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Members in Mind: Outreach & Education Strategies for CO-OP Insurance Plans. Final Report

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**Members in Mind:
Outreach & Education Strategies for CO-OP Insurance Plans**

Final Report

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I. Executive Summary

As envisioned by the federal policymakers who designed the Patient Protection and Affordable Care Act of 2011 (ACA), and the state-based health leaders who are founding them, Consumer Oriented and Operated Plans (CO-OPs) are intended to be a different kind of insurer: non-profit partners in health and healthcare. While many Americans (including Mainers) should welcome this new model, CO-OPs face challenges in establishing brand recognition and capturing the hearts and minds of consumers. The purpose of this research project was to support CO-OPs, particularly Maine's CO-OP, Maine Community Health Options (MCHO), in assessing and developing communications strategies that enable individuals and small business owners to make informed decisions about health insurance options.

Health insurance is a tough sell. Health insurance policies, claims processes, and pricing structures are difficult to understand. Despite the promises of the ACA, health insurance is expensive, and premium prices are likely to increase—at least in the short term. Buying health insurance often means making a major purchasing decision without having enough information to judge opportunity cost. Americans are philosophically divided on whether healthcare is a market commodity or a right of citizenship. And yet, in January 2014, the ACA will require us to have health insurance, and support an expansion of coverage to more of our friends and neighbors.

ACA language calls for the “establishment of health insurance exchanges” to operate in every state, enabling individuals and small business owners to access health insurance options online or by phone. Maine is one of 26 states defaulting to a federally-created and controlled exchange, which in January was rebranded by the Obama Administration as the “health insurance marketplace.” Some states that are creating their own entities, such as Idaho, continue to call them “exchanges.”

This project sought to gather some of the beliefs, knowledge, behaviors, and messaging exposure of individuals and small business owners related to health reform and health insurance. A total of 24 subjects were interviewed, including Maine-based thought leaders in healthcare, advocacy, and small business development, as well as individuals and small business owners. As

preparation for the interviews, the project included an environmental scan of on-going media coverage of the ACA and a review of social justice, economic and political decisionmaking theory. The combination of these research perspectives provided context for synthesis of thoughts, ideas and a series of recommendations for the CO-OPs and MCHO.

Interviewees' stories about their interactions with health insurance, and their hopes for something different were inspiring and valuable to the project. The responses provided insight into understanding how to create a dynamic communications strategy to engage potential CO-OP members, and provide traction with target audiences. Key findings from the interviews were that:

- Individuals and small business owners know very little, if anything, about the federal health insurance marketplace, CO-OPs, or Maine's CO-OP, Maine Community Health Options (MCHO).
- Price (also referred to as "cost" by interviewees) is the primary determinant in health insurance purchasing decisions.
- Respondents welcome additional information about MCHO's health insurance products and membership benefits, and are willing to share their opinions about what CO-OP membership would mean to them.
- Individuals view health reform as necessary, and are ready for new ways to access health insurance.
- Small business owners/leaders were skeptical about meaningful reductions in the increasing expense of health insurance premiums and the time and energy it takes to understand options and make decisions about them.

To set the stage for specific strategies to engage members and potential members, it is important to take into account how CO-OPs are fundamentally different from for-profit insurance companies in terms of product, membership, and business model. In creating brand identity, CO-OPs can consider the following:

1. What is the product that CO-OPs are selling? Is it health insurance, or is it something more than that?
2. A significant focus of traditional health insurance marketing has been directed at large employers; CO-OPs have an opportunity to frame communications to reach individuals and small business owners directly.

3. CO-OPs are aligned with an emerging “fourth sector” that seeks to balance economic and social performance by merging commitment to social purpose, earned income, inclusive ownership, stakeholder governance, and sustainable impact.

Project interviewees saw these differences as tremendous assets—and they are curious to know more, meaning that additional attention to defining them will support CO-OP branding and awareness, and the development of an all-important “elevator speech.”

Future CO-OP members are getting the information they have about health reform from the media, and if they are business owners, from trusted information sources such as brokers, accountants, and trade organizations. The recommendations from this project encourage the CO-OPs to connect with individuals and small business owners directly because:

- small business owners will require opportunities to hear from—and question--CO-OP leaders in person;
- individuals in personal care/caring professions are likely to be in the individual insurance market, and can be highly effective in endorsing and sharing businesses and products with their clients;
- young adults are very open to the CO-OP model, and will need information that is tailored to their income levels, insurance needs and membership preferences;
- serving as a source of (unbiased) information about health reform, the health insurance marketplace, subsidies, and benefits packages will encourage consumers to see the CO-OPs as trusted allies in the new insurance purchasing landscape;
- and finally, creating opportunities for members and future members to tell CO-OPs what they need will help inform language choice and communications strategies, as well as benefits design and membership engagement.

II. Introduction

The purpose of this research project was to support the new health insurance CO-OPs, particularly Maine’s CO-OP, Maine Community Health Options (MCHO), in assessing and developing communications strategies that help individuals and small business owners to make informed health insurance purchasing decisions. The Patient Protection and Affordable Care Act of 2011 (ACA) calls for the “establishment of health insurance exchanges” to operate in every state on or before January 2014, enabling individuals and small business owners to access health insurance options online or by phone. Maine is one of 26 states defaulting to a federally-created and controlled exchange, which in January was rebranded by the Obama Administration as the

“health insurance marketplace.” Some states that are creating their own entities, such as Idaho, continue to call them “exchanges.” For the purposes of this paper, I will refer to all of the states’ entities and the federal entity collectively as “marketplaces.”

Marketplaces will include plans sponsored by market dominant health insurance companies, as well as new options afforded by the ACA. Specifically, the law provides for the development of member-driven, member-created regional non-profit health insurance CO-OPs to compete with private insurers. To date, the federal Department of Health and Human Services has awarded loans totaling almost \$2 billion to 24 CO-OP insurance plans in 24 states.¹ In order to compete effectively in the marketplaces, CO-OPs must have sophisticated, timely, and efficient consumer engagement plans.

In Maine, Maine Primary Care Association (MPCA) marshaled people and resources to design and create a CO-OP health insurance plan. The brand-new non-profit insurance organization, Maine Community Health Options (MCHO), applied for and received a \$62 million federal loan in August 2012. MCHO’s startup plans call for enrollment to begin in Fall 2013, with coverage starting in January 2014. The organization projects enrollment levels of 15,000 members in the first year, with a goal of achieving 50,000 members by 2019. Of note, federal loans for CO-OPs disallow funds to be used for marketing purposes. MCHO has identified a need for \$600k-1M in the next six months to cover initial marketing expenses.²

This research project investigates the ways that CO-OPs can engage consumers, potential insurance plan purchasers, and members. The fact that established for-profit insurance companies effectively lobbied-out a provision for federal loan funds to be used for CO-OP marketing serves as a catalyst for research. Targeted, effective communications strategies that include consumer education and marketing are essential to the CO-OPs’ success.

There are enormously challenging and substantive tasks associated with making the massive and complicated ACA function effectively. At the same time, engendering support for the new law will require more advanced marketing than the Obama Administration has undertaken to date.³ CO-OPs will need to take steps (mirroring what is needed for the ACA

¹ Healthcare.gov newsroom page. Healthcare.gov website, managed by the U.S. Department of Health and Human Services. <http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html>. Accessed 12/3/12.

² Lewis K. Maine Community Health Options Business Plan (confidential). 2012.

³ Sage W. Brand New Law! The Need to Market Health Care Reform. *U of Penn Law Review*. 2011; 159:2121-2146/

itself) to explain who and what they are, build brand equity, and engage members in benefits decisions and health promotion.

MCHO conducted focus groups and surveys with consumers, small business owners, and health care providers to learn how to build a supportive relationship with them, and is actively reaching out to numerous stakeholder groups throughout the state. The member-led CO-OP model requires a larger voice and more opportunities for customer involvement in health care. On its website, MCHO promises to support shared decision making and member-focused decision support tools.⁴

Consumers, on the other hand, are confused about the difference between CO-OPs and ACA health insurance exchanges.^{5 6} They view health insurers with mistrust. Employers are skeptical about the prospect for effective change either through the addition of new insurance options or components of the ACA.⁷ Adding to the communications challenge is the following paradox: greater patient engagement increases the demand for detailed, high quality information about health insurance options. Electronic tools cannot replace the human element in facilitating informed choice.⁸ Overall, MCHO acknowledges an uphill battle in marketing and consumer education, particularly considering the limitation of the ACA loan and the need for additional funding to support this work.

To assist the CO-OPs with assessing and developing communications strategies, the project seeks to answer the following questions:

- What do individuals and small business owners know about the ACA, CO-OPs, and MCHO?
- How do individuals and small business owners access health insurance information, and what factors most impact their purchasing decisions?
- How can CO-OPs level the playing field in the health insurance market?

⁴ Maine Community Health Options Frequently Asked Questions—Providers webpage. Maine Community Health Options website, www.mcho.org. Accessed 11/12.

⁵ Gorn D. Why Basic Health Plan Failed and Why CO-OPs May Succeed. California Healthline website, www.californiahealthline.org. August 27, 2012; Accessed October 2012.

⁶ Maine State Representative Terry Morrison, oral communication, October 2012.

⁷ Maine Community Health Options. Research Summary Report: Executive Summary (Confidential draft for discussion). November 2012.

⁸ Woolf S, Chan E, Harris R, et. Al. Promoting Informed Choice: Transforming Health Care to Dispense Knowledge for Decision Making. *Annals of Internal Medicine*. 2005; 143(4):293-301.

- Are there other industry/business models that can provide new and different marketing strategies that may help inform CO-OP communications approaches?
- Do consumers have positive associations with the cooperative movement, and how can CO-OP insurance plans effectively distinguish their non-profit cooperative insurance model and for-profit insurance companies?

Answers to these questions, and others, will build a context for consumer outreach that centers prospective work in a framework of systems change and community organizing.

Stakeholders in Maine created MCHO so that consumers could have more control over their healthcare choices by having a say in health insurance benefit design and practice. Bi-partisan legislators in Congress chose “CO-OP” as the acronym for the new health insurance plans—tapping into the cooperative movement’s focus on shared leadership and reciprocity. Are the CO-OPs just selling health insurance, or are they selling an opportunity to become a partner with providers in health and healthcare? If the CO-OP insurance model is truly intended to shift the health insurance paradigm towards sustainability and community benefit rather than profit, additional related research may consider the context of organizational, political, and communal perspectives. The findings from this research may be relevant to MCHO and its members, other state CO-OPs, state and national funders, policymakers, the media—people and organizations that are watching the CO-OPs evolve, and contributing to and benefiting from their success.

III. Background

Approximately 58 percent of Americans have employer-sponsored health insurance (ESI) plans. Within this majority ESI health plan system, employers make major decisions about the kinds of health insurance benefits that they will make available to employees. Employers’ choices are limited by a finite number of for-profit insurance companies and rapidly increasing health insurance costs. ESI coverage in the U.S. is decreasing annually due to rising insurance premiums and national employment trends.⁹ Consumers and businesses need affordable health insurance options.

⁹ Gould E. A decade of declines in employer-sponsored health insurance coverage. Report: health webpage, Economic Policy Institute website. <http://www.epi.org/publication/bp337-employer-sponsored-health-insurance/>. February 2012; Accessed October 2012.

Thought leaders in healthcare welcome the ACA's call for innovation and equity. At a press conference announcing the CO-OP's loan award in August, Jim Davis, MCHO board president and CEO of Pines Health Services in Caribou, Maine, spoke about how cheaper health insurance could be an important indicator of economic success and a pro-business environment. Wendy Wolf, MD, MPH, president and CEO of Maine Health Access Foundation stated that having health insurance makes a dramatic difference in a person's life.¹⁰ Founders of state CO-OPs interviewed for an issue brief for The Commonwealth Fund understood that a "business-as-usual model will not meet congressional vision and mandates, nor offer a new alternative to consumers."¹¹

Maine benefits from a history of creative approaches to insurance coverage, including effective public/private partnerships. Maine's self-insured workman's compensation program collaborated with the Occupational Safety and Health Administration (OSHA) to create a voluntary consultation program funded by the MEMIC Group. The evolution of DirigoChoice health coverage offered by HarvardPilgrim in collaboration with the State of Maine offers valuable lessons in branding, marketing and consumer outreach.

Forerunners to the CO-OP model include Minnesota's HealthPartners (1.5 million members), and Washington's Puget Sound Health Alliance (2 million members) and Group Health Cooperative (700,000 members). Independent studies have placed these cooperatives in the highest-performing health plans in the country in terms of value and quality of care.¹² New CO-OPs in other states are forming partnerships with existing cooperatives such as farmers supply organizations and rural electric and telephone cooperatives, membership organizations for seniors and small business advocacy and service organizations.¹³ The appeal of CO-OPs to rural constituencies can be understood in the underlying principles of mutual aid and shared responsibility, which resonate with rural traditions.¹⁴ Existing cooperative organizations created

¹⁰ Wight P. Federal Grant to Fund Maine's First Health Insurance CO-OP. Maine Public Broadcasting website, www.mpbn.net. August 16, 2012; Accessed October 2012.

¹¹ Gardiner T, Neece R, Mendelevitz M. Realizing Health Reform's Potential: Innovative Strategies to help Affordable Consumer Operated and Oriented Plans (CO-OPs) Compete in New Insurance Marketplaces. The Commonwealth Fund website, www.commonwealthfund.org. 2012; 1591(8):1-12. Accessed October 2012.

¹² Ibid. Realizing Health Reform's Potential.

¹³ Ibid. Realizing Health Reform's Potential.

¹⁴ Coburn A, Talbot J, Ziller E, Gage-Croll Z. CO-OP Health Plans: Can They Help fix Rural America's Health Insurance Markets? State Health Access Reform Evaluation website, www.shadac.org/share. June 2011, accessed October 2012.

by and for farmers and other organized workers may offer lessons in member engagement, information sharing, and language development.

IV. Approach

As a primary goal, the project sought to identify targeted best practices in communications that address marketing challenges, support informed decision making processes, and trigger fundraising mechanisms. Key strategies for the project included extensive data and information collection, discussions with thought leaders in and beyond Maine, and collaboration with MCHO leadership. The research project supports the formation of an intellectual framework for consumer outreach and provides ideas, practical advice, and priority steps for CO-OPs to use in approaching target audiences.

Grounded Theory methodology allows for exploratory research and discovery as part of the research process.¹⁵ Developed by sociologists Barney Glaser and Anselm Strauss as they conducted research on dying hospital patients, Grounded Theory is a systematic generation of theory from data that contains both inductive and deductive thinking. In contrast to other research methods, researchers using grounded theory generate hypotheses after conducting data analysis. In addition, this approach encourages data collection from many kinds of sources, both traditional and non-traditional (e.g. “anything that gets in the researcher’s way when studying a certain area”).^{16 17}

For the purposes of this project, qualitative data were gathered in person, by phone, and via computer-based searches, contributing to a “snowball effect” of new sources, ideas, and opportunities. Research subjects included:

- MCHO leaders
- University of Southern Maine (USM) faculty and staff
- Maine-based thought leaders in health-related fields
- Individuals and businesses with a potential stake in the CO-OP
- Social change agents in Maine

¹⁵ Schwandt T. Dictionary of Qualitative Inquiry, Second Edition. Sage Publications, Thousand Oaks, CA. 2001;110-111.

¹⁶ Christiansen O. What is Grounded Theory webpage. Grounded Theory Institute, the official website of Barney Glaser. <http://www.groundedtheory.com/what-is-gt.aspx>. Accessed November 2012.

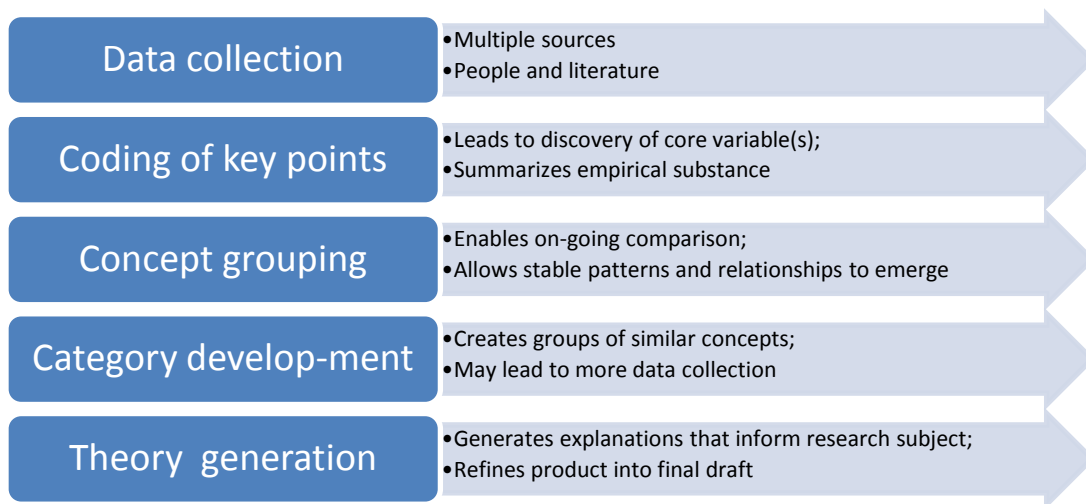
¹⁷ Chamaz K. Constructing Grounded Theory: A Practical Guide through Qualitative Analysis (Introducing Qualitative Methods series). Sage Publications Ltd; 1 edition. January 27, 2006.

Online searches and conversations with people provided links to the following data sources:

- Books
- Peer reviewed literature
- Web sites
- News articles
- Webinars and videos
- Marketing and business plans
- Meetings

As qualitative data were gathered, information was organized to enable on-going comparison and discovery of key concepts and language. Structured writing requirements within Grounded Theory methodology ensure that information is continually processed by the researcher for new ideas and momentum towards meaningful conclusions. Writing requirements take the form of “memos” that advance research by identifying information gaps, next steps, and new opportunities.

The following graphic illustrates the core elements of Grounded Theory methodology in practice, gathered from several key sources, including Dr. Glaser’s website, and a text written by Kathy Charmaz, professor of sociology at the University of California, San Francisco.



A total of 24 people were interviewed for this project in 22 separate conversations. In order to ensure the anonymity of subjects as required by the Institutional Review Board (IRB), throughout this project I refer to interviewees under three categories: individuals, business

owners, and thought leaders. “Individuals” include self-insured, underinsured, self-employed, newly-employed, or people who are between jobs. “Business owners” are small business owners who have less than 50 employees. Interviewees primarily include business owners who have between five and 10 employees. “Thought leaders” include social justice and healthcare advocates, funders, legislators, and business opinion leaders. I further separated “thought leaders” into three sub-categories: “social justice advocates,” “health system leaders,” and “business leaders.”



In Grounded Theory process, researchers organize information to enable comparisons, highlight themes, and identify questions and areas for further research. For the purposes of this project, organizing first occurred at a macroscopic level by segmenting interviewees by “like” categories, and examining their responses for similarities and differences.

Interviews commenced with five “individuals” because I believed that having a foundation in the consumer perspective would be helpful as I spoke to others. The second cohort of interviewees consisted of eleven “thought leaders.” Finally, I met with eight additional people representing the business, health system, and consumer perspective. Grounded Theory and the limitations of semester deadlines required that I stop in time to turn back to literature and synthesize findings. Interviews were conducted over a month and a half, and ended on March 15.

My reading list included feminist social justice theorist Iris Marion Young’s “Justice and the Politics of Difference,” Deborah Stone’s “Policy Paradox,” and dozens of news and journal articles on topics ranging from health reform, to insurance marketplaces, marketing, and social entrepreneurship. I also attempted to follow the latest information about health reform on

government, non-profit and trade websites. I sourced a significant amount of state, national, and international news from selected Twitter feeds.¹⁸

V. Findings

Several points, which will be revisited throughout this document, emerged from the first set of interviews. They are:

1. Consumers (individuals and small business owners) don't know very much, if anything, about the federal or state health insurance marketplace(s) or CO-OPs.
2. Interviewees are hopeful that health reform changes will make things better but recognize that there are many unknowns.
3. Price is the most important factor driving insurance purchasing decisions.
4. The "devil is in the details." While people need basic information about the what, when, where of the health insurance marketplace, they really want the information that is not yet available: how much insurance premiums will cost, and how they will navigate the system.
5. Interviewees are not likely to act on the information until they have to.

a. Individual Perspectives on Health Reform, Insurance Marketplaces and MCHO

If it is possible to draw broad conclusions from five interviews with individuals conducted between January 29 and February 4, 2013, consumers know very little about the specifics of health reform, insurance marketplaces, CO-OPs, and MCHO. The interviewees were four women and one man, and they range in age from 40-53. The women are all very interested in learning more; the man (married to one of the women) has "no interest in health insurance."

Three access new information about health insurance options online and from others in their communities. One has a broker that she uses when plan information changes, and the male interviewee relies on his wife to conduct insurance-related research.

None of the interviewees are happy with current health insurance options overall, though one is a CarePartners member and believes it to be a great program. The couple access health insurance via the husband's three-person limited liability partnership (LLC). They purchase

¹⁸ See Appendix.

health insurance in New Hampshire because one of their business partners lives there. The wife said, “*We are not looking into Maine insurance because it’s more expensive.*” Of the remaining two interviewees, one has health insurance and one does not have health insurance due to expense.

Despite having a moderate level of financial security, the interviewees feel vulnerable to the health insurance market. They said:

We are always at the risk...I don’t know how we rigged [our current insurance plan], we are always on the edge.

[Health insurance] could make or break you. If one of us got deathly ill, we would be done. How fair is that? I don’t think you should be penalized because you are self-employed. You shouldn’t have to be forced to work for a massive corporation.

I don’t want to be uninsured, or not have the protection of knowing if something happens...it’s just too risky.

What is the true impact of our employer-sponsored health system on the U.S. labor market? The second comment above reveals recognition that the employer-sponsored health insurance system penalizes self-employed workers. Almost 75 percent (149 million) of full-time workers in the U.S. get their health insurance from employers. In Maine, options for individuals and small businesses wishing to purchase health insurance are limited to a few carriers. A 2011 study by researchers at the Kauffman-RAND Institute for Entrepreneurship Public Policy (KRI) examined issues surrounding “entrepreneurship lock,” a phenomenon that may occur when workers with employer-based insurance are reluctant to leave jobs to start new businesses because of the high cost of premiums or concerns about the loss of or disruptions to health insurance coverage.

The study found that individuals with access to a spouse’s health insurance plan are more likely to become self-employed. Those with poor family health are significantly less likely to give up an employer plan and start a new business. Additionally, self-employment rates rise when Medicare becomes available, notably during the month when a worker turns 65 and qualifies for Medicare. In essence, the study found that bundling of health insurance and

employment may discourage business creation in the U.S.¹⁹ As The New York Times' Catherine Rampell put it, "nowhere else in the industrialized world does losing your job also mean losing your health care."²⁰

Interviewees shared their frustrations with the expense of health insurance and a perceived lack of return on investment:

All the consumer sees is a big company making all the money and not giving us anything. What pisses people off is that they don't understand what is happening to my money or why they won't cover this.

So many things got denied in the past...I'd wonder why are we paying all this money.

They found insurance practices confusing:

My mother worked in [health insurance] claims so I understand the backside of insurance and it's still really hard to understand. Hard for the lay person to figure out.

In thinking about health insurance plans and benefits, the interviewees listed expense as the most important consideration. These consumers do not yet know about essential health benefits (EHB) requirements or limits on insurance caps. The responses are interesting to consider in thinking about how to communicate about benefits in a way that is reassuring. They said:

The number one thing is price (how much money a month). Two...what kind of coverage would I get. Critical care coverage (cancer, heart attack, stroke). I'd want the bulk of it covered.

Certainly price. [And] anybody who's offering either alternative care or incentives for a healthy person. We need to move away from being a sick care system. Also...value. You can't always compare apples but ease of use is important...how hard is it to make a claim, process a claim. Ideally I would be a patient and part of the system as a provider. (Researcher note: this interviewee is a licensed massage therapist.)

I want a low deductible so that I don't not start going to the doctor. I don't want to defer care because I have to pay \$1000.

Preventive care covered. For a woman, that means a pap smear and mammogram. Acute care visits covered; it's all important. You want to make sure you have comprehensive

¹⁹ Leuschner K. Fact Sheet: Does Employer-Based Health Insurance Discourage Entrepreneurship and New Business Creation? Rand Corporation Reports and Bookstore webpages. Rand Corporation website. http://www.rand.org/pubs/research_briefs/RB9579/index1.html. Accessed 12/9/12.

²⁰ Rampell C. Who Gets Employer-Based Health Insurance? Economix: Explaining the Science of Everyday Life blog. The New York Times website. <http://economix.blogs.nytimes.com/2009/06/30/who-gets-employer-provided-health-insurance/>. Accessed 12/9/12.

coverage for every single disease, and hospital coverage. Any little thing can sink you. I think that you need to have no cap. If you have pneumonia, diagnostic tests need to be covered. I don't mind paying copays of \$20. But the current plan at [my new job] is 20% of everything. That can add up to a lot of money very quickly and I don't think that's right.

Because the interviewees were not familiar with MCHO or the CO-OP health insurance model, I provided some basic background information for them. When asked if the association with the cooperative movement impacted their opinions of how the CO-OP might function, interviewees were able to differentiate this brand new business model from the for-profit structure they are familiar with. They have positive associations with cooperatives. They said:

It definitely sounds more for regular people, like a food coop. Where a big group of people chips in and all benefit.

I think the term co-op is much friendlier than big business insurance. It feels homier and like you are less likely to be cheated. Just by nature.

Cooperative: a bunch of people in a sense looking out for each other. Everybody putting something in.

[I like] that it is member based, and member run. My mind automatically jumps to food co-op, where you are doing some work as well. But wanting to know that it is well run, and not wasting your money or time.

I wanted to know what the interviewees would expect in return for being a CO-OP member. How involved would they want to be? In regards to “having a voice” the interviewees liked the idea but had different levels of interest. As part of the “promise” to members, CO-OP business plans should include opportunities for varying levels of member participation:

I guess you kind of assume you don't have a voice in that kind of thing but it would be great to have one. I would participate in phone calls/meetings but the average person might not want to think about it that much.

I'd want to be able to have a say that I thought really counted and meant something in designing the benefits I thought were important, and hope that I would be heard.

I actually think that I would want a board of directors to make the decisions with me doing an interest survey or something like that. Maybe volunteer to get information. It would be hard for them to consider us all as experts.

Probably not much because insurance is like taxes to me. It would go right over my head. I have to read and read and re read 'cause it doesn't sink in. I'd want to know what I would have for coverage and the price and that's about as far as it would go for me.

As for return on investment, the interviewees shared the following thoughts about how they would hope CO-OP profits would be shared with members:

Any money/profit would be plowed back in to the coop in the form of lower premiums or extra coverage for other things.

I think reduction in cost. If you are going to have leftovers maybe you have money set aside right back to consumer or reduced benefits for people who are on the edge of the [Medicaid] line. Being able to give them something to keep them working. I would be willing to pay more and have that reduction there for that segment [low-income workers]. In Maine we almost force people stay on public assistance. [But] I can't imagine most people would be OK with that.

I would love to see a dental program.

The individuals that I met with are ready for new health insurance options, and eager to hear more about the CO-OP. With the right assurances that the CO-OP is going to cover their healthcare needs at a competitive price, it is conceivable that any of these individuals could become future CO-OP members. MCHO's "different" business structure was a plus for them. Based on my conversations, I would assume that if they knew about MCHO ahead of time, many individuals in the Maine insurance market would look for MCHO as an interesting alternative in the health insurance marketplace. For many, the marketplace may provide a first exposure to CO-OPs. We do not yet know what branding opportunities the insurance marketplace will offer to participating insurers and how MCHO can best take advantage of them.

b. Business Thought Leader Responses

The following two interviews with "thought leaders" from the business community took place on February 20 and 22, 2013. In summary, both subjects underscored the challenge of communicating with stakeholders about how they will be affected by health care reform given the lack of information that they have to share.

With the ACA, the problem is that the unknowns are more of a challenge than anything else. What is in it, and what are the rules? I think to some extent people are looking for information now. But some small business owners are somewhat in a wait and see mode. Information is changing each week. Someone running a business has so many things on their plate. This is [just] one of them.

The closer you get to the date of effectiveness...the more interest there is. We are saying this is what the law says and how the law could affect you. But it's not ripe yet for communicating a lot in how it is operational rather than public policy. When more information comes along about exchanges, that will start filling in an important piece. It's almost greyed out right now. At a Rotary Club meeting I was talking to a broker who said that we have...no information to tell people other than "we don't know." This is a wave that's still forming and many people don't know how to line up on it or what kind of surfboard to use.

These leaders are beginning to seek out more information for their communities. One said that his organization is signed on to a series of webinars produced by the federal government in order to educate his staff about "healthcare 101" in preparation for health reform related questions from clients.

The expense of health insurance is a critical concern, coupled with uncertainty about the level of federal government support. The business leaders said:

Healthcare costs are high on the list of concerns for [our] clients. They are a huge impediment to entrepreneurship. The [exchanges] have the potential to support movement, growth, entrepreneurship. I think the challenge of the ACA is that the feds can overdo it.

We've heard this for years: the biggest driver in decision-making is cost. [Businesses] feel driven out of the market place by the increasing cost of insurance. [With the ACA] there are some provisions that help out initially with the cost, but that phases out with size of business and size of the person's pay check after a couple of years.

Related to expense is a sense that small businesses have been (and continue to be) particularly vulnerable because health insurance has focused products and pricing on large employers.

Healthcare in the U.S. has been a big company market. Small businesses owners are going without or get insurance through a spouse. They will also have to figure out what to do about part time employees. It is a competitive advantage if they can. But they operate at the margin. It will be challenging to take on additional cost. What is the offset for revenue? At the end of the day are they selling more widgets because they offered healthcare to employees? It's a cost of doing business that is challenging...because there is no direct revenue return.

I did see something from Kaiser²¹ or fed source that showed coverage among small business is lower. There is a market uptick that comes somewhere in the 20-30 employee

²¹ The brief that he is referring to is likely a comprehensive comparison of large and small firms and health insurance offerings: A Comparison of the Availability and Cost of Coverage for Workers in Small Firms and Large Firms: A View from the 2012 Employer Health Benefits Survey. The Henry J. Kaiser Family Foundation website, www.kff.org, December 2012. <http://www.kff.org/insurance/snapshot/chcm121112oth.cfm>. Accessed 3/4/13.

range where suddenly you go from no coverage to the highest levels of coverage. But for those folks, the thing that I've heard is regarding cost in proportion to sales of business. They try to buy down their premium by shifting costs to employees. That is something they don't do cavalierly because they know it's putting more stress on employees. It's a vicious cycle.

The two thought leaders shared ideas on how to communicate with business owners so that they can make informed choices about new insurance options:

- 1) Create a matrix of information allowing individuals to access information from “the outer ring and into the inner ring from awareness to knowledge.”
- 2) The “messenger,” or person who delivers the information, makes a difference. The business community will look for information by word of mouth, and from chambers of commerce, financial advisors, attorneys, and insurance agents.
- 3) In-person (approximately 90 minute long) conversations will help to ensure that busy business owners focus on targeted information.
- 4) Consider the presentation, content, packaging, and availability of the information.
- 5) Business owners will need to understand insurance options for themselves and their families as well as implications for their businesses.
- 6) Information must be simple and accessible.
- 7) Provide enough lead time.

Small business owners may not be able to prioritize the economic benefits of investing in the health and healthcare coverage of employees. Can the CO-OPs distinguish themselves by providing clear and effective explanations about the importance of employee coverage? In certain instances, can MCHO serve as a trusted source for information (making marketing a secondary goal)? The business leaders noted challenges in disseminating information to populations with limited capacity or experience:

For someone without a [human resources] department, someone like an electrician...how will it work for him?

Some people don't even know what “financials” are. There are folks who struggle with basic technology like Quickbooks every day.

As was the case with the individuals, the business leaders knew very little about MCHO. One shared his opinions about the introduction of a new insurance organization in the state.

Maine does have a culture that has a bias towards a Maine-based organization. [They like that] it's neighbors, not Cigna, that I'm paying my fees to. That could be an advantage. There are other pushes in the economy to shop local and the upswell of support of local community that could be an advantage to a Maine-based company.

After the interview, the other business leader sent me a link to a February 2013 *Health Affairs* brief on CO-OPs.²²

Finally, I wanted to understand what the interviewees thought about the theory that greater competition in the insurance marketplace would lower expense. I believe that this continues to be a key messaging opportunity for ACA advocates. Business leaders work with the mechanics of our market-based economy on a daily basis, and could be critical of government regulation. On the other hand, insurance marketplaces could effectively challenge market failures that serve to increase business expenses. When asked how increased competition in the insurance market will make a difference for Maine businesses, they expressed uncertainty about whether fair competition could occur in the healthcare system:

As an operating principle, costs should flatten...but then there's how it will be carried out in practice. Competition should be healthy if it is fair competition. If one company in the market place [has an unfair advantage] that's not healthy.

It will be interesting to see if theoretical free market economics apply to the healthcare market. Fundamentally, the healthcare market is structured so poorly because it's not revenue based on income. Healthcare was always incentivized to push costs higher because they knew that they would be capped by insurance anyway. We've created an expensive system and it can't lose money. Pure free market competition can't answer that question.

One of my interviewees concurred that his members did not like the ACA, but recognized that it was not going away. At the end of the day, could the business community agree that government intervention is better than letting the system lurch forward unchecked? And, to follow up on one of the respondents who said that the “feds can overdo it,” how much intervention is perceived as too much?

The Kaiser Family Foundation conducts a monthly opinion poll on the public's perception of health care reform. As of February 2013, the nation continued to be deeply divided

²² http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_87.pdf

in opinions about the ACA, with general favorability *decreasing* from 43 percent to 36 percent of the population, unfavorability *increasing* from 30 percent to 42 percent, and “don’t know/refused” increasing from 19 percent to 23 percent since November 2012.²³ Is favorability on the decline because people are wanting, and not getting, the right information? And/or is this trend a reflection of our dislike of change and fear of the unknown? Does this track with consumer sentiments about the economy? How much of unfavorability stems from concerns about expense?

c. Online Health Reform Communications Tools for Small Business

The interviews prompted me to conduct a preliminary online search to find out what tools were available for small business owners as of March 2013. While a lot of information is being generated by the federal government and advocate groups, the details, particularly around premium pricing, are changing on a daily or weekly basis, and remain elusive. In the meantime, businesses will be considering 2014 expenses based on different scenarios. Without that information, business owners may hold off on accessing insurance information, meaning that many will experience a steep learning curve in the Fall.

A federal government website managed by the Department of Health and Human Services (www.healthcare.gov) provides a “checklist for small businesses”²⁴ suggesting seven things “you can do to get ready now” including understanding how insurance works, thinking about when to begin coverage, setting a budget, getting organized, making a list of questions, and looking for help. The site has a very simple video explaining the new insurance marketplaces. Missing, it seems, is the information on pricing that business owners will be looking for the most.

The federal government’s Small Business Administration website (www.sba.gov), provides an ACA implementation timeline, a glossary of key health reform terms, and implications of the new law for those who are self-employed, employers with fewer than 25 employees, employers with fewer than 50 employees, and employers with 50 or more employees. A link within the site to “online tools to help you find and price small business health

²³ Health Tracking Poll: Exploring the Public’s Views on the Affordable Care Act (ACA). The Henry J. Kaiser Family Foundation website, www.kff.org. Updated February 2013. <http://www.kff.org/kaiserpolls/health-tracking-poll-interactive.cfm>. Accessed 3/4/13.

²⁴ <http://www.healthcare.gov/marketplace/get-ready/small-business-checklist/index.html>. Accessed 3/4/13.

care insurance options” leads to a page that opens with the following sentence: “We all have questions about the Affordable Care Act, whether it’s deciphering facts from myths or trying to understand what your options for health care coverage are now and in the future.”²⁵ SBA.gov and healthcare.gov link to each other, and back to the same web pages without really answering key questions, which could be frustrating for business owners looking for solutions now. Businesses can find the answer to whether or not they need to provide insurance to employees, but not how much it will cost.

d. Small Business Owners Are Savvy About Health Insurance, But Not the ACA

On March 21, 2013, Bloomberg Businessweek reported that the public is “bewildered” by the 906-page ACA, including business owners who have “real-money decisions to make about health care next year—and apparently don’t grasp the most basic elements of the health reform law.”²⁶ The article cited a new survey by online health insurance marketplace EHealth.com that found that the majority of business owners with less than 50 employees believe that they must provide health insurance to employees or pay a fine. This belief supports and overarching perception that the ACA will drive healthcare costs up, and is not addressing the needs of small business owners. The federal government is unsuccessfully waging a high-stakes public relations and marketing campaign as the new health law begins to impact consumers in tangible ways.

The four small business owners I spoke to in March all consider health insurance benefits a necessity for employees. As a recurring, expensive budget item, health insurance is something that they have to make informed decisions about. All access information from insurance brokers, but also conduct research on their own to be certain that they are controlling costs as much as they can while understanding the full range of insurance options for themselves, their families, and the people that work for them. One of the respondents talked about how he had to consider a different kind of plan when his wife was pregnant, and the impact that would have on his employees. He said, “One size has to fit all. With a small business, you can [do the math and figure out if the cost to employees will be mitigated].”

²⁵ <http://www.sba.gov/community/blogs/community-blogs/health-care-business-pulse/online-tools-help-you-find-and-price-smal>. Accessed 3/4/13.

²⁶ Tozzi J. Small Employers are Clueless About Obamacare. Bloomberg Businessweek website, Small Business webpage: www.businessweek.com, <http://www.businessweek.com/articles/2013-03-21/small-employers-are-clueless-about-obamacare>. Accessed 3/26/13.

Despite the interviewees' clear grasp of the importance of healthcare coverage, and the financial pressures they feel due to the rising cost of health insurance premiums, understanding the ins and outs of the ACA has not been a priority. "I know nothing about the federally mandated Obamacare system," explained one business owner. "I've read a little about it two years ago when it was happening. My time is limited. What I'm going to have to do when Obamacare comes into play, I don't know." In fact, the interviewee is due for insurance renewal in April, and will be making decisions for the upcoming year within the next couple of weeks. As we spoke, he seemed resolved to learn more. Unlike the other three business owners who are not confronting insurance renewals in the next month, he is paying attention now because he has to.

The interviewees access information in a variety of ways to determine the best health insurance plans for their businesses. Brokers play a powerful role, and all of the business owners recognize the importance of seeking additional sources of information so that they can compare plans and prices. They said:

My broker has sent me a bunch of information. The insurance company has sent me some information. And it's my job to educate myself now.

No one has explained any of this to me. I'm kind of on my own in terms of figuring this out. There are not a lot of resources out there. The brokers don't know the whole [picture]...I wasn't impressed by the field of brokers. I knew more than they did.

We work with an independent agency. They have access to primary carriers. They provide us with a remarkable spreadsheet on what we are paying and what we would pay.

When I asked the business owners what they knew about the new healthcare marketplaces, a key provision of the ACA that is intended to help small business owners access health insurance information and potentially reduce costs, they communicated a mix of thoughts, facts, and misinformation.

It's my understanding that they are going to be unveiled in 2014 in the states that have agreed to offer them or have them available to their residents. Maine is not one of those states. It's the sole decision of our governor despite bipartisan recommendation that we have one. It's 100 percent funded by feds until 2016 and then a lesser amount thereafter.

Just what I've heard on the radio...just what I've heard on the news spoken in very general terms. [I think it's that] you would sign up with a group that would sign up for

insurance together. It was just all me imagining how it would work. No one really explains it.

I know about them but nothing more than that.

I would imagine that the government and the state wouldn't want everybody going on at the same time because the system wouldn't be able to handle it. They'd need to stagger the purchasing...within a year of it going on line.

All said that they would definitely be looking into the health insurance marketplace, but are not expecting them to provide immediate relief from complexity and high prices. Timing was an issue for a second interviewee as well. “October...That’s too late for us to do our renewal,” he said. “We are going to have to make a decision by mid September about what our health care coverage will be.”

Part of the challenge of capturing business owners’ attention on health reform is the complexity of healthcare legislation, frustration with high cost and a broken healthcare system, and a fundamental lack of interest in the details. “I’d rather do other things with my time [than research health insurance options],” expressed one of the interviewees. Dealing with health insurance is something that they have to do but the process is neither fun nor perceived as particularly rewarding.

As with other subjects interviewed for this research project, price is the primary driver in choosing insurance companies and plans. The business owner who has opted for a high-deductible plan said, “I don’t necessarily want more services. The only real attractive point is are you going to lower my premiums over a period of time.”

Case Study: One Business Owner’s Search for Affordable Health Insurance Coverage

Interviewee “Jim,” a small business owner based in Portland, ME, was determined to provide health insurance for his primarily low-income employees. “I know that the way that I’ve gone about doing this is really unique because the folks who run the [Dirigo Health Agency (DHA)] part-time voucher program seemed impressed by what we were able to put together,” he said.

Jim offers a mix of a preferred provider organization (PPO) plan, a health reimbursement account (HRA), and a health savings account (HAS) high deductible plan. He utilizes the part-time worker voucher program through the Maine Department of Health and Human Services (DHHS), administered by DHA. He contributes five percent of the cost, the employee’s contribution is based on their income level, and the state subsidizes the rest.

Jim explains:

The way I define full time, my full time employees are eligible. Our workload varies. Sometimes it will be weeks and weeks with 32 hours, sometimes 42, or 43 hours. But I can't guarantee full time. Because of how we look at employment over the course of a year, they are all eligible for the subsidy program.

My biggest challenge in getting employees to sign up for health insurance is that as lower income employees, a lot of them would qualify for free care. They wonder why they should pay for health insurance when if something really bad happens they can apply for free care.

I had to put together a package to make it irresistible to them. I needed over five people and that was the hardest part in order to get affordable rates. It was the part-time worker voucher that made it so I could get them to sign up. A lot of them are paying \$75 a month [with the state subsidy]. I had budgeted more than I ended up paying so I took that money and put it into the HRA instead. So we've been able to have a really generous HRA in addition to the PPO. The HRA is \$2,000 a year for deductible expenses. It makes their deductible \$500.

The state has been great to work with. They are really on top of it. [They are very responsive and do a good job outlining our costs.]

Administering this is such a headache for me especially around renewal time. It's not like I'm itching to get involved with Harvard Pilgrim. It's hard to compare because there is no standard for this. It's hard to compare apples to apples. Getting to where we are [with a good insurance plan] is so freaking hard. Picking a plan and deciding if it's right for you...all that stuff.

Jim is aware that DHA's funding is not renewed for 2014, and he is unsure of what he will do. He says, "We can't afford to do this once the subsidy goes away. We'd have to switch to an exchange plan once the subsidy runs out. Can we switch from Dirigo mid-year?"

None of the small business owners knew anything about Maine Community Health Options (MCHO) or the ACA's support for Consumer Oriented and Operated Plans (CO-OPs). When asked what they thought about the new insurance option, they were open to the idea and wanted to hear more.

It's like a credit union for health insurance. Listen, the system is severely broken. I'm not against it. The fact that somebody wants to try a new system is a good thing. It does bother me a little bit that federal money is going to it. My question is ...what's different? How is it structurally different than what an insurance company is going to do?

The fact that they are in bed with the Maine Primary Care Association is interesting. I get concerned with bifurcation ...when my insurance company is in bed with the doctors, I wonder what's going on. I believe doctors and hospitals charge too much. Whether that's because of the efficiency or not, I don't know.

We do all of our banking with a credit union and I don't agree with the whole concept of a for profit insurance company. It's not supposed to be an investment bank, it's supposed to be insurance. I use a mutual insurance company for all of our insurance (MEMIC). If we keep injuries down we get a check back. That would be the first place I would call. It's not that I don't believe that I think you should be allowed to have a for profit insurance company if you want. But I don't want that to be my only choice.

One of the business owners expressed concern about MCHO as a new player in the insurance market. He said:

Let's assume they are motivated for the common good. The stuff is very complicated and it does give me pause because I wonder, "What's my protection as a potential employer who would be in this?" My premiums are based on how well things are going. I'd want them to have been in operation for say 8 years and have worked out the kinks.

IF there was [an assurance of] some cap...that premiums wouldn't go up by more than the CPI associated with health insurance...

The connection to the cooperative movement inspired positive comments, and another comparison to a credit union:

Everyone's in it together. It's like the difference between a credit union and a bank.

I am not the typical consumer. I am a green business owner. I belong to an organization called Co-op America. I would consider myself to have a nuanced view of what a coop is - I don't think that this will be a hokey thing run by hippies.

These responses underscore some of the marketing and communications challenges that MCHO and other states' CO-OPs face in reaching the business community. Business owners need reassurance that costs will not skyrocket, that the insurance products are high quality, and that the organizations are run with the same expertise and efficiency that they would expect from a fellow business owner. Business owners will rely on information sources that they trust, including insurance brokers and other business leaders. The CO-OPs' marketing materials will need to reflect professionalism, credibility, and reliability, as well as a "we're all in this together" philosophy. The CO-OPs should welcome a wide range of questions about their business practices, as small business owners scrutinize how they are funded and how they operate.

Once small business owners are convinced that the CO-OPs will provide high-quality service and coverage at a competitive price, they may not seek a significant level of involvement as members. They said:

I would love knowing that there is a dedicated group of individuals who are working to take care of this for me. On my end, I'd be looking for responsiveness and the opportunity to have input if I want. It's not the opportunity to have input into the design of it that I'm interested in.

I'm already busy enough. I don't want to go to meetings. I wouldn't see that as a positive even though I understand it from the standpoint of democracy. We are a small player.

I'm cognizant of the problems of the system outside of my need for healthcare, but I can't impact that.

In addition to their willingness to talk about health insurance, the small business owner interviewees wanted to weigh in with their frustrations about the healthcare system. Their input underscores just how complex a struggle it is to generate any positive information about healthcare and have it track with consumers, who are weary from dealing with their own healthcare issues, and their interactions with healthcare providers and insurers. Breaking through the cycle of negativity will require creativity, and a willingness to listen to complaints and take them seriously. People have opinions that they want to share.

As with other interviewees, the small business respondents did think that increased competition would stabilize healthcare costs to businesses. Here are some of their thoughts:

A third party system makes it unlikely for you to question price. I can't think of anything else where you can't get a rack rate...it's a lack of clarity, transparency. For the American consumer the opacity in the system is part of the reason we have a problem.

I used to work for an insurance company and I've seen the waste first hand and I've worked for state government and the waste is huge. You'll be able to introduce small players like the CO-OP who can be more efficient. It comes back to introducing the need for this organization to serve shareholders. I can't imagine how that wouldn't lower rates and increase competition. But that's only part of it. We need to control costs on the provider side. The idea that an MRI can cost \$600 or \$6,000 and there's no difference-- that has to stop.

I would agree that increased competition will help to stabilize or slow down increase of costs.

It's that sense of right to health care. With catastrophic insurance we pay more attention. In the UK, it was designed post WWII and now it's graduated to something else. It can't sustain what it was designed for. We can't sustain our system either.

My interviews unlocked a series of ongoing questions from one of the small business owners, in particular, who is keeping me posted on his insurance renewal process. He is

skeptical, and perceives that the ACA is contributing to the complexity of the process. In two separate emails, he wrote:

So my insurance agent tells me today...they are expecting a 40% increase in rates next year due to Obamacare. (of course, mine went up “only” 10% this year-love this industry!!!)

I’ve talked to my tax person. But actually that’s a little frustrating as well. Normally as a business you can expense most anything –but here they are creating all sorts of complex deduction rules. Again, more frustrating to the business world...

In the battle for the hearts and minds of Americans, marketers will need to find the right balance between too much information, and enough detail to satisfy critics. Small business owners are smart shoppers, they care about their employees, and they want to do the right thing. They worry about cost and time, and they listen to each other.

Trusted resources can include small business associations and insurance sources that are highly critical of the ACA. These sources are reaching small businesses via news outlets and email outreach on a daily basis. According to The Wall Street Journal, health insurers are “privately warning brokers that premiums for many individuals and small businesses could increase sharply next year because of the health-care overhaul law.”²⁷ The federal government has promised a reduction in healthcare costs over time, but only insurance companies know how the ACA will ultimately impact insurance premiums when plans are posted on the insurance marketplaces on October 1. The projected increases are at odds with what the Obama Administration claims consumers can expect.

The Wall Street Journal and others underscore the confusing fact that government subsidies are supposed to help lower premium costs for individuals and families, but subsidy amounts are not included in the actuarial projections now being communicated by insurance companies. Requirements for risk pooling are changing due to the ACA, and insurers will have to maintain a state-wide pool for individual and small business markets.

The small business owner who is keeping me informed of his renewal process passed along the link to an enewsletter, “Health Reform Weekly,” from Aetna.²⁸ The enewsletter

²⁷ Mathews A, Radnofsky L. Health Insurers Warn on Premiums. The Wall Street Journal website, U.S. News. Updated March 22, 2013. <http://online.wsj.com/article/SB10001424127887324557804578374761054496682.html>. Accessed 3/26/13. Accessed 3-26-13.

²⁸ Aetna. Health Reform Weekly enewsletter. <http://www.aetna.com/health-reform-connection/reform-explained/health-reform-weekly.html>. Accessed 3-26-13.

provides an overview of the significant amount of current federal and state legislation addressing provisions of the ACA. It may be hard for a small business owner or individual consumer to find relevance to their own circumstances in the legislation, other than seeing that change is underway, and stakeholders are fighting for control.

Finding the right messenger and the right message can help encourage small business owners to seek out new options such as the CO-OP. Because of the amount of “noise” being generated about the ACA, insurance premium price increases, hidden fees, and government spending, in-person communications will be an important component alongside print and electronic outreach in convincing consumers to consider new insurance options.

e. Equity and Actuarial Fairness

Several interviewees compared the experience of going to a car mechanic with the experience of seeking health care. As consumers, we try to make sense of the healthcare system by applying economic models that we understand. In *Health Politics and Policy*,²⁹ Deborah Stone talks about the difficulties in telling what efficiency is in healthcare because we don’t know what the output is. We have, as she says, “crude population measures,” such as infant mortality and life expectancy, but those are not good measures of a health system’s output because they are affected by a lot of other things outside of healthcare. Disease specific outcomes and report cards represent attempts to measure performance. Stone argues that they invariably ignore things like “lower risk of future disease, reduced pain, education about caring for oneself...hope, and a sense of well-being.” Stone urges us to consider “whose costs count and what kinds of output we want from the medical system,” or we will risk shifting the burden of unintended results to others who can ill afford it. Neither efficiency nor fairness are neutral aspirations.

The history of healthcare in the U.S. reveals a deep struggle over whether medical care should be “distributed as a right of citizenship or as a market commodity.” To put it in other terms: is medical care just like any other consumer good? The answer is intrinsically connected to our ideologies and our views on insurance. These ideologies rest on conflicting principles that

²⁹ Stone D. *Health Politics and Policy*. Edited by Morone J, Litman T, Robins L. Chapter 1, *Values in Health Policy: Understanding Fairness and Efficiency*. 4th Edition. Delmar Cengage Learning: 2008; 24-36.

can be summarized in this instance by considering actuarial fairness or indemnity coverage vis a vis insurance.

Actuarial fairness, the logic that everyone pays for his or her own risk, is, as Stone says, a “deep contradiction,” and “more than an idea about distributive justice.” Insurance companies use actuarial fairness as a method to organize people into homogeneous groups, or “risk pools.” Stone says that, “it is a method that leads ultimately to the destruction of mutual aid,” by fostering a focus on “differences” rather than “commonalities” among people and communities. These differences are then organized into competitive markets. Under the actuarial principal, commercial insurers consider it to be a failure to have to redistribute costs from the “lucky” to the “unlucky.” A fundamental principle of competitive business practice in the commercial insurance market is the pursuit of the segregation of people into homogeneous risk classes so that no one will have to subsidize the cost of sickness of others. Such subsidies are equated with market failure.

Social insurance, on the other hand, operates through the “solidarity principle.” Under social insurance, people receive the care they need, and the amounts they pay for coverage encompass more than simply the costs of the care that they use. Solidarity requires people to accept that they will not get “equal shares of the pie.” Need is an elusive concept, and redistribution from the healthy to the sick, from the wealthy to the poor is built into what is expected and accepted, “what is supposed to happen in insurance” (Stone).

Interviewees expressed different and complex perspectives that fall into two sides of the efficiency versus fairness debate. Of the seven individuals I spoke to, all would accept having to pay what they would believe to be a predictable and fair percentage of their income to support a system that pays for healthcare for all. What they all wish for is simplicity—they are not opposed to co-pays and deductibles, but costs must be transparent and understandable.

Compared with individual purchasers, small business owners and the business leaders were more concerned about personal liberty, and were more versed in the logic of actuarial fairness. I would suspect that while none of the six would expect to get identical slices of the healthcare pie by paying for the same level of premiums, they are concerned with business efficiency. One in particular was adamant about not having to pay for other people’s behavior choices that lead to poor health. He is also passionate about what he sees as over-treatment in the healthcare system. Health and healthcare challenges in the U.S. cause the business owners to

default back into looking at the issues from within an economic framework they believe will create effective barriers to waste.

f. Social Justice & Communicating about Health Reform, Marketplaces, and CO-OPs

My professional interest in the field of communications stems from a belief that information exchange and knowledge acquisition can help “level the playing field” for all members of society, and support equitable obtainment and distribution of limited resources. MCHO, CO-OPs, insurance marketplaces and the ACA are intended to challenge market failure in ways that increase access to health and healthcare for more Americans. How do we extend the social justice intentions of the ACA to ensure that the “right” information is shared so that all populations are able to make informed decisions regarding health, healthcare, and health insurance? For the purposes of this project, do social justice frameworks offer any guidelines that could be helpful as we continue to shape our response to health reform?

A utilitarian approach would require that the greatest number benefit, with little regard for individual rights. In time, will most Americans recognize a utilitarian benefit and be “happy” with the outcomes of health reform? American philosopher John Rawls³⁰ envisioned a just society arranged to optimize the position of those who are the least advantaged. Three years from its passage, the ACA incorporates redistributive policies that are benefiting those most vulnerable, but it does not uniformly prioritize their rights and well-being over others. Right now, the more vulnerable (least advantaged) losers in insurance coverage would seem to be low-income families whose income levels prevent them from receiving health insurance subsidies, and small business owners facing premium hikes resulting from expanded benefits packages and risk pools.

In “Justice and the Politics of Difference,”³¹ political theorist Iris Marion Young builds on “capabilities” frameworks provided by philosophers Amarta Sen and Susan Nussbaum, which links resources and welfare through the equality of capability. For Young, “that basic equality in life situation for all persons is a moral value; that there are deep injustices in our society that can be rectified only by basic institutional changes...and that structures of domination wrongfully pervade our society.” The ACA certainly represents significant and fundamental institutional

³⁰ Nathanson S. *Economic Justice*. Prentice Hall Inc. 1998:81-99. Upper Saddle River, NH>

³¹ Young I. *Justice and the Politics of Difference*. Princeton University Press. 2011.

change—of a sort. It works towards Young’s “elimination of institutionalized domination and oppression” in the insurance market by increasing individual access and choice. Can we look at new health insurance marketplaces as a strategic challenge to limited competition and limited consumer *engagement* in health and health care? Is it appropriate to look more closely at Young’s theoretical framework in understanding the potential of the CO-OP model?

Young is critical of justice that is only concerned with distribution of goods. Our policy process, our own form of democracy, is insufficient to ensure equity because justice considerations are not carried out among all people. She said,

“The paradigm assumes a single model for all analyses of justice; all situations in which justice is at issue are analogous to the situation of persons dividing a stock of goods and comparing the size of the portions individuals have...The distributive paradigm thus implicitly assumes a social atomism, inasmuch as there is no internal relation among persons in society relevant to considerations of justice.”³²

In considering the health insurance marketplace model, and its stock of goods—bronze, silver, gold (and platinum?) insurance policies, will track people into possession of what they can afford (and understand).

One of the health system leaders I interviewed asked if the marketplace could serve to engage people about their health and healthcare. This will depend on information—shared and acquired through the application process. How will the process work? What kinds of information will be gathered, and what kinds of information will be provided to individuals and small business owners as they access the site and the process? Who is developing the navigation technology? Who is writing the questions to be asked and responses given to user answers? How will insurance choices be offered? Is justice a consideration as the marketplace is being created?

Political theorist David Miller aligns with communitarian David Senel in claiming that the nation-state that embodies non-voluntary and cooperative relationships is too expansive an entity to be able to consider distribution according to equality.³³ Communities offer an appropriate principle for distribution in that there is a common idea of need (stemming from humanity rather than justice). In communities, “membership” is defined by what people need and mutual dependence. The CO-OPs would seem to serve as a community, literally providing

³² Young I. *Justice and the Politics of Difference*. Princeton University Press. 2011:18.

³³ Dow K, Kasperon R, Bohn M. *Exploring the Social Justice Implications of Adaptation and Vulnerability. Fairness in Adaptation to Climate Change*. MIT Press. 2006:79-96.

membership to those who buy in. On this smaller scale, justice, Miller would argue, could happen through shared understanding of need.

Young is helpful in outlining what that might look like. She encourages open participation in discussion and processes of decisionmaking as it fosters communicative ethics. She said, “The idea of justice here shifts from a focus on distributive patterns to procedural issues of participation in deliberation and decisionmaking.” She believes in enabling all to express their needs and exercise their freedom.

Young provides me with a good reminder of the following:

- My interviewees are providing me with information that reflects their beliefs and knowledge at that moment.
- Patterns that I identify in my research are not “end-state,” and are shifting.
- I am capturing snapshots in time that provide me with clues in understanding both the big picture and the little picture, while contributing to a continuum of information that may be valuable to “the field” and to MCHO.
- The CO-OP model necessarily addresses distribution within a larger framework of for-profit, employer-sponsored health insurance.
- The success/failure of different elements of healthcare reform are likely to fall within the context of our free-market based economic system, unless the dominant conversation changes.
- CO-OPs intersect with established, complex healthcare systems, and must yield to the demands of these systems, while attempting to change consumer-provider-insurance relationship paradigms.
- Health insurance by design provides specific and comparable “bundles” of goods and services, and in practice, compares individuals based on the amount of goods/services they use/receive. From Young, I note that among health insurance subscribers, there are simply distributional considerations, and there is no “internal relation,” really, in terms of considerations of justice.
- How do we effectively look beyond the distribution logic (such as price) of health insurance goods and services to non-material goods and resources, which defy a material goods distribution framework?

Creating consumer demand for self-management and consumer engagement in health and the health insurance and delivery systems that is (ideally) responding to their needs may support our understanding of the true costs of health.

g. Navigating New Insurance in a Familiar Landscape

For social justice advocates interviewed, health reform is necessary to address a broken, costly system that does not meet the needs of all populations, particularly individuals and families who experience any or all of the following: low-income, low-literacy, disability, mental illness, substance addiction, and lack of transportation.

These social justice leaders shared concerns about the challenges ahead in implementing the federal law, citing many unknowns, “moving parts,” and an unsupportive governor.

Will Mainers be able to obtain the information they need in order to make informed decisions about new health insurance options? Insurance brokers have traditionally served as the go-to resource for businesses and self-employed individuals, while safety net organizations and providers serve as links to MaineCare enrollment and free and low-cost or other unsubsidized care options. Despite the uncertainties in how Maine’s marketplace will look and operate, how the subsidies will work, how many people will be engaged in the process, and whether or not Maine will expand Medicaid, interviewees are trying to anticipate issues, while grasping the big picture. The scaffolding of healthcare and healthcare coverage is changing but when these social justice advocates look out across the landscape, they see the familiar faces of the individuals and families that they know well.

As of March 2013, advocates were waiting for the federal government to release regulations and application information for navigators. Only one of the interviewees said that his organization was interested in serving in a navigator role for Maine. The others see themselves as supporting the process by referring information seekers to the navigator, or to the Department of Health and Human Services (DHHS) for MaineCare enrollment.

These interviewees raised concerns about barriers to information access including the lack of high-speed Internet access for rural populations, and language barriers for immigrants and refugees. First time insurance purchasers will have particular challenges. For those that need help, accessing insurance and assuring selection of the best option is complicated. “The law is

applied to everyone in the state but health needs are different and plans need to be tailored,” said one interviewee. It will be a time consuming process to educate people. Another said:

There is a role for health centers [as] in-person assisters. Most health centers make you apply for MaineCare and you need that rejection letter in order to get on a sliding fee. So they are already doing some of that and enrollment eligibility for prescription assistance and [connecting people to the] tobacco help line. [The health centers] may not have a broader reach outside the community they serve but for their patients, it will be valuable. Internet access [can be] a problem. Maybe health centers would be a place where people go.

Advocates are clear that brokers cannot serve as conduits for low-income Mainers:

Brokers will not talk to a homeless person. We learned that with Dirigo. The marketing around Dirigo was limited to brokers.

Brokers may not understand needs of all consumers and do not have the incentive to route people to look at public (Medicaid) offerings.

Based on these interviews, it is striking that despite the amount of information that the federal government is releasing on a daily basis, a news cycle that is filled with analysis and deconstruction of the health reform process underway, and how well the advocates understand their role in helping Mainers access resources and help, collectively, we are still so unsure of the logistics. Perhaps the process can be compared to any new challenge—we believe we can do this but we are not exactly sure how it will happen.

Advocates hope for new insurance benefits that will empower people to be and stay healthy. They report having been in contact with MCHO and believe that the CO-OP’s offerings could provide meaningful support.

[The benefits] would be reflected in Maine Community Health Options’ value-based insurance design, including promoting wellness and access to healthy foods. Smoking cessation would be [another] one. Another thing that they are talking about is tools to help patients to make good decisions. [There need to be] evidence-based and promising practices to support patients through preventing chronic disease.

Transportation is critical. A lot of low income folks live in rural areas with no transportation--or transportation doesn’t go where they need it to go. They have no personal leave or sick time. They need to be able to access providers after hours and on the weekends.

Some need very little, some need a lot. Mental health parity is going to be key. People with lower incomes have higher unmet mental health needs. Substance abuse services are

part of the [federally mandated Essential Health Benefits (EHB)]. Not that low income people have the market on substance abuse, but they will be able to access services.

Advocates support the CO-OP concept and hope for sustainability and a different kind of insurer-insuree relationship. They also stress the importance of relationship-building:

I assume that there will be a population that it will be attractive to. Low income clients won't know a difference because they don't come from a culture of private insurance. That culture is something you have to learn in order to appreciate the difference.

The CO-OP is going to be positively on the end of the consumer spectrum in looking out. It's one more positive piece.

If the price is right, yes...If the price is substantially higher than the lowest option then they can have the most wonderful mission and benefits and people are not going to do it. If they are close, in the mix for the right price point, I think it would resonate. And people might gravitate towards the benefits that they have to offer. For our patients, if they knew that it was health center driven, they might feel even more connected. But that would be a messaging piece.

One of the interviewees shared her concerns about the rollout of theoretical approaches to improved health and how they may not track with target audiences. Her points are important:

- *How do you dictate personal behavior from a corporate level? People perceive it as “entities that I am paying for telling me how to live my life—it’s potentially offensive and paternalistic.”*
- *People don't want to think about health care unless they need to. Women and moms make all of the healthcare decisions, so you have to appeal to them, and entice the parent to engage.*
- *We will not reduce costs if continuity of care is lost. How many times will people fluctuate between Medicaid and insurance? How do you keep people in their medical homes?*
- *Families on Medicaid have the same network and the same provider. If an entire family is covered and the parents and child are on the same network, kids get more care. How do you ensure that everyone in a family is in the same place?*

As with other interviewees, the advocates wanted to share their frustrations with the healthcare system. Their stories recognized just how difficult it can be to navigate healthcare, particularly if you lack knowledge. These stories are an important part of the health reform equation, and must be incorporated into targeted marketing strategies. For the right audience, they serve as a reminder of why the U.S. is moving forward with government intervention in a broken healthcare marketplace.

[Health insurance] is too expensive and people don't understand what they are purchasing. Insurance summaries are not for an average reader at a 6th grade level. I've seen an individual who thought she had a high deductible plan with a maximum out-of-pocket limit of \$10,000 to \$15,000 for her family. But that was per person and not per family. When she hit the maximum through a surgery and then a child broke a bone, she discovered that she had not hit her limit and that was shocking to her.

People don't understand lifetime caps. When you have a child with special needs you hit a cap and you hit it quick. It's the [fine print] information that people don't understand. I feel like a knowledgeable consumer and I purchase insurance for this organization and even I have a hard time comparing plans and understanding what's best for all of us. You have to spend significant time reading the policies and understanding them. The drug formularies alone are challenging enough. It's too complicated for people.

The ACA includes a mix of population-based approaches, coupled with enticements to improve health at the individual level. In response to those who are concerned by a mandated minimum level of benefits that may increase the cost of new insurance offerings, one of the advocates had an animated argument for why they are needed:

I am a firm believer in the concept of the Essential Health Benefits. People don't know what they don't know. The idea of any insurance is to cover the unexpected. Those are the high ticket items. Those who say we should have more stripped down benefits, forget about that. I don't think the average person has enough information about what should and shouldn't be in benefit design. In terms of any one person, I always ask, "The cost for what?" People don't always purchase insurance that is complete insurance. They won't be able to do that anymore. So they will pay more and get tangible benefits. The price of insurance for younger people is going to increase--but you need to look at the whole picture.

h. Health System Leaders Focus on People

The five health system leaders I spoke to provided perspectives from different vantage points in healthcare service provision: a major hospital, unpaid care coordination, accessible dental care, and community-based and clinical programs. In deconstructing the interviews, I decided to first take a quick look at the intersection of language used by the interviewees. I entered the text from the interviews into wordle.com, a "word cloud" program that gives greater prominence to words that appear more frequently. The program removes common words. This is

the Frameworks Institute,³⁴ and of our conscious and unconscious use of language in understanding how it impacts public policy. Positive versus negative framing is neither “right” nor “wrong,” but as leaders’ conversations become public, bringing consciousness to word choice can contribute to how community dialogue plays out.

A final point gleaned from the word cloud regards the federal government’s recent rebrand of the term “exchange” to “marketplace”³⁵ in reference to the entities where consumers and businesses will access new health insurance options beginning in October 2013. Health leaders have gotten used to using the word “exchanges” (interviewees used the term “exchange” a total of nine times, and “marketplace” was not used at all). In fact, throughout my project interviews, I initiated the use of the word “marketplaces,” and then defaulted back to “exchanges,” in response to my interviewees’ language choice and my perception that it was more readily recognizable. A quick check of the U. S. Department of Health and Human Services (DHHS) website reveals a new blog post by DHHS Secretary Kathleen Sebelius, referring to the (singular) “Health Insurance Marketplace.”³⁶

Health system leaders are concerned with how to ensure that people get the care they need. When reflecting on how to expand access to comprehensive care, key barriers include cost, lack of care coordination, lack of sophistication, low literacy, and the complexities of providing care to populations whose health problems are compounded by mental illness. Despite the significant structural hurdles associated with these issues, the leaders convey a connection to the people they serve that goes beyond an administrative role. They explained:

So many of our folks now have high deductibles, and pay out of their pockets. We have a framework but we don’t have healthcare. Insurance is about \$2,500 away.

What supports people is a case worker. What is the care coordination function going to look like? Rather than duplicate one more person in their lives, are there skills or training we can give our people because they have a relationship with the family.

³⁴ Frameworks Institute website. How Frameworks Analysis Plays out webpage. <http://www.frameworksinstitute.org/sfa.html>. Accessed 3-28-13.

³⁵ Baker S. Obama officials ditch ‘exchanges’ in rebranding of healthcare reform law. Healthwatch, The Hill’s Healthcare Blog. The Hill website. January 20, 2013. <http://thehill.com/blogs/healthwatch/health-reform-implementation/278105-obama-officials-ditch-exchanges-in-rebranding-of-healthcare-law>. Accessed 3-28-13.

³⁶ Sebelius K. Affordable Care Act at 3: Looking Forward and Expanding Access. HealthCare.gov website. HealthCare Blog. March 22, 2013. <http://www.healthcare.gov/blog/2013/03/anniversary-looking-forward.html>. Accessed 3-28-13.

So many folks lack sophistication of purchasing and around navigating and informed decision making for themselves and their children. What's happened is that as the system has gotten bigger, it's gotten more complex.

Most people don't "use" the system. They are struggling, hardworking people. They don't want to be users.

Health system leaders do not have much actionable information regarding the health insurance marketplaces, but they provide a new perspective. Their comments belie a close relationship with payers, and reveal insights into the role of insurance companies as part of the consumer/provider/payer dynamic. Payers are actively pressuring providers to reduce costs as a means to control premium prices. At the same time, I was told that payers are working with less actuarial data than ever because they do not know how many people will move to the exchanges and what the risk pool will be.

When asked about costs, health system leaders had a different perspective than consumers, who are concerned with paying for care. System leaders look at cost from three vantage points: cost to patient, cost to payer (and impact on price negotiations), and cost to system. One of the leaders expressed a pressure and obligation to reduce healthcare costs:

I believe that costs are going to come down. This is my own personal moral conviction. Plans are pushing us to increase discounts [so that they can] come into this market with lower prices.

The role of the health insurance exchange in lowering costs is still very uncertain. One health system leader suggested that initially, the exchange will represent a small risk pool, but that competition will drive costs down within that risk pool. Another wondered if the exchanges could serve as a tool to help people learn about health care decisions:

If the exchange is not going to be a big lever around cost, could it be a focal point to catalyze a greater understanding of health insurance? That would be huge. If there was a body of information about coverage and cost...that you could make decisions around, that would be huge.

A health system leader who works with lower-income clients has been surprised by the number of questions her program is fielding. From her perspective, the most important information to share now is that there will be places to call or go to for help.

[Our clients] are really anxious about [health reform]. We have been surprised by how many people call us every day with questions. I think we thought we were in the weeds with it all the time, but we didn't anticipate how many consumer phone calls we get every

day. They don't see it as a positive. They are concerned that something will change with their current health care. It's all coming from a place of anxiety.

Health system leaders agree with other interviewees that cost will drive people's decision to purchase insurance through the CO-OP or not. They urged simplicity, and a concise but thorough explanation of value-based purchasing.

i. Lessons from Dirigo

Maine's Dirigo Health Reform Act was passed in 2003 to make affordable health care coverage available to every Maine citizen by 2009, slow the growth of health care costs, and improve the quality of care.³⁷ The Act supported the creation of the Dirigo Health program, which helped expand coverage for low- and moderate-income individuals through two coverage initiatives: DirigoChoice, a subsidized insurance product, and a Medicaid eligibility expansion for low-income parents of dependent children. To pay for this expanded coverage, Maine utilized savings in the overall health care system due to lower uncompensated care and cost controls. However, the funds raised were insufficient to pay for greater subsidized enrollment in Dirigo programs, ultimately leading to the Legislature's decision to end Dirigo funding as of December 31, 2013.

Interviewees interacted with Dirigo in different ways and many (eleven out of twenty four) were eager to share their opinions about what the plan accomplished and why it will not continue to be funded after 2013. The comments can be summed up in six headings: marketing, funding, politics, competition, ease of use, and cost.

1. Marketing (a.k.a. promises)

Interviewees spent the most time talking about a major disconnect between public perceptions of Dirigo, and what the plan actually was. This misperception may have been exacerbated by a changed strategy mid-stream that was not effectively communicated to the public. It is likely that if the public perception was at odds with the Agency's work, elected officials also lacked a framework under which to support and defend state funding.

³⁷ Lipson D, Verdier J, Quincy L. Leading the Way? Maine's Initial Experience in Expanding Coverage through Health Reform. The commonwealth Fund Publications: Fund Report. December 5, 2007; Vol 78. <http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Dec/Leading-the-Way--Maines-Initial-Experience-in-Expanding-Coverage-Through-Dirigo-Health-Reforms.aspx>. Accessed 4-11-15.

Of note is feedback about the cost of comprehensive benefits. With new federal requirements around essential health benefits (EHBs), insurers, including the CO-OPs, will need to find ways to explain to consumers and business owners that comprehensive benefits protect us against the unexpected. Some of the interviewees likened health insurance to car or home insurance, except that in these cases, the cost benefit is easier to calculate. Consumers may be ready for relatively simple, yet applicable cost-benefit analysis to begin to connect them to the cost of care and the purpose of EHBs.

Interviewees' marketing-related comments included the following:

With Dirigo, people wanted it to be cheap. It was a robust plan. What they didn't realize was all the benefits are not cheap.

The lesson is, don't overpromise and under deliver because your proponents will never let you forget.

The highest they ever got [in terms of enrollees] was far less than what they promised. The Dirigo insurance product was not very well marketed initially. There was confusion in the consumer space.

It started off trying to achieve "A," but because of funding issues and the repeal of the beverage act, changed to "B." That change from "A" to "B" meant that it was never was going to be able to accomplish "A" and the [identity change] never come into public perception.

They over-promised and underperformed.

Brokers will not talk to a homeless person. We learned that with Dirigo. The marketing around Dirigo was limited to brokers.

Don't overpromise how many people you will cover. We learned a lot from the marketing. If you don't have funding for marketing then you can't compete.

2. Funding

There was clear understanding from individuals I spoke to that lack of sustained funding severely impacted Dirigo's chances for success, and contributed, ultimately, to its demise. I sensed that the interviewees believed that internal and external forces came into play in the Agency's funding challenges, and that politics (see next category) played a significant role.

I feel frustrated about the Dirigo experience because it immediately had its funding mechanism cut.

The funding mechanism seemed flawed from the start.

3. Politics

Having informed, well-spoken political champions can help buffer cyclical changes in dominant viewpoints. As the interviewee below suggests, simple, effective talking points can help set the tone, and provide leaders with the information they need to make reasoned arguments. However, Dirigo may ultimately demonstrate that despite careful planning and experienced know-how, politics is unpredictable. What is most at risk if political winds change direction? How can health reform advocates ensure that interventions are protected from shifts in political support?

You can never underestimate all of the politics. Our healthcare system is completely broken in terms of cost and quality. It is a failure on the macro level on any standard compared to the rest of the developed world. And yet, it is amazing how many people want to keep the current system as a market, fee-for-service system. Dirigo's lesson is that those voices are very powerful.

4. Competition

Two of the people I spoke to seemed surprised by competition from market dominant health insurers, who they saw as unjustly competing for Dirigo beneficiaries because Dirigo was the “disrupter,” the mission-driven public option. Perhaps, looking forward, stakeholders should not be surprised by challenges from for-profit companies as government-supported innovation gains traction in the market.

We know in hindsight that Anthem effectively created a competing product that they would shift you to if you came in asking about Dirigo.

From my experience working on Dirigo health, the big players have significant war chests, where they can significantly reduce premiums to be able to outbid.

5. Ease of Use

Consumer frustrations with the complexity of interacting with the healthcare system can be dominated by experiences with insurers, who can act, for better or worse, as gatekeepers to knowledge and access. Insurers may find relief in the standardized structure of the new insurance marketplace, but with increased competition, may accept greater responsibility for helping consumers understand and use front-end processes.

I worked at an organization that opted into Dirigo, which was not an easy process. [Dirigo] had a weird application process. Employers had to sign on, [but also] each employee had to provide financial information in order to get a rebate card.

If when you are shopping for insurance and you don't have the ability to see what products are in an apples to apples comparison, you are not in control.

6. Cost (price)

Throughout the research project, interviewees have cited cost as the first consideration in considering new plans. The second comment below raises a flag around the prospect of premium hikes over time—and consumer tolerance for cost shifting.

As I recall [Dirigo] was more expensive than my current plan.

I guess for the people who were insured by it, it was a good deal. But because it was so subject to external manipulation and political forces, that it has become less and less of a good deal for them. It seemed like it was going to be alright for them and now about half the people at my association have gone off and found individual insurance that costs a little bit less.

Several final thoughts highlight Dirigo's lasting legacy to Maine and to the country. Health leaders and advocates cite the ideas and partnerships that developed through and because of Dirigo, and how those will continue to impact health reform.

There are many things that did play out to put Maine in the lead in these healthcare pieces. And the big three players: Quality Counts, Quality Forum, and Maine Health Management Coalition are working together on issues that Dirigo brought to light. More came out than meets the eye in terms of how much further along Maine is on reduction of cost issues.

As a coverage piece it never really played out that well but as a think tank, I think it made a big difference.

It has provided access to thousands of people. It was a reasonable model and it helped. When you look at what Maine did in terms of health coverage, the state was at the forefront and is a model for what ACA is trying to do. There were a lot of positive things that could be learned from the Dirigo experience. One of the regrets that some people have is that Maine said no to the exchange, and the Dirigo Agency had skills that could have supported that.

j. Finding Inspiration in People's Stories

Accessing health insurance is just one of many challenges that interviewees face. Putting it into perspective, health insurance is one of those things that is an on-going concern if you are engaged in preventive care or chronic disease care and management, taking prescription drugs,

or have aging family members. Employers are concerned with employee benefits and expenses. People think about health insurance when it presents itself as a budget item, in the form of a bill, in budget planning, and paying taxes. That means there are multiple opportunities when consumers are seeking information or thinking about seeking information. Those are the times when marketers need to be ready with information.

As I approached the final interviews for the research project, I reviewed my findings, thoughts, interview data, and the news coverage of the ACA at large. I came to the following very basic conclusions:

- Do not underestimate people’s ability to determine what is best for them given adequate information.
- People are generous with their time and want to share their opinions.
- People want to talk about health reform.
- Everyone has a story about the healthcare system.
- Interviewees are jaded and hopeful at the same time.
- It can be boring, overwhelming, humiliating, frustrating, and exhausting to make heads or tails of insurance information.

1. Dan

The final business leader I spoke to, “Dan,” represents the interests of self-employed and small business owners primarily from rural areas in the state. He is also an employee at a company in a related field. He told me that as an officer in his company, he makes \$21 an hour with no benefits. The people below him make \$15 an hour. “And that’s ok,” he said. He talked about how we need to “understand that there are other rewards.” Dan’s comments about health insurance options can be grouped into three categories: asset protection, financial planning, and personal connection.

According to Dan, cost is the biggest single question for everyone. He has lacked health insurance for most of his life. He sees health insurance as unaffordable. Some people he knows are covered through a spouse. Finding affordable coverage in light of increasingly expensive options has been an ongoing conversation at work. He says that they’ve talked to brokers and to insurance companies, and “it all comes down to asset protection.” In his mind, it’s just like house insurance, and he is hoping for something “a little better than that.” He says:

I hear people who desperately feel they need to have health insurance and feel vulnerable if they don't but are concerned about the cost. Because what they are looking for is asset protection. They don't want to be saddled with a \$100K bill. They are willing to be saddled with \$200-300 per month. I liked the ACA because it seemed to look at how much should you spend on health insurance and seemed to set reasonable limits.

Dan's co-workers want major health coverage, "a certain amount of regular attention," and a fixed dollar amount. Being able to plan to spend a certain percent of your income on an annual basis makes sense to him. If people do not know what they have to pay, "they throw up their hands because they can't plan for it." People he knows are afraid of "a bottomless pit" of medical expenses.

Specifically, Dan talked about how hard it is to figure out what it means to have a deductible, and what it means to be paying for a prescription. He said, "people avoid addressing problems because they don't know how much it is going to cost." Dan likens health care to going to a mechanic and "being told we don't know what's wrong with your car but we'll work on it and then let you know how much it will cost." He said that people decide not to do it.

Dan also wishes for a closer relationship with a doctor. He remembers when doctors made house calls. For him, being treated as a cog in a wheel is difficult. It's not what he grew up with. "People want connection," he said. Dan thinks that MCHO could offer something different, but he worries about their debt obligation to the federal government. As an aside, he believes that accessing the exchanges online will be possible for most people he knows. "For the most part, people have gotten fairly used to dealing with the Internet."

2. Michelle

"Michelle" met me at her place of work in central Maine. She has insurance now, and will be looking into Maine's new health insurance exchange for insurance options. She has only the basic understanding of how it will work. She is looking for a "pretty basic, economical package:"

I'm not on medication. I'm healthy. I'm looking for the kind of package that would cover preventative care. I'd like regular dental, eye, and doctor visits. The dental part is really difficult to stomach year after year. Having to pay out of pocket for a filling or crown is hard to do. If it is cost prohibitive, though, I think I would go without.

Michelle has heard about MCHO, and is “absolutely” interested. “Mainers are independent-minded people and the CO-OP model appeals to us,” she says. Like Dan, connection is important to Michelle:

One of the biggest issues that people have with insurance companies is that it is a big name company that is not thinking of the people it is serving. The idea that you would be a person in the system that is considering you--that would be a huge selling point to me.

Despite the unknowns, Michelle is excited about healthcare reform. “Most people are disappointed with the health system and all of its flaws. Even if it’s not perfect, [the ACA] is a step in the right direction,” she said.

k. Members in Mind

Unfortunately for health reform advocates, the top three results in my Google search for “young people’s opinions of Obamacare,” were: “How Obamacare Will Hurt Young People,³⁸” “Obamacare will hurt young people most,³⁹” and “Obamacare Keeps Young People from Growing Up.⁴⁰” None of them were written by young people.

The health reform train keeps moving forward and special interest voices are likely to become stronger. Critical viewpoints appear incomplete in comparison to the positive pieces I’ve read. However, for a mind that is seeking an easy answer, the criticism is easier to take in. Points are simple, numbers are big, and news is neither complex nor neutral. Communications specialists are trying desperately to simplify messaging around the ACA so that the positives can begin to track with the media and with consumers in a direct and real way.

Is there a way to change the way that we think about communications to tackle challenges like this? A communications strategist would be loath to cede media space to ACA critics. At the same time, we know that people’s hearts and minds are won over at the water cooler, in church, at the playground, and in the grocery store.

³⁸ Morris D. How Obamacare will Hurt Young People. Creators.com: A Syndicate of Talent. Posted 2009. <http://www.creators.com/opinion/dick-morris/how-obamacare-will-hurt-young-people.html>. Accessed 4-2-13.

³⁹ Lambro D. Obamacare will hurt young people most. The Washington Times. February 20, 2013. <http://www.washingtontimes.com/news/2013/feb/20/obamacare-will-hurt-young-people-most/?page=all>. Accessed 4-2-13.

⁴⁰ Meyer Y. Opinion: Obamacare Keeps Young People From Growing Up. Young America’s foundation, Exclusive for Fox Nation. Fox Nation: Campus. Posted May 24, 2012. <http://nation.foxnews.com/obamacare/2012/05/24/opinion-obamacare-keeps-young-people-growing>. Accessed 4-2-13.

I truly believe that understanding audiences is the key to strategic communications. Target audiences and individuals are the best source of inspiration—they provide the language that they need, convey their gaps in knowledge, and share what gives them hope. They will identify the myths to dispel assumptions, and give clues to what will work and what won't in communicating with them effectively.

1. The Fourth Sector

Entrepreneur Heerad Sabeti, Co-founder of the Fourth Sector Network, points to a different approach to economic development that proposes valuable concepts in how to represent aspects of health care reform, particularly the health insurance CO-OPs. At a talk on April 2 at the University Of Southern Maine hosted by the School of Business, Sabeti spoke about the systemic problems we face in today's world including but not limited to climate change, slowing economies, persistent poverty, and healthcare disparities. Sabeti argued that non-incremental change only occurs when personal behaviors, organizations, and their supporting ecosystems shift together. Individual consciousness, he said, is the easiest thing to change—necessary but insufficient to ensure that billions of people are thinking and acting differently.

Sabeti believes that organizational structures around the world are, in fact, changing. For profit entities are moving towards increased social responsibility, and governments and non-profits are moving towards disciplines of the market through greater efficiency, accountability, etc. A new sector (the “fourth sector”) is emerging in the increasingly blurred space where governmental, non-profit and for-profit approaches overlap. Sustainable or social enterprises, social businesses, new profit companies, chaordic and faith-based organizations, and for-benefit entities are characterized by their explicit commitment to social purpose, earned income, inclusive ownership, stakeholder governance, limits on executive compensation, transparency, and sustainable impact.

In the talk, Sabeti highlighted the health insurance CO-OP model as a federal policy change creating for benefit organizations. The 25 state CO-OPs are a brand new approach to the provision of health insurance that defy market assumptions in that they are non-profit, and member-driven, but operate with the rigor of a business. Sabeti says that organizations like these are poised for growth.

In thinking about the MCHO and social entrepreneurship, I believe that the CO-OPs require an approach to communications that reflects this fundamentally different way of operating in the world. When I spoke to Sabeti after the talk, he shared his conviction that the CO-OPs will “catch on,” but that branding is a top priority. His thought is that the CO-OPs must have an umbrella brand that communicates for benefit/fourth sector values, under which MCHO and others are able to create their own identities.

CO-OPs were created in perhaps the most politically charged legislative process in U.S. history. And yet, they are not political. Conservatives appreciate the model as responsible privatization--an answer to government-run health insurance, while progressives value them as an alternative to big business. In recognition of this reimagined insurance entity, the CO-OPs--private, consumer-governed health plans with a social purpose--have been awarded their very own 501(c)29 tax designation.

Sabeti’s comment about branding struck a chord. Some of the first conversations I had with thought leaders about MCHO suggested that brand identity would be vital as the organization seeks traction with target audiences. A strong brand is vitally important to viral marketing, and instant recognition will help as MCHO establishes its presence in the health insurance marketplace. It does not appear that the National Alliance of State Health CO-OPs has made a commitment to working with the state CO-OPs to create an overarching brand that could serve as a trigger for public discussion and media coverage. Funding is undoubtedly needed; the CO-OPs themselves may not see a benefit in branded linkages. Perhaps a compelling case could be made to Fourth Sector funders to support the investigation of a branding process that is as collaborative and transformative as the CO-OPs themselves.

In a November 2011 article in the Harvard Business Review,⁴¹ Sabeti underscores how important it is for for-benefit organizations to explicitly define how they are distinguished in the market by invoking terms such as “social enterprise,” “sustainable business,” or “fair trade.” I would suggest that a link to the emerging fourth sector would serve to support public recognition of a welcome change, and also create potentially valuable connection with others pushing for balance between economic and social performance.

⁴¹ Sabeti H. A fourth sector of the economy is emerging, with the power to transform the course of capitalism. Harvard Business Review: Spotlight on the Good Company. November 2011: 98-104.

Thinking back on conversations about MCHO with interviewees throughout this project, I recognize an appreciation for the values of the cooperative movement, and a sincere hope that the CO-OP will be expertly managed and economically viable. The people I spoke to were intrigued that MCHO is designed by and for members, but need reassurance that the business model is sustainable. In an article in *The New York Times* about fourth sector firms, Juliana Eades, president of the New Hampshire Community Loan Fund says, “I think what people are increasingly looking for...is how you harness the vitality and promise of capitalism in a way that’s more fair to everyone.”⁴² Making that case to “independent-minded” Mainers does not have to be complicated or expensive, but it will require a commitment to connecting regularly (in person) with target audiences, and clarity of purpose, language, and visual imagery.

VI. Conclusions

In conclusion, it is clear that MCHO is entering the insurance marketplace with tremendous assets. The CO-OP model is attractive to the individuals that I interviewed, and all wanted to hear more. If policies are competitively priced, individuals will be poised to consider MCHO as an alternative to for-profit insurance companies. However, the CO-OP would benefit from increased awareness: the individuals knew very little, if anything, about MCHO in February and March of 2013—about six months before the marketplace is scheduled to open.

Small business owners are asking upfront for information about MCHO’s financial viability. Cost will drive business owners’ decisions about new health insurance options. They are busy, and capturing their attention will require outreach through trusted sources of trade and community information. They also lacked knowledge about MCHO and the marketplace. Of note, the youngest business owner I interviewed was the most interested in the CO-OP (though the others wanted to hear more). He may represent a promising sub-set of business owners who are committed to sustainable growth practices, and eager to support a “for-benefit” health insurance model.

Thought leaders in Maine are tremendously supportive of MCHO, and want the CO-OP to be successful. I believe that they will do what they can to help, though they are cognizant of the challenges ahead, including an ever-changing economic and political context for health

⁴² Strom S. Businesses Try to Make Money and Save the World. *The New York Times* online. May 6, 2007. <http://www.nytimes.com/2007/05/06/business/yourmoney/06fourth.html?pagewanted=all>. Accessed 4-3-13.

reform. MCHO is just one of the payers that they work with. All are concerned with reducing the cost of health care—one thought leader expressed cost reduction in terms of being a “moral imperative.”

The purpose of this project was to support CO-OPs and MCHO in assessing and developing communications strategies that will help consumers make informed choices about new health insurance options. The findings from this research project have been synthesized independent of any in-depth knowledge of marketing efforts MCHO has underway. Some of my recommendations may mirror what MCHO is doing and I hope that this project will serve to reinforce those strategies and suggest some new ones.

1. Build Brand Equity

In order to reach enrollment goals, the CO-OP will need to create brand awareness among individuals and small business owners. MCHO’s leaders are right to believe that awareness can happen organically—through viral marketing. The challenge is identifying what elements will cause “buzz” to occur. MCHO is new, different, and local. Branding should reflect that difference, while remaining rooted in the positives associated membership.

Developing an unforgettable brand can take time and money. Research could include conversations with CO-OPs in other states: is there interest in creating brand linkages among CO-OPs to demonstrate a larger, national movement that is harnessing a different kind of business model. I would investigate “for-benefit” and Fourth Sector networks, and pay attention to how they are re-imagining branding. As suggested by Heerad Sabeti, perhaps there is opportunity to explore branding challenges with funders who are not typically engaged in healthcare issues, but may appreciate healthcare market disruption.

Strong visual brand elements—logo, website, videos, print materials—do not have to be complicated or expensive. Self-employed and freelance graphic artists and web designers are a likely target audience for MCHO. Why not invite Maine designers to submit ideas as part of a contest? The winning designer could secure a contract and media coverage. Getting to know the creative design community in Maine could lead to an interesting campaign. For example, this month on the Maine Public Broadcasting Network is airing stories by listeners about music that moves them. There are multiple other examples for how to engage consumers through

storytelling and sharing.⁴³ In a similar vein, next year, MCHO could work with the freelance creative design community in Maine to produce audio and video stories about what it means for MCHO members to be able to get the healthcare they need. MCHO could seek a media partner for distribution, but at the very least, the stories could be posted online and sponsored by MCHO and the design community together.

Increased enrollment will benefit future MCHO members; branding, marketing, and “buzz” creation should be a part of advisory committee meetings. Perhaps MCHO could invite a local social entrepreneur to speak to the advisory committee about successful strategies, followed by a brainstorming session with committee members led by MCHO and/or Crescendo Marketing.

2. Go to the Small Business Owners

Small business owners in Maine and across the country share a significant frustration with the cost of health insurance, and the time and energy it takes to purchase it. Reaching the business community will require dedicated face-to-face time through presentations at the community and regional level. MCHO leaders should be prepared to answer tough questions about sustainability and business plans. Having an “elevator speech” specifically for small business owners will be invaluable in making a connection. Business owners may respond to language associated with the “Fourth Sector,” which can help remove CO-OPs from the politically charged and potentially negative context of the ACA. Increasingly, business leaders understand what it means to do well by doing good.

The “ecosystem” supporting business in Maine: lawyers, accountants, brokers, trade associations, and the organizations and media outlets that support business-to-business networking are part of the small business landscape. MCHO’s business strategy includes an actuarial process and targeted identification of potential members. Taking the time to do a market audit and analyze how “sales” data meshes with outreach and communications may lead to interesting discoveries that can provide clues to regional or community strategies.

3. Target Individuals who Care for Others

Licensed aestheticians massage therapists, hair stylists, and physical therapists are examples of self-employed individuals who may easily understand a different health insurance model and value-based benefits design. Moreover, individuals in these professions are trusted by

⁴³See another example at <http://www.facesoflearning.net/>.

their clients, and can be highly effective in endorsing businesses and products. I spoke to three individuals in care industries and they were eager to chat, share opinions and learn—and they were particularly curious about MCHO and what it had to offer.

4. Reach Out to Young Adults

The youngest person I interviewed (in her late 20s) stands out as someone who would welcome MCHO membership. Her primary concern was, of course, cost. But the different business model had strong appeal for her. It would be interesting to conduct a couple of focus groups with young adults to tease out what they are looking for, what kind of language they use to describe what they need in terms of healthcare and coverage, and where they would be most likely to access information, and how to tap into the buzz of social media. Young adults may need basic education about how health insurance works, including risk pooling, co-pays, deductibles, and benefits design. Costs may increase for this group; they have questions about insurance subsidies, and what impact that may have in making health insurance affordable. I would recommend that MCHO develop a fact sheet for young adults that goes beyond the basics to explain how the insurance marketplace. Young people will pay attention to brand identity.

5. (As Possible) Serve as an Unbiased Source of Information

Lack of information, perceived lack of information, lack of trusted sources of information—about the “best” cost, treatment, and provider is so pervasive among consumers that considerations about health insurance coverage are inevitably tinged with anxiety. In economic terms, healthcare knowledge is a “scarce good.”⁴⁴ We all experience an opportunity cost associated with the acquisition of health insurance and health care. Small business owners could be investing in other things, such as technology, that may seem more directly beneficial to business. Individuals make choices daily about purchasing decisions based on opportunity-cost decisions. But in healthcare, expenses are irregular and often unpredictable. Individuals and small business owners are desperate to minimize uncertainty. If the CO-OPs can help address consumers’ wide-ranging questions, they will be seen as an ally.

I would expand this role beyond potential members to the media and thought leaders, via speaking engagements, distribution of non-marketing materials such as one-pagers, fact sheets,

⁴⁴ Browning E, Browning J. Public Finance and the Price System: Financing Health Care. Macmillan Coll Div; 4 Sub edition (January 3, 1994).

and “white papers” that share the health, healthcare, and health insurance knowledge that MCHO and other CO-OPs own.

6. Bring Members to the Table

Finally, and perhaps most importantly, I would urge CO-OPs to work with members to create the means for regular participation, which, as Iris Marion Young would encourage, includes the ability for members to share their needs, opinions, and ideas with CO-OP leadership and with each other. Structured and ongoing internal, cooperative-wide communications will help to empower members to take ownership of health—and healthcare decisionmaking. Washington’s Puget Sound Health Alliance prioritizes consumer engagement as a means of “help[ing] people partner with their providers and better manage their health and make better, more informed decisions about their health care.” With members, CO-OPs could reach out to Puget Sound Health Alliance to learn more about their consumer outreach strategies as a starting point in helping new members define how they would like to be involved.

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VIII. Appendixes

Interview Questions (Guide):

Small Business/Self-Insured

What kind of health insurance do you currently have?

How do you access insurance information? How do you make health insurance decisions? (Do you have a broker?)

What do you know about the new health insurance exchanges?

Will you be looking to Maine's exchange for new health insurance options?

What will you be looking for in plans that you would consider?

What do you know about Maine's new Consumer Oriented and Operated Plan (CO-OP)?

Does the fact that it is designed by and for members spark your interest?

What does the CO-OP moniker mean to you?

What is your experience with other kinds of cooperatives?

When I say "health reform," what are the three words that come to mind?

How will increased competition in the health insurance market stabilize costs to business owners?

What kind of engagement/voice would you expect as a "member" of a non-profit CO-OP health insurance plan? What kind of return investment would you expect to get as a "member?"

Do you think the CO-OP is a good idea, and why or why not?

Are there any other small business owners you can think of whom I should speak to about the CO-OP?

Thought Leaders/Healthcare/Social Justice

How familiar are you with health care reform? Exchanges? CO-OPs?

What is the biggest complaint you hear about health insurance in Maine?

If you are familiar with Dirigo Health, what can we learn from the Dirigo experience?

What kinds of benefits do you think (Mainers/your stakeholders/your community members) need the most?

What forms of consumer outreach would help your stakeholders make informed decisions about new insurance options?

How will increased competition in the insurance market make a difference for Maine businesses?

Do you think that the CO-OP moniker for the new plan is beneficial in associating it with the cooperative movement in Maine?

In your opinion, what are the two most important factors self insured and uninsured Mainers will be considering as they look at new insurance options on the Exchange web site?

Can you name any other people I should be talking to for a better understand the information needs of consumers?

What other questions should I be asking as I talk to people in Maine?

Selected Twitter Feeds

@freakonomics
@RWJF_PubHealth
@AP
@Atul_Gawande
@TheLancet
@politico
@TheAtlantic
@NewsHour
@EconEconomics
@NYTimesDowd
@fivethirtyeight
@nytimesbusiness
@SCOTUSblog
@nytopinion
@cnbrk
@nytimeshealth
@WSJ
@nytimes
@PressHerald
@MorningEdition
@planetmoney
@nprnews
@adamdavidson
@democracynow
@NewYorker
@washingtonpost
@reuters
@NYTimesKrugman
@whitehouse
@CenterOnBudget
@KaiserFamFound
@publichealth
@Health_Affairs
@TheEconomist
@thehill
@healthtrust
@familiesusa
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BANGOR DAILY NEWS

Welcoming local say in Maine health care reform

By Elizabeth Rogers, Special to the EDN
 Posted March 18, 2013, at 2:48 p.m.

The Affordable Care Act became law in 2011, and, back then, 2014 seemed a long way off. Suddenly, what was once on the distant horizon — the requirement that all Americans have health insurance — is getting closer. The mandate kicks in less than a year from now, on Jan. 1, 2014.

Beginning on Oct. 1 of this year, individuals and businesses — with up to 50 employees — will be able to shop for health-care coverage in health insurance “exchanges” or marketplaces. And while there are still many unanswered questions, we know more than we did a couple of months ago.

Because Gov. Paul LePage decided not to pursue the creation of a Maine-made marketplace, we will access ours by phone or through a website developed by the federal government. Being part of the federal marketplace means that Mainers will benefit from efficiency of scale along with at least 25 other states that are opting out of a state-run system.

Like travel websites, insurance marketplaces will include apples-to-apples comparisons on coverage and cost for each state. We will access Maine-specific insurance plans by providing information about where we live. While all of the plans will cover a required (by law) minimum level of essential, comprehensive health benefits, they will vary by cost and design.

Both the federal government and consumer advocates here in Maine understand that we may experience a steep learning curve in understanding how to “read the fine print” as new insurance purchases. There are plans in the works to establish a network of independent navigators and application assistants to help us understand the details. Help will be available, but we will need to know who to call or where to go.

Health reform is intended to increase competition, and, from a market perspective, reduce costs. While insurers know that cost is the first consideration for consumers, the pricing structure of new plans is one of the biggest unknowns that we face right now. Compounding that unknown is the fact that cost will also be based on income. Many individuals will be eligible for financial support.

In truth, while all of us will have the opportunity to shop for new insurance coverage, most of us already have health insurance. How will greater flexibility in individual access to health insurance benefits affect our labor market over time?

In our marketplace we will see familiar insurance companies and some new names. For example, Maine is one of 24 states to launch a non-profit Consumer Operated and Oriented Plan. As envisioned by leaders in health reform, the CO-OP model taps into the cooperative movement’s focus on shared leadership, mutual aid and reciprocity, and CO-OP profits will be redistributed into member benefits.

New health insurance CO-OPs across the country are forming partnerships with farmers supply, electric, and phone cooperatives, membership organizations for seniors, and small business advocacy and service organizations.

Our CO-OP, Maine Community Health Options, will encourage consumers to have more control over their own health and health care by engaging them in insurance benefit design and practice. MCHO is reaching out to multiple communities across the state to understand what benefits are most important in value-driven health plans covering a range of health-care needs. CO-OP members will participate in decisions management makes to address cost, quality and other issues, and have a say in how profits are used.

Ultimately, increased opportunities for consumer participation in health insurance and health care decisions can provide greater choice in how we — collectively and individually — want to live. The marketplaces will force us to learn more as we decide what kind of benefits make sense for us, for our families, colleagues and employees. The more we understand about the health services we need to be healthy, the more we are able to reduce our individual and collective costs.

Elizabeth Rogers, of South Portland, is a master’s degree candidate in health policy and management at the University of Southern Maine’s Muskie School of Public Service.

<http://bangordailynews.com/2013/03/18/opinion/welcome-local-say-in-maine-health-care-reform/>, printed on April 17, 2013

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