roughly $1.3 billion in private investor funding from some of the nation's wealthiest venture capital and private equity firms.

OSCAR's long-term financial future is uncertain. The insurance industry is consolidating, and securing an independent place in the market is not easy. Moreover, private investors will not accept long-term deficits. The firm also needs to diversify beyond the individual and small-group markets, and new markets mean different target audiences and different management challenges. That said, OSCAR has fiscal resources that dwarf its co-op competitors, and those fiscal resources give it dramatically better odds for success.

Given the importance of deep fiscal pockets, one survival strategy for some co-ops is to partner with well-capitalized for-profit partners, though this approach risks undermining their original mission. Consider the current collaboration between NMHC and True Health, under which True Health paid $10.25 million to acquire the co-op's large-group members and its off-exchange small-group members. While NMHC retains its nonprofit co-op status, and continues to sell individual policies along with on-exchange small-group policies, nearly all of its management team transitioned to True Health, leaving only an administrative shell within NMHC itself. The controversial new arrangement triggered the mass resignation of the entire NMHC board of directors. The NMHC leadership subsequently constituted a new board, and has argued that without the cash infusion it would have gone bankrupt, leaving nearly 50,000 members to search for new coverage.

NMHC is not the only co-op plan that looked to for-profit investors: in the weeks before it closed, Evergreen Health negotiated its potential sale to

a group of private equity investors, a sale that its board approved even though it would have meant the end of its status as a co-op. These negotiations with the private equity firm failed, and Evergreen closed shortly thereafter. And while MHC has so far survived without an infusion of private sector funding, it did receive a significant revenue boost from a local hospital system.

From Co-ops to Public Options: Lessons for the Current Policy Debate

An amateur sleuth would have little trouble identifying clues to explain the disappointing performance of the ACA co-ops: political and regulatory obstacles, inexperienced managers, and inadequate fiscal resources. Could it have been otherwise? In principle, each of the four "levels" discussed here might have acted as a fail-safe to the ones before. The risk provisions might have compensated for the statutory handicaps, savvy management might have mitigated the damage from risk-related shortfalls, and the deep pockets of private investors might have saved faltering managers from their errors. In practice, however, the fail-safes all failed.

What lessons might policy makers take from the co-op fiasco? The prevailing wisdom among Democrats seems to be that initiatives further entrenching private (especially for profit) health insurers in the system should be staunchly resisted. Indeed, some Democrats (such as Bernie Sanders) suggest that the original sin of the ACA is its reliance on private-sector insurers, and that the best path is to adopt comprehensive publicly funded coverage for all, referred to generally as a "single-payer" model. More moderate Democrats (such as Joe Biden) propose creating a federally administered public option, available to anyone who chooses to join. Thus, the current debate between the two wings of the Democratic party is over whether a new publicly administered program should replace or compete with the private health insurance industry.

The argument here, however, is that the co-op saga discloses an uncritical embrace by policy makers of organizational innovation as an easy solution to complex problems. The co-ops suffered from (indeed, rested on) a facile assumption that we can simply posit a goal (more competitive insurance markets), imagine an organizational type that will advance it (say a co-op or a public option), enact authorizing legislation, and see what happens. In consequence, the co-ops were hastily conceived (a consolation prize for public option devotees), excessively ambitious (tasked with breaking into a newly competitive nongroup health insurance

market and competing with insurers with superior resources, experience, and expertise), burdened by unrealistic expectations (even if they had stabilized, co-ops would have held no more than a tiny share of the US health insurance marketplace, raising the question of what "success" might have meant).

Avoiding these organizational illusions is important for both sides in the current health policy debate. Liberals should not assume that a broader and fundamentally restructured Medicare will work seamlessly. Conservatives should not assume that newly formed Association Health Plans will thrive. Creating new insurance markets is hard. So too is starting new insurance companies, even for those (like OSCAR) with significant private sector resources.

Consider, for example, the proposal for a publicly administered public option available to all. Despite the supposedly incremental nature of the proposal, there would be fierce opposition from insurers (worried about public-sector competition), providers (fearing lower rates), and large employers (nervous about an adverse impact on their remaining risk pool). And although public option advocates assume that it will be simple and straightforward to create and implement the new plan, there will likely be serious management challenges, complicated further by limited fiscal capacity. Such a strategy also runs contrary to current trends in both Medicaid and Medicare, as more than 80% of Medicaid beneficiaries are now enrolled in private-sector managed care plans, as are more than one-third of Medicare enrollees.

The trend toward private-sector implementation of public-sector programs is illustrated nicely in Part D of the Medicare program, where participating plans offer a very specific and limited benefit, enjoy strong support across (parts of) the partisan aisle, operate under effective rules on risk assessment and adjustment, and are guided by seasoned managers and well-financed bureaucracies. Even so, the enactment and start-up of Part D was mired in controversy. The law passed in 2003 following a fierce political battle in which President George W. Bush put together a slim congressional majority, composed of moderates on both sides of the political aisle, barely overcoming liberal concerns that the law relied too heavily on private insurers and conservative complaints that the law created an unacceptable (and largely unfunded) federal entitlement. The vigorous opposition initially convinced large swaths of the population that the law was a bad idea. Medicare enrollees, generally supportive of the idea of new prescription drug coverage, worried that their choice of health plans would be too limited and that the premiums charged by participating plans would be too high.

Within a year, however, Part D evolved into a popular program with bipartisan support. The prescription drug marketplace grew stable, with a mix of Medicare Advantage plans and PDPs. Overall program costs were below initial predictions. Beneficiary satisfaction was relatively high. Three factors are key to explaining the success: politics, management expertise, and money. Part D's enactment reflected a bipartisan desire for a successful prescription drug marketplace. The co-ops, in contrast, were a legislative afterthought, with little political support. Equally important, Part D relied on well-established private insurers, with longstanding industry expertise and the fiscal resources to withstand early implementation snafus. The co-ops were under-capitalized start-ups with inexperienced and sometimes inadequate managers.

The experience of the marketplaces (aka exchanges) launched by the ACA (and which stand, as it were, midway between Part D and the co-ops) may shed additional light on the prospects for successful private implementation of public programs. The checkered career of the exchanges suggests that trying to make regulated health care markets "work" across the whole spectrum of insurance is much more difficult than it is to run a delimited benefit such as Part D (which, moreover, unlike the co-ops, relies mostly on established insurers with large reserves). Nor did the exchanges share the bipartisan support enjoyed by Part D, a deficit that may have contributed to disappointments with them because it prevented timely repairs and fueled attacks on them. In today's polarized political environment even privately implemented public plans may face enormous obstacles as the opposing party works to unravel them.

Whatever the record and implications for the public/private mix of the co-ops, Part D, and the marketplaces, the federal government should not be viewed as the sole feasible source of innovation in health insurance markets. Consider, for example, the recent enactment of Cascade Care in Washington State, under which buyers on that state's insurance exchange will soon be able to purchase a lower-cost private health plan in which premiums are kept low by state-mandated caps on provider reimbursement. While Governor Jay Inslee and others call the initiative a public option (mainly because for the first time a state will impose public sector reimbursement rates on a commercial insurance market), it differs from the classic public option model because it will be administered by a private-sector plan. The goal is to get the benefits of a public option while also generating the needed political support, fiscal resources, and management capacity (Sparer 2020).

The Cascade Care story is particularly stimulating because it occurred in a liberal state with a Democratic governor (who had presidential ambitions) and a Democratic-controlled state legislature. Even in that context, the idea of a state-based single-payer initiative was a political nonstarter, and the fallback option of a public option shifted away from the original publicly administered model to the alternative strategy of a publicly regulated but privately administered health plan. How—and how well—Cascade Care will work of course remains to be seen.

Such a scenario might well be repeated on the national level were the Democrats to control the presidency and Congress following the 2020 election. There will undoubtedly be strong opposition to even this redefined or quasi-public option approach (particularly from providers worried about lower reimbursement rates). But the political, fiscal, and management elements of such an approach are far more likely to succeed than either the single-payer or the traditional public option approach.

To be sure, the appeals of this approach come accompanied by uncertainties and contingencies. Is it wise to bet ever more heavily on "reforms" that (like Medicare Parts C and D, Medicaid managed care, and the health insurance exchanges) continue more deeply to entrench the presence and power of for-profit health plans in insuring the population? Can the population be confident that federal and state insurance regulators have the capacity to gauge the fiscal stability, organizational coherence, and implementation record of those for-profit plans and to hold them accountable? Still and all, in calculations of the costs and benefits of reforms, political pragmatism exerts legitimate claims of its own—and so the combination of public-sector regulation and private-sector implementation may be the best, most practical path toward a US version of affordable universal coverage.

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References

Bartoni, Steven. 2016. "Oscar Health Gets $400 Million and a $2.7 Billion Valuation from Fidelity." *Forbes*, February 22. www.forbes.com/sites/stevenbertoni/2016/02/22/oscar-health-gets-400-million-and-a-2-7-billion-valuation-from-fidelity/#5570821e5321.

Cox, Cynthia, and Larry Levitt. 2011. "How Competitive Are State Insurance Markets?" Kaiser Family Foundation, October. kff.org/wp-content/uploads/2013/01/8242.pdf.

Crain's New York Business. 2017. "Health Republic Posts Losses of $500M in 2015." *Modern Healthcare*, April 20. www.modernhealthcare.com/article/20170420/NEWS/170429996/health-republic-posts-losses-of-500m-in-2015.

GAO (US Government Accountability Office). 2014. "Department of Health and Human Services—Risk Corridors Program." September 30. gao.gov/assets/670/666299.pdf.

GAO (US Government Accountability Office). 2016. "Federal Oversight, Premiums, and Enrollment for Consumer Operated and Oriented Plans in 2015." March. gao.gov/assets/680/675742.pdf.

Goldberg, Dan. 2016. "Insurers Cite 'Reverse Robin Hood' Effect in New York Market." *Politico*, June 1.

Hempstead, Katherine. 2018. "Risk Adjustment and Co-op Financial Status." Robert Wood Johnson Foundation, November 21. www.rwjf.org/en/library/research/2016/07/risk-adjustment-coop-finance-status.html.

HSS (US Department of Health and Human Services). 2013. "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014." *Federal Register*, March 11. govinfo.gov/content/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

James, Julia. 2014. "The CO-OP Health Insurance Program." *Health Affairs*, January 23. doi.org/10.1377/hpb20140123.805525.

Joseph, Allan M., and Eli Y. Adashi. 2015. "Health CO-OPs of the Affordable Care Act: Promise and Peril at the Five-Year Mark." *JAMA* 313, no. 14: 1419–20.

Levinson, Daniel. 2015. "Actual Enrollment and Profitability Was Lower Than Projections Made by the Consumer Operated and Oriented Plans and Might Affect

Their Ability to Repay Loans Provided under the Affordable Care Act." US Department of Health of Human Services, Office of Inspector General, open file report A-05-14-00055, July. oig.hhs.gov/oas/reports/region5/51400055.pdf.

Livingston, Shelby. 2017. "Feds Owe Health Insurers $12.3 Billion in Unpaid Risk Corridor Payments." *Modern Healthcare*, November 14. www.modernhealthcare.com/article/20171114/NEWS/171119935/feds-owe-health-insurers-12-3-billion-in-unpaid-risk-corridor-payments.

Livingston, Shelby. 2018. "Oscar Health Drives Membership through Narrow Network Strategy." *Modern Healthcare*, February 6. www.modernhealthcare.com/article/20180206/NEWS/180209938/oscar-health-drives-membership-growth-through-narrow-network-strategy.

Norris, Louise. 2018. "CO-OP Health Plans: Patients' Interests First." Healthinsurance.org, February 3. healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/.

Sparer, Michael S. 2020. "Redefining the 'Public Option': Lessons from Washington State and New Mexico." *Milbank Quarterly*, March 18. doi.org/10.1111/1468-0009.12454.

Waldholz, Michael. 2016. "The Short and Chaotic Life of an Obamacare Darling." *Modern Healthcare*, April 18. www.modernhealthcare.com/article/20160418/NEWS/304189996/the-short-and-chaotic-life-of-an-obamacare-darling.