MANAGED HEALTHCARE
EXECUTIVE

{SPECIAL REPORT}

CO-OPs await launch commands

Budget cuts indicate the program might never get off the ground

By Matt Bolch

When is a co-op not a co-op? Health reform calls for establishment of the Consumer Operated and Oriented Plan (CO-OP), which permits nonprofit health insurers to offer competitive plans in the individual and small group markets. It may sound like a matter of semantics, but a true cooperative is owned and governed by members. This might not be the case with new CO-OPs, set to launch with grant money July 1, 2013.

For example, rural electric cooperatives still flourish across the country, many in areas that ceased to be rural decades ago. However, cooperatives in the healthcare arena are exceedingly rare. The two that operate under cooperative principles—HealthPartners in Minnesota and Group Health in Washington—both are decades old and have evolved into mature integrated healthcare organizations.

The CO-OP program has a budget of $3.8 billion to award grants to organizations for start-up costs and reserve requirements, which must be paid back in five and 15 years, respectively. The original budget amount was $6 billion, a figure that was reduced by congressional action in April and remains a target of political budget wrangling.

But until final rules are issued, uncertainty remains over the viability of the program and the final form CO-OPs might take. They will compete in insurance exchanges, and according to actuarial firm Milliman, many insurers assume there is a low probability of any CO-OPs actually emerging.

Experts on healthcare and cooperatives also question whether the program will be fully implemented.

The fact that cooperatives incorporated under general nonprofit statues are not bound to follow organizational criteria specific to cooperatives, such as democratic governance and member ownership, causes concern for the National Cooperative Business Assn. (NCBA), which testified before the CO-OP advisory board in January.

Entities created under legislation will operate as nonprofits under IRS regulation 501 (c)(29), which was established specifically for CO-OPs, says Adam D. Schwartz, a vice president for the association. The organization believes that CO-OPs will be created but hopes that NCBA's concerns about governance and the role of consumers will be taken seriously: Organizations should not be owned by physicians or be flipped to profit-making organizations after loans or grants have been settled.

"We don't want people to have a bad

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FOUNDED: 1957

HOSPITALS: 4

MEDICAL/DENTAL CLINICS: 70

PHYSICIANS: 700

HEALTH PLAN MEMBERS: 1.36 million

EMPLOYEES: 12,000

LAST YEAR, HealthPartners had a 2.7% cost increase, compared to a 7.8% increase regionally. In 2010, its administrative costs were 5.4%, excluding taxes and assessments, with a margin of 3.5%. NCQA ranks HealthPartners as the 19th top plan in the nation and tops in Minnesota.

Despite those impressive statistics, HealthPartners continues to innovate, says Mary Brainerd, president and CEO.

"We still think we have a lot to do and a lot to learn," says Brainerd, who recently was inducted into the Minnesota Business Hall of Fame. "Complacency is the biggest enemy we have. Nobody in healthcare can afford to sit back and say they are doing a great job."

HealthPartners is participating in an international care improvement program, which strives to improve population health, patient experience and costs.

The Institute for Healthcare Improvement (IHI) advocates for three critical objectives, known as the IHI Triple Aim:

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

Starting in October 2007, IHI began working with an international group of 15 organizations to implement components of the Triple Aim. The group has expanded to more than 40 organizations worldwide.

The integrated financing and delivery methodology allows HealthPartners to use premium dollars flexibly on such programs as a nurse care line and efforts to improve population health.

"The United States has a lot of work to do," Brainerd says of population health. "Other healthcare organizations have similar mindsets on health prevention. The difference is in the execution."

Brainerd says the HealthPartners 15-member board has 13 leaders that are elected by members. The diverse group includes women, minorities, a labor leader, a retired schoolteacher and the former CEO of the Land O'Lakes cooperative. A strong emphasis also is placed on the care team, with a high value on teamwork to reduce the prevalence of wrong-site surgeries and medical errors.

"The medical home is a wonderful opportunity to effectively integrate specialty care to create a continuum of care with both human and electronic formats," Brainerd says.

experience—that's a grave concern of ours," Schwartz says. "If we're given a fair shake, there's not a solution that cooperatives can't be an important part of."

In the fiercely competitive health insurance market, a new cooperative might not be able to compete on price but should be able to offer customer satisfaction. An appeals process for those denied treatment ideally would be handled by a group of member-owners who weigh the cost or the nature of a treatment against the overall cost structure of the organization.

Setting up a simple purchasing cooperative would not be capital-intensive, says Charles T. Autry, a partner at Atlanta-based Autry, Roland and Cole LLP. But Group Health and HealthPartners offer integrated care, which would be beyond the financial means of new organizations.

"From a political perspective, it's not government-run and not for-profit—that's a good compromise," adds Roland F. Hall, a partner in the firm. If funding remains available, activity should begin to pick up as the 2013 deadline for loan and grant funding nears. Schwartz says that groups looking at CO-OPs are active in 25 states, describing groups in Montana, New Mexico, Iowa and North Carolina as "fairly active."

Schwartz says the CO-OP legislation found broad support among those with widely differing political views because it provided a clear alternative to other federal healthcare programs.

The push to make physicians, hospitals and home health organizations more accountable for the care they provide will drive the need for CO-OPs, Hall says. The formation of cooperatives that are patient-centered with oversight by member-peers might not gain wholehearted support, but it likely wouldn't be met with much opposition either.

"In a cooperative, the only purpose is to serve members," Autry says. "Profit is not a bad word, but with no shareholders to return profit to, cost and quality of care become primary drivers. In other contexts [cooperatives] have been successful."

POTENTIAL CHALLENGES TO CO-OPS

But the legislation as currently written does not enable groups operating as CO-OPs to be viable, says Jordan Battani, principal, emerging practices in the healthcare group at CSC. She tackled the issue in a whitepaper last year, "Health Insurance Cooperative—A Real Reform Alternative?"

"CO-OP legislation is a cool idea, but it doesn't take into account the business and environmental challenges that are required to set up a health plan," Battani says. "It's mostly a question of scale."

Economies of scale in back-office functions do not occur until a threshold of 100,000 lives is achieved, and providers often won't give pricing concessions until a plan has 200,000 members, Battani says, putting start-up endeavors at a disadvantage against established health plans. It's the classic chicken-or-egg dilemma—plans won't be able to operate efficiently and in a cost-effective manner unless they enroll a significant number

of members, but members will be leery of joining plans that aren't proven entities with competitive pricing models.

"Providers, hospitals and physicians that participate in federal programs are accustomed to having their reimbursement rates cut back," Battani says. "They survive by transferring that cost to the private sector. Even big health plans have had a hard time getting concessions from providers, so CO-OPs that are just starting out won't be able to get provider concessions."

The advisory board that will structure CO-OPs has only met a few times and hasn't made much progress toward establishing final rules, which does not bode well for the plans, she says.

Established health cooperatives were formed decades ago and have had a chance to reach the proper scale, engage members, build the proper infrastructure and concentrate on competitive pricing and outcomes, she says.

INTEGRATION IS THE KEY

The differentiator for HealthPartners and Group Health isn't necessarily member governance but an integrated care structure, says Dr. Jason Hwang, executive director of the Innosight Institute, a nonprofit formed to apply theories of disruptive innovation to develop solutions in the social sector.

HealthPartners and Group Health are among five systems Innosight Institute has studied within integrated health. Hwang says that the movement toward CO-OPs has lost a bit of steam after being championed by Sen. Kent Conrad (D-ND).

Although Group Health no longer owns hospitals, it is intimately involved in care delivery—hospitals, physicians and insurance coverage—which make it financially responsible for the care experience and provides incentive to keep people out of the hospital. HealthPartners does own hospitals, and its mission is to run them as efficiently as possible.

Dr. Hwang and Battani agree that the ideal candidate to form a CO-OP would be a large self-insured employer, while Milliman identifies hospital and physician groups. In particular, Battani points to a large hospital where employees and dependents would receive care from the hospital provider network, keeping the reimbursements in the family, as it were.

Dr. Hwang points to employers such as QuadGraphics, a privately held printing company with 10 plants and 20,000 covered lives. The company's subsidiary operates worksite clinics at five plant locations, offering primary care and disease management services, in addition to fitness facilities and wellness programs. The company contracts directly with a "high-performance network" of hospitals, specialists and radiologists for services it doesn't provide.

The company says its healthcare costs are one-third below industry averages, and the arrangement has worked so well that QuadMed now operates on-site clinics for other companies, including Briggs & Stratton and MillerCoors.

"Integration is the key, offering high-performing, low-costing, highly satisfied healthcare," Dr. Hwang says. **MHE**

HOSPITALS: 1

MEDICAL CENTERS AND CLINICS: 65

PHYSICIANS: 1,005

TOTAL STAFF: 9,558

HEALTH PLAN MEMBERS: 674,278

UNAUDITED CONSOLIDATED OPERATING REVENUE: $3 billion (2010)

GROUP HEALTH, which serves members in Washington state and northern Idaho, began as a grassroots effort following World War II as an alternative to fee-for-service models.

At the time, paying for care often could lead to bankruptcy as medical bills outstripped income. Concerned consumers, union members and business leaders gathered to form Group Health, which operates as a nonprofit under cooperative principles. The initial organization had to fend off a lawsuit in its infancy to allow for paying physicians on salary, says Anne-Marie La Porte, director of governance services.

"One of the most important things Group Health has going for it are voting members who select trustees and can vote on by-laws," La Porte says.

A standing committee of members interviews potential trustees and performs background and reference checks before submitting names to the general membership. No trustees or board members serve on the standing committee, and the 11 trustees must be Group Health members and work 20 hours a month.

Members over 18 who express a desire can vote, but only 40,000 of the group's 450,000 eligible members exercise this right. La Porte says challenges facing Group Health include increasing voter participation and managing budgets during a tumultuous time for healthcare providers.

The umbrella organization includes Group Health Cooperative and its research arm, the Group Health Research Institute; Group Health Options, Inc.; Group Health Foundation; and Group Health Physicians—with whom Group Health Cooperative has an exclusive contract.

It also acquired KPS, a 62-year-old nonprofit health carrier based in Bremerton, Wash., in October 2005. KPS maintains a separate corporate identity.

Group Health divested itself of hospitals during the 1990s and estimates its costs dropped by 50%. It offers integrated care through the medical home model, which has shown improved HEDIS results and lower costs, including 29% fewer emergency room visits and 6% fewer hospitalizations, according to a case study from the Innosight Institute.

"It makes you more patient-focused than profit-focused," La Porte says of Group Health. "I believe that in my core."