HEALTH CARE SOLUTION FOR STRATEGIC PARTNERS IN THE ERA OF HEALTH CARE REFORM

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Abstract

As more attention is focused on quality and cost of health care in the United States, alternative solutions to providing health care will emerge. By working within the confines of existing legislation and leveraging strategic partnerships within member-owner cooperatives, a nationwide organization pursued its altruistic goal to establish an alternative means by which to provide health care to its member-owners. This ultimately creates a solution for these employers who tend to be most impacted by health care cost volatility. This alternative arrangement, which is similar to the structure of a traditional cooperative, may become a model by which other organizations or the government offers health care to employers or individual citizens. The establishment of such a solution may force employers and the government to partner in ways that had not been imagined.

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Health Care Solution for Strategic Partners

in the Era of Health Care Reform

Introduction

The United States is considered a leader in health care research and treatments. Although highly revered for medical advancements, this world-renowned, privatized health care system far outpaces other countries in terms of percentage of gross domestic product spent on health care. In fact, annual health care plan cost increases far exceed inflation and wage increases. In 2009, $2.5 trillion (CMS, 2011) was spent on health care in the United States, yet 50.7 million citizens were uninsured (U.S. Census Bureau, 2010). The rapidly rising costs of health care, among other factors, have prompted health care in the reform the United States.

Health care cost management and containment measures have increasingly become a challenge for organizations of all sizes, and have once again garnered significant attention by local, state, and federal legislators as evidenced by the passage of the Patient Protection and Affordable Care Act in 2010. Small businesses, as defined for health care purposes, are generally categorized as those with fewer than a couple hundred employees because they have small pools of plan participants and have less credible health claims data (U.S. Bureau of Labor Statistics, 2011). Employers of this size have particularly struggled in offering health care that is affordable for the employer and the employee.

Although one intent of national health care reform enacted in 2010 is to help mitigate the financial impact of health care to small businesses (U.S. Small Business Administration, 2010), that fact is yet to be evident because most components of health care reform are not yet implemented. The impact of increasing health care costs and the unknown effects of health care reform are more heavily felt in certain industries. One of those industries is that of agriculture

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where there are thin margins and where health care costs tend to be less predictable because of the physical demands and the demographics of that industry. These factors strain the bottom line of that type of organization (Nicol, personal communication, April 22, 2010).

Many agricultural cooperatives are considered small employers by health care underwriting standards and therefore can have difficulty managing health care costs (U.S. Bureau of Labor Statistics, 2011). These companies tend to be fully-insured with smaller pools resulting in higher health care costs and less year-to-year medical trend (financial) control. Because of the size of these organizations, it can be a burden and a distraction to their core businesses to focus attention and energy on health care management. As a result, this makes it more difficult to ensure optimal cost controls are in place within the plan design and cost-sharing, as well as maintain compliance with increasing and more complex legislative federal and state regulations.

An alternative for small employers is a health care cooperative. A cooperative for health care is one that is owned by independent businesses or municipalities that work together for greater purchasing power with the intent to better control health care costs (Richardson, 2011). A concept similar to a health care cooperative is a multiple-employer welfare arrangement (MEWA). The Department of Labor allows for multiple employers with a particular affiliation to participate in the same benefits plans in a MEWA. A MEWA is intended to provide the benefit of a larger pool, more health care financial stability for participating organizations and members and greater access to health care resources (Maher, E.R. & Grove, 2010a).

The MEWA is a leading edge solution which would allow specific member cooperatives with a common bond as member-owners of a sponsoring organization to join the plan. In joining the MEWA greater value is established for the organizations, their leaders, and their employees.

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By joining together into a MEWA, these small employers essentially create a health care cooperative for themselves, which results in the employers working together for the financial benefit of all members. The formation of such a health care cooperative as a MEWA provides the following: (a) a larger pool of covered lives that could control health care costs for the employer and the employee and provide greater purchasing power; (b) competitive medical plan offerings that incorporate more health care consumerism and wellness opportunities; (c) a more inclusive health and insurance package; (d) reduced mark-up costs; (e) established administrative efficiencies and (f) regulatory compliance (Maher, E. R. & Grove, 2010a).

The design of such an alternative couldn't be timelier given the recent attention paid to the health care environment and its impact on employers and employees in the United States. The Federal government is in the midst of issuing clarifications on the requirements of the Patient Protection and Affordability Act of 2010 and each state is working to create health care exchanges. Health care exchanges are intended to establish a more competitive health care market particularly by offering a choice of plans that have rules surrounding what is offered and how much (Henry J. Kaiser Family Foundation, 2009). Given the Federal and state focus on health care, the environment is ripe to construct a multiple employer alternative and one that may be a blueprint for future health care exchanges.

The benefits of a MEWA as an alternative solution to rising health care costs emerge through the exploration of the history of health care and the current health care climate in the United States, analyzing the cooperative system, understanding a MEWA arrangement and reviewing the impact of the status quo. The business case and considerations for this health care alternative are further explored through the analysis of key areas of organizational operation: strategic management, economics and finance, process consultation, organization behavior and

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communication and cultural competency. It is from this analysis that the viability of a MEWA as a health care alternative becomes evident and that future evaluation for success can be based.

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Literature Review

Never before in the history of the United States has health care been such a controversial topic. The continued rise in health care costs and number of uninsured or underinsured Americans has bolstered the country into a state of health care change (Krisberg, 2009). Health care has been a national focus spanning two centuries and the recent health care reform movement has grown from past initiatives. In fact, this recent political atmosphere has taken seventy-five years to create – going back to the last presidential term of Franklin D. Roosevelt (D) (Marone, 2010).

Just as the current health care climate cannot be viewed in a vacuum, neither can alternative health care solutions for employers be overlooked. Stakeholders including Democrats, Republicans, the political process itself (Marone, 2010), the insurance industry, and employers will face significant challenges within the new reform atmosphere. By examining the history of health care and the current health care climate in conjunction with alternative arrangements for specific groups versus maintaining the status quo, one can understand the basis for the business case for change.

History of Health Care in the United States

In many regards, health care changes in the United States have been as a result of reform movements (Hoffman, 2003). The first true movement to expand health care for all citizens began in earnest at the turn of the twentieth century (Hoffman, 2003). Employees would suffer lost wages as a result of illness, not only because of missed work time but because of the cost of health care itself, and as asserted by Hoffman (2003) this lost time "made sickness a major cause of poverty" (para. 7). This led social reformers to enter politics to attain a safety net for sick or injured people to avoid poverty (Hoffman, 2003).

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The Socialist Party, which formed in 1901 and began endorsing presidential candidates in 1904, included in its platform "accident, unemployment sickness, and old age insurance" during its inaugural convention (Birn, 2003, para. 1). Insuring Americans for sickness became a part of the Progressive Party's platform in 1912. The platform stated that a system of social insurance should be adopted for the "protection of home-life against the hazards of sickness, irregular employment and old age through the adoption of a system of social insurance" (Birn, 2003, para. 3).

Theodore Roosevelt (R) lost the 1912 Presidential Election to Woodrow Wilson (D). However, reformers who supported Roosevelt believed they helped educate the public about the need for compulsory health insurance, and campaigned in eight states to attain passage of a bill they drafted during the 1910s (Birn, 2003). The United States entry into World War I and the Russian Revolution were countervailing influences, which harmed the reformer's movement. By this time, several key stakeholders: physicians, businesses, insurance carriers, and conservative legislators, united in their campaign to label compulsory health insurance communistic (Birn, 2003).

Ensuring Americans received health care garnered little political attention until the Franklin Delano Roosevelt Administration considered the cause (Marone, 2010). At first, President Roosevelt feared alienating the American Medical Association (AMA) by supporting such an initiative. As a result, the New Deal Committee limited any proposed policy change to federal subsidies for health care and only under the Social Security Act when this act came into consideration during the 1930s. Because subsidies still angered doctors, this concept was subsequently dropped to better ensure passage of the Social Security Act (Hoffman, 2003).

Roosevelt revisited a plan for national insurance as the United States and its allies were

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winning World War II. However, Roosevelt did not live to see this movement come to fruition. That duty passed to President Harry Truman (D) upon Roosevelt's death (Marone, 2010). Support for health insurance reform grew during the 1940s, as organized labor championed the cause. The Wagner-Murray-Dingell bill of 1943 proposed a national insurance program financed through Social Security payroll taxes (Hoffman, 2003). However, three overwhelming forces continued to combat health care reform during this era: Cold War ideology, McCarthyism, and the American Medical Association. These forces halted any chance of substantial health care changes with the 1950 midterm election when eighty percent of pro-health insurance legislators lost their seats (Birn, 2003).

Without attaining legislative victories, organized labor turned to collective bargaining to earn health care benefits (Hoffman, 2003). In one way, collective bargaining and the unions' focus on health care proved fruitful: 75 percent of Americans attained health care insurance by the early 1960s, although problems still existed. While a majority of citizens were insured, coverage was far from expansive. Health plans covered merely twenty-seven percent of medical bills and attaining medical insurance required one to be employed full-time. Retirees, the unemployed, and the self-employed bore the cost and risk of illness on their own. It wasn't until the 1960's that one of these populations found an advocate. Citizens sixty-five years of age and older found a champion for their cause in Presidential candidate John F. Kennedy (D). Kennedy campaigned for health insurance for citizens in that age group. Kennedy's campaign included a Medicare plan, and after his presidential election he supported the King-Anderson Medicare bill of 1962 (Birn, 2003).

The American public found sympathy with senior citizens in this health care reform debate, which made the American Medical Association's opposition to health care reform much

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more difficult (Hoffman, 2003). Furthermore, major legislation moved forward during the Lyndon Johnson (D) Administration, in the wake of Kennedy's 1963 assassination. Medicaid - coverage for the indigent - and Medicare legislation passed in March 1965 (Birn, 2003).

Soon after, grassroots movements campaigned for universal health insurance (Birn, 2003). A variety of parties offered proposals for reform, including President Richard Nixon (R), the insurance industry, along with traditionally more progressive parties, such as unions, and one old foe turned ally – the AMA (Birn, 2003). However, the oil crisis, inflation, and the conservative movement withered support for universal health care during the 1970s. In fact, President Ronald Reagan (R) campaigned effectively for cutting federal social programs. During his administration, Medicaid experienced major program cuts (Birn, 2003).

Current Health Care Climate and Reform

In the 1980's, public discontent rose in response to the rising number of uninsured Americans. In fact 50 percent of Americans polled favored national health insurance paid for by tax dollars compared to 37 percent who opposed it (Blendon & Benson, 2001). As a result, President Bill Clinton (D) lobbied for health care reform during his 1992 campaign. Once in office, Clinton created the Health Care Task Force in 1993, led by his wife Hillary Clinton. Clinton's health care reform plan never gained momentum, despite the increasing need and public outcry for reform with nearly 60 percent of Americans polled favoring a fundamental change for the nation's health care system (Blendon & Benson). The proposal, which was 1,400 pages in length, was complex and favored employer-based health plans and the commercial insurance industry (Hoffman, 2003). This design of health care reform was in opposition to the grassroots supporters, which favored a more universal health care reform (Hoffman, 2003). As a result of its complexity and fractioning among supporters, the Clinton health care reform efforts

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failed.

Although the efforts of the Clinton Administration failed, health care lingered as a political issue for more than a decade and through the George W. Bush (R) Presidency. Policy changes were advocated throughout the campaign of the next Democratic President, Barack Obama (D). Obama advocated for employer insurance mandates, known as "play or pay", insurance exchanges, a public option, and a long-range goal of ensuring universal health care (Miller, T.P. 2010). Learning from the error of the Clinton Administration in which health care reform policy was drafted "secretively" (Hoffman, 2003), Obama relied on Congress to write the health care reform legislation as promised during this campaign (Zacharyczuk, Beadling, & Hasson, 2008). In an attempt for a more transparent process than had occurred with previous health care reform initiatives, Obama enlisted a bipartisan effort with the intention of keeping stakeholders such as the health care industry and the public more abreast of legislative details.

The proposal for health care reform crafted in 2009 through 2010 promised a larger pool of participants to health care industry players, such as pharmaceutical companies and hospitals, as well as carriers with lower government reimbursements and higher taxation (Miller, T.P. 2010). In an effort to avoid increasing federal debt as a result of increased health care coverage for all Americans, the proposal contained measures in which players in health care industry would be subject to new fees and excise taxes, and Medicare payments to private Medicare Advantage insurance plans would be cut (Miller, T.P. 2010).

As a result of the 2008 election, Democrats controlled the House of Representatives with a 256 versus 178 majority and the Senate with a 55 versus 41 majority (Miller, L. 2008). More significantly for the Senate, Democrats gained enough Senate seats to ensure closure on legislation, after Senator Arlen Spector switched to the Democratic Party (Miller, T.P. 2010).

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Debate regarding health care reform was steady in 2009. Legislation continued to develop and expand which resulted in further complications of the reform bill. Despite the "grave opposition" (p. 185) to the objective of health care reform, the balance of legislative power skewed toward the Democrats and the Patient Protection and Affordable Care Act of 2010 was passed in March of that year (United States Country Review, 2010). As a result, grassroots activists emerged. Such activists protested health care reform for fear of health care rationing and implementation of a public option (Miller, T.P. 2010).

Despite opposition, The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 were signed into law by President Barack Obama on March 23, 2010 and March 30, 2010 respectively. These two laws make up the most significant and controversial health care reform in the United States. The 2000+ page bill focuses on the : (a) reformation of the private health insurance industry; (b) creation of a level playing field for small employers; (c) standardization of coverage, including the elimination of pre-existing condition clauses, lifetime and annual limits with health plans, as well as a mandate to cover preventive care at no cost to the patient; (d) elimination of health care disparities by offering access to health care to traditionally uninsured populations, such as low-income individuals and minorities; (e) improving drug coverage within Medicare Plans; and (f) extending the life of the Medicare trust fund (healthcare.gov).

Multiple Employer Welfare Arrangement

MEWAs are generally defined as entities through which two or more employers or self-employed individuals with a common bond or association obtain health insurance coverage (Kofman, Bangit, & Lucia, 2004). A MEWA is separate from a multiemployer plan. A multiemployer plan is a collectively bargained benefit maintained by employers within the same

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industry and generally offered through a union. These are commonly referred to as Taft-Hartley Plans (Haraden, 2011).

Although the intention of a MEWA is to benefit the employers and members, by creating greater stability of the health care plan, this type of arrangement has been the subject of scrutiny. Historically, MEWAs have collapsed as a result of financial instability, mismanagement, and fraud (Kofman & Libster, 2005). The financial demise of MEWAs has resulted in thousands of uninsured individuals, companies left without insurance for their employees and millions of dollars of unpaid insurance bills (Hodge, 2003).

MEWAs tend to benefit small employers. This is because small employers often do not have access to the kinds of benefits and offerings that larger employers and MEWAs do (Maher, E.M., & Grove, 2010b). These small employers do not have health care expertise within their organization and their pool of employees can put them at higher risk for health care cost volatility. These employers miss out on administrative efficiencies, disease management and wellness programs, as well as the benefit of a larger pool over which to spread health care costs (Maher, E.M., & Grove, 2010b).

In fact, many small employers are subject to community ratings. This rating methodology is one in which a base rate for a region is established on the overall claims experience of small employers (Haraden, 2011). Once a base rate is established for a region, adjustments can be made to the rate based on demographic data specific to an employer, such as age and gender, industry, location, and coverage levels of employees, such as employee only coverage or family coverage. In community ratings and rate setting for a small employer, experience specific to that employer is not considered (Haraden, 2011). The community rated plans are fully insured in which the employer contracts with another organization, generally an insurance company, to

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assume the financial risk and responsibility for members' medical claims and all administrative costs (U.S. Bureau of Labor Statistics, 2011).

The community rating provides less benefit than that of a MEWA because the individual employer's demographics are looked at in isolation. Within the MEWA, there is a benefit of a pooled arrangement that is defined as 100 percent credible data. This means the group is large enough that past claims experience is a stable predictor of future claims experience (U.S. Bureau of Labor Statistics, 2011). With a larger pool of individuals, the impact of high claims is mitigated because of the number of lives over which the cost impact can be spread. Additionally, with credible data, rates can be set based on the historical claims experience of the entire group. Generally when a group is large enough, it is self-insured. Self-insured plans are those in which the employer or entity assume the cost for health insurance for participants. The plan can assume the entire risk or assume risk up to a set threshold and then contract with an insurance company insure for larger claims through stop-loss. (U.S. Bureau of Labor Statistics, 2011).

MEWAs can be self-insured or fully insured. With a self-insured design of a MEWA, the benefit plan is legally established in one state and then offered in three contiguous states (Maher, A. M., personal communication, April 21, 2010). The self-insurance means that the MEWA is not subject to specific state mandates except for the state in which the plan is legally established. Fully insured MEWAs can be offered in all states, but are generally subject to individual state mandates and laws. Fully insured MEWAs offer greater flexibility to an organization looking to create one if the intent of the MEWA is to include employers across more than three contiguous states (Maher, A. M., personal communication, April 21, 2010). By having the opportunity to offer the plan to employers with a common bond across the entire country, the pool of participants increases. This is the case for the plan being created by the sponsoring organization

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for its member cooperatives.

The Cooperative System

The idea of a cooperative or co-op business structure took root in the American Colonies prior to the Declaration of Independence, and later in Britain. In the Pennsylvania Colony, Benjamin Franklin organized a mutual fire insurance company in 1752. Franklin structured the Philadelphia Contribution-ship for the Insurance of Houses from Loss by Fire as a cooperative (Frederick, 1997). Franklin saw a viable business model that better allocated goods or services – allowing for like businesses to work together for their mutual benefit. Decades after the formation of the first United States cooperative, organization to sell food in the United States, and food and clothing in Britain began to take hold. Dairy farmers in rural locales of the United States began co-ops during the 1800s to organize milk and cheese processing (Frederick, 1997).

The American Farm Bureau Federation and the National Farm Union flourished beginning in the 1890s (Frederick, 1997); however, farmers risked federal anti-trust scrutiny. Farmers were thought to be violating anti-trust legislation by uniting together and setting prices for their commodities. Co-op members were provided relief from anti-trust violations through the passage of the Capper-Volstead Act in 1922. The Capper-Volstead Act of 1922 allowed farmers, as producers of such commodities, bargaining power and enabled them to enter for-profit organizations and sell their goods (Smith, 2010).

Farmers qualify under the anti-trust exemption granted in Capper-Volstead by enabling members to join together to mutually benefit as producers of farm commodities. Members are restricted from doing only a minority of their business with non-members and are limited to one vote regardless of the amount of capital invested in the co-op. Additionally, dividends, which are commonly known as patronage refunds paid to members, may be capped at an eight percent

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annual maximum (Smith, 2010, p. 10).

A co-op is profitable because it retains most of the revenue generated by purchases from the co-op and the capital investments of its members. Under Secretary of USDA Rural Development Dallas Tonsanger (2009) wrote, “Simply put, co-ops give marketplace clout to people who on their own would wield little power. In the cases of farmers, ranchers and fishermen, co-ops are the business vehicle which helps them gain the leverage they need to earn fair prices for their products in markets dominated by ever fewer, larger buyers” (p. 2). This statement is true, but the design of co-ops is not flawless. The strength of a co-op is in its members, but external competitive pressures can impact a cooperative because they operate at a capital disadvantage in the wake of pressure to increase brand investment and establish international partnerships (Cross, Buccola, & Thomann, 2009).

The co-op structure allows for earnings generated from the cooperative to be distributed to members according to the amount of business they performed with the co-op (Frederick, 1997). Additionally, most co-ops require an equity investment from a party to become a member. Members receive a certificate as proof of his or her right to vote on internal matters. Often the certificates are deemed shares of common stock from the co-op (Frederick, 1997) and in essence allow the member to attain legal rights and responsibilities. The patronage-based equity structures can establish financial reserves for the cooperative which is useful when financial markets are unstable, which allows them to better manage monopoly power associated with volatile commodity prices; conversely with the rise of competitive markets, the cooperative may be triggered into liquidating the capital it established (Cross et al, 2009).

The cooperative business structure serves a beneficial purpose in the United States economy. Today, co-ops and their products and services are widespread throughout the United

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States. Co-ops are present in virtually every segment of the economy: housing, credit and financial services via credit unions, educational services, and telecommunications (Frederick, 1997). Co-op members can unite marketing efforts, negotiations with buyers, product distribution, and develop processing facilities, among other benefits, while retaining their independence as individual business entities (Frederick, 1997). These benefits enable a co-op member to make their individual business more viable by increasing potential revenue and lowering costs. The Capper-Volstead Act allows such arrangements, but also stipulates what activities could entail anti-trust prosecution (Volkin, 1985). Examples include, co-ops cannot engage in predatory business practices, allow non-producer members to join, or restrain trade (Smith, 2010).

A governing board for a cooperative is established for each cooperative and consists of representation from its members (Frederick, 1997). They develop articles of incorporation, elect directors from among the co-op's members, determine organizational direction such as mergers and joint ventures, and ensure compliance with co-op policies. Membership demands more than a party providing an equity investment - members need to do business with the co-op in order for it to be profitable (Frederick, 1997). The members of the board retain control of the cooperative's equity and are responsible for distribution of capital to its members. Capital is distributed only when the board declares there is excess capital (Cross et al).

Depending on market pressures, additional equity capital can be secured. Because the distribution of equity lies with the board, there is the potential for misuse of this power. Distribution of additional equity to members can occur if the co-op decides to sell itself or even go bankrupt. Additionally, it can overstate the fair market price of its product. The latter type of manipulation is not easily detected by regulators until several years after it has occurred because

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financial ratios to monitor co-ops are backward looking (Cross et al, 2009).

A co-op is established for the benefit of its members. It enables people who use the goods and services created by the organization to own and operate the entity. Many everyday brands found at a grocery store are products from co-ops:

Land O'Lakes butter, Ocean Spray cranberries, Blue Diamond almonds, and Cabot cheese are just a few examples. In fact, a 2008 study sponsored by the USDA found that cooperatives in the United States have an annual economic impact of $653 billion (Tonsager, 2009). The extension of the cooperative concept into health care is not a far-fetched one.

Maintaining the Status Quo

The alternative to offering a MEWA for member cooperatives is to simply maintain the current state. What this means is that small employers will continue to manage their health care programs on their own or participate in their current community rated or pooling arrangements. The current state is not necessarily a poor alternative in that the member co-ops have been able to make this current state "work" as best they can.

As the Centers for Disease Control and Prevention highlights, 75 percent of health care costs result from illnesses that are preventable (Society for Human Resource Management, 2008). Over the past four years, member cooperatives eligible for this MEWA solution have experienced medical trend increases in excess of twenty percent in some instances because of the impact of the demographics of their population and the increase in preventable illnesses going undiagnosed or untreated (Maher, E.R. & Grove, 2010b) . Unfortunately, as a small employer, these organizations do not currently have access to the chronic condition programs offered to larger employers that help curtail the impact of preventable disease. As a result, it is not out of line to anticipate continued double-digit increases for many of these entities.

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As highlighted by Burgess (2002), communication and education of employees on the true cost of health care, how to take ownership of their health, educating on the use of generics, and making wise health care decisions such as utilizing urgent care clinics rather than the emergency room, help control health care costs. These types of communications are difficult for a small organization to create and distribute in a cost-effective manner. Larger organizations are more apt to have resources to dedicate to such efforts. Since controlling health care costs is a strategic effort of these member co-ops, communications such as these would be beneficial and something to which they would have access to through the MEWA.

The reasons for creating this alternative for the organization's members are numerous. Most specifically, such a solution would allow the members relief from the financial and regulatory instability of health care that they currently face or may face in the future. This arrangement allows the organization's member owners to leverage existing health care expertise that can generate additional value and stronger bonds among the stakeholders.

Just as agricultural cooperatives are established to provide synergies and benefits to all members, so is the intent of nationwide MEWA that has been created for the organization's member cooperatives. This MEWA is created just as Under Secretary Tonsager commented about the intent of cooperatives, they are ". . . based on the philosophy of being operated solely for the benefit of those . . . who use its services." (2009, p. 2). Given the health care climate today, these MEWA-eligible member owners of the sponsoring organization see the merits to Benjamin Franklin's statement during the signing of the Declaration of Independence, "We must all hang together, or assuredly we shall all hang separately."

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Methodology

The relationship between the organization and its member co-ops is a unique one. Over the past four years there has been an increased effort to establish opportunities to add value to members. The organization supports its member co-ops with high-value, business service offerings, such as consulting, training and development, sourcing and development, HR services and strategic insights and networking opportunities. The most recent high-profile value-added opportunity is that of an alternative health and insurance program through the establishment of a MEWA.

The intent of the MEWA is to create value for member co-ops by removing administrative, compliance, and financial barriers of offering health care to their employees, which in turn allows them to focus on their business (Maher, E. R. & Grove, 2010b). Through the application of strategic management, economics and finance, process consultation, organization behavior, and communication and cultural competency, the business case and foundation for the creation of the MEWA for the organization's member cooperatives becomes clear.

Strategic Management

Strategic Management embodies the activities critical to an organization's functions – it is the systematic analysis of the factors associated with the external environment (customers and competitors) and internal factors (the organization itself) to provide a basis for maintaining optimum management practices with the objective to achieve better alignment of corporate policies and strategic priorities (WebFinance, Inc., 2011). It is through this process that the need for an alternative health care solution for the organization's agricultural cooperatives is identified.

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Of the strategic management tactics commonly used, the most significant for this project is that of *Critical Question Analysis* in which one reviews the environment, the purpose and objective of the organization, its current direction and what can be done to better support that direction (Barnat, n.d.) The analysis of the external landscape shows that margins remain tight and that competition within the agricultural industry is increasing – mergers and acquisitions within and outside the organization's cooperatives are not uncommon. Hand in hand with the external landscape is that growth within the agricultural industry can be difficult and that those organizations must focus on their core competencies in which they excel in order to be successful (Nicol, personal communication, April 21, 2010). These cooperatives must embrace the approach of focusing their energy on what makes them successful, known as the Hedgehog Concept, outlined by Jim Collins in *Good to Great* (2002).

Many of these cooperatives have begun the process of an entire organizational review, which allowed for the identification of the last component of the *Critical Question Analysis.* One area that is not a core competency of many of these co-ops is that of health care management (Maher, E.R., & Grove, 2010a). Their organizational structure and lean management does not allow for a health care expert to be on staff. As a result, one means by which leaders can better support the strategic direction of their organization is to hand off health care strategy and management to an expert - an opportunity that hadn't previously existed.

As a result of the *Critical Question Analysis,* the following tactics and drivers were identified for the creation of the MEWA by the member-owned cooperative:

- Establish agreements and partnerships with key carriers and benefits administrator,
- Partner with Legal counsel to establish necessary contracts and filings,
- Create marketing materials and conduct in-person meetings with the member co-ops,

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- Construct a dedicated team to work on the MEWA, and
- Institute a Board of Directors for MEWA oversight consisting of executives from member co-ops.

Failure to fulfill these drivers would lead to poor results when implementing the MEWA.

Equally important as the tactics and drivers of the establishment of the MEWA are the mission, vision, and goals of the entity. It was imperative to create a mission that resonated with the organization's member cooperatives as a means to create a deeper connection among the organizations. The mission of MEWA is as follows:

> Add value to our cooperative members through a total benefits solution by more effectively and efficiently managing co-op member health care costs and programs by providing best-in class expertise and benchmark competitive offerings that increase the health and productivity of their workforce and allow co-op leadership to focus on their business (Maher, E. R., Grove, & Reuter, 2011).

Hand in hand with the mission are that of the vision and goals of the MEWA which would specifically:

- Control health care spend for the employer and the employee through the cooperative pooling arrangement,
- Incorporate more health care consumerism and wellness opportunities,
- Eliminate broker fees and commissions in the co-op health care plans,
- Leverage strategic relationships to provide best pricing with best in class vendors,
- Provide access to resources and technology not currently accessible to the co-ops,
- Utilize industry-leading vendor negotiation skills,

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- Increase employee health care education and engagement through the use of expert communication resources and tools,
- Provide focus on quality for vendors, networks and tools,
- Establish administrative efficiencies, and
- Ensure compliance with current and future regulations (including health care reform) (Maher, E. R. , et al, 2011).

The mission, vision, and goals of the MEWA address a gap for the targeted organizations.

Economics & Finance

The application of economics, a social science that studies how resources are allocated including labor, land, and investment of money, income and production, and of taxes and government expenditures (American Economic Association, 2011) and finance, a branch of economics concerned with resource allocation as well as resource management, acquisition, and investment (Garner, 1999), are two integral components for the business case for the member cooperative MEWA. Both the economics and the financial impact of this offering have to be considered.

The economic benefit to both the organization and the member co-ops is one in which the organization creates a valuable offering to its members. Through this offering, the members can focus on their business and leave health care management to a team of experts. The economic and financial impact of this value is difficult to measure. Much of the member owner structure is one of trust and relationships. The addition of a valuable program such as this may result in greater economic and financial gains by all parties.

An initial investment by the sponsoring organization is necessary in order to have a program to offer. This preliminary investment includes the cost of administration, dedicated

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personnel, marketing materials, communications for employees, and other costs associated with the launch of the program. The sponsoring organization's investment for year zero is $500,000; year one is $1.25 million, year two is $1 million and year three is $1.5 million (Maher, E. R., et al, 2011). Based on initial participation projections, the organization would break even and become self-sufficient in the middle of the third year during which the program is operational. Recouping the funds is not as high a priority as it may normally be. This is because of the added value created among the co-ops.

The value proposition to the participants – at the member cooperative level and at their employee level – is simple. There are increased benefits and offerings, greater access to providers and programs, more stability in health care costs because of the larger pool of members, and elimination of non-value added fees currently incurred. The opportunity to have more predictable health care costs is an advantage to any organization, especially a small one. This is because the impact of high claims is more easily mitigated when a larger pool of members is in place. Additionally, cost of compliance to ever changing regulations is eliminated.

Risks associated with any project are considered part of the business case. Within the business case analysis for economic and financial impact, the following threats were identified through the analysis of the health care landscape and the challenges posed by implementing a MEWA :

- Health Care Reform has unknown requirements that may develop and/or change as a result of Congressional political balance
- State Laws can create hurdles for implementation in a particular state or administrative burdens

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- Unexpected administrative burden and costs may make recouping start-up costs of the MEWA difficult
- Selecting the best strategic partnerships with carriers while maintaining transparency to any potential limitations for expansion to all states may prove difficult in some states
- Current relationships within and among the member co-ops with their current carriers, brokers, and employees, must be handled with care
- Strain on relationships with and among the member co-ops could occur if what was promised is not delivered or changes dramatically (Maher, E. R. et al, 2011).

Some of the risks associated with this project cannot be entirely mitigated. The strategy of the MEWA is intended to be proactive to accommodate any federal or state legislation as well as foster relationships with co-ops and carriers.

Process Consultation

The creation of a relationship that allows a client to perceive, understand, and act on events in the internal and external environment to improve the situation as defined by the client is the definition of process consultation (Schein, 1999). Process Consultation or PC is fundamental in approaching the establishment and growth of the MEWA with the client, which in this case is the member cooperative. Schein (1999) highlights as he begins to discuss the PC philosophy, clients:

> . . . often do not know what is really wrong and need help diagnosing what their problems actually are . . . Clients need to be helped to know what kinds of help to seek . . . Clients need help in identifying what to improve and how to improve it .

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. . Clients must learn to see problems for themselves and think through remedies, or they will be less likely to implement the solution (p. 18).

Each of these components must be kept in mind with the member cooperatives.

Although co-op management can easily identify health care management as a challenge, it is imperative that they feel as though they are making the decision to join the MEWA. Because of the historical relationship between the sponsoring organization and its owners, the sponsoring organization is trusted. Although this trust exists, there is strong ownership within each co-op of their finances and the benefits they offer their employees. Additionally, many co-ops have existing relationships with specific carriers or brokers. Each of these is the client's "current reality" (Schein, 1999, p. 6) and must be considered by the organization.

What this means is that the organization and the staff hired for this project must follow the ten principles of process consultation to address skepticism and assist with change management – starting with the executives at the co-ops. These ten principles will continue to allow the organization to build upon its reputation of the "helping relationship" (Schein, 1999, p. 38) but must be handled carefully:

1. Always try to be helpful: The mission of this offering is in essence that of being helpful – adding value to the co-ops by allowing for focus on core competencies. However, this helpfulness can easily be lost when reviewing financials and selling the program to members.
2. Always stay in touch with the current reality: Despite the intimate relationship between the organization and its owners, it will be integral to remember that the co-op's world may have complicating factors to which the sponsoring organization must be in tune.

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3. Access your ignorance: Growing off the second principle, the sponsoring organization and its staff cannot approach this project with the assumption that all facts are known. Rather to discern "what I know from what I assume I know, from what I truly do not know" (p. 11).
4. Everything you do is an intervention: Every interaction with the co-op has consequences. Whether meeting with the executives, discussing financial impact to the employer or the employee, or working through the enrollment process, all interactions must be honest and done with positive intent.
5. It is the client who owns the problem and the solution: The organization must realize that despite the fact that a solution has been created to meet the needs of a specific co-op, buy-in for the solution will not occur until the co-op realizes on its own the implications of joining or not joining the MEWA.
6. Go with the flow: This principle will manifest itself again when it comes to communications and with change management. The importance of understanding and recognizing the differences in culture with each co-op cannot be more emphasized.
7. Timing is crucial: In addition to acknowledging that each co-op has different culture, it is equally important to recognize that one's approach to an individual co-op will be dynamic based on where the clients attention is.
8. Be constructively opportunistic with confrontive interventions: By leveraging what is learned by "going with the flow" and building from any cultural strengths, the sponsoring organization must also find the areas where there is openness to change, including which decision maker to approach and how.

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9. Everything is data. Errors are inevitable – learn from them: Through consulting, there will times that the sponsoring organization will make missteps. This is generally because of lack of knowledge. However, based on the reaction received from the error, more knowledge can be obtained.
10. When in doubt, share the problem: Involving the co-op when questions or hurdles arise will maintain a trusted relationship and deepen the buy-in possibility.

The practice of these principles will guide the project for not only its initial implementation, but for future growth. Successfully practicing the principles can ensure successful partnerships.

As Schein (1999) outlines, PC is establishing the helping relationship. It is through the helping relationship that partnerships are created. The design of the MEWA is intended to provide a service and value to the participating member co-ops, but the design is also intended to mirror the existing co-op relationships – that of a partnership. A partnership is generally established for the mutual benefit of each party (Beaumont & Hunter, 2007) – similar to establishment of a cooperative. Because the MEWA, is in essence, a cooperative, a partnership is innate.

A win/win partnership, as outlined by Covey (1989) includes five key elements:

1. Desired results – identify what is to be done and when,
2. Guidelines – specify parameters in which the results will be accomplished,
3. Resources – identify the human, financial, technical, and/or organizational support needed,
4. Accountability – define standards of performance, and
5. Consequences – specify what will happen as the result of an evaluation.

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An agreement and partnership that contains these five elements results in trust and synergy being established in relationships and creates better alignment among parties (Humphries & Wilding, 2004). Because of the nature of the existing sponsoring organization and member owner relationship, the costs involved in health care, and the impact to employees, a joint agreement between the parties is necessary.

Organization Behavior

The study of what people do within an organization and how their behavior affects the organization's performance is the field of Organizational Behavior (OB) (Robbins & Judge, 2009). In order to understand an organization, it is necessary to identify and understand the stakeholders. There are internal and external stakeholders for this project:

1. Management at the member owner co-ops
2. Employees whose jobs include the administration of benefits
3. The employees of the target organizations are the internal stake holders.

The external stakeholders include:

1. Owners of the member co-ops, generally farmers
2. The sponsoring organization
3. Benchmark organizations for the co-ops
4. The insurance carriers and administrator, and
5. Local, state, and national government (Maher, E.R., & Grove, 2011)

This paper will focus on the internal stakeholders in the context of OB.

The first stakeholder group, management of the member cooperatives who are solicited as part of this MEWA, performs a unique role. These executives are financially and strategically responsible for their own organization. Yet also benefit financially and strategically from the

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sponsoring organization because they are member owners. The second stakeholder can be a lynch pin to the success of the MEWA within a specific co-op. This group of individuals currently is responsible for the enrollment and day-to-day administration of the current benefits. Their support of the MEWA is critical. The third stakeholder group is the one that will seemingly be the most impacted because of sheer mass. To assist these stakeholders, a change agent must be established, someone who acts as a catalyst and assumes the responsibility for managing change activities (Robbins & Judge, 2009) in support of the MEWA initiative is crucial.

On the surface, a change in benefit programs, or the administration of benefits does not seem to warrant much attention. The fact is that that benefits are very personal to employees and when a change is made the benefits, employees can often feel defensive and loss of control. In the case of the MEWA, it is not just the employees who will experience this "loss of control" and "defensiveness." Those who currently hold the positions of benefits administrator within the member owner co-ops and executives and higher management will all lose control of something they had to manage for years. Despite the loss of control that higher management may feel, they must demonstrate the positive impact of the changes that are to come in order for the change to be successful (Wanberg & Banas, 2000).

The losses experienced by these two latter groups will require more change management than that of the employees. Although the desire to pass on the complexities of managing health care is attractive to these organizations, it is still a loss of control. This loss is a threat to expertise and power relationships (Robbins & Judge, 2009, p.623). For those who have administered benefits and for the management of the entity who have handled the finances and broker relationships in the past, participation in the decision making process of participating in the MEWA is crucial. As stated by Robbins & Judge (2009), "involvement (in a change

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decision) can reduce resistance, obtain commitment, and increase the quality of the change decision" (p. 623-624).

For the third stakeholder group, that of employees, resistance to change can be attributed to fear of the unknown and fear of loss. This fear of unknown and loss may result in decreased satisfaction that employees have of their jobs and in their employer (Oreg, 2006). Although the benefits offered through the MEWA are in nearly all cases better than current benefits and would be a "gain" for employees, the new program is not familiar and may cause angst. This is in essence, a threat to their security because they are content with the way things are (Robbins & Judge, 2009, p.623). Identifying a champion within the rank and file employee population will bolster success of the program's implementation. It is through the understanding of the stakeholders and change management, that one can begin the process of communication planning.

Communication and Cultural Competency

As stated by social psychologist and cultural dimensions pioneer Geert Hofstead, "Culture is more often a source of conflict than of synergy. Cultural differences are a nuisance at best and often a disaster" (The Economist, 2008). This statement emphasizes the importance of ensuring communications are culturally appropriate. Understanding the cultural dimensions of the member owners could not be more critical. By avoiding the all too common error of imposing one's own system on another culture as advised by Schein (2001), one can uncover simple, but very important facts of the target culture.

Before determining the methods of communication, the targeted organizations' cultural dimensions should be identified. These entities tend to be collectivist, where the interest of the group prevail over the interest of the individual (Hofstede, 2005) and have a greater tendency

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toward masculinity, with a more paternalistic approach toward employment practices. Additionally, these cultures tend to avoid uncertainty, which is how one handles unknown and risk (Hofstede, 2005). Familiarity and security are important in this culture so there is a tendency to prefer what is known and familiar (Nardon & Steers, 2008) indicating a strong uncertainty avoidance.

On the power distance scale, which indicates dependence relationships (Hofstede, 2005), these entities have some contradiction. There is a paternalistic approach within the organization in protecting the welfare of the employees, but there is also low power distance in that all employees have equal rights and people trust each other. The members of these organizations believe in being thrifty and that perseverance to work through any difficulties is important – placing them with high long-term orientation.

Although the cultural dimensions within the organization are similar among all levels of employees, the communication strategy and tactics with the executives and the employees must be well thought out for these two distinct and targeted populations – the subcultures within the organization. Because establishing trust and developing a relationship is of core importance to co-op executives, it is integral that frequent in-person meetings and phone conversation occur. This supports Hall's assertion that communications are "deeper and more complex than spoken or written messages" (1998, p.54). It is the act and gesture in combination with the messages that reveal how the organization values the relationship with the owners. The importance of relationships, and nurturing them, cannot be emphasized enough with these entities.

Employees also require a personal approach to communications, but in a different way. Written and verbal communications must focus on "what's in it for me" and "how am I being taken care of" from the employee's perspective. This approach strikes a chord with the

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employees who are used to being taken care of and knowing that their best interests are being considered. As part of this approach, it is integral that management within these organizations demonstrate their support and enthusiasm for this program through verbal and written messages. Management must introduce and be present during the formal employee presentations that explain the new program. Doing so will reinforce the cultures within these organizations and lend to the success of the program.

The assumption of similarities, a common stumbling block of intercultural communication, is front and center as cause for many miscommunications. The communications tactics and delivery must recognize the extent to which the culture with these entities is unique from the parent organization. By searching "for whatever perceptions and communication needs are held in common" (Barna, 1994, p. 337), a better connection can be made to both sub-cultures and act as the lynch-pin to success of the program.

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Evaluation

As with any project, evaluation at certain intervals is essential. It is through evaluation that success is measured, changes identified, and adjustments made for the next phase – similar to Lewin's Three Step Change Model developed in the 1940's (Robbins & Judge, 2009, p. 629). Measuring success and the future state of the MEWA are dependent on two main factors: continued participation and interest by the organization's member co-ops and the outcomes of health care reform.

The continued participation of organizations and growth of this offering will be driven largely by the financial stability of the MEWA and ethical and responsible oversight of it. Financial stability is achieved through appropriate management of funds that flow through the MEWA that pay for premiums and administrative services. The greatest impact to this financial stability will be that of controlling claims costs through programs such as wellness, chronic care management, case management, health care service controls that ensure high dollar services are being appropriately used, control programs for prescription drugs, and engagement of employees to become wise health care consumers.

The MEWA will be governed by a Board of Directors that consists of executives from the participating member co-ops. It will be the Board's role to monitor the financial stability of the MEWA and establish recommendations for changes to its design or offerings. Part of their role will be to review the financial and ethical practices of the partner companies – the insurance carriers and benefits administrators. The Board, in partnership with several advisory groups consisting of Human Resource and other management professionals within the participating co-ops, with review opportunities for how to best control costs. The charge of these advisory groups include premium increase perimeters, additional services to offer to employees to help manage

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their health care, and provide oversight and direction to the communications that are issued from the MEWA.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 will change from how they were originally written. This is evidenced already by the clarifications, guidance, or repeals that have been issued since the fall of 2010. The total repeal of the bills is unlikely, but the specifics of the legislation, especially that which will be in effect in 2014 and beyond are not certain. What will likely remain is the drive to provide alternative health care options to citizens and companies. It with this belief, that the future of the MEWA is likely positive.

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