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ACCESS TO HEALTH INSURANCE

Public and Private Employers' Experience With Purchasing Cooperatives

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The Honorable Edolphus Towns
Chairman, Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Operations
House of Representatives

The Honorable Steven Schiff
House of Representatives

For over two decades, state governments and businesses have embraced the concept of purchasing cooperatives as a way to obtain more affordable health insurance coverage. Although the precise origin and history of these multiple employer purchasing pools is murky, their popularity has grown. More recently established or proposed public cooperatives differ, however, in both scope and purpose from earlier efforts. First, a growing number of states is turning to statewide cooperatives as a way of reducing the overall level of uninsurance, especially among those who work for small businesses.[1] An estimated 38 million Americans—over three-quarters of whom work or are dependents of workers—lack health insurance and many are employed by firms with fewer than 50 employees. Second, several bills now before the Congress would make purchasing cooperatives a national vehicle to (1) achieve universal coverage or expand access to insurance and (2) control premium increases.

The prominent role assigned to cooperatives in both state and national proposals has provoked an intense debate over their appropriate size, authorities, accountability, and other salient characteristics. During this debate, cooperatives have been viewed alternatively as

- big, monopolistic bureaucracies that would be too regulatory, would dictate prices, would have little accountability, and would be subject to political influence, or
- powerless organizations that would be prohibited from bargaining for reasonable premium increases, would attract too few enrollees to have any clout, and would be susceptible to unfair competition from insurance carriers who thrive on the basis of ientifying low-risk groups.

[1]California, Florida, Iowa, Kentucky, North Carolina, Ohio, Texas, Washington, and Wisconsin have either created or are considering purchasing cooperatives as part of health care reform initiatives.

The intensity of the debate comes as a surprise to those at public- and private-sector cooperatives who believe that pooled purchasing is both a sensible and proven mechanism to address recognized problems in the insurance market. In order to clarify and focus the debate about the role of purchasing cooperatives, you asked us to identify the varying forms cooperatives have taken and to examine the functions, organization, and governance of existing prototypes in the context of national reform proposals.

Results in Brief

Health insurance purchasing cooperatives are an increasingly important component of the changing landscape of health insurance. They continue to grow in the private sector, sometimes with state support, and often as a major element of state health care reform. We visited 11 existing cooperatives, ranging from the California Public Employees' Retirement System (CalPERS), offering health insurance for over 30 years with nearly one million covered lives, to the Council of Smaller Enterprises (COSE), a voluntary cooperative for small employers founded in 1973 and cited as a model of private initiative by President Bush, to Florida's statewide system of 11 regional cooperatives that began enrolling members in May 1994.

Both existing and proposed cooperatives embrace core functions such as enrollment, premium collection, and contracting with health plans. But, existing cooperatives are also empowered to perform additional policy and management functions—functions that federal reform proposals either reserve for other governmental entities or deny to cooperatives altogether. For example, the Health Insurance Plan of California (HIPC) actually developed the benefits package offered to small employers, and other cooperatives have standardized benefits to enhance market competition and simplify plan comparison by enrollees. Moreover, both private and public cooperatives are starting programs to measure, improve, and report on the quality of care delivered by participating health plans—efforts left to federal and state entities under national reform proposals.

Most existing cooperatives view their ability to negotiate with carriers as a critical factor for restraining growth in health insurance premiums. While private cooperatives limit choice of plans to maximize their market power in negotiations, public purchasing cooperatives offer a wide range of insurance plans to their members. Public cooperatives have recently started to augment market forces with negotiation. For example, CalPERS,

citing California's worsening fiscal situation, began aggressive negotiations in 1992 and has held premium increases to well below the national average. Similarly, HIPC negotiated a 6-percent reduction in premiums for 1994. Although Florida's regional purchasing cooperatives were denied the authority to negotiate, the governing boards are now seeking that authority from the state legislature.

Existing cooperatives are not big bureaucracies. Their operating costs range from about 3 percent of premiums for smaller or recently formed cooperatives to less than 1 percent of premiums for larger and more mature purchasing pools. Most cooperatives contract with private firms for enrollment and premium collection activities. Their relatively modest in-house staffs tend to focus on management and policy functions, including premium negotiations, plan monitoring, and contractor oversight.

Subsidy administration for low-income and unemployed individuals may be the most uncertain and potentially costly function performed by cooperatives in reform proposals. Only two of the cooperatives we visited administer subsidies or plan to do so. Washington's Health Care Authority (HCA) performs all subsidy administration functions with an in-house staff. It avoids the more administratively complex asset test and relies on employer/employee provided data. In Florida's statewide reform effort, purchasing cooperatives similarly expect to reduce the cost of administering subsidies by relying on tax returns and pay stubs. However, Florida plans to minimize the impact of subsidy administration on cooperative staffing by contracting out to the private sector.

Florida's experience with regional purchasing cooperatives suggests that more attention needs to be paid to several interrelated governance issues, including (1) the composition of governing boards, (2) representational safeguards, and (3) the potential for politicization of appointments.

Background

Building on the concept of pooled buying power, health purchasing cooperatives secure insurance coverage for the workers of all member employers and make that coverage more affordable by spreading risks over a larger population. Small groups and individuals are particularly vulnerable in today's market. Some cannot obtain insurance at any price because of their actual or perceived health status. And even those able to secure coverage may face very high premiums because their health costs are unpredictable and the costs attributable to one sick individual must be

borne entirely by each small group. The creation of larger risk pools gives small employers greater bargaining clout with health insurers, plans, and providers, approximating that traditionally enjoyed by large businesses. Furthermore, pooling reduces the administrative costs of buying, selling, and managing insurance policies—costs that are particularly high with respect to small firms and individuals.[2]

Purchasing cooperatives have developed independently in both the private and public sectors. Private cooperatives are voluntary associations of employers in a metropolitan area who band together to purchase insurance for their employees.[3] Although the concept of pooled purchasing power is generally discussed in the context of assisting small businesses, in fact, large firms have also organized cooperatives. Public cooperatives were originally established by state governments to purchase insurance for state employees and were subsequently expanded to allow voluntary participation by county and municipal workers or other public entities. As with small firms, obtaining reasonably priced coverage for small school districts or fire departments has frequently been difficult. These state programs sometimes segregate state and municipal employees into separate risk pools because of the perception that the latter's voluntary participation would attract higher risk groups.[4]

Recently, several states have again expanded public programs by creating voluntary cooperatives targeted at small businesses. Their creation has often been accompanied by state insurance market reforms that guarantee the ability to purchase insurance regardless of health status. Enforcement of these reforms is simplified by having small groups purchase coverage through a cooperative rather than directly from insurance carriers.[5] Some state programs exclude groups of one or two—those with the most unpredictable costs. Statewide systems of cooperatives being established in some parts of the country are an amalgam of public and private

[2]Administrative costs as a percentage of incurred claims range from 25 to 40 percent for firms with under 50 employees but decrease to 5.5 percent for businesses with 10,000 or more employees. Cost and Effects of Extending Health Insurance Coverage, Congressional Research Service, (Washington, D.C., Oct. 1988), p. 46. See also Health Care Reform: Proposals Have Potential to Reduce Administrative Costs (GAO/HEHS-94-158, May 31, 1994).

[3]In May 1992, we reported that 45 states had private purchasing cooperatives for small employers. See Access to Health Insurance: State Efforts to Assist Small Businesses (GAO/HRD-92-90, May 1992).

[4]Voluntary participation did result in higher risk groups enrolling in one of the private cooperatives we visited. For additional information, see the description of COSE in appendix I.

[5]For additional information on recent state initiatives, see Kevin Haugh, Elliot K. Wicks, and Richard E. Curtis, Health Policy Reform and Health Purchasing Alliances: A Guide for State Policymakers, (Washington, D.C.: Institute for Health Policy Solutions, 1993).

prototypes. They embrace state employees and Medicaid recipients and are open on a voluntary basis to a wider spectrum of groups, including private firms, the self-employed, and low-income individuals on government subsidies. Again, to prevent the health costs of higher risk groups from driving up the premiums for other participants, some of these cooperatives place each participating group into a separate risk pool rather than operate one large, community-rated pool.

Since the late 1980s, a bewildering array of acronyms has been attached to the concept of health purchasing cooperatives. Initially referred to as HIPCS (health insurance purchasing corporations), President Bush adopted the principle and transformed the acronym into HINs (health insurance networks). The terminology in current reform proposals ranges from HPPCs (health plan purchasing cooperatives) in the Cooper bill, to HPPGs (health plan purchasing groups) in the Chafee bill, and, finally, to alliances by President Clinton. Though the cooperatives called for in these and more recent bills (such as the Stark proposal) differ, they all embody the basic concept of pooled purchasing.

To examine the operation of existing health purchasing cooperatives, we visited prototypes in California, Florida, Minnesota, Ohio, Washington, and Wisconsin that have been frequently cited in literature on health care reform. Although our study emphasized the operation of public cooperatives, we also visited several sponsored by the private sector. Florida and Washington are both implementing reforms that call for dividing the state into geographic regions, each served by a separate cooperative. Table 1 identifies the purchasing cooperatives we visited and describes their membership. With the exception of state employees, the participation of most other groups was completely voluntary. For further details, see appendix I.

Table 1: Purchasing Cooperatives GAO Visited

Public Cooperatives	
California Public Employees' Retirement System (CalPERS)	State and local government employees
Washington State Health Care Authority (HCA)	
Public Employees Benefit Board (PEBB)	State and school district employees
Basic Health Plan (BHP)	Individuals on subsidies and those willing to join on a nonsubsidized basis
Caregivers	Caregivers
Health Insurance Plan of California (HIPC)	Firms with 5-50 full-time employees
Minnesota Department of Employee Relations	
State Employee Insurance Program (SEIP)	State employees
Public Employee Insurance Program (PEIP)	Local government employees
Minnesota Employers Insurance Program (MEIP)	Private employers with two or more employees
Wisconsin State Employee Group Health Benefits Program	State and local government employees
Private Cooperatives	
Business Health Care Action Group (BHCAG), Minnesota	Firms with more than 500 employees
Council of Smaller Enterprises (COSE), Ohio	Firms with fewer than 151 employees
Employers Association Buyers' Coalition (EABC), Minnesota	Small- to medium-sized firms
Employers Health Purchasing Cooperative (EHPC), Washington	Small and large firms
Statewide Cooperative Systems	
Florida	Firms with fewer than 51 employees, state workers, and individuals eligible for subsidies
Washington	Individuals and any size firm

During the course of our work, we interviewed (1) key staff members at cooperatives, representatives of employees insured through the cooperative, participating insurance carriers, and purchasing cooperative contractors; (2) state officials responsible for implementing systems of regional cooperatives similar to those envisioned by several reform bills; and (3) representatives of state insurance offices, insurance agents, and health care providers. Finally, we reviewed current literature on the role of purchasing cooperatives in health care reform and analyzed legislation

introduced in the fall of 1993, including the Clinton, Cooper, and Chafee bills.[6] Our review was conducted between November 1993 and March 1994 in accordance with generally accepted government auditing standards.

Existing Cooperatives Have Greater Regulatory Authority Than Permitted Under Most Reform Proposals

Existing purchasing cooperatives often exercise significant policy-making authority. They may (1) define and standardize benefits, (2) include or exclude carriers, (3) negotiate premiums, (4) initiate self-funded health plans, and (5) develop ways to measure and improve the quality of care provided. Many of these functions are either assigned to federal and state governments or prohibited entirely by national reform proposals. We found that the public and private cooperatives we visited approach some of these authorities quite differently.

Purchasing cooperatives have varying degrees of authority over benefits packages. Some cooperatives have actually designed the benefits package, while others have standardized the benefits offered by plans to (1) ensure competition based on cost and quality rather than benefits, (2) frustrate risk avoidance strategies, and (3) simplify plan comparison by members. Thus, the law that created HIPC in California also authorized the cooperative to design a benefits package. The standardized benefit structure was based on health maintenance organization (HMO) licensing standards and information gathered during a series of public hearings. Private cooperatives generally work with insurance carriers to develop benefit structures that reflect the needs of their membership. For example, COSE officials explained that member comments on covered services are closely monitored and used as a basis for continuing adjustments to the benefits design. Most reform proposals either specify the benefits package in the legislation or make a national commission responsible for defining covered services.

One of the most controversial functions in national reform bills that utilize purchasing cooperatives involves their degree of autonomy in contracting with insurance carriers. Except in a limited number of circumstances, these bills appear to require cooperatives to contract with all state-certified health plans. Although states have given the public cooperatives we visited wide discretion in determining the number and type of carriers offered, most still contract with a large number of carriers:

[6] For a discussion of the role of purchasing cooperatives in health care reform legislation, see appendix V.

- With 22 carriers, CalPERS limits new contracts to plans that introduce HMO coverage to unserved areas of the state.
- HIPC received bids from 25 carriers and contracted with 18.
- In 1983, the Wisconsin cooperative announced that, with the exception of its two self-funded fee-for-service (FFS) plans, only HMOs would be allowed to participate the following year. In a system that had been dominated by FFS plans, enrollment in HMOs more than tripled in 1 year.

In contrast to public cooperatives, private purchasing pools limit insurance carrier participation as a matter of policy. Thus, the four private cooperatives we visited offered plans, often designed to their specification, through only one or at most three carriers.

Price Negotiation Seen as Critical to Controlling Premium Growth

An equally controversial function in the reform bills is whether cooperatives can negotiate premiums with insurance carriers. For example, the Clinton bill permits but Cooper prohibits negotiation.[7] With the exception of those in Florida and Washington, all of the purchasing cooperatives we visited negotiate with carriers and most believe that this authority is critical to controlling costs. In fact, the businessmen and women recently appointed to Florida cooperative boards are now lobbying the state legislature to reinstate the negotiating authority removed from the original legislation at the behest of the insurance industry.

Public purchasing cooperatives have recently started to augment market forces with negotiation. The Wisconsin cooperative adopted a number of cost control measures in 1983 but simply accepted sealed bids from health plans without any discussion of premium increases. Over the next decade, initially low yearly premium increases were followed by several years of significantly accelerated premium growth. Wisconsin turned to negotiations in 1993. The cooperative hired an actuary to develop target premiums for each plan based on data submitted by health carriers. If a plan's bid was significantly higher than its target, cooperative officials discussed the discrepancy with plan representatives. Wisconsin officials told us that best-and-final offers from 9 of the 10 plans contacted for discussion had substantially lower premiums. Using a similar strategy implemented in 1989, Minnesota state cooperative officials told us that

[7]The implications of this authority are not clear since the Clinton bill has been widely read, despite some ambiguity in the language, as requiring purchasing cooperatives to contract with all state-qualified health plans. At the same time, the connotation of the term "negotiation" is clearly broader than simply the ability to exclude plans. For example, with regard to establishing FFS price schedules, negotiation is defined to include all collective and joint meetings, discussions, presentations, conferences, and consultations between providers and any regional alliance.

they had achieved premium savings of 20 times the $50,000 actuarial fee—savings that they attributed to altering the way plans calculated premium increases.

Although CalPERS had long discussed premium increases with health plans, pressure to contain costs became critical in 1991 when California froze the state contribution to premiums, magnifying the impact of rate increases on state employees.[8] As a result, CalPERS began aggressive negotiations with health plans in 1992.[9] Citing the state's worsening fiscal situation, CalPERS sought a zero increase in HMO premiums in 1992 with no change in benefits. Kaiser insisted on premium increases of more than 10 percent due to its richer benefits packages. CalPERS agreed to this increase but froze enrollment in the Kaiser plans for 8 months. CalPERS held the other plans to average premium increases of 3.1 percent. Rate negotiations were even more successful for the 1993 contract year with increases averaging 1.4 percent. For the 1994 contract year, CalPERS publicly announced it was seeking a 5-percent reduction in premiums but compromised on a 1-percent reduction. Another California cooperative, HIPC, achieved a 6-percent reduction over premiums offered in 1993, its first year of operation.

The private purchasing cooperatives we visited believe that their negotiating hand is strengthened by severely restricting the number of participating carriers. As a result, they offer a more limited choice of carriers compared to public cooperatives.[10] Although they may solicit bids from a number of competitors, private cooperatives approach negotiations with the implicit caveat that they will award the contract to a single competitor. For example, COSE, a private small business cooperative, contracts with only two carriers to obtain a volume discount. Constituting about 15 percent of Blue Cross's business in the Cleveland metropolitan area, COSE is the carrier's single largest customer. According to COSE officials, Blue Cross knows that the cooperative could "shop around" when the current contract expires.

[8]Prior to the 1992 contract year, CalPERS premiums had increased at rates near or above the average increases experienced throughout the nation.

[9]Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

[10]Some newer private cooperatives are offering multiple health plans.

New Emphasis on Measuring Health Plan Quality

Reflecting the state of the art, programs to measure, improve, and report on the quality of care delivered by participating health plans are in their infancy. Compared to the public cooperatives we visited, however, private purchasing pools placed more emphasis on measuring and improving the quality of care obtained through participating health plans. Though public cooperatives collect some data on the utilization of services, they are now beginning programs that focus on the quality of the services obtained. Some cooperatives will eventually provide comparative information on quality to enrollees but for the most part the data now collected are used in rate negotiations, quality improvement programs, and cost control efforts. The following are among the quality data initiatives currently underway:

- Business Health Care Action Group (BHCAG), a private Minnesota business cooperative, fostered the establishment of the Institute for Clinical Systems Integration, a $2 million nonprofit foundation chartered with facilitating continuous quality improvement and better integration of the health care delivery system. Through the institute, and working with physicians, BHCAG has developed practice guidelines and a system to monitor treatment and patient outcomes. To encourage provider participation, BHCAG agreed not to share this information with employees at this point.
- Starting in 1994, CalPERS will require plans to submit data on a list of indicators[11] during the rate renewal process. After analysis, health plans will be ranked according to their ability to meet target guidelines for delivering these services. This comparative performance information will be published in a "Quality of Care Report" beginning in 1995 and distributed to members prior to the open enrollment period.

Florida health care reform calls for cooperatives to issue "report cards" on quality. Participating health plans must submit quality data to the Agency for Health Care Administration (AHCA), which will analyze and package comparative information for publication and distribution by each cooperative.[12] Key indicators to be phased in during 1994 and 1995 include (1) incidence rates for certain services/outcomes, (2) patient satisfaction, (3) costs, and (4) accreditation. As now envisioned, the report cards will

[11]Childhood immunizations, mammography screening, cervical cancer screening, prenatal care—first trimester, cholesterol screening, low birth weight, asthma inpatient admission rate, diabetic retinal exam, and ambulatory follow-up after hospitalization for major affective disorder (mental health).

[12]Florida's approach is similar to some reform proposals that make federal or state authorities responsible for developing and analyzing quality measures.

compare plans offered by the cooperative to each other and to a national norm.

Existing Cooperatives Operate With Modest Budgets and Staffs

Irrespective of enrollment, the operating costs of existing purchasing cooperatives are modest. However, large public cooperatives benefit from inherent economies of scale and thus have proportionately lower operating costs. Contracting out labor- intensive administrative functions to private firms allows many cooperatives to operate with small staffs that focus on policy and management issues such as negotiation with health plans or quality of care issues.

The cooperatives we visited operate with budgets ranging from less than 1 percent to 3 percent of premiums.[13] Larger purchasing cooperatives spend a smaller share of premiums on operating costs because they are able to spread their fixed costs over more members. Smaller cooperatives such as HIPC and the Minnesota Employers Insurance Program (MEIP) expect the share of premiums allocated to their operating costs to decrease as enrollment expands. Limitations on operating costs, when specifically set in reform proposals, range from 1 percent to 2.5 percent of premiums. The experience of new, voluntary cooperatives such as HIPC and MEIP suggest that a cap of 1 percent of premiums may not be realistic until such cooperatives attract sufficient membership.

Because they must advertize to increase enrollment, voluntary cooperatives incur marketing costs that mandatory purchasing pools are able to avoid. Florida estimates that marketing will be a significant portion of each cooperative's operating budget as well as the primary task assigned to the staff. HIPC officials told us that one-third of their operating costs of 3 percent of premiums are marketing related. MEIP's experience with marketing costs is similar. As enrollment increases, marketing expenses decrease as a percent of premiums. Thus, marketing accounts for less than 12 percent of COSE's operating budget.

The extent to which existing public and private purchasing cooperatives contract out administrative functions accounts for differences in overall staff size. HIPC—like many private cooperatives—contracts out all administrative functions to the private sector, allowing its 13 staff members to focus exclusively on policy functions. On the other hand, CalPERS, with a total staff of 94, performs labor-intensive administrative functions inhouse. Sixty-five staff (70 percent) are dedicated to enrollment

[13]Cooperative budgets are often expressed as a percentage of total payments to health carriers.

and premium collection—that is, (1) processing members' plan selection forms, (2) updating records to reflect changes in marital status or the number of dependents, (3) collecting premiums from state agencies and participating local governments, and (4) distributing premiums to the appropriate health plans. Because of economies of scale, large cooperatives such as CalPERS, which covers almost 1 million lives, are able to take on such administrative functions inhouse. CalPERS's policy and management staff of 29 negotiate rates, contract with carriers, and evaluate/monitor the financial stability and delivery of medical services by 27 plans. Because they offer a wider choice of carriers and renegotiate premium increases annually, public cooperatives tend to have somewhat more personnel involved in policy-making.

Often developed from existing programs rather than from scratch, lessons on start-up costs for new cooperatives are weak. Larger and older purchasing cooperatives such as CalPERS, Minnesota, and Wisconsin, minimized the costs of expanding coverage to local government employees by building on the existing structure. Similarly, giving the Minnesota cooperative responsibility for MEIP probably reduced the total appropriation required. In Florida, where the legislature appropriated $275,000 for each of 11 cooperatives, it would be misleading to exclude other associated costs. Thus, the appropriation does not reflect the considerable efforts of the AHCA, which is responsible for implementating and overseeing Florida's health care reforms.

Subsidy Administration: A New Role for Purchasing Cooperatives Under Reform

Consistent with the goal of improving access to coverage, most reform proposals call for national subsidies to assist low-income individuals and the unemployed with purchasing health insurance. And at least one bill assigns their administration to cooperatives. Considerable uncertainty exists about the resources required for subsidy administration. Only one purchasing cooperative we visited—Washington's HCA—administers subsidies. Florida's will do so soon. While HCA uses in-house cooperative staff to administer its subsidy program, Florida's plan calls for the state's 11 health cooperatives to use an approach that minimizes the impact on the staff of each cooperative.

HCA has 23 personnel dedicated to administering the low-income subsidy portion of its Basic Health Plan (BHP).[14] In addition to performing the administrative tasks associated with eligibility determination and enrollment, this staff is responsible for contracting with the 21

[14]This figure represents about one-quarter of HCA's 94 employees.

participating HMOs, for standardizing benefits, and for premium collection/distribution. HCA officials said that processing application forms is the most labor-intensive aspect of administering the program. Tax returns and pay stubs—rather than an asset test—are used to determine eligibility. The staff must verify the information on the application form every 6 months. With enrollment of about 32,000 subsidized individuals, operating costs for the program total 7 percent of benefits paid out. Adding BHP to the existing large program for public employees only increased HCA's overall operating costs by 1 percent—from 1.3 to 2.3 percent of benefits paid out. While the addition of smaller new voluntary programs to existing cooperatives increases their overall operating costs, the actual increase is moderated significantly by their already large enrollment and low operating costs.

Many of the tasks performed with in-house staff by HCA are shifted to insurance agents or contractors under the Florida plan. Thus, insurance agents would be responsible for helping individuals complete the eligibility determination forms. As in Washington, a simplified eligibility determination process based on income tax forms, pay stubs, or documented participation in another publicly funded program would be used. There would be no burdensome and costly asset test. A private-sector contractor hired by the cooperative would be charged with reviewing eligibility applications for accuracy, verifying the information, certifying eligibility, and calculating the premium contributions.

Florida proposes to use its Medicaid fiscal agent, a private-sector contractor, to pay the public subsidy to the cooperative contractor. Thus, the fiscal agent would submit a monthly list of eligible individuals, indicating the employer and/or individual premium contribution and the amount due from state and federal contributions. The fiscal agent would transmit the appropriate lump-sum payment to the cooperative contractor who would in turn reimburse the appropriate health plans. Finally, eligibility determination procedures for Medicaid recipients would remain unchanged. The Department of Health and Rehabilitative Services and the Medicaid fiscal agent would continue to accept Medicaid eligibility forms and process claims. As with subsidies, the cooperative contractor would be responsible for collecting the federal/state contribution and reimbursing health plans.

A major area of uncertainty with respect to subsidy administration is the historically low participation rate of those eligible. Based on the fact that only 50 percent of those qualified for Medicaid are enrolled, Florida

estimates that a similar percentage will sign up for its proposed subsidy program. Since several bills call for universal coverage, achieving very high participation rates may entail larger than anticipated administrative costs.

Clarification of Governance Structure Needed

To many Americans, purchasing cooperatives are an unfamiliar new entity, raising legitimate concerns about the role of government, employers, and employees in their operation. Governance is a central issue because under many reform proposals cooperatives are the vehicle through which many Americans would obtain portable health benefits.[15] And for those unable to obtain or afford insurance under the current system, government subsidies channeled through purchasing cooperatives would facilitate access to coverage. This nexus of interests highlights the importance of establishing a proper balance between public and private accountability. Although many of the cooperatives we visited provide limited lessons for establishing such accountability, we believe that the experience of Florida cooperatives identifies some of the potential pitfalls.

The private purchasing cooperatives we visited were typically employer-controlled organizations with no employee representation on their governing boards and limited government oversight of their activities. At the other end of the continuum, existing public cooperatives often evolved out of government sponsored health benefits programs. Run by state agencies, employee input may be obtained through collective bargaining or advisory panels rather than through formal governing boards. Only CalPERS had a governing board with elected employee representatives. In general, cooperatives prohibited providers or insurers from serving on the board.

Since it is the first large-scale implementation of a statewide system of cooperatives, Florida's governance structure merits a more detailed examination. The Director of AHCA, who is responsible for establishing and overseeing cooperative operations, told us that Florida opted for political as opposed to bureaucratic accountability because politicians are sensitive to public opinion. However, the appointment process for board members has been criticized in the Florida and national press as overly politicized.

- Boards may not meet the law's requirement that they reflect the demographics of the population served. One official told us that political

[15]Estimates project that as many as 50 to 90 percent of Americans could obtain health insurance through proposed purchasing cooperatives. See appendix V.

rivalry among the three appointing officials impeded the coordination needed to achieve this goal.

- The "consumer" representatives on the boards—defined in the law as "an individual user of health care services" —are virtually indistinguishable from the 11 statutory "business" representatives. Many of these "consumers" are also lawyers or businessmen.
- One official told us that the governor avoided appointing lawyers because of the potential conflict of interest if their firms ever representd clients in the health care business. Appointments by the other two officials included lawyers.
- According to a Florida official, inadequate screening resulted in board members whose appointments could be challenged—for example, appointees with prohibited affiliations such as health care consulting.

Politicization, with the potential to undermine public confidence in purchasing cooperatives, suggests that serious attention should be paid to provisions regarding the composition and appointment of boards. Currently, none of the bills calling for the creation of purchasing cooperatives contains a requirement for governing boards to be representative of the populations they serve. Florida's experience suggests that the appointment process should include a mechanism to ensure achievement of that goal.

As arranged with your office, unless you publicly announce its contents earlier, we will make no further distribution of this report until 15 days after its issue date. At that time, we will send copies of this report to other interested committees and Members of Congress. We will also make copies available to other parties upon request.

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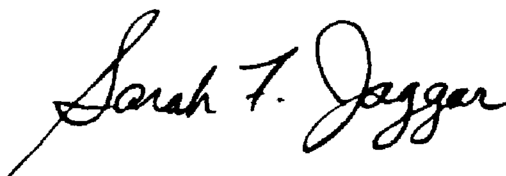

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Abbreviations

AHCA Agency for Health Care Administration
BHCAG Business Health Care Action Group
BHP Basic Health Plan
CalPERS California Public Employees' Retirement System
COSE Council of Smaller Enterprises
EABC Employers Association Buyers' Cooperative
EHPC Employers Health Purchasing Cooperative
HCA Health Care Authority
FFS Fee-for-Service
HIPC Health Insurance Plan of California
HMO health maintenance organization
MEIP Minnesota Employers Insurance Program
PEBB Public Employees Benefit Board
PEIP Public Employee Insurance Program
POS Point of Service
PPO Preferred Provider Organization
SEIP State Employee Insurance Program

Descriptions of Purchasing Cooperatives

The following summaries pull together information on the origin, evolution, governance, and operation of each purchasing cooperative we visited. The intent is to give the reader with a specific interest in a particular cooperative a ready reference to information that is presented topically throughout the report.

Public Cooperatives

We visited five publicly sponsored multiple employer purchasing cooperatives operated either by a state agency or an independent state board. Four of the cooperatives cover state and local government employees, and one was expanded in 1993 to private employers. The fifth cooperative, a purchasing pool targeted at small employers, was authorized in 1992.

California Public Employees' Retirement System

After 40 years of administering the state's retirement program, CalPERS was given the additional responsibility of managing health benefits for active and retired state employees and their dependents in 1962. Several years later, participation was extended on a voluntary basis to local government employees. Both state and local workers were merged into one risk pool, the former accounting for about 70 percent of overall enrollment.[1] CalPERS covers 916 public employers representing over 930,000 enrollees. Since 1988, CalPERS has charged employers one-half of a percent of health care premiums to cover the cost of operating the cooperative.[2]

The CalPERS Board of Administration governs the health benefits and other programs. Board composition is mandated by law with six elected by the membership of CalPERS[3] and seven appointed or statutory members.[4] Six board members serve on a Health Benefits Committee that is responsible for reviewing and revising the benefits package and approving plan

[1]All employees are offered the same health plans at the same prices.

[2]State law allows the CalPERS board to charge up to 2.0 percent of gross premiums as an administrative fee.

[3]Of these six, two are elected by all CalPERS members, one is elected by active state members, one is elected by active local members of CalPERS who work for a school district or a county superintendent of schools, one is elected by the active local members other than those employed by a school district or county superintendent of schools, and one is elected by retired members.

[4]Of these seven, one is from the State Personnel Board; three (the Director of the Department of Personnel Administration, the State Controller, and the State Treasurer) are members by virtue of their appointed or elected state government positions; two members, a representative of a life insurer and an elected official of a public agency, are appointed by the governor; and one member, a public representative, is appointed by the California legislature. No life insurance representative currently sits on the board since another California law prohibits participation on state boards by any individual who might have a financial conflict of interest.

premium increases. The board has also appointed a Health Benefits Advisory Council, consisting of 17 health benefits experts such as doctors and health plan executives.

CalPERS' health benefits staff of 94 are divided between two divisions—one covering policy and management issues and another focusing on routine administrative services. The former, with 29 employees, negotiates rates, contracts with individual health plans, and oversees the two CalPERS self-funded plans. It also evaluates and monitors the financial stability of and delivery of medical services by plans offered through the cooperative. The other division, with 65 employees, performs enrollment-related activities, including processing, adjusting, and deleting enrollee coverage. Moreover, it distributes health benefit information booklets and acts as a liaison between the enrollees and health plans in resolving claims service problems. CalPERS offers a choice of 27 health plans, consisting of 21 Health Maintenance Organizations—including 3 out-of-state HMOs, 2 self-funded preferred provider organization (PPO) plans (PERSCare and PERSChoice), and 4 employee association PPOs. Due to the geographic distribution of HMOs in California, not all plans are available to all employees. PERSCare offers its enrollees access to a large preferred provider network with about 36,000 physicians and 270 California hospitals. PERSChoice is designed as a more affordable PPO option with members paying lower premiums than for PERSCare, but with higher deductibles and coinsurance.[5] Health plans are not allowed to screen applicants for medical conditions; all enrollees may switch plans once a year during open season and must be accepted by any plan they choose.

In 1992, after several years in which premiums increased at rates near or above nationwide averages, CalPERS adopted an aggressive negotiating style. The catalyst was California's budget crisis and the legislature's decision to freeze the state contribution to employee premiums. Since 1992, CalPERS has held premium increases to well below the national average, actually achieving a 1 percent premium reduction in 1994. During negotiations, CalPERS analyzes health plan service, cost, and utilization data to determine if any rate increase is justified and to identify areas for potential savings. In 1992, CalPERS also standardized its benefit structure to simplify the comparison of health plans by enrollees and to reduce the differences that health plans cited during negotiations as justification for rate increases.

[5]A coinsurance payment is a fixed percentage of covered expenses paid by an enrollee after any deductible has been met.

Starting in 1994, CalPERS will require plans to submit data on a list of quality indicators during the rate renewal process. After analysis, health plans will be ranked according to their ability to meet target guidelines for the delivery of these services. This comparative performance information will be published in a "Quality of Care Report" beginning in 1995 and distributed to members during the open enrollment period. Previously, CalPERS reviewed some performance indicators during contract negotiations but did not share this information with members. CalPERS conducts and distributes member satisfaction surveys.[6]

Health Insurance Plan of California

As part of 1992 insurance market reforms, California established HIPC—the first government-sponsored, voluntary purchasing pool for small employers. By March 1994, after only 9 months of operation, HIPC had signed up almost 2,500 firms representing 44,000 workers and their dependents. About 80 percent of the firms that joined HIPC previously offered health insurance but found that the cooperative offered a wide choice of plans with lower premiums. Participation in the cooperative is open to any firm with 5 to 50 full-time employees—the threshold will be lowered to 4 employees in July 1994 and to 3 employees in 1995.[7] Operating costs are about 3 percent of the average premium.

HIPC is administered by the five-member Managed Risk Medical Insurance Board, an independent organization within California's Health and Welfare Agency.[8] Appointments to the board—three by the governor and two by the legislature—are not divided up among different interest groups. Although board members may have a background in business or health insurance, they are precluded by statutory conflict-of-interest provisions from having current ties to the health insurance industry. In addition to HIPC, the board manages two other programs,[9] with a total staff of 13. The board and its staff are responsible for the following policy and management functions: developing the benefits package, establishing participation rules for employers and employees, selecting participating

[6] For additional information on CalPERS, see Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

[7] In September 1993, the legislature amended the statute creating HIPC to allow enrollment down to one for groups and individuals joining through programs sponsored by trade and professional associations that cover a minimum of 1,000 individuals.

[8] California's small group health reform legislation required the Managed Risk Medical Insurance Board to develop the cooperative and a standardized benefits package.

[9] The Board was created in 1989 to administer a high-risk medical insurance program for those unable to obtain coverage. In 1992, the board was also given responsibility for administering a program for pregnant women who are not covered by the state's medical assistance program.

health plans, negotiating contracts, monitoring contract performance, and serving as ombudsman. A contractor performs all eligibility and enrollment functions as well as premium collection and distribution. In addition, the contractor markets the pool and serves as the public's source of information on HIPC.

In its first year of operation, HIPC offered a choice of 18 health plans—15 HMOs and 3 PPOs, each available with two different levels of copayment/deductibles. Each plan must offer the standardized benefits package established by the cooperative governing board. Premiums may vary only by age, geographic location, and family size. Health plans are not allowed to screen applicants for medical conditions; all enrollees may switch plans once a year during open season and must be accepted by any plan they choose. Firms must contribute 50 percent of the rate for the lowest cost plan and 70 percent of their employees must participate. Employees may choose any plan offered in their geographic area. Although firms may bypass insurance agents and join HIPC directly, about 75 percent have enrolled through agents. HIPC limits the amount agents may charge to a flat fee and bills the firm separately for that amount rather than concealing the charge in its premiums.

According to HIPC officials, the premiums they negotiated with health plans are extremely competitive with those available on the outside market. HIPC's lowest rates undercut the market by approximately 15 percent. Attributing their price advantage to negotiation, they believe that this authority is key to achieving cost containment in the short term. All plans offered through HIPC have agreed not to offer lower rates for the same coverage to attract business away from the cooperative. HIPC recently announced its rates for the second year. Officials noted that, due to strong enrollment and negotiations by HIPC staff, second year rates average 6 percent lower than those offered in the first year.

Minnesota Department of Employee Relations

In operation since the 1940s, the Minnesota state employee health insurance program was opened to voluntary membership by local governments in 1990 and by private employers in 1993. Each of these three groups is segregated in a separate risk pool. Enrollment in the cooperative, as of March 1994, totaled 150,000 active and retired employees and their dependents as follows: (1) 144,000 in the state pool, (2) 5,000 in the local government pool, and (3) 1,000 in the private-sector pool.[10] Open for

[10]The three pools are known respectively as the State Employee Insurance Program, the Public Employee Insurance Program, and the Minnesota Employers Insurance Program.

enrollment since late 1993, any firm with two or more employees may participate in the private-sector pool. Employers must contribute a minimum of 50 percent of the premium. Unlike other states, Minnesota does not limit participation to small employers.

The Minnesota Commissioner for the Department of Employee Relations is the governing authority for the cooperative. Although there is no governing board, each pool has an advisory committee consisting of employer and employee representatives—the latter typically are union representatives.[11] The department has a staff of 41 managing all three programs—31 assigned to the state employee pool and 5 each working for the two voluntary pools. Overall, 8 staff members perform policy and management functions such as contract negotiation and plan oversight and 33 focus on administrative functions. While enrollment and premium collection for the state pool are handled by the in-house administrative staff, a contractor performs these duties for the two voluntary pools. Cooperative operating costs range from 0.83 percent of premiums for the state employee pool to about 3 percent for the other two smaller pools. Overall, the cooperatives operating costs are about 1.8 percent of premiums.

Health plans are not allowed to screen applicants for medical conditions, and each of the three pools offers employees an annual open enrollment period in a choice of health plans. The state employee pool provides a choice of six plans—four HMOs and two PPOs, one of which is a self-funded PPO plan. The local government pool offers a choice of four health plans—one HMO, two PPOs, and one fee-for-service (FFS);[12] in addition, the private-sector pool offers a second HMO option. Health Plans are required to offer benefits that are "roughly comparable, but not identical." According to officials, the state employee benefit package is more comprehensive than that offered to local government enrollees.

Facing a crisis in state employee health care costs, Minnesota implemented a managed competition approach to health insurance purchasing in 1989. These same principals have now been incorporated in the local government and private employer pools. First, the employer contribution is based on the lowest cost family premium and the employee pays the difference if a more expensive plan is chosen. According to

[11]Cooperative officials noted that Minnesota is a "very strong labor state" and that union representatives are closely involved in the state's efforts to control the costs of health insurance and reassessing the required benefits package.

[12]The FFS plan is only offered in areas where HMO or PPO plans are not available.

cooperative officials, health plans that provide comprehensive benefits and maintain high patient satisfaction for a lower price than their competitors are rewarded with greater enrollment. Thus, the lowest cost plan in the Twin Cities has seen its share of enrollment increase from 19 to 35 percent statewide. In addition to utilizing a lowest cost plan approach, the cooperative controls costs by subjecting each health plan's rate proposal to a review by independent actuarial consultants. The purpose of the review is to determine whether the health plan's rate proposal is based on sound methodology and is reasonable. If any inconsistencies are found, department officials meet with the health plan to seek additional information and to negotiate rate changes. Cooperative officials told us that the rate of premium increases for the state pool fell from 42 percent in 1989 to 14 percent in 1990. The decrease is attributable in part to the introduction of managed competition reforms but also reflects resolution of financial problems related to the cooperative's Blue Cross managed FFS plan. Premium increases in 1992 and 1993 averaged about 6 percent.

Officials noted that efforts to measure quality of care are still in their infancy. The cooperative plans to establish a new group within the health insurance staff charged with the responsibility of developing an outcome measures program. The cooperative has developed consumer satisfaction surveys for state employees.[13] The first two surveys were conducted in 1991 and 1993, and officials said that they plan to continue them every other year. Intended to help state employees select their health plan, the survey measures overall satisfaction with plans and the services provided, including the quality of customer service; the length of time it takes to make an appointment; and doctor's medical knowledge, experience, and listening skills. Survey results listing plan-specific "scores" are provided to members along with other health plan materials prior to the annual enrollment period.

Wisconsin State Employee Group Health Benefits Program

Having provided health insurance to its state employees for over 30 years, Wisconsin opened the program to local government participation in 1987. Due to concern that the voluntary nature of the program for local government employees would result in an influx of high-risk groups, state employees maintained a separate risk pool. Total cooperative enrollment—including active state and local employees, retirees, and their dependents—is about 195,000. Currently, only 13 percent of eligible local

[13]The Minnesota Department of Employee Relations is involved in a state effort to develop quality of care measures to include specific protocols describing acceptable treatments and tests for a particular medical condition.

governments—representing about 9 percent of the system's total enrollment—has opted to buy health insurance through the cooperative.

Wisconsin's cooperative is governed by a 10-member board of directors with broad policy responsibility for decisions about plan participation, benefit structure, and premium rates. Administered by the Department of Employee Trust Funds, a state agency, the cooperative has about 11 staff members. Operating costs are four-tenths of a percent of premiums, including the cost of the cooperative's contracts for claims processing and actuarial analysis. Enrollment and premium collection are primarily the responsibility of each state agency, although the Department of Employee Trust Funds maintains all enrollment records and distributes premiums to participating insurance carriers.

Health plans are not allowed to screen applicants for medical conditions; all enrollees may switch plans once a year during open season and must be accepted by any plan they choose. Although participating insurance carriers are only allowed to offer HMOs, the state is required by law to provide at least one FFS plan, with a minimum specified benefit level. In an effort to ensure flexibility for state employees who live in areas where FFS is their only option, the state provides three different plans through a single carrier, with varying levels of coverage and cost. In 1994, 27 plans were available.

The Wisconsin cooperative has initiated major cost containment strategies during the past 10 years. After premium rates grew rapidly in the early 1980s, the cooperative announced that, with the exception of its two self-funded FFS plans, only HMOs would be allowed to participate the following year. The next year, the number of participating HMOs doubled from 8 to 16, and member enrollment in HMOs increased from 18 percent to 62 percent.[14]

At the same time, the state contribution to premium rates was restricted to encourage members to choose the lowest priced plan. The state pays up to 105 percent of the lowest priced plan or 90 percent of the conventional FFS plan, whichever is less. In metropolitan areas of the state, the lowest priced plan is always an HMO, and members who choose the higher priced conventional plan must pay the difference, which is usually a significant amount. In some areas, however, no HMOs are offered, so the FFS plans are generally available for little or no employee premium contribution.

[14]Currently, about 82 percent of the cooperative's members is enrolled in 24 HMOs, and the remainder is enrolled in the three FFS plans.

Cooperative officials told us that premium growth would be more effectively constrained if the state limited its contribution to 100 percent of the lowest priced plan. By allowing a payment of 105 percent, the state may reward some plans for targeting their premium slightly above the lowest priced plan, rather than encouraging true price competition.

Premium growth slowed considerably from 1983 to 1987, but rates increased significantly in 1988 and remained high during the following years. Despite some stabilization in premium increases by 1992, the Wisconsin cooperative decided to initiate additional strategies designed to constrain premium growth. Thus, they began negotiating premium rates with health plans in 1993 and instituted a standard benefits package to (1) simplify comparison of plans, (2) encourage competition solely on quality and price, and (3) prevent plans from trying to enroll only healthy people.

Washington Health Care Authority

HCA was established in 1988 to administer health benefits for state employees.[15] Washington's 1993 health care reform legislation designated HCA to become the state's single health services purchasing agent by 1995 and greatly expanded its current responsibilities. First, enrollment in the state employees purchasing program was expanded to include school district employees, and the program's name was changed to the Public Employees Benefit Board program. Second, HCA was given responsibility for Washington's 4-year-old subsidized health insurance program for low-income individuals, known as the Basic Health Plan. In addition, enrollment in BHP was opened to any individual or employer on a nonsubsidized basis. Finally, HCA was required to establish a purchasing program for caregivers.[16] The goal is to combine all these groups into a single community-rated risk pool by 1996.

Current HCA enrollment in these three purchasing pools comprises 265,824 state and school district employees and their dependents; 32,697 individuals and families in the BHP; and 50 caregivers and their dependents. A staff of 95 manages the three purchasing pools. The public employee and caregiver pools have 71 employees (1 staff member works half time on both the public employee and caregivers programs), and the BHP has 24 employees. Operating costs are 1.3 percent of benefit expenditures for the public employee pool and 7 percent for the BHP. Overall, operating costs

[15]Prior to 1988, state employee health benefits were managed by the State Employee Insurance Board.

[16]Owners and operators of child care centers, foster care parents, home care workers, and nonprofit organizations contracting with the state.

for programs managed by HCA (with the exception of the new caregivers program) total 2.3 percent.

Accountable to the governor, HCA's responsibilities include contracting with health plans and developing the benefit and rate structure. The HCA administrator serves as chairman of the public employee board, which focuses on benefit design and eligibility issues. No medical underwriting is allowed by any health plans offered through the cooperative, and preexisting condition exclusions will be phased out by 1995. At present, HCA offers (1) a choice of 21 HMOs to individuals enrolled in the BHP. Public employees and caregivers can choose from among 16 HMOs and the cooperative's own self-funded PPO plan.[17]

Available across the state, the cooperative's PPO serves as a "benchmark plan." The idea is to force the managed care plans to compete against an employer-based standard. According to HCA officials, the benchmark plan concept will help the state's four regional purchasing cooperatives[18] to determine target premiums, acceptable baseline price levels, utilization and service patterns, and service quality.

Private Cooperatives

Although our study emphasized the operation of public cooperatives, we also visited four cooperatives sponsored by the private sector. Business Health Care Action Group members are all large companies while the Council of Smaller Enterprises and the Employers Association Buyers' Cooperative were established to assist smaller businesses. Membership in the Employers Health Purchasing Cooperative is open to both small and large firms.

Business Health Care Action Group

BHCAG is a cooperative of large Minneapolis/St. Paul-based employers. Formed in 1988 to monitor and influence state health care legislation, the focus of BHCAG shifted 3 years later from lobbying to collective purchasing. The cooperative began offering its health plan to members in January 1993. A year later, 90,000 employees and dependents of 20 member firms were enrolled in the plan—about 40 percent of those

[17]Caregivers are offered the same health plan and benefits package (including copayments) available to public employees but pay higher premiums.

[18]See summary of the Washington state managed competition system later in this appendix.

eligible.[19] Firms with a minimum of 500 employees may join the cooperative.

According to the cooperative's executive director, BHCAG's approach differed from other group purchasing efforts in that it focused on working with providers to set standards for the necessity and effectiveness of medical services. With the assistance of an employee benefit consulting firm, BHCAG developed a request for proposal that articulated the following goals: (1) increased provider accountability using practice parameters and outcomes measures, (2) streamlined administration emphasizing data collection for purposes of continuous quality improvement, (3) increased employee responsibility for health care consumption and health habit behaviors, and (4) better management to control costs while documenting and improving the quality of care available.

BHCAG selected GroupCare Consortium to operate the cooperative health plan. The Consortium, an integrated provider network established in response to the request for proposal, consists of two HMOs that joined forces with three major group practices. To help meet BHCAG quality objectives, the Consortium created the Institute for Clinical Systems Integration, which is responsible for designing and implementing consistent medical practice guidelines and information systems for participating providers. The cooperative's health plan uses the point-of-service concept in which an employee can choose treatment from an in-house provider network or choose non-network treatment at lower benefit levels. The plan requires each covered family member to select a primary care clinic. The primary care clinic manages referrals to outside specialists.

The cooperative effort to control long-term costs is directly linked to its efforts to improve the quality of health care. BHCAG achieved some immediate cost control through its ability to deliver a large number of employees from member companies. BHCAG further used its buying leverage to obtain quality-related concessions from its provider group. BHCAG hopes to reduce the expense of inappropriate care by educating members, establishing best practice parameters, and holding providers accountable for performance. BHCAG employers and health providers have jointly developed a consumer education strategy that includes a worksite education program. To develop a baseline for how effectively the Consortium is improving the overall health of workers and their families, a

[19]All BHCAG members are self-insured companies, and some will continue to offer other health benefit plans in addition to the newly developed cooperative plan.

survey was conducted to measure health status of enrollees at the start of the contract. A sizeable portion of the service fee that the Consortium receives for overhead and profit is tied to meeting quality improvement goals.

The cooperative is a for-profit corporation governed by the employee benefits directors of its 22-member firms. The cooperative board is supported by a staff of two. Each firm pays an annual membership fee of $5,000 and $3.75 per employee in the network area. BHCAG operating costs are difficult to estimate because expenses that were part of the budget of other cooperatives we visited, such as enrollment and premium collection, are included in an 8-percent administrative fee paid to the Consortium.[20] In addition, the cooperative's quality initiatives, such as the $2,000,000 cost of the clinical institute, are also covered by this fee. The cooperative's executive director estimated that BHCAG's direct operating costs, including staff, rent, and legal fees were about .5 percent of premiums.

Council of Smaller Enterprises

COSE—the small business council of the Cleveland, Ohio, Chamber of Commerce—is a private, nonprofit cooperative for firms with 150 or fewer employees. Established in 1973, COSE's goal is to secure affordable health care coverage and low and stable premium rates for its 200,000 enrollees. To join COSE, a firm must first become a member of the Cleveland Chamber of Commerce.[21] COSE requires member firms to abide by the following rules: (1) all employees must be offered health insurance, (2) all employees that do not choose an HMO must be insured through the same group model plan,[22] (3) insured groups can only include employees and their immediate family members, and (4) employers must contribute at least 25 percent of the premium for each employee.

COSE's operations are governed by a Board of Directors composed of four top officers from COSE and the Cleveland Chamber of Commerce, plus five small business owners. With a staff of about 10, COSE's operating costs are

[20]Each member company is assessed an administrative fee of $21.89 per employee per month that covers developing practice guidelines, the cost of the Institute, claims processing, employee health benefit cards, member services, statistical data gathering, and enrollment/premium collection. GroupCare Consortium performs most of these functions, but member firms assist by collecting enrollment data at the worksite.

[21]Annual fees to the Chamber of Commerce are $400. COSE members pay a monthly fee of $11 per company and an additional $1 per employee.

[22]Although all employees must be offered health insurance, some employees may choose to be insured through another route, such as a spouse's insurance, or, in some limited circumstances, may choose to be uninsured. Each employer may offer only one group plan unless reasonable distinctions exist among categories of employees, such as salaried and hourly workers.

about nine-tenths of a percent of premiums. This amount includes the cost of the cooperative's contract with a third-party administrator, which handles enrollment, premium collection, and billing.

The cooperative offers one traditional FFS plan, two PPOs, one point of service (POS), and two HMOs. Only 21 percent of enrollment is in HMOs. About 60 percent are enrolled in either the traditional FFS plan or a hospital-based PPO option that allows individuals to chose their own doctors. Older people pay more for their health insurance than younger people, regardless of the plan chosen. By requiring the elderly to pay a higher premium for coverage, COSE is able to cover the higher costs that are likely to be incurred. The rate structure also encourages elderly members to choose HMOs, while younger members face lower rates for FFS plans.

In the early 1980s, COSE's leadership chose to contract with only a few carriers in an attempt to maximize its leverage during price negotiations. Today, COSE only offers coverage through Blue Cross and Kaiser. COSE represents 15 percent of Blue Cross's business in the Cleveland metropolitan area. Cooperative officials believe that their strategy enables them to negotiate discounts. They told us that their rates with Blue Cross are 35 to 50 percent cheaper than those available to most small businesses in the Cleveland metropolitan area.

In addition to limiting the number of participating carriers, COSE has developed several strategies to keep premiums low. In particular, COSE's senior vice president cited the cooperative's growing emphasis on managed care, aggressive oversight of Blue Cross and Kaiser administrative costs, and the cooperative's eligibility rules as key to constraining costs. COSE also relies on medical underwriting. Although COSE originally required its carriers to accept all applicants, it decided to allow underwriting in 1983 because it had attracted many older and sicker individuals who could not obtain coverage elsewhere. By screening for and denying coverage to people who are sick or at risk, Blue Cross can lower its costs and thus offer lower rates to COSE members. COSE, however, requires Blue Cross to accept or reject the entire firm. Although most of COSE's members are enrolled in plans that utilize underwriting, COSE's participating HMOs must accept all applicants.[23] Similarly, new employees must be accepted by their company's health plan, regardless of pre-existing medical conditions.

[23] However, the HMO offered by Blue Cross will not cover any applicant who has been denied coverage under another Blue Cross plan within the past year. The only other participating HMO is the one offered by Kaiser which—as a federally qualified HMO—is required to accept all applicants.

Finally, COSE has operated a high-risk pool since 1986, with 24 companies currently participating. Members who have experienced expensive medical care are required to pay a 35-percent surcharge on their premium until their medical costs decline. COSE officials told us that the high-risk pool will be eliminated in July 1994.

Employers Association Buyers' Coalition

The Employers Association, an organization representing both small and large firms in the Minneapolis/St. Paul area, formed the nonprofit Buyers' Coalition (EABC) in 1992 after a survey of member employers found health care to be the number one issue. The goal of the cooperative is to improve the quality of health care while containing costs. By January 1994, the Buyers' Coalition was providing insurance to over 100 participating companies with 5,000 employees and 13,000 covered lives. Member firms range in size from 2 to 340 employees, with an average of 50 employees.

The cooperative contracted with a single insurance carrier in order to receive a volume discount for delivering all members to that carrier. The carrier's plan, developed to the cooperative's specifications, utilizes the POS concept, allowing employees to seek non-network providers at a higher cost. The plan has four rate bands based on experience and demographics with a 15-percent difference between the least and most expensive bands. The health plan guaranteed a maximum annual trend increase of 10 percent for each year of the 3-year contract. Member employers have the option of using a broker to obtain coverage through the cooperative. These employers pay brokers' fees in addition to insurance premiums. Administrative functions are split between the cooperative and the insurance carrier. The cooperative acts a conduit between member firms and the carrier for billing and information on employee status. The carrier is responsible for initial enrollment, computing and collecting enrollee premiums, and developing detailed marketing material to explain how the program works.

EABC is attempting to contain costs through several measures that also seek to improve the quality of health care. Thus, the cooperative emphasizes preventive services and consumer education. Enrollees are given a book describing preventive health measures and when it is appropriate to seek care. In addition, they are given an opportunity to obtain a confidential health assessment and specific information on how to improve their personal health. The cooperative also emphasizes developing protocols to reduce inappropriate and unnecessary procedures. These clinical protocols have been developed for

hysterectomy, heart surgery, angioplasty, gall bladder surgery, and smoking cessation. Finally, the delivery system includes toll-free access to skilled nurses who give advice on handling simple health problems that do not require a doctor's time.

The cooperative has established a quality council, consisting of providers, employers, employees, and insurers. The council's goal is to share information among these stakeholders and to enhance health plan quality. For example, the council has tried to delineate the difference between emergency and urgent care and is encouraging enrollees to improve their health through better diet and exercise.

The cooperative's board of directors consists of the Employers Association president, three Employers Association board members, and five to eight representatives of Coalition member firms. A staff of two assists the board. The cooperatives operating costs are difficult to estimate because the carrier performs some enrollment- and payment collection-related tasks and the associated costs are included in premiums. A charge to member employers of $2.95 per employee per month covers the cost of the cooperative's staff, rent, and other miscellaneous expenses. These charges totaled approximately $150,000 in 1993 and represent 2.5 percent of premiums.

Employers Health Purchasing Cooperative

Formed in February 1993, EHPC represents both large and small employers in the Puget Sound area of Seattle, Washington. The cooperative evolved from a grant by the Hartford Foundation to a group of 40 of the state's largest employers to study alternative ways to purchase health insurance. EHPC has 270 member companies—the smallest has 4 and the largest has 10,000 employees in the Puget Sound area. According to a cooperative official, many companies joined simply as a sign of support and to keep an option open to purchase health insurance in the future. As of April 1, 1994—one month after the cooperative began offering coverage—enrollment stood at 1,050 workers and dependents representing about 5 percent of the employees of member firms.

The cooperative is a nonprofit corporation with a five-member governing board—three elected by member companies and two from the original group of employers who received the Hartford Foundation grant. The board is responsible for selecting and contracting with health plans, defining the benefits package, negotiating premiums, and establishing

employer/employee participation requirements. A staff of two assists the board.

To obtain health insurance through the cooperative, an employer must become a member, have a minimum of four employees, and agree to purchase coverage for 3 years. Membership dues range from $50 to $200 annually based upon the size of the firm. Employers must also pay a one-time per employee initiation fee and a monthly per employee administrative fee of $10 and $3, respectively. Seventy-five percent of a firm's employees must reside in the network service area and sign up for coverage. The cooperative requires the employer to select the plan and benefit level to offer its employees and to pay 50 percent of the premium rate. Each plan offers three benefit levels (high, medium, and low) and has different benefit and rate structures. The premium rates depend on the size of the firm. For small firms, the cooperative calculates the premium rates after factoring in the age and sex of the employees and the type of business. If a firm has more than 149 employees, however, experience rating is used. In addition, premium rates are guaranteed for 3 years with increases limited to the consumer price index rate for Washington state plus 3 percent.

Although the cooperative had intended to select only one carrier to serve the three-county area, it ultimately contracted with three different carriers—each offering one health plan. The selection was based on a response to the board's request for proposal, which specified the required and optional benefits, rate structure, and health plan responsibilities. All plans offered by the cooperative are POS, giving the employee the option of network or non-network providers when care is required. They provide a nearly standardized benefits package, but some variation exists in benefit levels and copayments. Finally, health plan responsibilities include enrollment, education, premium collection, and other administrative duties. EHPC's operating costs are difficult to estimate because, unlike most of the cooperatives we visited, enrollment and premium collection are included in premiums paid to the health plans. Officials told us that the cooperative's operating costs for expenses such as salaries and rent were 1.7 percent of premiums.

Statewide Cooperative Systems

In 1993, both Florida and Washington enacted health care reform legislation that divides each state into a number of distinct regions, each to be served by an exclusive cooperative. Passage entailed considerable political compromise. Officials in both states characterized the bills as

transitional—that is, subject to clarification and amendment in subsequent legislative sessions.

Florida

Florida's 1993 legislation authorized the state's Agency for Health Care Administration to assist in establishing and overseeing the operation of cooperatives—one for each of 11 pre-existing health service planning districts.[24] Chartered as nonprofit corporations with a state appointed governing board, each cooperative received $275,000 in start-up funds.[25] Enrollment in the cooperatives began in May 1994—about a year after enactment of the initiative.

As specified in the legislation, the governor appointed a majority of the 17-member cooperative governing board, with the remaining nominations divided between the speaker of the House and the president of the Senate. The following criteria apply to board appointments: (1) overall membership must reflect the demographic characteristics of the population served, (2) over half of the board positions are allocated to "business" with the remaining seats reserved for "government" and "consumer interests," and (3) no providers or insurers may serve on the board. The boards, appointed in October 1993, will each hire three full-time staff members. Major tasks assigned to the cooperative board and staff are marketing to persuade small firms to sign up for health plans offered through the cooperative and oversight of contractor/plan performance.

Cooperatives are limited to the functions specifically enumerated in the legislation. They must offer all state-certified health plans and distribute "report cards" comparing the quality and price of the plans. They can neither negotiate premiums nor enroll members in the cooperative. With the support of cooperative board members, however, the governor is asking the legislature to grant cooperatives negotiating authority during the 1994 legislative session. Enrollment must be through a licensed insurance agent. Maintenance of enrollment records, premium collection/distribution, and some marketing activity will be contracted out to the private sector.

[24]The act permits up to three cooperatives to merge, providing they are predominately rural. For additional information on Florida's cooperative boundaries, see Health Care Alliances: Issues Relating to Geographic Boundaries (GAO/HEHS-94-139, Apr. 1994).

[25]The governor has requested an additional $275,000 per alliance for 1994.

A firm's decision to purchase health insurance through a cooperative is purely voluntary. Membership is limited to the self-employed or businesses with fewer than 51 full-time workers, state employees, and the Medicaid population. Each of these three groups will be segregated in a separate risk pool. Firms are not required to contribute toward the cost of the premium, and each participating firm selects the two or three health plans from which employees may choose. The governor has asked the legislature to amend the 1993 legislation to (1) raise the threshold for participation to firms employing up to 150 individuals and (2) allow the use of Medicaid savings to subsidize the purchase of insurance for low-income workers and the unemployed through the cooperatives.

In December 1993, the cooperatives issued a formal request-for-proposal inviting state-certified accountable health plans[26] to submit bids for a state-defined benefits package. Small firms may buy this benefits package through the cooperative or directly from a health plan. Bids were received from 45 designated accountable health plans.[27] According to AHCA, some plans offered substantial discounts to those buying through a cooperative while others did not. Cooperatives began enrolling small businesses and their workers in May 1994. State employees, Medicaid recipients, and individuals eligible for a subsidy are expected to begin enrolling several months later. Federal waivers are required for Florida's implementation of the Medicaid and subsidy portion of its reforms.

Washington

The Washington Health Care Reform Act of 1993 established the Health Services Commission to oversee and regulate a reformed health care system with the goal of providing comprehensive benefits to all state residents through competing certified health plans. The Health Services Commission consists of six full-time state employees, five voting members appointed by the governor and the Insurance Commissioner, as a nonvoting member. The Health Services Commission is tasked with duties such as establishing the uniform benefits package, determining the maximum premium, and establishing health plan certification rules. The commission also must designate four noncompeting, nonprofit regional health cooperatives and define geographic boundaries for each

[26]Unlike a traditional insurance company that reimburses providers for services, an accountable health partnership integrates the traditional risk bearing role of an insurance carrier with the operation of health care delivery systems such as clinics and hospitals.

[27]Additional bids were received from health plans in the process of designation.

cooperative.[28] Although members of the Washington Health Services Commission have been appointed, full implementation of the act is not anticipated for several years.

The act does not address the size or composition of the health cooperative board of directors but specifies that it be a member-governed and owned, nonprofit cooperative. It prohibits management control of a cooperative by any individual or organization with a pecuniary interest in providing health services. Finally, no state funds were provided to establish the cooperatives.

Several legislative provisions were designed to make cooperatives operate on a value-added basis. Thus, the cooperatives authorized by the act are completely voluntary with neither employers nor individuals required to purchase insurance through the cooperative. The act requires each certified health plan to offer insurance at a community rate, irrespective of whether it is sold directly or through a cooperative. Employers and individuals may choose to deal directly with health plans, use brokers, or purchase through the cooperative. If a cooperative is selected, any administrative expenses incurred by the cooperative are to be listed separately from premiums.

The act limits the powers of health cooperatives but stipulates services to be provided to health plans and members. Cooperatives are prohibited from negotiating premium rates with certified health plans and must offer all certified health plans in their geographic area. All individuals, employers, and other groups wishing to participate must be allowed to join. Cooperatives must provide centralized enrollment and premium collection and distribution to all certified health plans. They are required to assist members in selecting certified health plans and must serve as ombudsman for their members to resolve inquiries, complaints, or other concerns with respect to those plans. The act also requires cooperatives to devise a rating system to judge the quality and cost effectiveness of participating plans.

[28]In addition, the legislation designates a state agency—the Health Care Authority—to act as a statewide cooperative. See above for a more detailed explanation of the expanded authorities of the Health Care Authority.

Existing Cooperatives Have Greater Latitude in Providing Affordable Coverage Than Under Reform Proposals

While considerable controversy surrounds the authorities that purchasing cooperatives would have under health care reform, existing cooperatives generally have wider latitude in ensuring the quality and affordability of the coverage offered. Although the current debate has focused on the ability to exclude plans during negotiation, for the most part, private, not public, cooperatives have done so. In fact, rather than exclude plans, most public cooperatives provide a large menu of different types of health plans. In today's market, private—not public—cooperatives offer the most limited choice of health plans. Finally, existing cooperatives believe that their authority to negotiate with health plans is their most effective cost control tool.

Existing Cooperatives Perform Wide Variety of Policy Functions

Existing public and private cooperatives generally operate in an environment where federal and state governments play a limited role in ensuring access to affordable health care coverage. As a result, they often perform a broad array of functions. On the other hand, recently established statewide systems in Florida and Washington more closely resemble the narrower role assigned to purchasing cooperatives under national reform proposals.

The functions of existing purchasing cooperatives frequently go beyond the core functions found in most reform proposals, including contracting with health plans, enrolling individuals in those plans, collecting and distributing premiums, and providing comparative information to consumers on health plan quality and price. In addition, the cooperatives we visited can

- determine how many health plans to contract with,
- decide what types of health plans to offer,
- develop self-funded health plans to ensure coverage in rural areas,
- review and control health plan marketing materials,
- analyze as well as distribute quality data submitted by plans to improve member services,
- develop risk adjustment methodologies, and
- negotiate premiums with health plans.

Only one of the cooperatives we visited currently administers subsidies for low-income individuals. However, Florida is preparing to implement a plan under which its 11 purchasing cooperatives will play a role in subsidy administration.

Table II.1: Responsibility for Policy/Management Functions in Reform Bills Versus Existing Purchasing Cooperatives

	Who performs function under reform bills	Can existing cooperatives perform function?
Benefits package	National commission	Yes
Quality measures	Federal	Yes
Grievance procedures	Federal/state	Yes
Health plan participation criteria	Federal/state	Yes
Develop risk adjustment methodology	Federal/state	Yes
Creation/management of self-insured health plans	Cooperatives prohibited from bearing risk	Yes

Purchasing Cooperatives Determine Health Plan Participation

With influence over the number and types of health plans offered, the cooperatives we visited have significant power over both health plan participation and consumer choice. Although most are allowed to exclude plans, public cooperatives tend to be inclusive, offering enrollees a wide variety of health plan options. Plans are rarely excluded after they have been authorized to participate. In contrast, private cooperatives limit plan participation. Since private cooperatives generally cover only a portion of the population in a metropolitan area, exclusion of a plan is not as severe a penalty as it would be under cooperatives that may cover between 50 to 90 percent of the population. The type of plans offered by both public and private cooperatives generally reflect an emphasis on managed care but preserve some degree of provider choice.

Table II.2: Number and Type of Health Plans Offered Through Cooperatives

Health cooperatives		Carriers offering health plans[a]	Types of plans[b]
Public	California Public Employees' Retirement System	22	21 HMOs; 2 self-funded PPOs; 4 PPOs for special groups
	Washington State Health Care Authority		
	Public Employees Benefit Board	16	16 HMOs and 1 self-funded PPO
	Basic Health Plan	21	21 HMOs
	Caregivers	16	16 HMOs and 1 self-funded PPO
	Health Insurance Plan of California	18	17 HMOs; 3 PPOs
	Minnesota Department of Employee Relations		
	State Employee Insurance Program	4	4 HMOs; 1 self-funded PPO; 1 other PPO
	Public Employee Insurance Program	3	1 HMO, 2 PPOs, and 1 FFS[c]
	Minnesota Employers Insurance Program	4	2 HMOs, 2 PPOs, and 1 FFS[c]
	Wisconsin State Employee Group Health Benefits Program	21	24 HMOs; 3 self-funded FFS
Private	Business Health Care Action Group	1	1 POS
	Council of Smaller Enterprises	2	1 FFS; 2 PPOs; 1 POS; 2 HMOs
	Employers Association Buyers' Coalition	1	1 POS
	Employers Health Purchasing Cooperative	3	3 POS
Statewide	Florida	Ranges from 19 to 37 carriers[d]	
	Washington	not yet operational	

(Table notes on next page)

[a]This table distinguishes between the number of carriers cooperatives contract with and the number of health plans offered. The number of carriers and health plans may not correspond because a carrier may provide more than one plan. For example, COSE has only two insurance carriers but six health plans. One carrier offers five of the six plans.

[b]Traditional fee-for-service plans allow enrollees to receive care from any doctor or hospital. Preferred provider organizations provide care from a selected panel of doctors and hospitals typically reimbursed on an FFS basis. Enrollees may go outside the network of providers at greater out-of-pocket costs, and specialist visits are permitted without prior authorization. Point-of-service plans require enrollees to identify a primary care physician that acts as a gatekeeper for network-based care. However, enrollees may choose to receive care outside the network at additional cost. Health maintenance organizations provide comprehensive, prepaid benefits only through doctors and hospitals associated with the HMO. Enrollees are generally required to obtain referrals to receive care from a specialist. Self-funded plans are ones in which the cooperative rather than an insurer bears the financial risk.

[c]The FFS plan is only offered in areas where HMO or PPO plans are not available.

[d]Florida's cooperatives are required to offer all state-certified health plans that submit bids. Those health plans may include HMOs, PPOs, POS plans, or indemnity plans. Overall, 53 different carriers submitted bids to the 11 cooperatives. Since some carriers do not operate statewide, the range of plans available in each cooperative region is less than the total number of bids received.

Some Purchasing Cooperatives Encourage While Others Limit Competition

Most states allow public cooperatives to determine the number of plans offered and the criteria for plan participation.[1] Thus, the legislation establishing the Health Insurance Plan of California is broadly drawn and gives the cooperative considerable discretion. According to an official, the Minnesota cooperative's authorizing legislation was amended in 1987 to allow the exclusion of any health plan from the program. Previously, any licensed carrier had to be offered. Allowing public cooperatives to determine which plans to offer does not appear to have constrained competition. However, in response to concerns that such authority would restrict market competition, 1993 Florida legislation required the state's 11 cooperatives to offer all state-certified health plans that submit bids.

The public cooperatives we visited generally offered a large choice of health plans, with most plans sponsored by a separate insurance carrier. For example, the Wisconsin cooperative and CalPERS in California each offer over 25 health plans.[2] HIPC, also in California, contracted with 18 of the 25 plans that submitted bids. Only Minnesota's cooperative for state employees has limited participation to six plans statewide, down from 10 in 1988. Having too many health plans, we were told, limits the ability of

[1]Other state agencies, however, are responsible for reviewing plan solvency and ensuring that plans meet minimum operating standards.

[2]Because most plans have limited service areas and are not available throughout the state, employees usually have a more limited choice of plans. For example, Wisconsin enrollees generally can choose from among six or fewer plans.

each plan to attract sufficient market share. Thus, all participating plans have at least 7 percent of the market share in their primary service areas.[3] In comparison, only four of the carriers offered by CalPERS have a significant market share[4] while the remaining 18 carriers have 4 percent or less.

The private cooperatives we visited limit the number of insurance carriers as a matter of policy. For example, the Council of Smaller Enterprises, a private small business cooperative, only contracts with two carriers. About 90 percent of COSE's members are enrolled in the five plans available through one of these carriers—Blue Cross. COSE officials believe that having one primary insurance carrier maximizes the leverage of their purchasing pool. Two other Minnesota business cooperatives also contract with only one insurer. In both cases, the insurer developed a health plan designed to the cooperatives' specifications. However, based on the effectiveness of the Minnesota public cooperative in constraining costs, one of these business cooperatives is considering offering a number of competing plans when its current contract expires.

Plan Choices Emphasize Managed Care

The public and private cooperatives we visited generally offer managed care options to enrollees (see table II.2).[5] Public cooperatives, however, offer a wide choice of managed care plans—usually HMOs—and at least one PPO option. Decisions about the types of plans to be offered are influenced by (1) the emphasis placed on controlling costs, (2) the types of plans available in the marketplace, (3) the necessity of responding to consumer preferences, and (4) the need to ensure that at least one plan is available on a statewide basis.

Public and private cooperatives generally believe that HMOs or some other form of managed care are more effective at controlling costs. At one extreme, the Wisconsin cooperative announced in 1983 that, while its own two FFS plans would be grandfathered, only bids from HMOs would be accepted for the 1984 contract year. The switch to HMOs was a major step in a campaign to control premium increases that averaged 25 percent in

[3]John Klein and Robert Cooley, "Managed Competition in Minnesota," Managed Care Quarterly, Vol. 27, No. 4 (1993), pp. 58-67.

[4]These plans have enrolled between 9 percent and 35 percent of CalPERS members.

[5]The term managed care has been used to characterize a wide range of health care plans. Some employers broadly define the term to include all plans that incorporate mechanisms to monitor and authorize the use of health services. Others more narrowly define managed care to include only health plans that direct enrollees to selected physicians and hospitals with which the plan has negotiated payment methods and utilization controls. See Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

1982 and 1983. CalPERS also offers primarily HMOs—21 of 27 plans—as an integral part of its emphasis on controlling costs through managed care.[6]

Unlike Wisconsin, California, and Minnesota, HMOs have had a difficult time establishing themselves in the Ohio insurance market. Officials at Cleveland-based COSE told us that their members prefer FFS plans and that this preference has limited the cooperative's ability to more actively encourage enrollment in plans with stronger cost control features. Thus, about 60 percent of COSE's members are enrolled in either the traditional FFS plan or a hospital-based PPO option that allows enrollees to choose their own doctors. Only 21 percent are enrolled in HMOs.

In addition to ensuring choice to those who prefer greater flexibility in selecting health care providers, statewide public cooperatives must grapple with the challenge of providing options for employees who live in rural areas. Despite the greater market penetration of HMOs in Wisconsin, Minnesota, and California, FFS is the only viable option in some rural areas. Thus, cooperatives have found it necessary to maintain either traditional FFS plans or large PPOs even though their premiums are generally significantly more expensive.[7]

In 1993, CalPERS began offering a more affordable PPO option that is targeted to families in rural areas where no HMO is available. Although CalPERS believes it offers a sufficient number of plans in most areas of the state, it will only contract with new plans that expand HMO coverage in unserved areas. Similarly, HIPC requires health plans who contract with the cooperative to offer coverage in rural areas such as the Monterey Peninsula as a precondition for access to the more profitable San Francisco and Los Angeles markets. Finally, Minnesota also requires participating carriers to offer coverage anywhere in the state in which they have a provider network. This policy is intended to (1) insure coverage to rural areas and (2) discourage plans from only targeting more lucrative markets.

[6]Despite its emphasis on managed care plans, CalPERS had premium increases above the national average until 1992.

[7]In 1989, CalPERS created PERSCare, a large PPO network, to replace three FFS health plans. Eighty-three percent of the total physicians in California are included in the PERSCare network.

Purchasing Cooperatives Enforce Rules of Competition

With the authority to control health plan marketing materials, monitor enrollment and disenrollment, designate or standardize benefits, and require submission of quality data, the cooperatives we visited have significant power over health plan operations. That authority is aimed at preventing insurance carriers from avoiding those who are sick or at risk.

Marketing

Public cooperatives generally review health plan marketing materials in an attempt to prevent risk avoidance strategies. For example, the Wisconsin cooperative approves all direct mailings by plans and actually controls the mailing lists for its members. A purchasing cooperative official told us that, by reviewing all marketing materials, it has been able to prevent health plans from trying to exclude certain groups who could be more expensive to insure. For example, plans might advertise coverage for all pharmaceuticals except insulin, in an attempt to dissuade diabetics from enrolling. Another example of such a strategy would be a southern California health plan advertising only in English, to avoid enrolling poorer, foreign-speaking minorities. HIPC in California also approves the marketing used in all participating plan brochures, which has resulted in revisions or clarifications to plan advertising.

Monitoring Enrollment/Disenrollment

As with marketing, cooperatives monitor enrollments and disenrollments to ensure that plans are not targeting only healthy people. For example, HIPC reviews all extraordinary transfer requests to make sure that a plan has not been deliberately providing poor service to sicker enrollees. Even COSE, which allows Blue Cross to screen for and deny coverage to groups with individuals at risk for certain health conditions, receives weekly reports on denials. A COSE official told us that a sharp jump in the denial rate was traced to a unilateral Blue Cross decision to include pregnancy as a basis for rejecting new applicants. COSE informed Blue Cross that pregnancy was not a valid condition for rejection under the terms of their contract.

Standardized Benefits

Cooperatives have varying degrees of authority over benefits packages. Some cooperatives have actually specified the package while others have standardized benefits to (1) ensure competition based on cost and quality rather than benefits, (2) frustrate risk avoidance strategies, and (3) simplify plan comparison by members.

The law authorizing the creation of HIPC in California also authorized the cooperative to design a benefits package. The standardized benefit structure was based on HMO licensing standards and information gathered during a series of public hearings. Private cooperatives generally work with insurance carriers to develop benefit structures that reflect the needs of their membership. For example, COSE officials explained that member comments on covered services are closely monitored and used as a basis for continuing adjustments to the benefits design.

Two public cooperatives recently standardized their benefits packages. Prior to 1993, plans offered by the Wisconsin cooperative were required to offer "substantially equivalent" benefits packages. However, plans were able to offer ancillary benefits and marginally adjust basic benefits in order to deter bad risk enrollees. As a result, benefit structures were different enough that it became increasingly difficult for consumers to compare plans. The cooperative director explained that, with the new requirement for identical benefit structures, plans will no longer be able to design for risk selection, employees will better understand their plan coverage, and the state will be better able to evaluate each plan's efficiency. With similar objectives, CalPERS also standardized HMO benefits in 1993.

New Emphasis on Measuring Health Plan Quality

Compared to the public cooperatives we visited, private cooperatives placed more emphasis on efforts to measure and improve the quality of care obtained through participating health plans. Though public cooperatives collect some data on the utilization of services, they are now beginning programs that focus on the quality of the services obtained. Some cooperatives will eventually provide comparative information on quality to enrollees but for the most part the data now collected are used in rate negotiations, quality improvement programs, and cost control efforts. The following are among the quality data initiatives currently underway:

- BHCAG, a private Minnesota business cooperative, fostered the establishment of the Institute for Clinical Systems Integration, a $2 million nonprofit foundation chartered with facilitating continuous quality improvement and better integration of the health care delivery system. Through the institute, and working with physicians, BHCAG has developed practice guidelines and a system to monitor treatment and patient outcomes. To encourage provider participation, BHCAG agreed not to share this information with employees at this point.

- EABC, another private business cooperative in Minnesota, has also sponsored the development of practice guidelines to reduce inappropriate and unnecessary treatment. To date, guidelines have been developed for heart surgery, hysterectomy, smoking cessation, and other procedures. EABC has also created a Quality Council—with representatives from providers, employers, and employees—to review plan efforts at quality improvement and to suggest additional measures.
- Starting in 1994, CalPERS will require plans to submit data on a list of indicators[8] during the rate renewal process. After analysis, health plans will be ranked according to their ability to meet target guidelines for the delivery of these services. This comparative performance information will be published in a "Quality of Care Report" beginning in 1995 and distributed to members prior to the open enrollment period.
- In Minnesota, after health plans balked at providing quality data, the cooperative amended its 1993 contract to require the collection and submission of such data. Officials told us they plan to work with the data in house for several years and eventually to publish and distribute comparative quality data to their members.

Florida health care reform calls for cooperatives to issue "report cards" on quality. Participating health plans must submit quality data to the Agency for Health Care Administration, which will analyze and package comparative information for publication and distribution by each cooperative. Key indicators to be phased in during 1994 and 1995 include (1) incidence rates for certain services/outcomes, (2) patient satisfaction, (3) costs, and (4) accreditation. As now envisioned, the report cards will compare plans offered by the cooperative to each other and to a national norm. Table II.3 lists the specific indicators recommended by the Agency's Data Advisory Committee.

[8]Childhood immunizations, mammography screening, cervical cancer screening, prenatal care—first trimester, cholesterol screening, low birth weight, asthma inpatient admission rate, diabetic retinal exam, and ambulatory follow-up after hospitalization for major affective disorder (mental health).

'able II.3: Indicators for Proposed 'lorida Cooperative Report Cards

Indicator
Desired high incidence
Mammography screening rate
Pap smear rate
Pediatric immunization rate
Prenatal care in first trimester rate
Chronic disease follow-up rates
Postoperative recovery rates
Desired low incidence
Cancers diagnosed at late stages
Hospital mortality rate (surgical)
Low birth weight (percentage of births)
Postoperative wound infection rate
Rate of preventable hospitalizations
C-section rate
Patient satisfaction (percent highly satisfied)
Overall
Hospitalization
Physician
Costs
Premium (per month)
Administrative costs per member (per month)
Annual premium increase
Other
Accreditation status
Percentage physicians board certified
Number of hospitals in network

isk Adjustment

Risk adjustment is the process by which premium dollars are shifted from a plan with relatively healthy enrollees to another with sicker members.[9] While none of the cooperatives we visited currently adjust the premiums paid to health plans to correct for such disparities in the health status of enrollees, several have established committees to develop a risk adjustment methodology. One cooperative, MEIP, plans to begin implementing a risk adjustment methodology, developed with the assistance of an accounting firm, in 1994.

[9]GAO will discuss risk adjustment in more detail in two forthcoming reports.

Price Negotiations Seen as Critical to Controlling Premium Growth

With the exception of new, statewide systems in Florida and Washington, the cooperatives we visited have the authority to negotiate premiums with health plans and believe that this authority is critical to controlling costs. Although public cooperatives also rely on competition to limit premium increases, private cooperatives deliberately restrict the number of carriers, approaching negotiations with the implicit caveat that they could award the contract to a competitor. Despite differing tactics, the negotiating strategies of cooperatives are similar. Assessing the success of negotiations, however, is difficult because of other factors that affect premium increases.

Negotiation: A Recent Public Cooperative Initiative

Although cost control was one of the driving forces behind the creation of many private cooperatives, the public cooperatives we visited had only recently emphasized or initiated negotiations with health plans in an attempt to moderate premium rate increases.

Public cooperatives believe that competition among plans is key to achieving reasonable premium growth, but they have begun to augment competition with price negotiations. The Wisconsin cooperative adopted a number of cost control measures in 1983 but, until 1993, simply accepted sealed bids from health plans without any discussion of premium increases. Although premium growth averaged about 6 percent a year for the first 4 years (well below the previous double-digit increases), increases for the 1988 to 1992 period were significantly higher. Similarly, the Minnesota cooperative began negotiations with health plans in 1989 when it adopted a number of managed competition principles with the goal of bringing insurance costs under control. Although CalPERS had previously discussed premium increases with health plans, pressure to contain costs became critical in 1991 when California froze the state contribution to premiums, magnifying the impact of rate increases on state employees. As a result, CalPERS began aggressive negotiations with health plans in 1992.

In contrast to public cooperatives, private cooperatives believe that by severely limiting the number of participating carriers they are able to wield greater influence over plan structure and affordability. Two of the private cooperatives we visited—BHCAG and EABC in Minneapolis—are each in their initial multiyear contract with a single carrier who agreed to design plans to their specifications. Although they solicited and received a number of bids, EABC officials told us that they were able to obtain a volume discount by delivering all their business to one carrier. In addition to tying carrier

fees to performance, BHCAG was able to obtain a 3-year guarantee on premium increases.

COSE, in Cleveland, attributes its low and stable annual premium increases to the long-term relationship it has maintained with two carriers—Blue Cross and Kaiser Permanente. COSE reduced the number of carriers it does business with about 12 years ago with the goal of being a "really big" customer to only a few insurers. In fact, COSE is Blue Cross's single largest customer, constituting about 15 percent of Blue Cross business in the Cleveland metropolitan area. COSE officials point out that this significant market share gives them substantial leverage during negotiations with Blue Cross. According to COSE officials, Blue Cross knows that they could "shop around" when their current contract expires.

urchasing Cooperatives xhibit Similar Negotiating trategies but Negotiating tyles May Differ

We found that, although their negotiating styles may differ, cooperatives share a common negotiating strategy. Most cooperatives rely on an informed discussion with health plan representatives to debate the justification for premium rate increases. All cooperatives require plans to submit data, and some use actuaries to develop target premiums—a methodology that attempts to validate the reasonableness of health plan premium increases.

egotiating Strategy

Most cooperatives utilize plan operating data during negotiations. Thus, CalPERS requires plans to submit data to support its rate requests, including detailed information on the cost and utilization of services and the plan's organization and management. CalPERS analyzes these data to determine if the plans' proposed premiums are reasonable. For example, an analysis of plan pharmaceutical costs revealed that one of its participating HMOs had significantly higher prescription drug costs than other HMOs. The HMO has since obtained a new contract for its pharmaceutical services that will provide a discount.

In addition to collecting and analyzing plan data, cooperatives in Wisconsin and Minnesota hire actuaries to develop target premiums for each health plan. If a plan bid is significantly higher than the target premium developed for that plan, cooperative officials discuss the discrepancy with plan representatives. Plans are then asked to submit a best and final offer. Wisconsin officials told us that, in 1993, 9 of the 10 plans contacted for discussions resubmitted bids that were substantially lower. Similarly, Minnesota officials indicated that they had achieved

premium savings of 20 times the $50,000 actuarial fee—savings that they attributed in part to errors in how plans calculated premium increases.

HIPC had to use a different strategy when it negotiated initial premium rates with health plans since it had not yet opened for enrollment. After reviewing the opening bids, HIPC met individually with plan representatives and discussed their proposed premiums in comparison to those of other plans. For example, one plan was told that its premiums were 40 percent higher than the lowest priced competitor in the same market area. Although HIPC did not tell plans that they were too expensive or that they had to reduce their prices, one-third lowered their premiums after these meetings. In its first contract, HIPC required health plans to participate for 3 years and established a ceiling on premium rate increases. HIPC recently announced its rates for the second year. Officials noted that, due to strong enrollment and negotiations by the HIPC staff, second-year rates averaged 6 percent lower than those offered in the first year.

Despite the authority to do so, none of the public cooperatives we visited excluded health plans during negotiations over premium increases. As noted earlier, since private cooperatives deliberately contract with only one or two carriers, the exclusion of plans occurs when the initial multiyear contract is signed. One public cooperative director noted that cooperatives may be hesitant to exclude plans because enrollees would be required to change health care providers, potentially leading to significant enrollee dissatisfaction. For example, Kaiser covers almost 40 percent of CalPERS's members. Similarly, about 90 percent of COSE enrollees are in Blue Cross plans. In Minnesota and Wisconsin, unions representing state employees have a strong voice in the operation of the cooperative, and elimination of a plan would require close consultation. For example, Minnesota state employees were actively involved in the decision to convert the traditional FFS plan and substitute a more restrictive PPO option.[10]

Negotiating Style

Two cooperatives we visited—CalPERS and COSE—exhibited innovative negotiating tactics in their pursuit of low-cost coverage. Prior to the 1992 contract year, CalPERS premiums had increased at rates near or above the average increases experienced throughout the nation. Citing the state's worsening fiscal problems, CalPERS sought a zero increase in HMO premiums in 1992 with no change in benefits. Kaiser insisted on premium increases

[10]About 60 percent of Minnesota physicians participate in the PPO, with higher percentages in rural areas.

of more than 10 percent due to its richer benefits packages. CalPERS agreed to this increase but froze enrollment in the Kaiser plans for 8 months. CalPERS held the other plans to average premium increases of 3.1 percent. Rate negotiations were even more successful for the 1993 contract year with increases averaging 1.4 percent. For the 1994 contract year, CalPERS publicly announced it was seeking a 5-percent reduction in premiums but compromised on a 1-percent reduction.

COSE officials told us that they have agreed to higher premium increases than they believe are justified but with the following caveat: COSE requires Blue Cross to put the disputed portion of the increase in the bank and, if the carrier's costs justify the increase, it keeps the money. If not, the premium increase for the following year is reduced by the disputed amount.

npact of Negotiations ifficult to Isolate

While the cooperatives we visited believe rate negotiations are a critical cost control tool, a myriad of other factors make it difficult to isolate the impact of negotiations. For example, CalPERS's success in controlling premium growth since 1992 cannot be separated from (1) the downturn in the California economy, (2) the state decision to freeze its premium contribution, (3) CalPERS recent standardization of benefits, and (4) the general national slowdown in the rate of health care inflation. Similarly, Wisconsin standardized its benefits package at the same time it initiated price negotiations with health plans.

orida Cooperatives Seek egotiating Authority

Recently authorized, statewide cooperatives in Florida and Washington are the only cooperatives we visited that are not allowed to negotiate. According to Florida officials, negotiation authority was originally included in the legislation that created the cooperatives but was removed in response to insurance industry concerns. However, board members of cooperatives, who are primarily business men and women, agree that cooperatives should have negotiating authority and have formed a group to lobby the state legislature. In addition, Florida's governor continues to pursue negotiation authority for purchasing cooperatives.

Subsidy Administration: A New Role for Purchasing Cooperatives Under Reform

Reform proposals call for national subsidies to assist low-income individuals and the unemployed to purchase health insurance, and at least one bill assigns their administration to cooperatives. With the exception of HCA in Washington, the purchasing cooperatives we visited do not currently administer such subsidies. Florida, however, is preparing to implement a subsidy program through the state's 11 health cooperatives[11] and plans to eventually provide Medicaid services through the cooperatives. While both states rely on employer- and employee-supplied data for eligibility determination, HCA uses in-house staff to administer subsidies while the Florida approach avoids increasing the size of the purchasing cooperative bureaucracy by contracting out to the private sector.

The actual mechanics of subsidy administration can be broken down into the following elements: (1) eligibility determination; (2) calculation of the subsidy; (3) collection of any applicable federal, state, employer, and employee contribution; (4) distribution of the premium to health plans; (5) reconciliation of premium contributions due to changes such as income or family size that occur throughout the year; and (6) oversight.

HCA has a staff of 23 dedicated to administering the Basic Health Plan, a low-income subsidy program.[12] According to HCA officials, these staff not only perform all of the subsidy related functions outlined above but are also responsible for contracting with the program's 21 participating HMOs and for standardizing benefits. Processing application forms is the most labor-intensive aspect of the enrollment process. Unlike Medicaid's asset test, tax returns and pay stubs are used to verify income. Staff are required by state law to verify the information on the application form every 6 months. HCA is projecting that by July 1995 enrollment in BHP will quadruple from its current level of about 32,000 subsidized individuals. Using a staff-to-enrollee ratio of 1 to 800, HCA officials project that about 150 personnel will be required for all program functions, including contracting with managed care organizations.

At current enrollment levels, operating costs for the program total 7 percent of benefits paid out. Adding BHP to the existing large program for public employees only increased HCA's overall operating costs by

[11]Currently awaiting approval of a federal waiver, Florida expects to implement its subsidy program in the summer of 1994.

[12]BHP is now open to individuals and firms who are not eligible for a subsidy. One additional staff member works with such applicants. The 24 staff members assigned to BHP represent about one-quarter of HCA's 94 employees.

1 percent—from 1.3 to 2.3 percent of benefits paid out (see table III.1). While the addition of smaller new voluntary programs to existing cooperatives increases their overall operating costs, the actual increase is moderated significantly by their already large enrollment and low operating costs.

Under the Florida plan, most of the subsidy administration tasks listed above would be performed by insurance agents or contracted out. Thus, insurance agents would be responsible for helping individuals complete the eligibility determination forms. A simplified eligibility determination process based on income tax forms, pay stubs, or documented participation in another publicly funded program would be used. There would be no burdensome and costly asset test. A private-sector contractor hired by the cooperative would be charged with reviewing eligibility applications for accuracy, verifying the information, certifying eligibility, and calculating the premium contributions. For example, in the case of a low-income worker, the contractor would calculate the employer and/or individual contribution and arrange for payment either through payroll reductions or automatic fund transfers from designated accounts. The cooperative contractor will be expected to develop automated systems to facilitate eligibility determination and premium collection.

Florida proposes to use its Medicaid fiscal agent[13] to pay the public subsidy to the cooperative contractor. Thus, the contractor would submit a monthly list of eligible individuals, indicating the employer and/or individual premium contribution and the amount due from state and federal contributions. The fiscal agent would transmit the appropriate lump-sum payment to the cooperative contractor, who would in turn reimburse the appropriate health plans. Finally, eligibility determination procedures for Medicaid recipients would remain unchanged. The Department of Health and Rehabilitative Services and the Medicaid fiscal agent would continue to accept Medicaid eligibility forms and process claims. As with subsidies, the cooperative contractor would be responsible for collecting the federal/state contribution and reimbursing health plans.

Lastly, the Florida Agency for Health Care Administration would be responsible for the development, implementation, and oversight of the overall subsidy program. Current state plans call for expanding the agency's staff by about 40 personnel allocated among three principal functions: (1) policy and evaluation, (2) monitoring of cooperative contractors, and (3) fraud and abuse detection.

[13]A private contractor responsible for processing provider claims.

A major area of uncertainty regarding subsidy administration is the historically low participation rate of those eligible. Based on the fact that only 50 percent of those qualified for Medicaid are enrolled, Florida estimates that a similar percentage will sign up for its proposed subsidy program. Since several bills call for universal coverage, achieving very high participation rates may entail larger than anticipated expenses.

Existing Purchasing Cooperatives Operate With Modest Staffs and Budgets

Existing purchasing cooperatives are not big bureaucracies. Contracting out labor-intensive administrative functions to private firms allows many cooperatives to operate with small staffs that focus on policy and management issues such as negotiation with health plans or quality of care issues. Operating costs range from less than 1 percent of premiums to 3 percent—the latter reflecting the fixed cost and small enrollment of publicly sponsored voluntary cooperatives for small businesses. The proportionately lower operating costs of larger public cooperatives reflect inherent economies of scale.

ontracting Out to rivate Sector linimizes Staff Size

Generally, the purchasing cooperatives we visited had small staffs, most ranging in size from 10 to about 40 employees. Two cooperatives had staffs of nearly 100. Variation in staff size appears to be influenced less by policy/management functions and enrollment than by the extent to which labor-intensive administrative tasks are contracted out. Thus, the two largest cooperatives perform administrative functions in house while many others utilize private contractors. Table III.1 summarizes cooperative enrollment, number of staff, and operating costs.

Table III.1: Health Cooperative Enrollment, Staff Size, and Operating Costs

Health cooperatives[a]		Number of enrollees	Total staff	Operating costs[b] (percent)
Public	California Public Employees' Retirement System	**930,000**	**94**	**0.5**
	Washington State Health Care Authority			
	Public Employees Benefit Board	265,824	71	1.3
	Basic Health Plan	32,697	24	7.0[c]
	Caregivers	50	[c]	[c]
	Total	**298,571**	**95**	**2.3[c]**
	Health Insurance Plan of California	**44,000**	**13[d]**	**3.0**
	Minnesota Department of Employee Relations			
	State Employee Insurance Program	144,000	31	0.8
	Public Employee Insurance Program	5,000	5	3.0*
	Minnesota Employers Insurance Program	1,000	5	3.0*
	Total	**150,000**	**41**	**1.8**
	Wisconsin State Employee Group Health Benefits Program	**195,000**	**11**	**0.4**
Private	Business Health Care Action Group	**45,000**	**2**	**0.5***
	Council of Smaller Enterprises	**200,000**	**10**	**0.9**
	Employers Association Buyers' Coalition	**13,000**	**2**	**2.5***
	Employers' Health Purchasing Cooperative	**1,050**	**2**	**1.7***

[a]See appendix I for a description of each cooperative.

[b]Operating costs in this table are roughly comparable and suggest an order of magnitude rather than precisely analogous amounts. For most cooperatives, operating costs (personnel, rent, equipment, and contracting) are expressed as a percentage of total premiums. However, the Health Insurance Plan of California's operating costs represent a percentage of the average premium, and those of Washington are a percentage of benefits paid out. In addition, many cooperatives include the expenses associated with enrollment and premium collection (either in-house staff or outside contractors) in their operating costs. However, three private cooperatives as well as two new voluntary pools managed by the Minnesota Department of Employee Relations (each marked by an asterisk) do not include all these same expenses in their operating budget. Moreover, Wisconsin Department of Employee Trust Funds maintains enrollment records and distributes premiums but relies on state agencies for enrollment and premium collection. If such expenses were included, their operating costs as a percentage of total premiums would be higher.

[c]One staff member works half time on the public employee and caregiver programs. Operating costs for the caregivers program were not available and are not included in overall Health Care Authority operating costs. See appendix II for a discussion of the cost of administering the Basic Health Plan subsidy program for low-income individuals.

[d]The 13 HIPC staff members also manage two other programs.

›licy and Management ınctions Not Labor tensive

Cooperative policy and management activities do not require large staffs. The cooperatives we visited generally perform the following functions with small in-house staffs: (1) establishing or standardizing health benefits; (2) determining the type and number of carriers to be offered; (3) negotiating premiums; (4) establishing participation requirements for and overseeing implementation of contracts with carriers; (5) developing ways to measure and improve the quality of enrollee health care; and, (6) in the case of most public cooperatives, initiating self-funded plans. Policy and management staffs range in size from less than 10 to 29. As illustrated by table III.1, private cooperatives have 10 or fewer employees. These small staffs are essentially policy oriented. With larger overall staffs, public cooperatives tend to have somewhat more personnel involved in policy-making.

Private cooperatives appear to have fewer policy and management staff because they contract with fewer carriers and negotiate multiyear rate guarantees. The Employers Health Purchasing Cooperative, for example, contracts with three carriers and has a 3-year rate guarantee. The Business Health Care Action Group has a similar arrangement with its carrier. In part because they offer members a significantly larger number of carriers than the private sector and renegotiate premiums annually, public cooperatives appear to require somewhat larger policy and management staffs. Thus, the California Public Employees' Retirement System, with 22 carriers and two self-funded plans, has a policy-oriented staff of 29. Similarly, the Health Care Authority's largest program offers 17 plans, contracts with 16 carriers, and operates with 16 policy-oriented staff. Florida, on the other hand, plans to hire only three staff members per cooperative. Since Florida cooperatives are prohibited from negotiating and contracting with insurance carriers, their policy and management role is expected to focus on oversight of plan and contractor performance.

Policy and management staff are sometimes assisted by a few outside experts. Thus, most cooperatives contract with actuaries to help assess the reasonableness of premium increases. Some cooperatives' staffs, such as the Council of Smaller Enterprises, include a lawyer, while other cooperatives acquire legal services on an as-needed basis. BHCAG hired a consulting firm to develop its contract specifications and to evaluate the resulting bids.

Labor-Intensive Administrative Functions Often Contracted Out to Private Sector

The extent to which existing private and public cooperatives contract out administrative functions accounts for the differences in total staff size evident in table III.1. According to purchasing cooperative officials, the most labor-intensive administrative functions are enrollment and premium collection—that is, processing members' plan selection forms, updating records to reflect changes in marital status or the number of dependents, collecting premiums from each employer, and distributing premiums to the appropriate health plans. Other administrative functions include (1) preparing and distributing health information booklets; (2) conducting an annual open enrollment; (3) responding to consumer complaints, and (4) marketing, for some cooperatives.

As reflected by their small staffs, all the private cooperatives shown in table III.1 contract with the private sector for enrollment and premium collection—often with the participating insurance carrier. COSE, the Minnesota Public Employee Insurance Program, the Minnesota Employers Insurance Program, and the Health Insurance Plan of California, however, rely on a firm other than the carrier to perform these services. Similarly, Florida plans to contract out these functions. Purchasing cooperative officials told us that one factor that influenced this decision was uncertainty as to how quickly the programs would attract enrollees given their voluntary nature. They also noted that a contractor can hire employees more quickly than a state agency and is not limited by slow state hiring practices or hiring freezes. In addition, HIPC staff suggested that rather than taking on a function that the private sector can and does perform efficiently, cooperatives should simply buy the expertise and technology.

The larger overall staff size of most public cooperatives reflects the fact that all or some administrative functions are carried out in house. Thus, CalPERS dedicates 65 employees to enrollment, premium collection, and the other administrative functions outlined earlier. Since their members are primarily state employees, some public cooperatives receive assistance from officials at other state agencies. These parent agencies may distribute the open enrollment information, collect enrollment forms, and forward premiums to the cooperative. For example, the Wisconsin cooperative minimizes its involvement in such administrative functions and relies primarily on other state agencies. In a similar fashion, private cooperatives often depend on the employer to distribute information on health plans and to withhold employee premiums from wages.

The extent to which other administrative functions, such as marketing, are handled in house or contracted out varies from cooperative to cooperative. HIPC contracts out marketing along with other administrative functions, such as production of materials and distribution of health plan information, allowing its staff of 13 to focus exclusively on policy-making. In contrast, a major function of Florida cooperative staff will be marketing—that is, persuading small businesses to purchase insurance from one of the state-certified insurance carriers offered by the cooperative.[1] In general, responding to consumer complaints is a responsibility shared among the health plans, cooperative contractors, and cooperative in-house staff.

mall Bureaucracies ranslate Into Low perating Costs

Purchasing cooperative budgets are sometimes expressed as a percentage of total payments to health carriers, with larger cooperatives having lower operating costs as a percentage of premiums.[2] As illustrated by table III.1, the cooperatives we visited operate with modest budgets ranging from .4 percent to 3 percent of premiums.[3] These operating costs are roughly comparable and suggest an order of magnitude rather than precisely analogous amounts. For example, some cooperatives include the expenses associated with enrollment and premium collection (either by in-house staff or outside contractors) in their operating budgets while others do not. Generally, budgets include equipment, rent, personnel, and contracting, the latter two items representing the most significant costs. The primary factors affecting operating costs are (1) the economies of scale associated with larger enrollment, (2) whether the cooperative is voluntary, and (3) contracting out for administrative services. We found that the lessons on start-up costs for new cooperatives are weak.

:onomies of Scale ıprove Operating ficiency of Large ›operatives

Economies of scale are reflected in the proportionately lower operating costs of the larger cooperatives we visited. Because many costs are fixed and do not grow with increased enrollment, larger cooperatives are able to spread these costs over more member premiums. Among the relatively fixed costs are salaries of cooperative policy staff, rent, and equipment.

[1] A contractor hired by the cooperative will also have marketing responsibilities.

[2] Cooperatives use two methods to collect their operating budget. Most of the cooperatives we visited charge each employer a fixed amount plus a per-employee enrollment fee. CalPERS, however, includes a flat one-half-percent surcharge in its premiums.

[3] Two reform proposals specifically cap the operating cost of purchasing cooperatives at 1 and 2.5 percent of premiums, respectively. The experience of new, voluntary cooperatives such as HIPC and MEIP suggest that a cap of 1 percent of premiums may not be realistic until such cooperatives attract sufficient membership.

Several cooperatives we visited stated that their membership could grow significantly without increasing fixed costs. Thus, as enrollment expands, smaller cooperatives such as HIPC, MEIP, and Employers Association Buyers' Coalition expect their operating costs to decrease as a percentage of premiums. Finally, large cooperatives also benefit from economies of scale because they are able to take on labor-intensive administrative functions in house. For example, CalPERS staff perform enrollment and premium collection functions for almost 1 million enrollees with an operating budget of one-half of a percent of premiums.

Voluntary Purchasing Cooperatives Incur Marketing Expenses

Participation in the private and statewide cooperatives we visited is purely voluntary, and all of the public cooperatives we visited have a voluntary component.[4] The success of purely voluntary cooperatives depends on attracting sufficient market share to give them bargaining clout with insurance carriers.[5] To attract members, voluntary cooperatives often advertise, and some permit the use of insurance agents. Both add to the costs of voluntary cooperatives, but the latter is not always reflected in the cooperative operating budget.

Florida estimates that marketing will represent a significant portion of administrative costs as well be as a major task assigned to cooperative staff. HIPC officials told us that one-third of their operating costs are marketing related. MEIP's experience with marketing costs is similar. As with overall operating costs, marketing expenses decrease as a percentage of premiums with increasing enrollment. Thus, marketing accounts for less than 12 percent of COSE's operating budget. Currently, Wisconsin does not advertize to attract local government enrollees.

Insurance agents' fees can be an additional marketing expense for voluntary cooperatives. Agents' services include helping the employer and employees select a participating health plan, with fees ranging from about 3 to 8 percent of premiums for firms with fewer than 50 workers.[6] Florida requires the use of an agent, while HIPC and MEIP leave the decision up to

[4]Public cooperatives are mandatory for state employees but voluntary for local governments.

[5]Public cooperatives such as CalPERS, Minnesota, and Wisconsin that primarily provide coverage to state employees already had significant market share when they were given responsibility for voluntary programs for local government employees.

[6]Congressional Research Service, p. 46.

the employer.[7] Because HIPC requires the agent's fee to be clearly identified and paid on top of the health insurance premium, its operating costs do not reflect the full cost of marketing. However, three of the cooperatives we visited allow agents' fees to be included in the premium, and thus, in comparison to HIPC, their operating costs are overstated.[8]

:eliance on the Private ector Increases :ooperative Costs but ields Benefits

As noted previously, existing voluntary cooperatives used either the insurance carrier or an independent contractor to carry out labor-intensive administrative services. These contracts represent a major portion of operating costs but reduce in-house bureaucratic structure and increase the cooperative's flexibility in responding to enrollment growth. Moreover, some evidence suggests that the use of an independent contractor instead of the carrier may be more cost effective.

HIPC illustrates both the expense and flexibility of using an independent contractor. The cooperative contractor handles most of HIPC's administrative functions for a fee of 80 percent of the employer paid membership charge.[9] The contractor reimbursement also represents about 80 percent of the operating cost of HIPC at its current enrollment level. HIPC officials noted, however, that the use of an experienced contractor allowed them to begin selling insurance just 9 months after the passage of state legislation creating the program.

The Florida legislation allows cooperatives to use an independent contractor for premium collection if it proves economical to do so. Based on a survey of health insurance carriers, Florida concluded that it would be less expensive for an independent contractor to perform this administrative service. To obtain significant economies of scale and simplify the process for individuals who reside in one cooperative region but work in another, eight cooperatives are using the same contractor. COSE, which hired an independent contractor for enrollment and premium collection rather than relying on its two insurance carriers, also believes that this alternative is more cost effective.

[7]HIPC reduced the fee that agents are allowed to charge. As of March 1994, 74 percent of employers enrolling in HIPC had done so with the assistance of an agent. Initially, MEIP also instituted reduced agents fees. MEIP recently brought those fees into line with market standards because they were adversely affecting enrollment in the program. One official told us that the success of Florida cooperatives depends, in part, on the willingness of agents to steer employers toward the cooperatives.

[8]Florida also plans to include the agent's fee in its premium.

[9]Each employer pays a monthly enrollment fee of $20 for the group plus $2.50 per employee.

No Comprehensive Data on Start-Up Costs

Lessons on start-up costs for new cooperatives are weak because they were often developed from existing programs rather than from scratch. Although several new cooperatives have been provided easily identifiable start-up funds, others have not. Finally, start-up costs can be misleading if other associated costs are not included.

Costs were minimized by giving cooperatives already managing state employee programs the responsibility of providing coverage to local government employees. In some cases, additional staff were hired. While CalPERS could not readily identify any start-up funds, Minnesota officials told us that between $200,000 and $250,000 was appropriated. The Wisconsin expansion, however, occurred without specifically designated start-up funds. Although the Minnesota legislature set aside $1.7 million for MEIP start-up costs, a new program for private businesses, program responsibility was assigned to the Department of Employee Relations—the state agency already responsible for managing coverage for state and local employees. Only about one-half of this amount was used during the first year because it proved unnecessary to establish MEIP as a self-insured program. Only five staff members from the department are assigned to MEIP. A departmental official noted that most states have similar organizations that should make it less costly and quicker to establish new cooperatives.

COSE, BHCAG, EABC, and EHPC are examples of private cooperatives that were also formed by existing employer associations. Although all of these organizations have since been established as separate legal entities, the founding parent organization contributed time and resources toward their establishment. For example, over 300 companies who belonged to the Minnesota Employers Association contributed financially, and 20 donated staff to conduct a study that led to the establishment of EABC. Generally, private cooperative officials agree that founding organizations had contributed start-up funds but could not accurately estimate the amount.

September 1992 California legislation gave the Managed Risk Medical Insurance Board 9 months to establish HIPC. The board, which administers two other programs, was authorized to borrow funds from board reserves to start HIPC. According to board officials, the borrowed $3 million is being used entirely for marketing, including direct sales and advertizing. They were unable to estimate board or staff time devoted to HIPC start-up.

While the Washington legislature provided no start-up funds for the new statewide cooperative system approved in 1993, the Florida legislature

appropriated $275,000 for each of 11 cooperatives.[10] One cooperative board chairman told us that 40 percent of the appropriation had been allocated for salaries for three staff members and another 7 percent for rent and a computer system. While some officials had worried about the ability to recruit a qualified staff director, this chairman told us that there were 65 applicants, about 10 of whom were eventually interviewed by the board.

Not reflected in Florida's appropriation are the considerable efforts of the state's Agency for Health Care Administration. AHCA is responsible for implementation and oversight of Florida's statewide cooperative system. Although AHCA did not develop the benefits package, its responsibilities are analogous to the national health commissions proposed by the Clinton and Cooper bills. Among the implementation tasks already completed by AHCA are (1) conducting a 2-day orientation for 187 cooperative board members, (2) certifying and providing technical assistance to each cooperative, (3) developing specifications used by cooperatives to secure premium bids from insurance carriers, and (4) establishing criteria for cooperative contractors. AHCA officials were unable to estimate the cost of the agency's contribution to establishing Florida cooperatives.

[10]The governor has requested an additional $275,000 for each cooperative for 1994.

Concerns Remain Regarding Purchasing Cooperative Governing Structure

To many Americans, purchasing cooperatives are an unfamiliar new entity, raising legitimate concerns about the role of government, employers, and employees in cooperative operations. Reform theorists as well as the Clinton, Cooper, and Chafee bills differ over (1) the nature of the relationship between government and cooperatives and (2) the selection and composition of cooperative governing boards. Although many of the cooperatives we visited offer limited insights on the proper balance between public and private interests, the recent implementation of Florida's cooperative-based reforms offers some lessons.

Reform Proposals Attempt to Balance Public and Private Interests

In the United States, the majority of health insurance is a benefit provided by employers (purchasers) to employees (consumers).[1] The theory behind cooperative-based reform proposals asserts that new incentives need to be provided to both the purchaser and consumer of health insurance. By organizing employers into cooperatives, their bargaining power vis-a-vis insurance carriers is strengthened. By educating employees about the choices available and allowing them to actually choose among competing health plans, the ultimate consumer of health insurance is also empowered.

The incorporation of cooperatives into national health care reform bills raises the issue of the role of government in the operation of cooperatives. Under major reform proposals, cooperatives would transcend their employer-based origins and assume an important public role in expanding health insurance coverage. Thus, cooperatives would become the primary vehicle through which many Americans would obtain portable health insurance. Those unable to obtain or afford insurance under the current system would receive government subsidies channeled through cooperatives to facilitate access to coverage. This nexus of interests highlights the importance of establishing a proper balance between public and private accountability.

The reform proposals reflect different philosophical approaches to the role of government. Purchasing cooperatives would either be quasi-governmental entities with governing boards appointed by elected officials in each state or private entities founded and governed by their members. The proposals also differ somewhat in how the board would be divided up among employers, employees, and individuals insured through

[1]Nearly two-thirds of nonelderly Americans receive health insurance through an employer. A number of analysts, however, have pointed out that, while most coverage is employment based, it should be viewed as money that would otherwise have been a part of employee salaries. See Victor R. Fuchs, "The Clinton Plan: A Researcher Examines Reform," Health Affairs, Vol. 13 (1994), pp. 104-5.

the cooperative. Finally, under most reform proposals, the federal and/or state governments would establish standards applicable to purchasing cooperatives and ensure that these standards are being met.

xisting Cooperatives ffer Few Lessons on :countability and overnance

Because of their origins and role, the cooperatives we visited provide limited insights on ensuring accountability to both the government and consumers. On the one hand, private cooperatives were typically employer controlled organizations with no employee representation on their governing boards and limited government oversight of their activities. For example, the Council of Smaller Enterprises, the small business division of the Cleveland Chamber of Commerce, operates as a nonprofit entity with a board of directors consisting primarily of small business owners. COSE has no formal mechanism to obtain employee input on health benefits issues.

At the other end of the continuum, existing public cooperatives evolved from government-sponsored health benefit programs. The state, as employer, exerts a major influence over public cooperatives. The involvement of the governor and state legislature varies but can include such matters as stipulating which employers have access to the cooperative, the level of the state contribution to employee premiums, and the powers of the state administrative agency and the cooperative governing board. Employee input to these state-run agencies may be obtained through collective bargaining or advisory panels rather than through formal governing boards.

Only the California Employees' Retirement System had a governing board with elected employee representatives. Of the 13 board members, 6 are elected by specific employee groups, 4 are statutory state agency heads, and 3 are appointed by the governor and legislature. CalPERS officials believe that minimizing the number of appointed positions shields cooperative operations from outside political influence. At the same time, the CalPERS board composition makes the cooperative accountable to the major stakeholders—employees and employers.

orida Suggests tential Exists for liticization

Since it is the first large-scale implementation of a statewide system of purchasing cooperatives, Florida's accountability and governance structure merits a more detailed examination. Florida's 11 cooperatives are quasi-governmental organizations. They were established by the state through its Agency for Health Care Administration with public start-up funds. Their governing boards were appointed by elected state officials.

This appointment process for board members has been criticized in the Florida and national press as overly politicized.

The director of AHCA, which is responsible for establishing and overseeing cooperative operations, told us that Florida opted for political as opposed to bureaucratic accountability because politicians are sensitive to public opinion. Under the Florida model, the governor appoints a majority of the 17-member board with the remaining nominations divided between the speaker of the House and the president of the Senate. Each board member is accountable to the governor and may be removed by the governor for neglect of duty. The following criteria apply to board appointments: (1) overall membership must reflect the demographic characteristics of the population served, (2) over half of the board positions are allocated to "business" with the remaining seats reserved for "government" and "consumer interests," and (3) no providers or insurers may serve on the board.

Lack of coordination among the three appointing officials made it difficult to achieve the representational and other goals spelled out in the Florida legislation. Thus, the cooperative boards may not meet the law's requirement that they reflect the demographics of the population served. One official told us that as a result of political rivalry among the three appointing officials—the speaker of the House is planning to run for governor in 1994—the appointments were not coordinated to ensure adequate representation of groups such as minorities. We were told that selections made by the other two appointing officials left it largely up to the governor to attempt to achieve demographic balance. The AHCA director suggested that some of these problems could have been avoided by giving the governor the authority to appoint the entire board of each cooperative. He told us that giving the other two officials a role was a compromise required to secure passage of the 1993 Florida managed competition law.

Although the law calls for "consumer" representatives on the boards—defined as individual users of health care services who are employees of businesses within the cooperative region—we found that consumers are virtually indistinguishable from the 11 statutory "business" representatives. In fact, many of the "consumers" are lawyers or businessmen. The legislative director of the union representing state employees told us that the union raised this issue with the governor after the president of the Senate and speaker of the House had made their consumer appointments. As a result, we were told, more of the governor's

appointments were within the intent of the law. The union is considering suing the state over inadequate consumer representation on the cooperative boards.

One state official suggested that the screening of board appointments proved inadequate to enforce the laws conflict-of-interest provisions. Board members are prohibited from being employed by, affiliated with, an agent of, or otherwise a representative of any health care provider or insurance carrier. A number of appointees, for example a dental hygienist, only declined at the last minute when asked to sign a disclaimer form about affiliations prohibited by the law. Although the governor avoided appointing lawyers because of the potential conflict of interest if their firms ever represented clients in the health care business, appointments by the other two officials included lawyers. To avoid even the appearance of a conflict of interest, the governor also refused to appoint any individual if an immediate family member was a provider or insurer. One official suggested that some board member appointments could be challenged because of prohibited affiliations such as health care consulting.

A final problem involved the selection of cooperative board chairmen. The law calls for board members to elect a chairman. By virtue of his ability to appoint a majority of the board members, the governor was able to have his candidate elected. A cooperative board chairman told us that the governor's pre-emption of the board's right to select the chairman created some "hard feelings," especially among those who had been appointed by the speaker of the House or the president of the Senate.

Politicization, with the potential to undermine public confidence in cooperatives, suggests that serious attention should be paid to state flexibility regarding the composition and appointment of boards. Currently, neither the Clinton, Cooper, nor Chafee bills contains a requirement for governing boards to be representative of the populations they serve. Florida's experience suggests that care must be taken if such a goal is to be realized.

ɔvider and Insurer rticipation Is nited

At least one reform proposal prohibits the appointment of providers and insurers but would establish medical advisory boards. In general, existing cooperatives do not allow providers or insurers to participate on governing boards. Many cooperative officials told us that they are working toward different goals than providers or insurers. For example, a COSE official described the relationship between the purchaser and provider of

health care as adversarial—the purchaser wants to minimize the cost while the provider wants to maximize the gain. Even though the legislation establishing CalPERS allowed a representative of a life insurer to serve on the board, CalPERS officials told us that another California law prohibits participation on state boards by any individual who might have a financial conflict of interest, such as an insurer or provider. No representatives of health insurance carriers or providers now serve on the CalPERS board.

'he Role of Purchasing Cooperatives in [ealth Reform Proposals

The health insurance purchasing concept is embedded in a number of major health reform bills. This appendix provides a brief overview of the role cooperatives play in three proposals introduced in late 1993—Clinton's regional health alliances, Cooper's health plan purchasing cooperatives, and Chafee's purchasing groups. While some clear differences exist on key cooperative attributes, all three bills rely on cooperatives to provide a core set of insurance functions.

ll Differences)scure Agreement ι System Functions

The Clinton, Cooper, and Chafee bills diverge on three major policy issues: financing mechanisms, explicit cost controls, and the number of people likely to receive coverage through cooperatives as a result of participation and other requirements discussed below. This latter issue has a major impact on the size, number, and other salient characteristics of cooperatives. Table V.1 summarizes those disagreements.

ɪe V.1: Major Policy Disagreements

	Clinton	Cooper	Chafee
Universal coverage	Yes—1998	No	Yes—2005[a]
Mandatory vs. voluntary			
Employer to offer insurance	Mandatory	Mandatory	Mandatory
Employer contribution	Mandatory	Voluntary	Voluntary
Employer/individual to purchase through alliance	Mandatory	Voluntary[b]	Voluntary
Participating firm size	< than 5,001 employees	< than 101 employees	< than 101 employees
Percent of nonelderly population potentially served by cooperatives	70-90 percent	up to 50 percent	up to 50 percent
Cost controls	Yes	No	No

[a]Implementation of universal coverage could be delayed if anticipated savings to help finance subsidies are not realized quickly enough.

[b]Only health plans purchased through an alliance would be tax deductible for individuals and firms eligible to join a cooperative.

ancing and Cost ıtrol Differences

In the Clinton bill, the major financing mechanism for achieving universal coverage is the requirement that employers contribute 80 percent of the weighted average cost of premiums. Chafee, on the other hand, attains universal coverage by placing the responsibility for financing insurance premiums on individuals. Neither Cooper nor Chafee requires any employer financial contribution. Because the Cooper bill requires neither

employers nor individuals to purchase health insurance, it does not guarantee universal coverage. To increase the affordability of coverage for low-income workers and the unemployed, all three bills provide government subsidies. Finally, while Cooper and Chafee anticipate a slowdown in the rate of health care inflation due to increased competition among health plans, the Clinton bill also incorporates backup cost controls. Thus, Clinton calls for the establishment of national and regional health care budgets with limits on the rate at which insurance premiums could increase.

Potential Size of Purchasing Cooperatives

The operating scale of purchasing cooperatives would vary considerably under each of the three bills. A mechanism for achieving universal coverage, alliances under the Clinton bill would include the most people—estimated at between 70 percent and 90 percent of the nonelderly population.[1] In addition to Medicaid recipients, low-income workers, and the unemployed, individuals working for firms with fewer than 5,001 employees and the self-employed would purchase insurance through alliances.[2] The Administration estimates that up to 29 million eligible individuals are employed by very large firms or other entities that could continue to provide insurance directly to their workers.[3] Although the bill gives each state the responsibility for determining the number of alliances, administration officials have suggested that alliances should cover about 1 million lives. Considering the eligible population, there could be over 200 alliances under the Clinton plan.

The number and size of cooperatives under Cooper and Chafee are more difficult to estimate because (1) purchasing coverage through a cooperative is voluntary in both bills, (2) cooperatives could cross state boundaries, and (3) Chafee permits competing purchasing groups in the same geographic region.[4] Purchasing cooperatives are mandatory in the Cooper bill only in the sense that a small firm is required to join and offer insurance to its employees through the cooperative. If a small employer provides insurance to employees outside the cooperative, the firm would forfeit the tax deductibility of any contribution toward premiums. Both

[1]Although Clinton also allows firms with more than 5,000 employees to form corporate alliances, we use the term alliance to refer uniquely to regional alliances.

[2]Medicare beneficiaries would generally continue their coverage through that program.

[3]In addition to firms that employ more than 5,000 full-time workers, firms participating in large multiemployer group plans, rural electric cooperatives and telephone cooperative associations, and the U.S. Postal Service would be entitled to establish separate corporate alliances.

[4]Cooper—like Clinton—calls for a single alliance to operate in each region.

Cooper and Chafee limit participation in cooperatives to individuals eligible for subsidies, the unemployed, the self-employed, and to workers at firms employing fewer than 101 individuals. If all eligible individuals purchased their insurance through a cooperative, some estimates suggest that up to 50 percent of the nonelderly population could potentially be included.

itical Functions signed to Federal d State Entities

In all three bills, the most critical functions are assigned to federal entities or state governments. Cooperatives play a subsidiary role, administering purchasing pools according to policies and standards established at higher levels. They have no direct role in developing or designing

- the health benefits package;
- quality outcome measures;
- health plan grievance procedures;
- health plan participation, quality, and solvency criteria; or
- risk adjustment methodology.

Table V.2 indicates whether establishing these standards would be a federal or state responsibility. Although many of these functions would be assigned to a new federal entity by Clinton and Cooper—the National Health Board (Clinton) or the Health Care Standards Commission (Cooper)—Chafee vests greater authority in the Department of Health and Human Services.

: V.2: Federal/State Responsibility tandards

	Clinton	Cooper	Chafee
Benefits package	federal	federal	federal
Quality measures	federal	federal	federal
Complaint procedures/ mechanism	federal	federal	state[a]
Health plan participation criteria	federal/state	federal	federal
Develop risk adjustment methodology	federal	federal	state

[a]Chafee provides for binding arbitration and places the burden of proof on the individual bringing the complaint.

Under all three bills, federal and state governments also play an active role in implementing health care reform and in oversight of the reconfigured system. Thus, analysis of quality measures, certification of qualifying health plans to be offered by cooperatives, oversight of alliance operations, enforcement of insurance reforms, and monitoring of health

plan operations all occur at the federal or state level. Finally, since all three bills seek either to guarantee or to expand health care coverage, they require federal entities to monitor the status of progress toward universal coverage.

Bills Agree on Core Purchasing Cooperative Functions

Agreeing on the general role of cooperatives, the Clinton, Cooper, and Chafee bills assign purchasing pools a set of common functions. With the exception of cooperatives' authority over health plans, differences between the bills are essentially distributional—that is, they assign similar functions to disparate entities. In general, Clinton and Cooper emphasize the purchasing cooperative role while Chafee shifts some responsibilities to state governments.

Role of Purchasing Cooperatives

Acting as a multiple employer purchasing pool, the principal role of a cooperative is to (1) ensure access to insurance by all individuals who want coverage, and (2) make insurance more affordable by spreading risks over a larger pool of individuals. Enforcement of insurance market reforms such as guaranteed issue and pre-existing condition limits would be simplified by having individuals purchase coverage through cooperatives rather than directly from insurance carriers. Finally, bigger risk pools would give small employers greater bargaining clout with health insurers, plans, and providers, approximating that now enjoyed by large businesses.

Key Purchasing Cooperative Functions

The three bills agree on a core set of cooperative functions: (1) contracting with health plans, (2) enrolling individuals in those plans, (3) collecting and distributing premiums,[5] and (4) providing comparative information to consumers on health plan quality and price. However, they sometimes assign additional responsibilities differently. Table V.3 summarizes distributional differences in the assignment of functions beyond the common set of core duties.

[5] A purchasing groups collection of premiums is optional under the Chafee bill.

e V.3: Distributional Differences in
ltional Purchasing Cooperative
ɔonsibilities

	Clinton	Cooper	Chafee
Analyzing quality data	federal	cooperative	state
Implementing risk adjustment	cooperative	cooperative	state
Handling consumer complaints	cooperative	cooperative	state
Enforcing rules of competition	cooperative	federal/ cooperative	state
Expanding services to under served areas	cooperative	state/ cooperative	federal/ state
Administering subsidies	state/ cooperative	federal	federal

Many alliance/cooperative functions under Clinton and Cooper are assigned to states by the Chafee bill. First, analyzing—in addition to simply distributing—quality data is a cooperative function under Cooper but is performed at the federal level in Clinton and at the state level in Chafee. Second, implementing the risk adjustment methodology, responding to consumer complaints, and enforcing the rules of competition (that is, monitoring marketing and preventing risk selection) are assigned to state governments by Chafee but to cooperatives by Clinton and Cooper. Third, Clinton assigns responsibility for expanding health care coverage in underserved areas to cooperatives while both Cooper and Chafee assign primary responsibility for this function to state governments. Finally, the function of administering subsidies is (1) shared by states and alliances under Clinton, and (2) left to the federal government by Cooper and Chafee.

An additional difference in cooperative functions is attributable to the coverage goals of the three bills. Thus, the goal of universal coverage under Clinton results in a mandate for each alliance to establish rules and procedures to ensure that all eligible individuals are enrolled. On the other hand, the voluntary nature of Cooper and Chafee requires marketing to encourage firms and individuals to purchase insurance through the cooperative.

chasing Cooperative hority Over Health ıs

Perhaps the most serious area of disagreement with regard to cooperative functions involves their authority over health plans—specifically, the power to negotiate with and exclude such plans. While Cooper expressly prohibits cooperatives from negotiating premiums, both Chafee and Clinton permit such bargaining.[6] The implications for negotiation are not

[6] Clinton requires alliances to negotiate while Chafee omits the prohibition on bargaining found in Cooper.

clear, however, since Chafee requires purchasing cooperatives to contract with all state qualified health plans. Although Clinton has been widely read to yield the same result, the language in the bill is somewhat ambiguous. The connotation of the term negotiation in Clinton is clearly broader than simply the ability to exclude plans. For example, with regard to establishing fee-for-service price schedules, Clinton defines negotiation to include all collective and joint meetings, discussions, presentations, conferences, and consultations between providers and any regional alliance. In addition, Clinton alliances would (1) have a role in enforcing national health budgets while the other two bills eschew cost controls altogether and (2) be charged with negotiating a fee schedule with providers for an FFS health plan option.

As noted earlier, all three bills call for state governments to determine which health plans are qualified to contract with a cooperative. Each bill allows a cooperative to exclude plans that are decertified by the state or that failed to comply with previous contracts. Clinton and Chafee, however, stipulate some additional causes for exclusion.

- Under Clinton, an alliance may—but is not required to—exclude a health plan whose bid exceeds the alliance's per capita target premium by 120 percent.
- Under Chafee, a cooperative may exclude plans if either their enrollment or premium is too low.

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