The Role of Group Health Cooperative in the Development of Washington State's Basic Health Plan

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Group Health is a 42-year-old health maintenance organization (HMO). It existed before the term HMO was created. Group Health is a cooperative HMO and the largest consumer-owned and consumer-controlled HMO in the country. The unit in Seattle, which covers 375,000 enrollees, is primarily a staff model, nonfederally qualified. We have a Medicare risk contract with the Health Care Financing Administration and a contract with the state’s Department of Social and Health Services (DSHS) on a capitated basis for Medicaid enrollees.

Group Health Northwest, a subsidiary affiliate, is federally qualified. It is a staff model but also has a substantial network throughout eastern Washington. This model has 63,000 enrollees, a Medicare cost contract, and a capitated contract with DSHS.

Together, Group Health and Group Health Northwest worked to support the Washington Basic Health Plan starting in 1983. The Committee on Affordable Health Care, created and chaired by Gail Warden who was then Chief Executive Officer of Group Health Cooperative of Puget Sound, took a strong role in supporting and discussing these issues in our state. The legislature viewed the benefits of the Basic Health Plan as being derived from the combination of patient care management and resource management.

Because Group Health is truly a managed care system, we try to deliver cost-effective, quality medical care. Group Health wanted to be a partner with the state in the Basic Health Plan and was the first provider to join. The contract we designed with the Basic Health Plan became the prototype for the providers that followed.

Marketing The Basic Health Plan

The issues of most concern to us included adverse selection, the benefit package, and the enrollee mix. Adverse selection was the most worrisome issue because our plan might be selected not only by the uninsured but also by the uninsurable. As the first participating provider, we were concerned that our plan might attract a large number of patients with significant unmet health care needs. Even with the 12-month exclusion for preexisting conditions, patients with diabetes, asthma, cancer, or arthritis might pay premiums for one year just to have coverage for these medical problems, particularly since no other insurance plan would be likely to accept them on an individual basis.

Utilization of the Basic Health Plan was estimated as being between standard and Medicaid usage, which in our case is a difference between 100% and 150%, a fairly wide margin for estimation purposes. In Seattle, Medicaid utilization is 50% more than our standard utilization. In Spokane, it is about the same or slightly less. The lack of information about the utilization relationship between potential Basic Health Plan enrollees and Group Health’s Medicaid enrollees made our initial rate setting problematic.

We had some problems with the original benefit package. It was understandably limited, due to the state’s budget constraints and concerns about potential discontinuities in mental services. The absence of outpatient prescriptions in the program was a serious omission, although we understood the basis for that. Physicians can develop diagnoses and treatment plans, but if patients don’t follow through and acquire the medication on their own, they tend to return to the physicians complaining of the same symptoms; the problem is that they haven’t used the medication because they could not afford it. This leads to more medical need than would otherwise occur and possibly some emergency room use which also might not otherwise occur.

Other benefits which were originally and are still excluded from the plan include physical therapy and mental health. The maternity benefit originally covered only prenatal and postnatal care, and delivery was covered only if the enrollee was not pregnant at the time of enrollment. This led to the problem of recently pregnant women enrolling in the plan, receiving prenatal care, and then not being covered for the care received, leaving us with a substantial bad debt. We helped to convince organizers of the plan to include maternity coverage, and between us we devised an ingenious way to capitate the costs by adjusting the capitation every three months, which seemed to meet the law without making it fee for service.

The enrollee mix was another issue. As we reviewed the marketing plan, we became concerned that it might be limited in approach and might not attract a balanced enrollee mix. We became directly involved in the marketing effort and developed a marketing strategy. We identified the target market, in this case

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the broadest possible group of low-income families, and we planned a campaign strategy to deal with that particular group. Our marketing objectives included the selection of our audience, minimization of adverse selection, deciding how carriers can work together and with the Basic Health Plan to reach the broadest population, and selecting our message. We wanted to position the Basic Health Plan as a good choice for healthy people who wanted affordable financial or insurance protection, and we wanted to help generate an adequate level of inquiries to the Basic Health Care Plan office.

Our marketing strategies included a general publicity program, a television public service announcement campaign, a direct mail campaign to target households, and a community outreach program if proven necessary. To get a television public service program we approached a major local television station which contributed the production and airing time for the Basic Health Plan program. Approximately 1,400 inquiries were generated by the television campaign in the first months of the program. Our direct mail campaign, which reached 20,000 households, generated 670 inquiries. The community outreach program has not yet been implemented. The program consists of sending letters to students' homes, to public schools, to employees and parents through day-care centers, and contacting employers with part-time workers, such as health care organizations, retailers, and restaurants, and also professional organizations to reach self-employed artists, contractors, and consultants.

We wanted to be included early on in the marketing negotiations in order to achieve the result of a broad-based campaign. We sought publicity to generate inquiries and members and to minimize adverse selection. We helped organize a multicarrier marketing committee, which consisted of representatives of most of the managed health care plans that made initial proposals to the Basic Health Plan. This committee helped to organize a committee with the Basic Health Plan so that we would have a cohesive marketing plan for the state, rather than individual plans for each carrier. This is vital when working with a limited number of state dollars identified for marketing.

There were some internal marketing issues. To prepare providers for this new population, we set up a special group from our medical staff and our operating and administrative support staff to develop the implementation details. We included the Basic Health Plan enrollees in our Welcome Calling Program in which we attempted to contact by telephone each new enrollee to familiarize them with Group Health and to assist them in selecting a primary care center and a primary care physician and identifying the services they needed.

Obviously, the premium we quoted was a concern. We calculated the rate based on the expectation that the Basic Health Plan utilization would be somewhat higher than standard, but we concluded that it probably would not be nearly as high as our Medicare rate of utilization. We set our premiums at 10% above the standard utilization rate and had a special modification on a quarterly basis at that time for the maternity benefit.

We found that we had fewer maternity cases than initially expected. We continued to lower the cost on a quarterly basis and recently agreed to eliminate the add-on for maternity because of a new program called First Steps, which is funded by Medicaid in our state and to which the funding is now being transferred for the maternity patients under our Basic Health Plan.

We limited our risk by restricting the number of people we were to serve initially to 1,000 in the Spokane area and to 3,000 in the Seattle area. We chose delivery sites that had the capacity. We didn't think we had the capability to add additional enrollees that might come from the Basic Health Plan in our fastest-growing areas outside of King County. We identified four to five clinics in King County which had the capacity; this is where most of the enrollees are now served. Group Health Northwest in Spokane uses all of their Spokane facilities without limitation.

We encourage and support the expansion of benefits as soon as the Basic Health Plan budget allows, and we believe we must continue to pay special attention to provider education because the benefits of the Basic Health Plan are somewhat less than those for other enrollee groups in Group Health. We do not want these patients treated differently, and they are not treated differently, but it is important for our physicians to recognize the limitations on the coverage, particularly on drug coverage.

Current Status

Enrollment has gone smoothly. For this year's contract we agreed to expand by another several thousand enrollees in western Washington and by 1,000 in eastern Washington. By the end of 1990 we will have approximately 7,000 enrollees in the Group Health system.

Since the program became effective in February 1989, it is still too early to have data on the total group utilization. Our original assumption that utilization will be slightly higher than the standard rate is probably correct. We did get a good mix of people from a health-care risk standpoint.

The administrative procedures between us and the state have worked well in this program. A user group of participating plans has been established in which representatives of all the plans meet periodically to discuss administrative issues.

This type of approach is probably preferable to undertaking a total universal coverage program in a single state. We are encouraging our state to expand the Basic Health Plan and believe it makes a significant contribution to the national dialogue on health care reform. However, it is important for managed health care systems to become involved with such a plan early on in order to help shape the program so that it operates well within their structure. Early involvement is critical to effective participation. Once the commitment is made, spend time to form and educate your providers about program requirements, benefits, and limitations. This is critical with any new program.

There are several benefits from participating in such a plan. It helps to solidify important political liaisons, provides an opportunity to support and promote the managed care approach, and allows support of providers by offering an alternative to accepting low or no reimbursement from patients. It also provides an opportunity to assume a leadership position in being a responsible corporate citizen.