Consumer Operated and Oriented Plans
Federal Advisory Board – Public Hearing

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Good afternoon, members of the CO-OP Advisory Board. I am Diana Birkett Rakow, Executive Director of Public Policy at Group Health Cooperative, an integrated health care coverage and delivery system based in Seattle, Washington. Thank you for inviting me here this afternoon to discuss Group Health; how our consumer governance structure has contributed to our success; and how some of our experiences might offer lessons for design and development of new Consumer Operated and Oriented Plans as authorized under health reform.

Group Health Cooperative is a nonprofit, tax-exempt health system that provides both coverage and care. Our mission is to design, finance and deliver affordable, high-quality health care. Directly and through our subsidiaries, we cover more than 650,000 residents of Washington State and Northern Idaho, about two-thirds of whom receive care in one of 30 Group Health owned-and-operated medical facilities. About 1,000 physicians are part of the Group Health group practice, and we contract with more than 6,000 physicians and 44 hospitals. Extending Group Health's reach into the community, we also include a Foundation, making donations to increase childhood immunization rates and improve community health, and the world-renowned Group Health Research Institute, which conducts research in the public domain on health care system design, treatment options, and comparative effectiveness.

Our "members" are our consumers, who are also our patients. You can join Group Health just as you would any other entity that offers health insurance coverage. We offer health coverage through public programs and in the commercial market– in Medicare, Medicaid, the state Basic Health Plan, on the individual market, and to small, medium and large employer groups. We also support employers who have elected to self-fund their employee health coverage. And we are one of the largest employers in Washington, ever-conscious about the cost and quality of health care for our own staff as well as our patients, with 9,500 employees from actuaries to nurses.

We are fairly unique in the health care market for several reasons. First, we provide healthcare directly to the majority of our members. Second, we are a regional plan, serving Washington State and northern Idaho, subject to Washington state insurance regulation (and for our large employer coverage in northern Idaho, to Idaho regulation),

and responsive to the needs of our local communities. And third – and of course the primary reason I am here today – we are a consumer-governed not-for-profit corporation.

These three differentiating characteristics are integrally related to one another, as reflected in the story of our origins, our survival, and our success.

In 1947, when Group Health was founded, the idea of consumer-governed, prepaid group medical coverage was a radical one. But the health care system at that time left many middle-class people out of coverage, personal health care was becoming more and more difficult to afford and people in post-war Seattle felt there must be a better way. On a smaller scale, this is not unlike what happened in society over the last several years: while we may not have agreed on a particular solution, there developed broad agreement that the status quo, with rising numbers of uninsured and people slipping through the cracks, was unacceptable and unsustainable, and the groundswell of discomfort led to partnerships, negotiations, and ultimately a plan – health reform.

On the smaller scale of 1940s Seattle, the players were the unions, rural granges, physicians, and leaders and members of other local cooperatives – telephone, grocery, and farm suppliers. The conversation was about how to make American healthcare more affordable, accessible, and accountable. And the outcome was Group Health.

The founders of Group Health chose to incorporate under Washington state law as a cooperatively-governed, not-for-profit corporation, and we are classified under the tax code as a 501c(3) organization. Over the years, this structure and the consumer governance infrastructure that was initiated over 60 years ago have endured. During that time, Group Health has evolved from a single-clinic organization, serving a small number of members, and strongly resisted by the medical community – to one that serves hundreds of thousands, both within and outside our own medical group, and with strong and mutually respectful partnerships with community physicians, hospitals, and other providers. We have been subject to the same market forces and regulatory structure as other coverage entities, but have proven that it is possible to be consumer-governed, competitive in the market, and successful in delivering higher-quality affordable coverage and care.

Our successes are demonstrated on many fronts – member experience, quality of care, and cost savings. In 2010, for the second time, J.D. Power and Associates, one of the most trusted and recognized quality award organizations in the US, ranked Group Health "Highest in Member Satisfaction among Commercial Health Plans in the Northwest Region." We were also last year ranked the #1 HMO in the United States by Consumer Reports. We received the highest possible scores in the Puget Sound Health Alliance's (PSHA) "Community Checkup", a report on health care quality among providers in Washington State. And our Medicare plans have been awarded 4.5 out of 5 stars by the Centers for Medicare and Medicaid (CMS) – a reflection of performance in everything from preventive and chronic disease care to customer service and compliance.

We continue to invest in and improve our primary care-based delivery system, and have seen positive returns on our investments. Three years ago, we tried out a new patient-centered "medical home" model in one of our clinics, systematically addressing comments from both patients and providers. We reduced the number of patients seen by each primary care team, lengthened the average appointment time, scheduled time for phone calls and emails, and established regular processes for pre- and post- appointment outreach to patients. The pilot was successful, andwe have rolled this out to 26 primary care centers, now saving $4 for every $1 invested in enhanced staffing. The bulk of the savings come from a reduction of emergency room visits of 29% and hospital days of 19%. Quality measures, as illustrated by HEDIS and CAHPS, have skyrocketed. Patients are healthier and thrilled. And our doctors and nurses and pharmacists have never been happier – many primary care physicians previously awaiting retirement have decided to continue working, and we have many times more applications for new primary care slots than we are able to accept, despite the primary care shortage.

We have seen similar success through a program to reduce unnecessary hospital readmission rates by ensuring that patients discharged from the hospital are well connected with a care team to see them through the transition either home or to a post-acute care facility. Now, while more than 20% of all Medicare patients are readmitted to a hospital within 30 days of being discharged, the rate among Group Health Medicare members is only 14%, and still going down.

These improvements, innovations, and successes happen for many reasons. Our integrated structure includes both the incentives and the tools to provide both affordable *and* high-quality care – we are able, more than other organizations, to redesign care systems, invest in primary care, and improve care transitions so that patients stay healthier. At the same time, we are regulated on a level playing field with other coverage providers operating in Washington State, subject to a set of rules and regulations that are different – and in many cases more stringent – than elsewhere around the country. We must keep our premiums in line with the market in order to stay competitive, and we must be accountable and responsive to our members. Striking the right balance between these forces has sometimes been a challenge, but in the end being responsive to all three – our regulators, the market, and our members – has made us who we are.

Our consumer governance structure is a core part of our identity, and our members continuously and systematically shape our business decisions, and the result is a more patient-focused, high-quality organization. But this doesn't happen automatically. We have a department dedicated to the upkeep and maintenance of our consumer governance structures, in support of our core and founding values. The result is a set of formal, structured, and regular opportunities for consumers to provide input, and a different kind of business consciousness.

From the top down, Group Health is led by our members – members elect the Board of Trustees, who in turn hire and direct the CEO and executive leadership, set policy, review financial plans, and approve our strategic direction. Candidates for the Board are rigorously vetted, and our Trustees bring a diversity of critical expertise to bear, as CFOs,

physicians, nurses, business owners, government workers, and attorneys. In 2006, the Board referred a position on health reform to the membership; the resulting member-approved position provided guiding principles for Group Health's advocacy and influencing activities during the health reform debates of the last several years. In the 1990s, a position taken by our Board led Group Health to be the market leader in providing mental health coverage in the individual market and supporting the policy of mental health parity – the first and for some time the only insurer in Washington State to do so.

Beyond the Board, the general membership has and continues to have a profound impact on our organization. A decade ago, ahead of most of the country and before our doctors even had an electronic medical records system up and running, Group Health launched an online patient records system, MyGroupHealth, to fulfill the needs of our members. The common wisdom in the industry was to let physicians get comfortable with technology before giving it to patients, but we prioritized the patient. Our members enjoyed a personalized home page, better access to their doctors via secure messaging with their primary care team, online prescription refills, "condition centers" tailored to a patient's health conditions, and access to lab results – all while the more complex clinical system was being built out.

We see the impact at a large scale, as in the case of MyGroupHealth, and at smaller one as in the case of a reading program called "READ" at our Northgate Medical Center, north of Seattle. There, a group of volunteers from the Medical Center Council – one of the entities in our consumer governance structure – developed, implemented and continue to maintain a program designed to give families information and resources to support reading to children at an early age. Kids from 6 months to five years of age receive an age-appropriate new book each time they come in for a well-child visit at the clinic, and a member of the child's care team talks to the family about the importance of reading.

At Group Health, consumer governance has allowed us to be patient-centered, and vice versa – at some points, against all market odds. One of Group Health's founders, Hilde Birnbaum, liked to say that "To survive as a cooperative we must survive as a business." To survive as a business, we have had to remain competitive and to innovate, especially by leveraging our close relationship and connection – and the strong engagement – of our patients, our members.

Looking to the future, Group Health is committed to six basic elements of care delivery that we can influence, that can help us achieve exceptional results for our members:

- First, we are a committed to a system that is truly patient-centered. For us, this means that members are engaged not only through governance but as active, engaged participants in their own care, using tools such as electronic records and shared decision-making.
- Second, we structure our medical practice to manage care and promote health – not just provide services. The patient-centered medical home and readmission rate reduction successes are excellent examples of this point.

- Third, our providers – and those with whom we partner through contracted networks – share a common set of values and a common approach to care.
- Fourth, we have information systems that support health, wellness, and health literacy of the patient – electronic records and other tools must help patients champion their health, not just physician communication or claims processing.
- Fifth, we will develop and implement payment structures that encourage better health, from our current and traditional model of pre-payment, also known as capitation, to new and innovative provider incentives for quality and service, value-based benefit designs that encourage patients to use preventive and effective chronic disease care, and shared-savings arrangements with community partners. Within all of these models, the goal will be better health for the patient, better affordability and service for the member.
- Finally, we will continue to position our care systems as part of a broader community, collaborating with government agencies, social services, public health, and community organizations. As our members' lives extend far beyond our clinic walls, our stewardship of their health must also expand to cover whole lives, families, and communities.

The CO-OP program provides the potential in the reformed health care environment, to support and expand a more patient-centered model of coverage and care. As one of the model organizations, Group Health would like to help bring our own values and successes to other parts of the country. Under the statutory language, we are prohibited from participating as a new CO-OP, but I hope we can find a way to support the program through innovative partnerships, since there is great value in learning from what has gone before.

With that in mind, and in closing, I encourage you to consider five elements which would support success and sustainability in the new program.

First, promote systems that will deliver more member-centered, patient-centered care and coverage than the rest of the marketplace, through either true integration of care financing and delivery or close partnerships and networks with high-quality providers, and through value-based payment and benefit design.

Second, select organizations that seek to approach health coverage for members across the continuum of their lives and experiences; that will have an active community presence to promote broader public health, disease prevention, and well being. Consider requiring that CO-OPs ultimately serve Medicare and Medicaid beneficiaries, allowing for continuity of coverage across the spectrum of life and experience.

Third, ensure that CO-OPs are held to an even and rigorous standard of regulation and quality, on a level playing field with other coverage providers. While CO-OPs will benefit from up-front grants and loans, they should be required to be licensed under state regulation, subject to standard insurance regulations in their state, accredited by a major independent quality-assurance organization such as the National Committee on Quality

Assurance (NCQA), and provided incentives to continuously improve quality of care. Consumer-governed should be consistent with consumer-protection.

Fourth, look for organizations that are intentional in their design, prepared to build a structured set of opportunities for consumer engagement, as well as developing from a set of roots and values that are inherently consumer-responsive.

Finally, don't forget the legacy co-ops such as Group Health Cooperative, Health Partners, and Group Health Cooperative of Eau Claire. Find a way to benefit from both past and present success, to build upon the experiences and lessons learned by the organizations sitting before you today, and support our ongoing efforts to innovate and improve health care and coverage for our members and communities. Possibilities for partnerships may exist in several areas, from consulting or technical assistance support to shared networks, partnerships, and expertise.

Three years ago, looking ahead to another health reform debate – outcome, as always, uncertain – one of our founders, CEOs, and living legacies, Aubrey Davis wrote the following: "In 1947, our Cooperative started something that hadn't been done before – providing both full insurance coverage *and* comprehensive medical care. There were no books, no guidelines, and no experts to look to.... Through the years, Group Health has navigated a series of transitions. But through these changes our core values have remained constant. We still look for ways to provide what is best for our patients through good stewardship, scientific discipline, and integrity – coupled with an innovative spirit… We've organized a… system so valuable to our consumers and the communities we serve that we should be prepared not just to react to, but to *lead* the coming changes. After all, it's part of our heritage!"

In that spirit, I thank you for the opportunity to offer Group Health's perspective on one of the exciting coming changes in our health care system, and I welcome your questions.