The Evergreen Project

Redefining Health Care

Overview

Maryland's Evergreen Project will facilitate a completely new conversation on both sides of the exam table where informed and involved patients, working with their physicians, can and will improve outcomes and reduce costs in a system that responds to evidence and rewards excellence. We seek to create genuine change in the structure and methods of Health Care delivery, the cost of and access to Health Insurance and the standard practices used in determining what should be covered and under what circumstances.

Using a cooperative membership model and professional health coaches, The Evergreen Project will serve as the facilitator of new models for funding and delivering health care where the members share in the savings brought about by increased efficiencies and reduced costs. We will use a social enterprise model where the benefits of operational efficiencies will be reinvested in additional program features.

Project Status

Initial discussions on undertaking this project began in April of 2010. Milestones achieved to date include:

- Formation of a steering committee composed of experts in Public Health, Insurance, Entrepreneurship, Venture Capital and Health Economics (see appendix A)
- Development of an initial plan for feasibility studies to be conducted in 2011
- Receipt of initial funding grants of $175,000 to perform feasibility studies
- Completion of a Fiscal Sponsorship agreement with Baltimore Health Care Access, Inc.
- Appointment of a Full Time Project Manager to lead our efforts
- Validation of our initial assumptions through consultation with experts in the fields of health economics, actuarial science and consumer behavior in health care utilization and underserved communities
- Identification of a strong opportunity within our model for the incorporation of a community engagement and workforce development strategy that we believe will not only enhance the overall benefit of our efforts to aid the underserved, but also increase our ability to attract and retain members
- Receipt of additional independent indications that the health coaching aspects of our program can bring about significant reductions in the cost of care for the underserved
- Significant notice in local press for our efforts

A Sponsored Project of
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Background

With passage of the Patient Protection and Affordable Care Act (PPACA), Section 1322 of the legislation created the Consumer-Owned and -Oriented Plan ("COOP"). This allows for the creation of not-for-profit cooperatives that would provide affordable health insurance by creating a pool of consumers who could then negotiate with providers for health care. The creation of these COOPS would address three principles of health care reform: choice, quality and cost. COOPS would ensure that Americans would be able to continue to choose their doctors, and COOPS would provide greater value by returning surplus revenue to members in the form of lower premiums, lower cost-sharing, or expanded benefits. COOPs would be self-governed by an elected board, but would operate within the health reform exchange, subject to the same rules and regulations regarding minimum benefits, actuarially equivalent packages, and reserve funds. Co-ops could be formed statewide or in geographic regions.

Regulatory Objective

From Evergreen's perspective, the challenge, and in many ways the opportunity presented is to develop regulatory guidelines that enable COOPs to offer reasonable, market based, risk returns for sources of funding which permit COOPs to be adequately capitalized for the benefit of its members. These sources of capital, the types of risk they undertake and the purpose for which they invest are each multifaceted and at this time, unknown. However, there is ample precedent in the public and non-profits sectors where privately sourced capital assists in furthering capital intensive efforts such as local government capital projects for schools as well as expansion of non-profit hospitals and service providers in mental health and disabilities. An additional challenge is to structure the associated regulations in a manner that enables flexibility in how capital can be sourced and put to work for the COOP, while ensuring that no resultant commitment compromises the COOP's independence and ability to achieve long term benefits for its members.

Key Issues and Solutions

As the Evergreen Project continues to develop its plans, we have identified several key issues and a need for guidance.

Loans and Grants

Section 1322 provides for loans and grants that will serve as a much needed resource for COOPs for the establishment of initial loss reserves needs and critical start-up expenses. However, it is generally recognized that this initial funding may not be sufficient to fund the ultimate needs of a reserve fund to manage the anticipated risk pool.

Possible Regulatory Solution: Accordingly, we believe that the regulations need to address multiple layers of funding dynamics to develop: (i) a definition for "profit" that allows appropriate risk based returns for capital invested, and (ii) rules regarding access to and use of the authorized reserve funds.

Access to Capital

The ability to attract risk-based capital into the enterprise will be a key element to developing an entity that is fully sustainable and actuarially sound. Further, the ability to provide some sort of financial return to equity based investors may be needed in order to build a reserve fund of sufficient size to support the projected loss ratios. Our intention is to make certain that operating income is used to further the mission of the venture and not to enrich shareholders. However, we expect that the COOPs will require some level of outside investment in order to support both operating costs and reserves, and we hope to be able to structure a mechanism that will allow the entity to use these investments to grow the venture. In addition, the process for applying for federal funding and the timing of capital needs for the entity may not be aligned in the most opportune fashion.

Possible Regulatory Solution: The regulations should explicitly permit outside investment so long as it furthers the mission of the COOP venture. Additionally, the process and timing for accessing the federal funding should be flexible.

Profit / Invested Capital

A COOP will need to be adequately capitalized in terms of reserves for losses, initial start-up costs and then ongoing working capital until the COOP is cash flow positive after paying claims and operating expenses. There is also an understanding that the COOP will not commence operations with sufficient members or, frankly any members, to fund operations with positive cash flow after costs. The challenge that this presents for any group seeking to establish a COOP is to figure out an approach to capitalization that balances in an acceptable manner the intent of Section 1322's goal of using excess funds for the benefit of its members with the need to adequately structure the capital required to succeed.

For example, it is anticipated that the COOP, as the insurance carrier, would contract with other nonprofit entities to deliver health care services. The COOP would also contract with sources of capital to fund its operations and reserves. While the COOP cannot earn or receive profits, it needs to be able to provide sources of capital with a return commensurate with their risk in funding the COOP, a risk that should be measured in terms of market standards for similar investments.

Capital is divided into its two components---equity and debt. In a traditional start-up of an organization or enterprise, equity plays the initial and greater role. Since it does not normally require an immediate dividend or pay back of the invested capital, equity allows a start-up to advance its strategic plan while reinvesting all returns in the enterprise. Traditional debt financing, because of interest and principal payback provisions, is generally more useful in funding established entities with fully developed and predictable cash flows. Nevertheless, depending on the structure and support for an investment, either equity or debt may be applied to initial funding of COOPs.

Possible Regulatory Solution: Private sector investors will be needed for start-up and other operational needs beyond federal grants and loans. Permit COOPs to obtain outside capital, earn or receive profits as long as the revenue is reinvested in the COOP and allow investors a market standard return. See Appendix B for suggested guidelines for where capital could be obtained and used.

Legal Status

While the legislation refers to non-profit co-ops, a 501(c) 3 entity may not be the ideal structure if the entity is to be able to raise the needed capital. Further, while the legislation calls for the governance of the organization to be subject to a majority vote of its members, there are several mechanisms for organizing a risk pool that would fit this category. Therefore, further refinement of this issue will be needed in order to make an informed decision on the viability of the enterprise.

Possible Regulatory Solution: The regulations should permit other legal structures that are not purely "non-profit" in nature. Any given legal structure should and must remain true to the mission of the COOP.

Technical Parameters

While the legislation is quite clear regarding existing carriers and markets, there are a number of technical questions regarding various issues such as the use of Medicaid vouchers, Age bands and benefit structures, medical loss ratios, allowable variances, certification criteria and the like as they specifically apply to the co-ops. Defining these parameters will be a critical issue as we examine the feasibility of the enterprise.

Possible Regulatory Solutions:

- Permit a COOP a prominent position on health exchange websites
- Free or low cost reinsurance with guarantees provided by governmental entities
- Voucher acceptance of Medicaid patients at our clinics in order to allow us to care for entire families when one or two family members are on Medicaid
- Require certain organizations to participate (hospitals, specialist centers) and provide their best rate to cooperatives in order to offset the inequity in pricing power that is currently available only to large insurers.

Appendix A

Steering Committee

Peter L. Beilenson, MD, MPH (Co-Founder)
Howard County Health Officer/Chair of Board, Healthy Howard

Henry Cha
Chief Executive Officer, HealthCare Interactive, Inc.

Newton B. Fowler III
Partner, Rosenberg-Martin-Greenberg LLC

Liddy Garcia-Bunuel
Executive Director, Healthy Howard, Inc.

Aaron J. Greenfield
Managing Director- Duane Morris Government Affairs.

Bradley Herring, PhD
Assistant Professor and Director of the PhD Program in Health Economics & Policy, The Johns Hopkins Bloomberg School of Public Health.

J. Howard Kucher (Co-Founder and Executive Director)
Executive Director, Social Entrepreneurship Program, University of Baltimore (December 2005 – December 2010)

Douglas M. Schmidt
President, Chessiecap Securities, Inc.

Sean Tunis, MD, MSc
Founder and Director, Center for Medical Technology Policy

Dawn O'Neill, MPH
Deputy Health Officer, Howard County Health Department

Kathleen Westcoat, MPH
Executive Director, Baltimore Health Care Access, Inc.

Appendix B

The following outline is a suggested guideline for where capital would be obtained and where it may be used:

1) Sources of Capital
    a) COOP would receive funds for its capital needs from three primary sources:
        i) Premiums from members
        ii) Federal funding of reserves and startup expenses
        iii) Funds from third parties (not COOP members)
    b) The capital is needed to fund
        i) Reserves
        ii) Operating / overhead (startup/capital) expenses for service delivery
        iii) Working capital
    c) Third party funds may come from the following sources:
        i) Foundations and non-profits who support the mission of the COOP
            (1) These funds might be provided such forms as grants, loans or program related investments (PRIs)
        ii) Individual Donors
        iii) Private Investors
        iv) Social Venture Investors
    d) With these funds there are any one of three possible repayment scenarios:
        i) There may be no expectation of repayment
        ii) There may be an expectation of repayment, but no expectation of a risk based return (interest)
        iii) There may be an expectation of repayment and a risk based return
    e) In order to ensure the legislative intent of Section 1322 that COOPs remain independent from, and not influenced by, the health care industry, health care companies, insurers and their affiliates should be excluded from financing a COOP

f) This definition of "financing" a COOP should acknowledge that COOPs may need to contract with existing health care delivery systems, to meet certain health care delivery needs of COOP members, such as hospitalization and specialists

g) Any delivery of health care services to COOP members must be on market based terms and the regulations should clearly indicate that they cannot effectively be financing vehicles in tandem with such services

h) In furtherance of the legislative intent, health care systems (providers) should be able to offer COOPs below market benefits, discounts or other incentives that help reduce costs, provided that no such relationship can involve a return in excess of a market based payment for such activity, or function as an return for investment or affect or influence the operation, governance or control of a COOP, beyond customary contractual provisions directly related to the delivery of services.

2) Use of Capital

a) COOPs will require capital to fund:

i) Start-up expenses and ongoing working capital needs

(1) These needs include such items as real estate, equipment, staffing, and working capital for service delivery

ii) Payment of bona fide expenses associated with claims (delivery of health care services), excluding (as indicated above) any payments designed to provide a return for investment

iii) Payment of actual overhead associated with operation. This should include compensatory programs for incentivizing staff to achieve improved health care delivery and wellness goals

iv) Payment of wellness and healthy life and similar programs for the benefit of its members

v) Reductions in premiums, copayments or other direct or indirect incentives for COOP members

(1) Such incentives are to be computed based on member behaviors and not in relation to the financial performance of the COOP

vi) Establishment and maintenance of reasonable operating reserves which are independent of the reserve funds established in the management of member health claims

vii) Establishment and maintenance of claims reserves

(1) COOP can contract with third parties to finance the reserve fund as a supplement to and in addition to the Federal reserve fund support, in exchange for a "market based risk return" for such investment, payable to the third party, and not to inure to the benefit of the COOP, its staff or members.

(a) As in any professionally managed risk pool, this return would be paid from investment income received on the principal of the reserve fund

3) Capitalization Structure

a) Risk based return available to either funders of reserve fund or of start-up and ongoing working capital may have the following attributes

i) In order to ensure the legislative intent of Section 1322, traditional equity structures should not be available

ii) While no funding source should receive equity or an equity like right in the COOP, the payment or debt obligation

(1) Can accrue (deferred payment), or be paid on a current basis

(2) Take the form of a blend of current and accrued obligations

iii) Return can be fixed or variable

iv) Variable rates of return may be based on:

(1) market terms,

(2) risk profiles within the COOP

(3) duration of the investment

(4) the position of a particular investment relative to other capital sources

v) Investments may also be secured by

(1) Lien on fixed assets of business

(2) Liens on reserve funds (including those that have been created using federal capital as a seed fund)

4) Use of Investment income and operating profits
   a) After payment of all claims and reasonable operating expenses, a viable COOP is likely to have generated an operating profit
   b) Any professionally managed risk pool will generate interim income from claims funds held in reserve
   c) Such operating profits and investment income should:
      i) Not inure to the benefit of the COOP, its staff or members.
      ii) Be able to be used to fund any required risk based return from funders of any part of the COOP's operations as outlined in section 2
      iii) not require sinking fund (or other capitalized repayment strategy) but a business model that will allow such funds to be replaced by market based investors or by premium activity of COOP members at maturity
   d) COOP would be allowed to tier loss experience payouts from Reserve Fund, so that earlier years when results are not actuarially mature might require a lower repayment than later years when claims results are more stable.
5) Timing of creation, scaling of Federal funding for reserves and start-up costs
   a) Given start-up nature of COOP, it will require the commitment of Federal funds for the establishment of claims reserve upon formation/licensing or other organizing event of the of COOP
   b) COOP may need to be able to access funds prior to enrollment of members
   c) Federal commitment should be able to scale as the COOP grows based on a formula of increases in covered lives.
   d) COOP should have the ability to combine funding from all sources listed in item1.a. to manage and grow its operations