COVER MISSOURI Quality, Affordable Health Coverage for Every Missourian

2009

An Examination of Health Cooperatives: Do they have a place in health reform?

What is a health cooperative?

A cooperative (or co-op) is an organization owned by and operated for the benefit of people who use its services. Within this model members have ownership and elect a governing body for the organization. Thus co-ops must be responsive to their members, not shareholders. Within the health care arena, co-ops are a means of pooling the purchasing power of individuals or small businesses to access affordable health coverage. Premiums paid by members would be used to cover the cost of claims. Generally operated as non-profits, any profits from the health co-op are invested into the organization in the form of increased benefits or lower premiums.

Health co-ops usually operate in one of two ways. In the first, the organization contracts directly with providers for medical services as any insurance company does. Their ability to negotiate with providers is dependent on the number of members participating in the co-op. The larger the co-op is (i.e. the more members enrolled) the greater leverage it has to negotiate provider rates, as the co-op can guarantee a minimum number of patients using their services. An example of a health co-op using this model is United Agricultural Trust operating in California and Arizona.

The second way health co-ops operate is to offer a network of health care providers who are employed by the co-op for members to utilize, similar to some managed care models (e.g. a health maintenance organization like Kaiser Permanente). In this model, doctors are salaried employees and health care facilities are owned by the co-op. Thus the health co-op operates as both an insurer and a health care provider. Examples of this model include Group Health Cooperative based in Seattle and HealthPartners operating in Minnesota.

This second model has been praised for its ability to provide high quality, integrated, and coordinated health care while controlling costs. The integrated health care model may be more effective at controlling costs, than the health co-op itself. It should be noted that health co-ops are not the only non-profit organizations providing integrated health care; examples include Geisinger Health System, Kaiser Permanente, and Intermountain Healthcare.

Success and Failure

Cooperatives of all types have had varying levels of success. It takes multiple years and a large capital investment to establish a health co-op. Some of the successful health co-ops cited here and in news articles have taken 20 to 60 years to overcome barriers, develop the organization, and reach current membership levels.

Health co-ops have failed in the wake of conflict between consumer-led management and medical

providers. Several have had to close due to low enrollment and financial insolvency. Others have converted to for-profit status in order to compete in the insurance marketplace. Some state laws prohibit the development of the second type of health co-ops by making it illegal for a physician to be employed by a non-physician.

How do they fit into health reform?

The basic idea is that health co-ops would be independent consumer-driven insurance options that could compete with existing insurance companies. Enrollment would be open for individuals who buy their own insurance coverage and small businesses which often pay higher rates than larger companies. It is believed that health co-ops would lower health insurance costs for these groups by creating larger risk pools. However, many questions remain about how effective health co-ops would be at lowering health care costs and providing affordable health coverage.

The locality of health co-ops is also a factor. A health co-op could be established in every state, or there might be regional co-ops to allow states with smaller populations to form larger pools of members. State-based health co-ops are likely to be more responsive to consumers; however, they may have a difficult time competing with large, well-established health insurers, which would limit their ability to lower insurance costs. State co-op plans are also unlikely to be portable between states.

It is unclear how many years it would take to create a new co-op that could compete with private insurers. Developing a health co-op would include hiring staff, contracting with medical providers, and enrolling customers. Additionally, the cost for creating a health co-op is prohibitive. Initial health reform proposals include $6 billion from the federal government to offset start-up costs. It is unclear if new health co-ops would be sustainable after this initial investment or if continued federal monies would be needed.

Conclusion

While the health co-op model may be attractive to policymakers because it creates a private market option to increase competition in the insurance market, implementation of this model involves significant obstacles. Initial start-up costs are prohibitive and even with federal dollars success is not guaranteed. The majority of health co-ops have failed. In addition to cost, low enrollment, difficulties competing with large insurers, state regulations, and the length of time to get established in a given marketplace have contributed to this high failure rate. Finally, the integrated model utilized by two of the most successful health co-ops is not dependent on this insurance structure to work, and is used by several existing nonprofit insurers.