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Co-Ops Gain Backing as Alternative to Government Insurer

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Nonprofit health-insurance cooperatives are gaining favor among lawmakers working to revamp the U.S. health-care system, but whether these entities could rein in prices by competing with private insurers is unclear.

The idea, first floated by Democratic Sen. Kent Conrad of North Dakota, represents a compromise on one of the most contentious points in trying to craft a bipartisan bill.

President Barack Obama is pushing for a government-run health-insurance plan that would compete with private insurers as a way to help extend coverage to 45 million uninsured Americans. But most Republicans and some moderate Democrats counter that the government's cost advantage would unfairly upend the private market.

The co-op idea is now the main option in play in the Senate Finance Committee, whose health-care overhaul is the leading initiative under consideration in Washington. In remarks this week, Mr. Obama said he would consider the idea if it helped reduce coverage costs for individuals and small businesses.

Mr. Conrad said his proposal stems from his experience with the rural electricity, farming and telephone co-ops in his state that are owned and run by members. Though short on details, his plan calls for creating state or regional entities that would sell insurance to small firms and individuals, which in turn would become part owners of the co-op. The groups would negotiate rates with health-care providers and possibly employ some of their own doctors, while abiding by the same rules that apply to other health plans, such as capital requirements.

Though some Republicans have voiced support, private insurers say that whether they back the idea will largely depend on the details, such as the amount of federal support co-ops would receive.

Meanwhile, skeptics argue that not-for-profit insurers already exist and have evolved in recent decades to operate much like their for-profit rivals, despite the fact that they originated as charitable organizations.

Blue Cross and Blue Shield plans, for instance, were established as community-based nonprofits in the 1930s by hospitals and doctors who wanted to make sure they would be paid for their services. Over time, though, most states have pared some of the tax breaks they gave them and freed them from their insurer-of-last-resort mission.

"Half of all covered lives in the United States are in not-for-profit health plans," said Robert Laszewski, a health-care consultant and former insurance company executive. "Day for day, you can't tell the difference in prices."

Mr. Conrad said the co-ops he envisions would differ from Blue Cross plans because of they would use a collective -ownership model. "When you have a member-based entity, it alters the feeling of people toward the group. The psychology of the way people think of the organization makes them much more bought into the mission that they are trying to accomplish," Mr. Conrad said.

The health co-op isn't a new concept. Seattle-based Group Health Cooperative, whose chief executive met with Mr. Conrad last week, is a survivor of a movement that began after the Great Depression to provide affordable

coverage, particularly in rural areas. But most co-ops remained small, and folded after the federal government stopped subsidizing them in the late 1940s.

With 600,000 members in Washington and Idaho, Group Health today operates much like an integrated health-maintenance organization. It employs many of its own doctors, runs its own clinics and spends more of the premiums it collects on medical care than most private insurers do.

How much its co-operative approach contributes to lower insurance costs is unclear, however. Many of Group Health's efficiencies come from the organization's integrated model of using its own providers. In recent years, the co-op has introduced high-deductible policies and plans not tied to its providers to stay competitive with private insurers, and its premiums are in line with others'. Health-care costs in the Pacific Northwest tend to be lower than the country's average, but the prevalence of HMOs and the supply of doctors and their practice patterns are big factors.

"We like to think we have something to do with that efficiency," said Pam MacEwan, Group Health's executive vice president for public affairs. "But we're not starting from scratch," as the proposed co-ops would.

Then there is the question of start-up costs. State laws require insurers to hold reserves of up to one-third of premiums, said Mr. Laszewski, who estimates that it costs between $50 million and $100 million per market to launch an insurance plan. Assuming a co-op is created in each state, it would cost a minimum of $2.5 billion to get the system going.

Mr. Conrad said his proposal would be funded by states, the federal government and co-op members. The government could provide seed money, perhaps as loans, but the co-ops would run independently after that. Each would likely have a minimum of 500,000 members, and a national board would likely oversee the system, he said.

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