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CO-OP Point of View

Essential tactics for CO-OP prosperity

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Even before the first member is enrolled, consumer operated and oriented plans (CO-OPs) will invest thousands of hours in developing the operational infrastructure that will provide healthcare coverage for their members. Conventional approaches to managing cost, such as contract negotiations with network providers for competitive unit costs and implementing medical management models to curb excessive utilization, are important starting points for controlling the cost of claims. However, recent changes to the nation's healthcare system have created a few additional items for CO-OPs to consider as they prepare for October 2013 and enrolling their first members.

In order to prosper, CO-OPs must strive to position themselves as a lower-cost alternative in the exchange market. Several positive benefits are likely to follow such positioning.

First, more members will enroll and help the CO-OP to achieve scale. Achieving scale is vitally important for CO-OPs for a number of reasons. Scale will enable the CO-OP to spread its fixed costs across a larger member base, thereby reducing the per-member-per-month (PMPM) administrative costs and lowering the medical loss ratio. Scale will also allow the CO-OP to achieve a stronger negotiating position and will likely improve network discounts for 2015, the second year of CO-OP operations. Scale will permit tougher vendor negotiations with pharmacy benefit managers (PBMs) and other suppliers. Without scale, life will be difficult for a CO-OP and premiums will be higher for CO-OP members.

As a lower-cost alternative in the exchange, the CO-OP is more likely to attract a younger, healthier population. People who are unlikely to use their medical coverage usually shop on price. While there will be a risk adjustment process in all exchanges, it is certain that the CO-OP will make money on members who have no claims during the benefit coverage period, even if the risk score is low and the CO-OP receives less than average revenue for providing their coverage. We've seen other examples of risk adjustment arrangements in healthcare, and enrolling a disproportionate share of very healthy people always helps profitability (even with the lower revenue). Becoming a lower-cost alternative must be a top priority for a CO-OP.

So how exactly will a CO-OP be able to achieve this lower-cost position in the market? The first step should be to consider using a restricted network of preferred providers to drive lower unit costs. In a commercial large group market, introducing a preferred network can create problems because of the number of plan participants who might need to change doctors. But in the individual market, and even in the small group market, this is less of a concern because buyers are more price-sensitive and will consider changing doctors to obtain lower premiums. Preferred networks are crafted by identifying the highest-cost providers and finding a way to live without them. This is done by identifying other providers who can adequately provide sufficient geographic dispersion and coverage, and considering other options for treatment—for example, using centers of excellence for high-cost procedures when high-cost teaching hospitals are not included in the network, or using mail order facilities when certain retail chains are not included in the PBM network. Other providers located nearby are usually willing to offer competitive terms when it means greater volume and the concentration of members that the CO-OP can provide. The CO-OP should also identify centers of excellence for high-cost procedures (e.g., transplants) that might require travel but also offer high success rates at competitive costs. CO-OPs might find that using a preferred network strategy is essential for driving claims (and therefore premiums) to a low-cost level.

In addition to preferred networks, CO-OPs should consider negotiating collectively for certain vendor services. For example, PBMs are unlikely to provide very attractive terms for a CO-OP that has no membership, even if it is projecting up to 100,000 members. However, a consortium with the potential of 500,000 or even 1 million members is likely to get extremely attractive terms in

response to a request for proposals for PBM services. The same is true for lab vendors and others. Even the centers of excellence might offer more attractive terms if the consortium negotiates on behalf of individual CO-OPs. Competing with large national health insurers will be extremely difficult if CO-OPs do not have the same negotiating clout, and fortunately that clout is possible with a consortium approach.

While the two topics discussed above primarily address unit costs, utilization can also be improved with focused effort. Wellness is a burgeoning new industry that has begun to produce some impressive results. This industry has grown in response to a dramatic increase in poor health habits in the United States over a very short period of time. Obesity in the United States has risen to over 35% of adults and, according to a Society of Actuaries study, now has a cost of nearly $300 billion annually. A carefully designed wellness program could help reduce disease burden associated with obesity and the treatment cost of those conditions (e.g., hypertension, type 2 diabetes). A carefully designed wellness program can provide an attractive return on investment (ROI) for the CO-OP and favorably position it for future years with a healthier population.

Getting off to a good start in 2014 by having a large member base and achieving scale is essential for long-term success because of the importance that scale has to the fundamental financial drivers. This article presented a few essential approaches that are likely to help achieve the lower-cost positioning needed to prosper. Successful CO-OPs will undoubtedly develop other new approaches to reduce claims and compete with larger carriers.

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