S. HRG. 103-918

HEALTH CARE ALLIANCES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 24, 1994

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

82-897—CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046635-0

S. HRG. 103-918

HEALTH CARE ALLIANCES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 24, 1994

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

82-897—CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046635-0

COMMITTEE ON FINANCE

DANIEL PATRICK MOYNIHAN, New York, *Chairman*

MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, JR., Michigan
JOHN D. ROCKEFELLER IV, West Virginia
TOM DASCHLE, South Dakota
JOHN B. BREAUX, Louisiana
KENT CONRAD, North Dakota

BOB PACKWOOD, Oregon
BOB DOLE, Kansas
WILLIAM V. ROTH, JR., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
DAVE DURENBERGER, Minnesota
CHARLES E. GRASSLEY, Iowa
ORRIN G. HATCH, Utah
MALCOLM WALLOP, Wyoming

LAWRENCE O'DONNELL, JR., *Staff Director*
LINDY L. PAULL, *Minority Staff Director and Chief Counsel*

CONTENTS

OPENING STATEMENTS

COMMITTEE PRESS RELEASE

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

HEALTH CARE ALLIANCES

THURSDAY, FEBRUARY 24, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Bradley, Rockefeller, Daschle, Breaux, Conrad, Packwood, Dole, Roth, Danforth, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No.–9, February 18, 1994]

FINANCE COMMITTEE SETS HEARING ON HEALTH ALLIANCES

WASHINGTON, DC—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on health care alliances.

The hearing will begin at *10:00 a.m. on Thursday, February 24, 1994* in room SD–215 of the Dirksen Senate Office Building.

"Health care alliances play a prominent role in many of the proposed health care reform plans, including the President's," Senator Moynihan said in announcing the hearing. "It is imperative that the Committee understand their intended function, and how they are envisioned to fit into overall health care reform."

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished guests and our very welcome attendees and witnesses.

This morning in the sequence of hearings that Senator Packwood and I and the committee agreed on earlier, in that we would follow a thematic sequence rather than move from one particular bill to another, we are going to spend the morning on the subject of health alliances.

We have the great honor to have with us Governor Rosselló of Puerto Rico. I do not know what this means, but it used to be that only lawyers got to be Governors, now we have doctors all over the place. Your colleague in Vermont is a medical doctor and so, of course, are you. We welcome you very much, sir.

I wonder if Senator Packwood and Senator Dole would like to do the same.

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. A very brief statement, Mr. Chairman. Thank you. I had a chance to talk with Governor Rosselló before and clearly what Puerto Rico is trying to do is, I think, close to what some of us are thinking of in terms of what I would call a voluntary alliance, not a compulsory alliance. Insurance providers will still be writing.

Having now had dinner with the President on Tuesday night, and having listened to him last night at the business counsel, I am convinced an accommodation can be reached between 70 Senators to come to a conclusion on a bill without compulsory alliances and with some kind of universal coverage.

I think those are the two critical issues. Mr. Chairman, I am convinced we can harmonize them and I look forward to the Governor's testimony.

The CHAIRMAN. Thank you.

Senator Dole?

Senator DOLE. I am happy to have you here.

The CHAIRMAN. Senator Daschle?

Senator DASCHLE. No comment.

The CHAIRMAN. And Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Well, I would only make a reference, as I did in part of my opening remarks that I will put in the record, to a quote from the CBO analysis on what an alliance is.

They say this. In making the case that the Clinton plan goes beyond ordinary regulation, they say that the boundaries of regulation have been crossed. They say, "In particular, this appears to be the case with respect to regional alliances. Federal statute would establish and define these new institutions. The terms and financing of the insurance they offered would be specified by Federal law, and their activities would be regulated and monitored by the Department of Labor and Human Resources."

So CBO concludes that health alliances would be more like Federal agencies than like State or private entities. I think it is very important that we put a great deal of reliance upon the Congressional Budget Office around this Capitol Hill. And in this particular instance, they are not making a case that the alliances are some sort of innocuous little organization that is being created by the President's program.

The CHAIRMAN. Thank you, Senator Grassley.

Governor Rosselló, would you come forward, sir. We will put your statement in the record. You proceed exactly as you desire.

STATEMENT OF HON. PEDRO ROSSELLO, M.D., GOVERNOR OF THE COMMONWEALTH OF PUERTO RICO, SAN JUAN, PUERTO RICO

Governor ROSSELLÓ. Thank you very much, Mr. Chairman, and members of the Committee on Finance. For the record, my name is Pedro Rosselló. I am Governor of Puerto Rico.

As a candidate for that office I promised to reform the island's health care system. The voters gave me a mandate to do so. We took office January of last year and health care reform has since begun to become a reality in Puerto Rico.

I might say that we acted fast, but I think we also acted responsibly. Nearly two decades ago when commencing my private practice as a pediatric surgeon I quickly recognized grave deficiencies in Puerto Rico's health care system. Hoping someday to be able to improve that situation, I went back to school and obtained a Master's Degree in Public Health.

In 1985 I accepted the post of Director of the San Juan Health Department, our largest city, our capital of San Juan. There I initiated a reform program, actually wrote a book on the subject. That book was titled, "Alliance for Health."

When becoming Governor, in other words, I was no stranger to the concept of health care reform, and no stranger either to the concept of health care alliances. That explains why we were able to move both quickly and responsibly to address those issues during 1993.

Reform was needed in Puerto Rico to ensure equal access to quality care. The majority of our population was being served by government facilities, the government as a direct provider. These facilities were overburdened and underfunded. They were victimized by bureaucratic inefficiency and by partisan politics. Radical change, I think all of you would have agreed, was imperative.

The cornerstone of our reform philosophy would have included choice and excluded discrimination. We have set those cornerstones within the framework of managed competition. Last September to implement that philosophy, we created the Puerto Rico Health Insurance Administration. This is a public corporation endowed with full authority to promote, negotiate, contract and administer comprehensive health insurance coverage so that every resident of Puerto Rico of every income level can be guaranteed medical care.

This public corporation, the Health Insurance Administration, is fully operational, functioning in essence as the island's first health alliance. And health care reform is now becoming a reality for the residents of six municipalities located in eastern Puerto Rico.

Before I summarize the success of this pioneering venture, let me acknowledge that on our road to reform we have had our share of rough spots. I think that will be equally applicable at the national level.

Like the national program, ours has confronted its share of skepticism, cynicism, criticism and even occasional mockery. At one point, for example, political adversaries began joking that our reform minded government was launching so many pilot projects that the public thought we were founding an airline.

I responded by saying that my administration refused to ignore urgent priorities, that we refuse simply to wash our hands when confronted with the island's problem. It is better to be a project pilot than to be a Pontius Pilate. [Laughter.]

The CHAIRMAN. That is just on the edge. [Laughter.]

Governor ROSSELLÓ. All right. I get the message. So we persevered and our perseverance has begun to pay dividends for the people of Puerto Rico. Two months ago with the approval of the

Federal Health Care Financing Administration our health insurance administration signed a contract with a private insurance firm.

That company, chosen from among several bidders, agreed to provide health coverage in a managed care system for approximately 46,000 persons, comprising three major groups of beneficiaries. The health insurance administration pays the insurer a premium based upon the contracted benefits for either individual or family coverage.

Both monthly premiums come to $52 for individuals and $149 for families. Most necessary procedures, including preventive services, are provided under the program's basic coverage plan at primary care centers located in each of the participating towns. Additional benefits are available under special coverage through a network of providers that are under contract to the insurer.

Senator PACKWOOD. Could I ask a question there just to understand?

Governor ROSSELLÓ. Yes, sir.

Senator PACKWOOD. When you say additional benefits are available under special coverage, you mean additional coverage? It does not come within the basic premium that is paid?

Governor ROSSELLÓ. No. In this case I am talking about required coverage, but it is not at the primary level. We are talking about specialized secondary, tertiary protection.

Senator PACKWOOD. But it is covered by the monthly premium?

Governor ROSSELLÓ. Yes, they are covered.

Senator PACKWOOD. Thank you very much.

Governor ROSSELLÓ. Health reform is being implemented sequentially, both in terms of geographical regions and interims of participant categories. With respect to the latter, three stages are involved.

Stage one took effect the first day of this month and applies to persons previously served directly by the island's health department and public facilities. This category encompasses the following groups: everyone eligible for Medicaid, either federally or locally; plus police officers, military veterans and their immediate families.

Of the estimated 46,000 individuals eligible, more than 45,000 have been duly certified. Within just 15 days after the screening process got underway, of those certified, moreover, 28,000, nearly 29,000, persons are now enrolled in the plan.

As you can see, therefore, implementation has been both rapid and comprehensive. We are likewise encouraged by some other surprising data concerning Puerto Rico's first experience with a health care alliance. The price being paid by the health insurance administration to cover its beneficiaries is more than 31 percent lower than the cost of a traditional fee-for-service plan.

Also, the price is 29 percent lower than the cost of comparable coverage supplied by similar health maintenance organizations on the island. Despite grumbling from providers, some of which are my colleagues, about how some prefer the traditional fee-for-service approach, we are nevertheless receiving a massive influx of inquiries from providers asking how they participate or how they can participate in our health reform plans.

Companies who have bid for the December contract and were rejected have begun to restructure their health insurance plans into managed care systems so that they can be competitive in bidding for the second geographical area where operations are scheduled to commence this coming June.

Numerous primary care providers are organizing into groups with the intention of adopting the managed care concept, so that they can compete with established Senators in this new health care market place.

Spectacular progress has been made during the program's first month in addressing one of the most critical shortcomings of our public health care system. Under our first health alliance, the primary care physician to patient ratio has improved dramatically from 1 to 2,500 down to 1 to 835. And major gains have been recorded as well in the ratios applicable to specialists, clinical laboratories, pharmacies and hospitals.

In Puerto Rico then, health care has evolved from a proposal into what is actually now a program. It is alive and well or maybe more accurately to the point, it is keeping the people alive and well. The alliance concept is at the heart of this thriving young initiative, pumping blood of security, tranquility, and dignity through a society that is eagerly embracing a long-awaited opportunity for health care equality.

Earlier I mentioned that Puerto Rico health reform entails three stages and I described the parameters of stage one. To supplement that, let me say that we expect to extend the stage to cover the entire island during the next 4 years.

Meanwhile, stage two will be getting underway in 1995 to include under our health alliance all government employees. During this stage we shall explore how we can bring into the program persons currently insured under the government's worker's compensation system, known as the State Insurance Fund, and those covered by the no-fault injury protection that is provided by the State's automobile accident compensation administration.

Stage three will bring every remaining resident of Puerto Rico into the program under guidelines that will respond to the provisions of the national health care reform system that you are now considering. As our health program moves forward, the alliance feature of our health insurance administration will increasingly mirror the alliance concept and vision under the Federal proposals. I understand this is being discussed at this present moment.

Near the beginning of my testimony, I mentioned that choice is a cornerstone of our health care reform program, specifically in this regard. Our reform legislation stipulates the following: Participants, except as noted below, must have the option of selecting from among two or more health insurance firms certified by the health insurance administration.

The exceptions essentially are these: Implementation complexities have necessitated temporary designation of a single insurer for the first coverage area. Options will be guaranteed for stage one participants after they have been in the program for 5 years.

The second cornerstone of our program cited earlier is the absence of discrimination. On this front, the law prohibits contracted

insurance firms from issuing two or more types of identification cards for the same class of coverage.

In other words, we have ensured that the medically indigent will never be stigmatized on the basis of the type of card that they carry. Furthermore, the anti-discrimination aspect of our program is reflected in the breadth of coverage with its minimal exclusions and its total lack of waiting periods or exclusions for pre-existing conditions.

Cornerstone number three for Puerto Rico health care reform is managed competition—a model for improving services to the medically indigent population of our population. As noted previously, we already are seeing evidence that managed competition is stimulating a reorganization of delivery systems. This in turn is producing greater efficiency in the form of lower prices and higher quality.

Currently, funding for Puerto Rico's health care reform program is derived to some extent from the participant deductibles. Most of its funding, however, comes from State Government sources. As we expand into stages two and three in the coming years, it will be imperative that we broaden the system's resource base.

Of necessity, truly universal coverage will require contributions from all sectors capable of making such contributions. A healthier population in our estimation is a more productive population and a more productive population is a more prosperous population. A more prosperous population is the goal of a free market economy. And in the global economy that we are experiencing, it is a competitive advantage.

Good health, therefore, is good business. Because universal health care requires a broad resource base, I strongly support the provisions of the pending Health Security Act, including those involving employer mandates.

As a participant of the health care task force of the National Governor's Association, it was my privilege last year to work closely with the White House in designing its program.

Moreover, in Puerto Rico we have made certain that our own program would be fully compatible with the national plan. Puerto Rico's alliance for health is on the books and it is off to a strong start. I am confident that the President's plan can serve the nation well, just as our plan in Puerto Rico is serving Puerto Rico well.

Thank you, Mr. Chairman, for offering me the opportunity to testify today on behalf of 3.6 million American citizens of Puerto Rico. That concludes my prepared remarks. But I would be glad to answer any questions.

[The prepared statement of Governor Rosselló appears in the appendix.]

The CHAIRMAN. And specifically on behalf of the 46,000 who are in your first stage of the alliance arrangement.

Governor ROSSELLÓ. Yes.

The CHAIRMAN. If I can say thank you, Doctor.

Governor ROSSELLÓ. Thank you.

The CHAIRMAN. It is the custom of the committee to defer to the Republican Leader and the Majority Leader when they are present. The Republican Leader has been unfailing in this regard. Senator Dole?

Senator DOLE. I appreciate it. I have no questions, but I appreciate very much your testimony.

Governor ROSSELLÓ. Thank you, Senator.

Senator DOLE. I think you are off to a good start.

Governor ROSSELLÓ. Thank you.

The CHAIRMAN. Then I will take the opportunity to ask you just three questions, just because I think it will help the committee.

Does your alliance include Medicaid beneficiaries at this point?

Governor ROSSELLÓ. This first stage is precisely for Medicaid beneficiaries, but Puerto Rico starts from a different scenario in that Puerto Rico does not participate under the Medicaid program with the same rules as applies in the States.

The CHAIRMAN. That is right.

Governor ROSSELLÓ. Puerto Rico gets a block grant.

The CHAIRMAN. A block grant.

Governor ROSSELLÓ. And as I said previously, most of the Medicaid eligible people are funded by State resources.

The CHAIRMAN. That block grant is a minimal block grant, is it not?

Governor ROSSELLÓ. That is right. The block grant is about $112 million at the present time and cost recovering services for the medically indigent or Medicaid eligible population surpasses the $600 million mark.

The CHAIRMAN. Five times and more than what you get from the Federal Government.

Governor ROSSELLÓ. Yes. That is right.

The CHAIRMAN. Did you have either an employer or individual mandate?

Governor ROSSELLÓ. We do not have it now. What we are—and I must say from Puerto Rico's perspective, it would make it easier to reach the goal of universal coverage in Puerto Rico if we had that as a national mandate.

Obviously, Puerto Rico could opt to do it without having other States doing it. I think that would put Puerto Rico at a disadvantage in terms of competing.

The CHAIRMAN. You think there is that State question? If you are first, there is an innovator cost in these matters?

Governor ROSSELLÓ. Oh, yes. I think it would add a significant cost. I think the decision has to be made on a national level that all States will be put on an even playing field and not have these disadvantages for those that take the initial steps.

The CHAIRMAN. Right. So is the alliance voluntary or is it mandatory?

Governor ROSSELLÓ. Mandatory.

The CHAIRMAN. It is mandatory. It might help if you could tell us, where is the present alliance located?

Governor ROSSELLÓ. In San Juan.

The CHAIRMAN. It is in San Juan?

Governor ROSSELLÓ. Yes.

The CHAIRMAN. Where in San Juan?

Governor ROSSELLÓ. In Caletta One. I do not know if you know.

The CHAIRMAN. Yes, sure. That is sort of a middle level neighborhood.

Governor ROSSELLÓ. Yes.

The CHAIRMAN. Well, thank you very much.

Senator Packwood?

Senator PACKWOOD. Governor, let me make sure I understand how the alliance will operate when it is in full effect. There is no mandate and yet it is going to cover everybody.

Governor ROSSELLÓ. There is no mandate now.

Senator PACKWOOD. Right.

Governor ROSSELLÓ. I must say that in what we consider stage three, there would be a mandate for employers and employees. We feel that, for example, in Puerto Rico there is a sector of our population that would be under the levels that we cover now in stage one, which is up to 200 percent poverty level.

Some of those are employed, but they do not make enough to essentially obtain their own insurance. We feel that one of the very necessary steps would be to have the employer mandates so that this is shared by a sector of our society that I think should share in this.

Senator PACKWOOD. In your stage one you are obviously covering lower income people to start.

Governor ROSSELLÓ. Exclusively.

Senator PACKWOOD. Exclusively. And I assume, therefore, that very few of them are sharing in much of the premium, that the State is paying most of the—Puerto Rico is paying most of it; is that correct?

Governor ROSSELLÓ. It is paying all—for services they are paying nominal deductibles.

Senator PACKWOOD. All right. Now when you get to stage three and everybody is in, how will the premiums be paid?

Governor ROSSELLÓ. The premiums, we are looking for in that sense the outcome of the national reform.

Senator PACKWOOD. You are beyond the poverty level now?

Governor ROSSELLÓ. That is right.

Senator PACKWOOD. You have normal employees?

Governor ROSSELLÓ. That is right.

Senator PACKWOOD. Would the employee and the employer then pay a fair portion of the premium?

Governor ROSSELLÓ. Yes.

Senator PACKWOOD. Do you know what percentage or are you assuming that whatever the national program is that will be yours?

Governor ROSSELLÓ. We are assuming whatever the national program is would apply to Puerto Rico.

Senator PACKWOOD. All right.

Governor ROSSELLÓ. I think it is, you know, debatable whether it should be 80/20 or it should be 50/50. I think that is a legitimate debate.

Senator PACKWOOD. Now when the alliance is in full effect, will it decide which insurance companies can write and which ones cannot or will you basically say all of them who submit a qualified plan will get to write? You really will not have any discrimination in that sense, everybody can write so long as they meet the standards.

Governor ROSSELLÓ. That is correct.

Senator PACKWOOD. All right. So you can have 20 or 30 writing. And you will have a basic plan and they can write above the basic plan if they want. But they all must provide the basic plan.

Governor ROSSELLÓ. They all must provide the basic plan. That is correct.

Senator PACKWOOD. Now, when it is in full effect—let us say you have 30 or 40 providers that are qualified and I suppose you will by the time you are there—will all of the premiums be paid to the alliance and the alliance pays the provider? Or once you have it in full effect, will premiums be paid directly to providers?

Governor ROSSELLÓ. No. The alliance would act as a collector of the premiums and would pay the health plans.

Senator PACKWOOD. So in essence you would have a compulsory alliance?

Governor ROSSELLÓ. Yes.

Senator PACKWOOD. And collect the premiums and act as the middle man with the premiums coming in and the payment going out then to the carriers or to the providers?

Governor ROSSELLÓ. Not to the providers, to the carriers.

Senator PACKWOOD. The carriers, who will then pay the providers.

Governor ROSSELLÓ. The health alliance does not assume the insurance risk. In other words, it pays for it and the health plan, the carriers, would then be paid their premiums. The only thing is that it is a mandatory type of inclusion and so the health alliance would act as the collector and ensure that that participation is present.

Senator PACKWOOD. All right. Now you pay it out to the carriers.

Governor ROSSELLÓ. Yes.

Senator PACKWOOD. Do they then have any bargaining power with the providers or is all of the bargaining done by the alliance?

Governor ROSSELLÓ. No. No. The alliance does not enter into the carrier/provider relationship.

Senator PACKWOOD. So that is up to them to negotiate with the physicians and with the hospitals?

Governor ROSSELLÓ. Absolutely.

Senator PACKWOOD. So really in this case the alliance is almost an administrative function rather than a tremendously discretionary function.

Governor ROSSELLÓ. It is basically that. It is an instrument to ensure that all individuals that have to be participants, that are mandated to do so, will do so. In essence, it takes that function away from the carriers.

Senator PACKWOOD. Right.

Governor ROSSELLÓ. What it does is, it also assures the carriers that they will be paid for the people that they are carrying insurance on.

Senator PACKWOOD. And it almost looks like it acts as the equivalent of an Insurance Commissioner in the State to make sure there is no fraud in the selling of the policies and to monitor the companies.

Governor ROSSELLÓ. That is correct.

Senator PACKWOOD. But in the last analysis it is the companies that end up bargaining with the hospitals and with the doctors.

Governor ROSSELLÓ. Oh, absolutely. The government will not enter into that relationship. That is a competitive relationship and it behooves the carriers to make sure that they get the best deals with their provider so that they can compete with other health plans.

Senator PACKWOOD. Let me ask you this one question on page 6 of your statement. One duty of the health insurance administration is to "devise control mechanisms that will prevent unjustified increases in the cost of health care services." What is that particular function?

Governor ROSSELLÓ. Well, the health alliance will have data and will look at quality aspects, will look at cost aspects, and will in essence provide us information.

Senator PACKWOOD. But it will not set prices?

Governor ROSSELLÓ. No. No, it will not set prices.

Senator PACKWOOD. Thank you.

The CHAIRMAN. That is refreshing.

Senator PACKWOOD. A good approach.

The CHAIRMAN. I think you have a social invention going on down there.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

Governor Rosselló, thank you for your testimony. Let me ask you about the conclusion you reached about the requirement that there be employer-employee participation in paying health premiums. Why did you draw that conclusion?

Governor ROSSELLÓ. I feel that if we adopt as a goal universal coverage, if that is a goal, I am not too hopeful that just leaving it up voluntarily to the individual will accomplish that goal. I, as an individual, might have other priorities at a given moment. It might be housing; it might be food, whatever.

So I think that if we agree that that should be a goal, then the only way of ensuring that is to make it not voluntary but mandatory. Then you reach a point of saying, well, how will we do it. I think, again, if we look at all States, it would be illogical for me to permit some States to do it this way and others the other, because that does have an impact in terms of the competition or the competitiveness of the different States.

Senator DASCHLE. So you concluded that, to achieve universal coverage, there has to be some kind of mandatory participation in the system.

Governor ROSSELLÓ. Yes.

Senator DASCHLE. You cannot avoid mandating participation?

Governor ROSSELLÓ. Yes.

Senator DASCHLE. And secondly, is building upon the current employer-employee base the most practical way to achieve mandatory participation?

Governor ROSSELLÓ. Absolutely.

Senator DASCHLE. Would you conclude that the alternative to an employer-employee mandate is a mandate on families to obtain coverage? That we must either build upon the current system or instead require families to be sole participants?

Governor ROSSELLÓ. Well, that could be an alternative. I think it might not be the most efficient type of alternative.

Senator DASCHLE. Right.

Governor ROSSELLÓ. Because you could probably monitor the other much better.

Senator DASCHLE. Let me also ask you about some of the concerns that have been expressed about alliances. Although we already spend about $48 billion a year on health care administrative costs, there have been charges that alliances will bring more bureaucratic spending.

Meanwhile, in the Federal Employee Health Benefits Plan which is similar in structure to the newly proposed alliance and is the system that Congress itself uses; only 175 administrators are required to cover a total of 9 million enrollees, at less than two-tenths of a percent of total cost.

Can you indicate whether the total administrative costs under your alliance will go up or down from what they were before?

Governor ROSSELLÓ. Well, I think Puerto Rico is starting again from a different ground. We have a very inefficient system. The government is the direct provider through hospitals, doctors that are government employees, to over 50 percent of our population. I can tell you that that is not the way to go, that government becomes a direct provider.

So we are turning away from that and going through the private sector, through the insurance sector, to provide in a more efficient way these services. We also have in Puerto Rico the government employees. Essentially what has been maybe a precursor of a health alliance in that through our Secretary of the Treasury plans are qualified for the government employees and then the government employee chooses which of the plans that have been certified by the Secretary of the Treasury he wishes to enroll in.

The government, instead of the way we have and instead of having a certain percentage, has a fixed apportionment fixed to the health plan so that the employee pays the difference.

Senator DASCHLE. Before my time expires, let me ask you about personal choice under alliances, an issue addressed by CBO testimony a couple of weeks ago. CBO indicated that, based upon its analysis of the Clinton Plan we would actually see enhanced choice under an alliance system.

Have you been able to determine whether choice has improved under your alliance?

Governor ROSSELLÓ. I think you have to talk about choice in theoretical terms and in practical terms. Even though you might talk about choice in the system that we have, those that are not insured have no choice. Those that are insured in practical terms essentially also have limited choice.

So I think the concept of managed competition where you do choose your health plan, you choose your primary provider, and then you in essence trust the primary provider to help you, it is a partnership type of relationship. I think it does offer improved choices as far as I am concerned.

Senator DASCHLE. Thank you, Governor Rosselló.

Governor ROSSELLÓ. Thank you.

Senator DASCHLE. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daschle.

Senator Grassley?

Senator GRASSLEY. Governor, I am from a rural State. In our State we would be—every rural State, I think, would be concerned about the implications of drawing certain boundaries.

The next panel, the General Accounting Office, is going to tell us about some of the implications of drawing boundaries for alliances. You evidently will have more than one alliance. I do not know whether it is two, three or four. But how many will you have? And more specifically, what principles inform the way in which you drew those alliance boundaries and whether or not the distribution of health care costs had anything to do with it?

Governor ROSSELLÓ. We have not drawn any alliance boundaries yet. What we are doing again is rolling in a population that in some of the States is already taken care of by Medicaid. Again, Puerto Rico does——

Senator GRASSLEY. Will you be drawing boundaries?

Governor ROSSELLÓ. We probably will. In our stage, which is our third stage, we have provisions in the law that we passed, there are provisions for multiple health alliances. But we have not gotten to that point where we are drawing alliances.

Puerto Rico in essence could function because of its, as you mentioned, geographical characteristics, its demographics also. We are a small island, 100 by 35. We have a very high population—3.6 million; a very high density, an average 1,000 people per square mile, and in San Juan it is 10,000 per square mile.

So we do not have the problem that maybe in some large rural areas would be present. We are very compact. Conceivably, we could also have a single area under a health alliance.

Senator GRASSLEY. Well, then your experience would not be much help from us then from the standpoint of where those boundaries might be drawn then, what concerns would go into them, because you are not even going to approach it from that standpoint.

Governor ROSSELLÓ. No. In Puerto Rico a problem of access due to distance or transportation to different facilities is not a factor, because we have enough facilities within a reasonable distance.

Senator GRASSLEY. Do you have any concern in your alliance then when you end up with one alliance as opposed to a second alliance or third? Will you have any concern about the distribution of health care costs being a factor?

Governor ROSSELLÓ. That could be a factor, I think, because of the proximity and the uniformity of our conditions. It probably would level out. I do not think we will see major differences between regions.

Senator GRASSLEY. Mr. Chairman, thank you.

The CHAIRMAN. Thank you, Senator Grassley.

Senator Bradley?

Senator BRADLEY. Mr. Chairman, I have only one question of the Governor. It is good to see you again, Governor.

Could you tell me where does Puerto Rico raise the money to pay for the beneficiaries?

Governor ROSSELLÓ. At the present time?

Senator BRADLEY. Yes.

Governor ROSSELLÓ. It is their State funds. They are raised through our State income tax and our corporate taxes.

Senator BRADLEY. Thank you.

The CHAIRMAN. Taxes [Laughter.]

Governor ROSSELLÓ. I did not want to mention that.

The CHAIRMAN. Have you not heard?

Governor ROSSELLÓ. Unfortunately, yes. [Laughter.]

Senator BRADLEY. Are you sure they are not premiums? [Laughter.]

The CHAIRMAN. I think we had better change the subject quickly.

Senator Dole? [Laughter.]

I just think the record ought to show what your employer base looks like. What percentage of people are employed by large employers—for example you have a lot of pharmaceutical companies there. They probably all provide coverage now, right?

Governor ROSSELLÓ. Yes. The manufacturing sector is the biggest sector of our economy. Of that two-thirds are multi-national type corporations, big corporations, that include about 105,000 employees. Those have very good benefits. Those have very ample coverage.

Senator DOLE. What does your plan do to those?

Governor ROSSELLÓ. Well, essentially they already would be mandated, but they are already doing it. So it would be no change. They can either do it in the President's plan where you would have a corporate alliance or if your number of employees was below a certain number, which also has to be decided——

Senator DOLE. What is the total employed? How many people are employed in Puerto Rico?

Governor ROSSELLÓ. There are 1,027,000.

Senator DOLE. How many unemployed?

Governor ROSSELLÓ. About 220,000.

The CHAIRMAN. That is about 18 percent.

Governor ROSSELLÓ. The latest was 16.7 percent unemployment, a very large proportion.

Senator DOLE. Do you have a lot of small businesses? How many people are employed in, say, small businesses?

Governor ROSSELLÓ. Oh, the great majority are employed in small businesses.

Senator DOLE. But employer mandates are not going to reach everybody, right, because a lot of people are not working?

Governor ROSSELLÓ. Those that are not working essentially come under the population that we are covering now.

Senator DOLE. Step one?

Governor ROSSELLÓ. That is right. And presently, before we started that, would get their services in government-run hospitals.

There is a proportion of workers that are still below the 200 percent level of poverty that would be included in the employer mandates, if they are working. And so that would alleviate that portion where the State would through its resources have to pay for their premiums.

Senator DOLE. What percent of the employed have coverage now? Do you have any idea?

Governor ROSSELLÓ. Percent of the employers? I do not have that.

Senator DOLE. Employees. Of all the people employed, what percent have coverage?

Governor ROSSELLÓ. In Puerto Rico, I cannot recall that figure, but I can look it up. I do not know.

Senator DOLE. What about price controls on drugs? Are you supporting that?

Governor ROSSELLÓ. No.

Senator DOLE. I did not think so. [Laughter.]

The CHAIRMAN. Thank you, Senator Dole.

Senator Bradley?

Senator BRADLEY. No more questions.

The CHAIRMAN. No more questions.

Senator Rockefeller?

Senator ROCKEFELLER. No questions, Mr. Chairman.

The CHAIRMAN. Governor and Dr. Rosselló, we are very grateful to you for coming up here.

Senator BREAUX. Mr. Chairman?

The CHAIRMAN. Yes, of course. Forgive me, Senator Breaux.

Senator BREAUX. I have been bouncing in and out. I apologize.

Doctor, Governor, welcome once again to the Finance Committee. I just have one question. I was not here for all of your testimony and I apologize. But the health alliances that you have in Puerto Rico, would you describe it as more of a regulatory authority or more of a purchasing cooperative?

Governor ROSSELLÓ. It is more of a purchasing cooperative. It also has an authority to obtain data and information and it is charged with letting people know about that information.

Senator BREAUX. Did you all make a decision that you would prefer the health alliance to be a purchasing cooperative as opposed to a regulatory authority with what purpose in mind? Did you consider the alternative of making it a regulatory body?

Governor ROSSELLÓ. Yes. We feel that the basic role that the alliance should play is in trying to pool the purchasing power of the individual where that purchasing power is not represented through other means. If you are a large corporation, you can make use of that strong purchasing power.

We have conceived this as allowing these smaller businesses and the individuals to participate in this competitive purchasing power. So it is mostly geared towards that and not necessarily having a strong regulatory aspect.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

Again, thank you, Governor Rosselló.

Governor ROSSELLÓ. Thank you.

The CHAIRMAN. It is very generous of you to come up. Any time you want to invite us down at this time of year, we would be very happy to accommodate you.

Governor ROSSELLÓ. Mr. Chairman, and Senators, thank you very much.

The CHAIRMAN. We are now going to have a panel which will address some of the specifics of the alliance system proposal, in particular the question of boundaries that Senator Grassley raised and with which he was concerned.

We are going to have Richard Curtis, who is president of the Institute for Health Policy Solutions here in Washington, DC. We are particularly happy to have Sarah Jaggar, who is the Director of

Health Financing and Policy Issues of the General Accounting Office.

In our order of listing, Mr. Curtis, you are first. I assume from the name of your Institute that you are here with solutions. And if I know the General Accounting Office, they will be here with problems. [Laughter.]

So we have a very nice balance. Good morning, sir. Could I ask each of you to confine your opening statements to 5 minutes so we will get a chance to ask questions?

STATEMENT OF RICHARD E. CURTIS, PRESIDENT, INSTITUTE FOR HEALTH POLICY SOLUTIONS, WASHINGTON, DC

Mr. CURTIS. Thank you, Mr. Chairman. By way of background, we are a not-for-profit, non-partisan applied think tank and we do not take positions on specific legislation. We have been working with a number of States, as well as purchaser employer coalitions, on the development of health purchasing alliances. We have been funded by several foundations to do background analysis for that audience as well as for the Federal policy audience.

The purpose of my testimony is to briefly review what functions the three principal bills before this committee that include variously named organizations, all of which I will refer to as health purchasing alliances, are assigned to purchasing alliances and how those functions differ across these bills and how the policy judgments about their roles differ.

First of all, I would like to emphasize that all three of these bills—the Chafee-Dole bill, the Cooper-Breaux bill, as well as the Clinton Administration plan—in some significant measure attempt to achieve the same thing—a system in which people are covered through private plans that compete for enrollees on the basis of quality, cost effectiveness and service rather than risk selection.

They all seem to agree that to achieve such a system there are a number of functions that need to be performed and they agree that some of those functions could be performed by alliances where they exist. They disagree about some other functions.

Let me just in very, very brief terms review those.

The CHAIRMAN. Please, do not feel confined by time.

Mr. CURTIS. All right.

The CHAIRMAN. We are very happy to have you.

Mr. CURTIS. First of all, three core functions are contracting with health plans, enrolling people in the plans of their choice and collecting and distributing the premiums—collecting them from the people who are going to be covered by the plans and distributing them to the plans themselves.

All three of these bills would envision purchasing alliances, playing these roles, although in the Chafee bill where there are purchasing groups, the actual collection and distribution of premium is an optional function, rather than a required function for those organizations.

There are several other core functions that under the Clinton and the Cooper-Breaux proposal are given to alliances, but that under the Chafee-Dole bill are largely given to State government. The reason for that is simply that under the Clinton and Cooper-Breaux bills, the alliance is the only place certain populations

would go to choose a plan. And under the Chafee-Dole bill they are an optional vehicle for coverage that may or may not exist in a given area. So these functions are in that bill assigned to State Government.

Providing consumers with comparisons of health plan features and performance, some of these functions. Right now in most parts of the country nobody does that and where it does happen often it is not done well. Again, in the Cooper-Breaux bill and the Clinton bill, it is the alliance that largely plays that role.

In the case of the Chafee-Dole bill, the State would provide information about all plans participating in the market. It requires the purchasing group to give that information to the people that come in through the purchasing group, just as it requires agents or brokers to provide that information to people who obtain a plan through that vehicle.

Risk adjusting premium is also performed by, under both the Clinton and Cooper-Breaux bill, the alliance; and because, again, these are optional entities and there can be more than one of them per area in the Chafee-Dole bill, this function is played by State Government.

Enforcing rules of competition. I would argue that by the very nature of the structure of the alliance in large measure under the Clinton or the Cooper-Breaux bills, this is largely accomplished and it is a matter of monitoring to make sure it is working as it is supposed to. Obviously, under the Chafee-Dole bill State insurance regulators would play that role.

There is one other function that is a highly controversial one, that I mention because States that have established these organizations have given this function to alliances. That is negotiating and selectively contracting with health plans. Many States, as you will hear from the folks in California, feel this is an important role, particularly when the alliance is voluntary.

Now there are a number of functions that can be given to an alliance that do not really have much to do with the core purpose of the alliance itself—restructuring the way private plans compete and people access them. I am mentioning these functions simply because they are extraordinarily controversial and I think the controversy over these functions can be separated from the question of whether or not these kinds of organizations (health purchasing alliances) are a sensible way to restructure what I would think most people would agree is a largely dysfunctional market right now.

Whether or not there are budget limits or fee schedules or limits and who determines eligibility for subsidies, are highly controversial issues. I am not even going to discuss them here. You are going to be making policy judgments on whether they should be performed if they are to be performed, and making judgment about who performs them.

I think the debate about whether or not there need to be health purchasing alliances or something like them as a way to structure the market and a way to give people access and choice through plans is an entirely separable debate.

There are a number of policy issues here. I have referenced a couple of them. But before I go into them, I would like to remind

the committee of some of the structural defects in the current market.

Number one, in the small employer and individual health insurance markets, as you are all aware, administrative costs are extraordinarily high, averaging between 25 percent and 40 percent for individual and very small group coverage.

It may well be that some inefficiencies and inequities are endemic to a system in which agents for individual health plans are marketing to and directly dealing with very large numbers of very small groups and individuals. That is something that I think should be taken into account, especially as this committee thinks about how it wants to spend subsidy dollars.

There are going to be billions and billions of Federal dollars somehow invested if we are going to cover the uninsured. And I remind the committee that the wage structure as well as the average family income profile of people that work for very small firms, is substantially lower than for very large firms. So you are going to be investing a lot of subsidy dollars for small firm employees if you do make subsidy dollars available.

It seems to me, therefore, that you have a sensible concern about the administrative overhead of whatever structure you invest those dollars. And again, the current structure is I think by any measure profoundly inefficient.

The other thing I would like to mention that often is overlooked is, there is a very high level of turnover, not only in small firms themselves, but a high turnover in their workers. There is substantially more job mobility. There are more people with part-time jobs, with multiple employers, et cetera, making the small employer a relatively unstable place to base coverage.

And if you look at population based data, of those workers who are employed by employers under size 25, only 28 percent report they actually now get coverage through their own employer. I think that is testimony to a number of these factors that I have mentioned.

Now I will turn to a few of the most important policy issues and how those defer. I will only mention a few of them. We have provided a detailed matrix of a number of these issues.

The CHAIRMAN. That will be placed in the record, of course.

[The information appears in the appendix.]

Mr. CURTIS. Yes. Thank you, sir.

Number one, most importantly, and of greatest controversy: are these organizations to be the exclusive vehicle through which people who are eligible for them get coverage or are they to be an option. Again, under the Chafee-Dole bill they are optional. In fact, whether or not they exist in a given area is optional.

Under both of the other bills, they are exclusive. In the Clinton bill they are exclusive, for firms of 5,000 and less, making them the exclusive vehicle for covering the vast majority of the non-Medicare population. Whereas, under the Cooper-Breaux bill they are exclusive for small firms under size 100.

The Chafee-Dole bill makes people under size 100 eligible for purchasing groups where they exist; larger employers are not eligible.

One thing I would like to emphasize here, simply because as you all know, there has been a lot of advertising on this issue, a major purpose of these organizations is to give individuals choice of plans. And, in fact, small firm employees typically do not now have choice of plans when their employer happens to offer coverage, which is relatively unusual.

Because of the way the insurance market works and risk selection problems carriers would otherwise incur, the carrier contracting with an individual small employer will typically require as part of the contract that another plan not be offered. So it is nothing sort of disingenuous to represent health purchasing alliances as constraining choice of plans relative to the current market. Yes, small employers have choice of plans where they can find them; small firm employees typically do not.

The other thing I would emphasize is that under all three of these proposals all qualified health plans have to be offered by these organizations. They are not allowed to selectively contract, with the exception of the Clinton plan ties to their budget proposal, saying that the purchasing alliance could deny a contract to a plan whose premium is 20 percent over the average in the area.

In short, under all these plans, health purchasing alliances would be a vehicle that dramatically improves choice of plans. I would mention one other factor. Increasingly Americans are enrolled without reform in more or less integrated health plans. About 50 million people are now in HMOs. A large number of workers are in hybrid plans, be they PPOs or PHOs. The alphabet soup is almost endless these days.

The point is, choice of plan in large measure also relates to choice of provider. Health purchasing alliances, therefore, can give people complete choice of provider because every competing plan in the market would be offered through them. And as people change jobs, which often happens in the small employer market, they can keep their doctor.

I would be happy to answer any questions.

The CHAIRMAN. Thank you, Mr. Curtis.

[The prepared statement of Mr. Curtis appears in the appendix.]

The CHAIRMAN. And now, Ms. Jaggar, you have arrived with maps. We welcome you. You have a GAO study which you are going to summarize for us, if I am not mistaken—The Health Care Implications of Geographic Boundaries for Proposed Alliances.

STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. JAGGAR. Yes, sir. We have been thinking about Florida during these snowy and icy days. So we wanted to warm the place up a little.

I am pleased to be here today to discuss questions that have been raised about the implications of boundary alliances.

The CHAIRMAN. Could I just inform the committee, the committee requested this study from GAO.

Ms. JAGGAR. Thank you.

I will focus on four matters. First, the boundary provisions of the Cooper-Breaux, Chafee-Dole and Clinton health reform bills; brief-

ly, how metropolitan statistical areas are drawn; third, the experience of a State that has established alliances; and fourth, I will bring up several issues relating to the potential effects of alliance boundaries.

Before proceeding, I want to make clear that several matters of geography are separate from any health care reform proposal. As a generalization, while the provisions of each proposal affect the concerns I will discuss later, where or how a boundary is drawn probably cannot correct problems of access for underserved or rural areas.

First, to the provisions of the bills. The health alliances in the three bills all place enrollees in an alliance. The States are given responsibility for establishing the alliance boundaries. There are only a few constraints. One of these is that alliance boundaries may not subdivide a metropolitan statistical area (MSA).

Both the Chafee-Dole and Cooper-Breaux bills require a minimum population base of 250,000. While the Clinton plan does not specify a number, it does require that the alliance area include a population large enough to provide the alliance with bargaining power and to promote competition among plans.

Further, both the Clinton and the Cooper-Breaux plans specify that a single alliance will operate in each area. The Chafee-Dole plan only requires that the State designate health care coverage area boundaries. If one or more alliances is formed, then it must serve the entire area.

Finally, the Clinton plan does not permit alliance boundaries to cross State lines, although both the Cooper-Breaux and the Chafee-Dole plans do. All bills do permit health plans to operate across State lines or alliance boundaries.

Now a word briefly about the basic building block of the proposals, the MSA. In general, an MSA is a statistical area designated——

The CHAIRMAN. Ms. Jaggar, would you wish to introduce your colleague.

Ms. JAGGAR. Yes, thank you. This is my colleague, Mr. Glenn Davis, who has been working with us on this project.

The CHAIRMAN. Good morning, Mr. Davis. Welcome to the committee.

Ms. JAGGAR. He is going to point out a few things to you to help you understand the many lines that are on this map.

In general, an MSA is a statistical area designated by the Office of Management and Budget using the results of the decennial census. Standards and criteria for these designations are published——

The CHAIRMAN. Did you say that the MSA is designated by the Office of Management and Budget?

Ms. JAGGAR. Yes, sir.

The CHAIRMAN. And not the Bureau of the Census?

Ms. JAGGAR. Yes, sir.

The CHAIRMAN. Where does the work get done in the first instance?

Ms. JAGGAR. I am sorry?

The CHAIRMAN. Surely this was the Bureau of the Census.

Ms. JAGGAR. The Bureau of the Census, of course, gives to the Office of Management and Budget the information specifically about what has happened numbers wise in terms of the population changes in specific areas. That information comes routinely after the analysis of the decennial census.

That information is given to OMB. And then OMB, in accordance with criteria and standards that are published by them before the census is actually taken, analyzes those data and then works with those data to develop the boundaries of the metropolitan statistical areas.

The CHAIRMAN. We will get on to that later.

Senator DOLE. That is a fact, because I will add, we could not get them to agree to one. So I had to put it in a bill.

The CHAIRMAN. That is what I was thinking.

Ms. JAGGAR. That is why we wanted to talk about that.

The CHAIRMAN. It has long since left the pristine decisionmaking of the Bureau of the Census. Good. We will get back to that.

Ms. JAGGAR. All right. Good.

Each health care proposal requires States to keep MSAs intact when defining alliance boundaries, primarily to prevent discrimination of disadvantaged or high risk groups by health plans.

There are 329 MSAs in the United States. Mr. Davis will point out, just so you can interpret our map, that we have in Florida 20 metropolitan statistical areas. The different shades merely designate different ones. They do not indicate one is more dense or less dense than another in terms of population. Since they were next to each other, we needed to shade them in some way. So Florida has 20 different MSAs.

The CHAIRMAN. Why do you have 11 numbers?

Senator DOLE. That is 11 alliances.

Ms. JAGGAR. Right.

The CHAIRMAN. I got it.

Ms. JAGGAR. Thank you, sir.

I would like to point out that no plan deals with the issue of whether alliance boundaries must change in the future when MSA boundaries change. And as you know, MSA boundaries do change to reflect shifts in population.

Let me just for a moment talk about Florida, since we have it here on the map. Florida is the only State that has already defined alliance boundaries. Using planning districts that were established in 1976, Florida legislators divided the State into 11 separate alliance areas that they call Community Health Purchasing Alliances (CHPAs), ranging in population from about 500,000 each in Regions I and II, which are up in the panhandle, to about 2 million population in Miami, which as you see is down there. So Regions I and II and also III are generally considered to be more rural areas of the State.

Florida's decision on its alliance boundaries was the result of a difficult debate requiring compromise. Legislators provided for future mergers among these initial alliances, for example, up to three contiguous alliances that are not primarily urban.

Florida's alliance boundaries generally conform to the proposed requirements of the national health reform proposals that we are discussing. However, portions of the Tampa/Saint Petersburg/

Clearwater MSA are included in three separate alliances, which are Regions III, V, and VI that Glenn is pointing out there.

Also, the smaller alliances, numbers II and III, smaller in terms of population, in the Florida panhandle have relatively small MSAs themselves and greater rural populations and may not meet the Cooper bill requirement of a minimum of 250,000 eligible individuals to remain in an alliance.

Moving now on to some issues associated with a State's placement of boundaries: Questions arise as to whether the location of alliance boundaries will affect care. Specifically, citizens may ask whether they will still be able to use physicians, hospitals, and other health care facilities located outside the boundaries of their alliance.

Likewise, physicians and hospitals may ask whether they will be able to maintain the part of the patient base that is located in another alliance area. These concerns depend upon plans in the service areas covered and coordination between health plans, rather than on geographic boundaries. For example, some plans now provide care to residents of both Miami and Fort Lauderdale, areas XI and X on the map. That can continue if proper coordination occurs.

Another question is whether the structure of the alliances will make coordination of networks by health plans easier or more difficult. On the one hand, the creation of a standard benefits package could make coordination easier. On the other, it could be more difficult if States or alliances have different administrative requirements. It is possible that plans could be discouraged from seeking certification to operate in multiple alliances.

Coordination could be most critical in areas where alliance boundaries divide health markets, such as could occur in the 41 metropolitan statistical areas that span State boundaries.

The CHAIRMAN. That number once again. How many span State boundaries?

Ms. JAGGAR. Forty-one.

The CHAIRMAN. Forty-one?

Ms. JAGGAR. Right.

The CHAIRMAN. Almost as many as there are States.

Ms. JAGGAR. Right.

On the very back page of the testimony we have included a list of what those areas are that span State boundaries. In Florida you can see the potential for this problem for patients and providers in the Jacksonville, Pensacola, and Tallahassee areas.

Other questions that arise are as to whether alliances within a State will have a disproportionate share of a State's high risk population. Such alliances could have difficulty attracting a sufficient number of health plans to offer consumers an adequate choice. The extent to which boundaries could cause this to happen depends upon factors like the number of alliances in a State and whether States have metropolitan areas with markedly different demographic patterns.

This could exist when two adjacent MSAs have different proportions of Medicaid populations. And in southern Florida, 16 percent of the population in Miami is Medicaid or Medicaid eligible; whereas, only 8 percent is eligible in neighboring Fort Lauderdale.

Another question that has been asked about alliance boundaries is whether boundaries will be drawn in such a way as to redistribute health costs among different groups. Under each proposal, some people pay more for insurance than they do now and those extra payments will indirectly subsidize other people who will pay less than before.

In general, however, such redistribution is less a consequence of health alliances than of reform itself. While cost redistribution is inevitable under reform, alliance boundaries could affect whose premiums change and how much. Larger alliances would provide greater risk sharing among a State's population. Those premiums will be community-rated. Persons living in lower cost areas would pay more and persons in higher cost areas would pay less if health plans attempt to serve the entire alliance area. For example, persons in West Palm Beach or Boca Raton will pay more if their alliance is included with Miami.

At present, average net health insurance claimed costs in the Miami area are about 60 percent higher than costs in West Palm Beach and Boca Raton, and about 80 percent higher than in Panama City, which is located in Region II on the map, in a more rural area.

On the other hand, creation of smaller alliances within a State could also result in higher premiums for some persons, if disproportionate shares of high risk persons are concentrated in some alliances.

In summary, while an alliance has been proposed as a means for accomplishing several objectives under reform, provisions for establishing boundaries have been raising concerns. This includes whether alliance boundaries will be fixed or will change as populations change, whether patterns of giving and receiving care will change for individuals and providers, whether high risk groups will be segmented and/or isolated, and whether the way the boundaries are drawn will affect an individual's health care premiums.

This concludes my statement, Mr. Chairman. I would be glad to answer questions.

[The prepared statement of Ms. Jaggar appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Jaggar. I think it is the case that the GAO has not completed this work. You are here just to give us your findings as of this date.

Ms. JAGGAR. Yes, sir. We are here to raise questions.

The CHAIRMAN. Yes. You have not gotten very far along toward making some estimate of what we could expect in terms of the proportion of population that would see their premiums go up under various arrangements, as against those who would see them go down or find themselves covered where they have not been.

Ms. JAGGAR. That is correct, sir. We do not have data on that.

The CHAIRMAN. We had earlier testimony from Secretary Shalala, but we turn to you for this matter. You had better hurry.

Ms. JAGGAR. Yes, sir.

The CHAIRMAN. Senator Dole?

Senator DOLE. I was just given information about, State boundaries. I note that we talk about alliances in the States. Six States have zero to 15 percent living in border cities and counties; 15–20 States have 15 to 50 percent living in border cities and counties.

There are a great number of States with 50 to 85 percent of their population living in border cities and counties including States like South Dakota and West Virginia. States with 85 to 100 percent living in border cities and counties include—Delaware, District of Columbia, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, and Rhode Island.

I think your testimony is very important. We talk about State alliances and in many cases that is not the answer at all. There have been a lot of questions raised about plans. If I live in Kansas can I go to Missouri for treatment?

You have a map of Florida. I do not know how many hundreds of thousands of people from all over America go to Florida in the winter time. When I go, I am in alliance X. [Laughter.]

The CHAIRMAN. Yes, that is a very nice place. [Laughter.]

Senator GRASSLEY. Twenty percent higher than alliance XV.

Senator DOLE. But I guess the point is, if all this ever happens that we have all these alliances, are we going to be able to move around and get care anywhere or do you have to have permission from my alliance, say, in Kansas to have treatment in Florida or my alliance in Kansas to cross into Kansas City, MO for treatment? Could you address that?

The CHAIRMAN. Mr. Curtis, you might want to join in.

Ms. JAGGAR. Senator Dole, in fact, many of these issues occur today. You could be enrolled in one particular plan and go to another part of the country which does not provide services through that plan and you need to work out the arrangements for that.

Most plans, or, I think, virtually all plans——

Senator DOLE. Do I have to call somebody in the alliance that I am going to Florida to give me an okay?

The CHAIRMAN. No, no. You simply have to get a chit signed by the Chairman and the Ranking Member of the Committee on Finance. [Laughter.]

No problem. Anytime.

Senator DOLE. But I think it is a real problem out there. Maybe it is addressed in all these bills. But I think it does raise questions, practical questions, because this is a very mobile world we live in and people are moving all the time all across America. They may be in New York one night, Chicago the next night, and L.A. the next night.

If somebody gets sick and they are covered in an alliance in South Dakota or Kansas, what is going to happen?

Mr. CURTIS. As Ms. Jaggar mentioned, this is really an issue of health plan service areas and provider networks. It is an issue now. It is a growing issue. But under the Clinton proposal, for example, the States would continue to determine the service areas for which a health plan is licensed.

So really this issue does not change very much. There are things, of course, you could do in Federal legislation to help make sure that in all parts of the country plans are offered that make coverage available wherever a mobile worker might go. That could be a fairly simple clause. It would simply be to require, as in the Clinton bill, that there be a fee-for-service option, and to require that such fee-for-service coverage be accepted by providers around the country.

Again, this is not a terribly different issue than it would be now if someone visiting Florida is from a State that has a Blue Cross/ Blue Shield plan that has a fee schedule that a provider in Florida does not like. This kind of negotiation happens now.

It is not necessarily one that directly relates to the geographic boundaries for an alliance. It depends on which functions you give to alliances, vis-a-vis States.

Senator DOLE. I was at Mayo Clinic recently, just for sort of a check up and they have some concerns. Senator Durenberger knows better than I. They get about 60,000 patients a year who come from all over the country at Mayo. So I think it is a real concern. Maybe we can address it in the legislation.

Mr. CURTIS. Actually, as Senator Durenberger knows, I was on a panel with the president from Mayo at another committee hearing and he raised that issue. My understanding of their concern is the relationship back to the Clinton proposal and the budgets States are accountable for meeting which then pertain to State boundaries; I think this is a very legitimate concern, and one that you should address, if indeed there are budgets in whatever final legislation you propose.

But in that case States are holding alliances accountable to live within a certain number of dollars and the concern is whether a State will try to keep those dollars within their boundaries and make sure those dollars go to their own service providers.

Again, I think that is a completely separable issue from whether or not we are restructuring the market through health purchasing alliances.

The CHAIRMAN. Could I interrupt just to say, the great medical centers of this Nation are not a peripheral concern to this committee.

Mr. CURTIS. Oh, of course not.

The CHAIRMAN. What did the Director of the Mayo Clinic say was his concern?

Mr. CURTIS. Well, Senator Durenberger can correct me if I heard it wrong. But what I heard him say was simply that under a structure where a national health board sets budgets, per capita budgets, on a State and per alliance level, and they are not allowed to spend more than that.

Now is it not going to be natural human instinct to try to keep those dollars, that limited budget, within the State and make sure those dollars go to providers within the State?

The CHAIRMAN. So that you do not send someone to Mayo?

Mr. CURTIS. There could be an incentive not to send someone there.

The CHAIRMAN. Senator Durenberger?

Senator DURENBERGER. Mr. Chairman, and this is only by way of clarification. Using the District of Columbia as a health alliance, which is apparently a Clinton proposal, we are going to make some geographic area like the District of Columbia a health alliance, and get rid of FEHBP.

They will operate with a fixed budget with premium controls and so forth. And the first issue is, if you live in Arlington and commute in here, where do you get your health care. That is the first one.

Second is, are you entitled to get care in the District of Columbia if you live in Arlington and vice versa.

And the third one that I think we are getting at here is suppose you want to go to Sloane Kettering for cancer. Suppose you want to go to Johns Hopkins for liver.

The CHAIRMAN. Or need to.

Senator DURENBERGER. Suppose you want to go to Cleveland or Oxnor or Mayo for hearts or something like that and the cost of doing that is not provided for within the plan or more dangerously—I think the Mayo concern is that—let us use Iowa as an example, because Mayo is going into Iowa right now.

Suppose the Iowa Hospital Association goes to the Iowa legislature and says, let us make sure we have a provision in here that the first hospital access always has to be an Iowa hospital. That is their way of impeding competition and choice within that State.

Senator DASCHLE. Mr. Chairman, could I respond to that, too?

The CHAIRMAN. Please. Well, Senator Daschle, you are next.

Senator DASCHLE. All right. I am sorry.

Senator DURENBERGER. I am finished.

The CHAIRMAN. Senator Daschle?

Senator DASCHLE. Thank you.

I would just say that this issue of portability is important right now. Employees often choose plans for employees, who are then automatically required to use local or regional providers. Or, employees themselves choose plans that restrict geographic flexibility.

For example, I myself just received a list of providers that my plan tells me I have to go to. Now, remember that I do not have to sign up for that plan. I can choose because I am a member of the FEHBP.

But it seems to me that we are missing the point about the difference between an alliance and a plan. The alliance is an opportunity for a community to pool its resources in order to contract with the plans. The plan, on the other hand, determines the relationship between the provider and the user.

Under the Clinton plan if you want to maximize the number of providers accessible to you, you would pick a fee-for-service plan. That would give you opportunities to go to Switzerland for care if you wanted to.

But, what we can do is ensure maximum portability regardless of the plans we use.

Even if you were in an HMO that limits you to providers in a certain area, if you happen to be traveling or have a certain problem that cannot be addressed within that HMO, there should be a requirement that that HMO have contracts with providers outside its service area.

I think we all recognize that portability is critical. I would be interested in your answer to that, Mr. Curtis.

Mr. CURTIS. Well, this is, I think, restating in a slightly different way your point. Under all three of these plans, purchasing groups, or alliances or cooperatives would have to contract with all certified health plans in their geographic areas. Right now if people live in the Washington, DC area they enroll in a plan that is either licensed where they work or where they live.

Those plans have huge incentives to be licensed in all three jurisdictions for obvious reasons. They still would. The State would still be the entity that determines whether or not they are licensed and what their service areas would be. And, in fact, under most of these plans you enroll in an alliance based on where you live, not where you work.

My point is simply that with respect to geographic access, unless States did something about the way they certify and license health plans, not much would change. If you layer on top of this state-by-state global budgets, whether or not you have alliances, States might start doing something different in the way they license plans and review what their provider networks are.

I think that is entirely separable from whether or not people come through alliances to access health plans.

Senator DASCHLE. So it would seem to me that if you were to declare that portability is a fundamental goal here, that it has to be protected regardless of alliance boundaries, would you not then also protect access to providers of choice?

Mr. CURTIS. Yes.

Senator DASCHLE. We have talked about voluntary and mandatory alliances. I would be interested in your answer to concerns that voluntary alliances would multiply areas of isolated risk. Would you not exacerbate the problem of isolating high risk areas if you had voluntary alliances?

Let us assume, for example, you have an inner city that providers have traditionally avoided because you have a high number of uninsured people, maybe a high level of poverty. Or, perhaps you have a large rural area that is inaccessible to providers. You have a broad range of problems that cause most insurance companies to avoid serving certain areas.

Do you not exacerbate this problem if you give insurance companies the opportunity to concentrate alliances in those areas where risk is lower and a higher concentration of healthy people can be found?

Mr. CURTIS. Potentially you could. I suppose you could come up with a litany of rules that would solve that by saying, as the Dole-Chafee bill does in part, that there would be geographic areas defined and you would have to serve the whole geographic area if you are an alliance. You would have to be more careful about those boundaries to address that kind of a problem.

Senator DASCHLE. That is my point. If Congress is ingenuous in designing Congressional Districts, could we not gerrymander a risk pool in an alliance?

Mr. CURTIS. Yes, please do not take this as a political observation. It is, I think, a technical one. In this part of the market the population is highly fragmented and as long as you have entities out there that can selectively market and choose their risk, be it desirable socioeconomic groups, it will happen. And unless we are going to hire a legion of regulators, unless we restructure how people access health plans——

Senator DASCHLE. Say that again, Mr. Curtis. I am not sure I understood. You said unless we——

Mr. CURTIS. Unless we hire, in my view, a huge number of regulators to monitor plan behavior in direct marketing to contractors

with tens of thousands, hundreds of thousands, of individual establishments and individuals, there are going to be all sorts of risk selection games going on.

And while we all have hope that a risk adjuster can fix the problem across health plans, they only have the hope to do that if we are talking about substantial populations in given plans.

For instance, if we have a highly fragmented market with individual plans or multiple employer welfare arrangements or association groups or whatever having the ability to go out and pick who they want to make themselves attractive to, and by serving only healthier populations make themselves more affordable, and through one such way or another in a subtle way providing better service to the people they find to be more attractive in their actual experience, it is going to happen.

To me an attractive feature of the alliance or cooperative structure is, it makes it very difficult to do those things. You do not have to have a huge bureaucracy to regulate behavior. You have a level playing field by design.

The CHAIRMAN. Thank you, Mr. Curtis. I simply point out that in the summary paragraph of Ms. Jaggar's testimony on behalf of the General Accounting Office, it says of the various concerns, "These concerns include the potential for gerrymandering."

Senator Packwood?

Senator PACKWOOD. No questions.

Senator DOLE. Could I just ask a question?

The CHAIRMAN. Senator Packwood yields to you.

Senator DOLE. Tom asked an important question. I understand in California, for example, where they have a voluntary alliance plan, a fairly new plan, it does not seem to be attracting a higher percentage of bad risk.

About 22 percent of the companies applying to the alliance have never had any health insurance before. That is about the same percent of uninsured firms that apply to California Blue Cross and Blue Shield. So far it has not caused a problem.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Yes. I think my question follows right on Senator Daschle's. I do not think you have answered it. I hope you did not, because I think there is always an element of insurance market reform here that is going to eliminate the cherry-picking that insurance companies can do and the games that can be played that you define very well.

I want some further clarification then on this risk selection process and how it works with the alliances. I think one expressed what I think is some disagreement. First of all is whether or not the alliances would have a major role in this. I think you have just said to Senator Daschle that they will have.

But some people think that the elimination of risk selection is really a function of a small market, group market reform rules. I think that that is going to be in any plan we have that goes through here, even plans that are not all encompassing. We are going to have that as just kind of a consensus thing we ought to do.

Now some others argue that you cannot really eliminate risk selection without alliances and that would be particularly a basis for

President Clinton's plan. So would you address the question of whether alliances help eliminate risk selection, what is it about them that does that? Is it enforcement powers or pooling features, their administration of risk adjustment mechanisms or anything else you might want to think that does it?

Mr. CURTIS. In very simple terms, an alliance basically presents an individual a broad range of choices of plans and evenhanded information about plans. Nobody in the alliance structure makes more or less money if a high or low-risk person chooses Plan A versus Plan B.

In California with their voluntary HIPC, they do have an option for employers to pay more to use an agent or to pay less and directly enroll. The amount is laid out very explicitly and on a value added judgment basis, people can choose whether or not to use the option.

But if they use an agent, the agent is not paid more or less depending on which plan the person chooses. The person chooses based upon information about plans, including patient satisfaction and other kinds of objective data. Yes, there would be mass marketing and that might influence some people's choice. Also word of mouth is going to inevitably influence people's choice.

But you do not have a structure where you have not only health plans but all sorts of other kinds of intermediary organizations with a proprietary interest in getting higher or low-risk person to choose this plan versus that plan because they make more money. I think that is a fundamental difference.

Senator GRASSLEY. And your answer to me is that this takes all this risk selection——

Mr. CURTIS. Oh, no, no, no. There is still going to be risk selection. Some of it by luck of the draw, some of it because the health plan in an area that happens to include Mayo is going to get more people who are high risk with respect to certain clinical conditions than will other plans, for all the right reasons, not for the wrong reasons, because that plan is going to take better care of them.

And the risk adjuster can deal with that kind of environment if you have large pools of people. But I do not think any time soon, based on what the experts tell us, that a risk adjuster can cope with systemic fragmentation of risks across many, many small pools of people.

Senator GRASSLEY. Well, you are saying that the alliance takes care of this then in their pool selection process. They will have a risk adjustment mechanism and they are also going to have enforcement powers. So it is all of those; is that right, that is going to be involved in this risk selection problem that comes out there.

Mr. CURTIS. Right. And again, it provides by definition a level playing field through which individuals can choose a plan.

Ms. JAGGAR. Perhaps I might add to the table the concept of community rating. This is an important component of the alliance, part of its value. What it does is, by having a community rating, by including within it the people who have different risks, different needs, different ages, different sex, various different factors, you establish one fee, one price for a particular plan for a particular group of people for everyone based on the community rating.

You are not going to have the individual rating, individual price.

Senator GRASSLEY. Well, I think it is almost a given that—it is a little more controversial on community rating, but it is almost a given that there is going to be some sort of community rating, modified community rating, and eliminating cherry-picking, et cetera.

Ms. JAGGAR. Right.

Senator GRASSLEY. The extent to which you do that then the problems of the alliance are less and that makes less necessary mandatory alliances, as opposed to voluntary cooperatives or something.

Ms. JAGGAR. What that does is makes a more or less level playing field for the consumer, for the patient. The risk adjustment is designed to level the playing field, if I may oversimplify things, of the insurer, of the plan. So if a risk adjuster can be put in place that works effectively, it takes away the financial advantage to a plan to deal with a particular population group or group of individuals as opposed to dealing with some other group of individuals.

The CHAIRMAN. Well, thank you, Ms. Jaggar.

Thank you, Senator Grassley.

Senator Breaux of Cooper-Cooper-Breaux.

Senator BREAUX. And Durenberger.

The CHAIRMAN. And Durenberger.

Senator BREAUX. Thank you very much, Mr. Chairman. I thank the panel. I think we have gotten some helpful discussion here, but I am concerned that the CBO report and Mr. Curtis' testimony, while very helpful in a discussion on the boundaries and perhaps the size of the health alliances, have not gone into the most important issue in the debate over health alliances.

It is not so much the boundaries and the size. I think we can handle that. There is not that much difference between I think the administration's proposal and the so-called Cooper-Breaux proposal and the Chafee proposal as far as the goals of the alliances. I think they are all very similar—to share administrative costs, to spread the risk and also to give leverage to purchasers of health insurance. All that is all right.

The real problem is the role of the alliances, whether they are a purchasing cooperative or whether they are a regulatory agency. And the CBO report that we had really, I think, emphasized that. We have not got it on Cooper-Breaux. We will see what they say about ours.

But what they said about the health alliances and the CBO report was really, I think, very, very important. We have not had any discussion on that. I would hope that at some point we would have an opportunity to have a discussion.

The CHAIRMAN. And we will.

Senator BREAUX. Is there going to be another panel on health alliances about the role of the alliances?

The CHAIRMAN. Let us talk about the schedule. But anything anybody wants to discuss on this committee——

Senator BREAUX. Because I think that is going to be the real problem. Are we going to have the health alliance as a regulatory body or are we going to have a health alliance that is more of a non-regulatory purchasing cooperative.

Because what the CBO report said and the Clinton plan—again, we have not had it on ours yet, we will—but the health alliances in the President's plan would combine the functions of purchasing agents, contract negotiators, welfare agencies, financial intermediaries, collectors of premiums, developers and managers of information systems, coordinators of the flow of information and money between themselves and other alliances. They would also have to implement the premium controls.

They point out that any one of those things for an existing agency would be a real problem, let alone doing them all for a brand new agency.

Mr. Curtis was saying—I do not know if that is what you looked at. Do you have any comment on that?

Mr. CURTIS. Well, as I said earlier, those issues which are raised by the regulatory role of alliances, specifically in the Clinton proposal, I believe involve separable macro policy judgments that you people need to debate.

Whether or not an alliance is asked to play those more governmental roles with respect to fee schedules or enforcement of global budgets or administration of subsidies, I believe is separable from their role as purchasing cooperatives.

There is an elegance if you decide to have one organization do them because these functions do interrelate. However, my subjective view is, at least for now, it would be better to have the health alliances focus on being the purchasing cooperatives. If you want to do those things, do them separately.

The CHAIRMAN. We want to do the things that were in the list of the GAO report that Senator Breaux read; is that what you are saying?

Mr. CURTIS. The things that he labeled regulatory things.

The CHAIRMAN. Which the GAO—you were reading——

Senator BREAUX. No, this is the CBO report.

The CHAIRMAN. CBO.

Senator BREAUX. CBO, this was Reischauer's report.

The CHAIRMAN. Yes. Forgive me.

Senator BREAUX. Ms. Jaggar, do you have a comment on that?

Ms. JAGGAR. Many of the functions that were listed there are ones that already are going on. For example, enrollment, eligibility, and many of those determinations are being done in other parts of the social services system.

I think that there is considerable opportunity to discuss whether those functions could, in fact, still be done by those entities and organizations, parts of government in some instances—State Governments or whatever—that do them now or whether they necessarily need to be brought under the control of an alliance.

We have had an opportunity to look at some of the functions in California, of the CalPERS system and later today you will hear testimony from the folks who run the HIPC there in California. They have found that they are able to perform the functions that they have to perform either in-house or out-house in different ways, very effectively with a smaller staff.

I think the issue of what the costs and roles will be is something that turns a lot on what those final functions are of the alliances.

Senator BREAUX. Well, we want to make sure we do not create an outhouse.

The CHAIRMAN. Senator Breaux, we thank you very much, sir.

Senator Bradley?

Senator BRADLEY. Ms. Jaggar, let me try to go back to an earlier question. They have New Jersey; we have New York. Each one has a State health alliance. Right? And yet we have an MSA that is somewhat overlapping. If you were brainstorming for the committee, what are the difficulties that you see with a State-based health alliance and a divided MSA?

Ms. JAGGAR. In fact, essentially this same thing exists today because the State regulations that New Jersey places upon the health plans that exist and serve people within the State of New Jersey, those plans must abide by those regulations, those rules that the State of New Jersey places upon them.

Similarly, those plans that operate in New York, whether they are the same plans or different plans, must abide by New York rules. So those issues of coordination from the plans' perspective exist today and people have pretty much worked out how to make that cross between the two.

If a State alliance or maybe not a statewide alliance, but a local alliance, establishes requirements that the individual plans must meet to operate within that alliance, and those requirements are unusual or very onerous or quite different from the requirements from its contiguous MSA or contiguous alliance—whether it is within the same State or across the State boundary—you then may have a disincentive as it were for the plans to serve people in both of those places. It would be a plan's choice as now laid out and they could choose not to serve someone, to provide services within that next alliance.

So you would hope, you would want to strive, for ease of coordination between and among the alliances regardless of whether it was an MSA boundary or not.

Senator BRADLEY. And you said that you could write rules so that that would not happen. Why would you write a rule that says that a New Jersey resident effectively could not have his State based alliance pay Mt. Sinai if he were going to get treatment at Mt. Sinai or New York Hospital?

Ms. JAGGAR. Well, the kind of things that might occur would be perhaps one alliance may have very demanding data collection requirements because they want it for their report cards or for the outcomes and they would place a lot of demands upon a plan to provide onerous information. They may have a very complicated process.

It is perhaps farfetched, but it may be an example that is simple to understand and plain, to say, "we just do not want to play in that alliance anymore. It is just not worth it to us because of the onerous administrative burden."

Senator BRADLEY. You mean New York could have onerous data collection.

Ms. JAGGAR. It seems unlikely.

Senator BRADLEY. And New Jersey was—[Laughter.]

The CHAIRMAN. That will be stricken from the record. [Laughter.]

Senator BRADLEY. Is that your only concern?

Ms. JAGGAR. Well, there are a number of other concerns in terms of coordination. But I think we find that there are many of the kind of coordination activities that States naturally do in State regulation.

Senator BRADLEY. But the fact that the premiums will be set on a per capita basis would imply that you see no problem about comparative costs across State lines in a metropolitan statistical area?

Ms. JAGGAR. Well, yes, you are correct in pointing out that if the fee schedule, the amount that was reimbursed providers, or that plans received back, were greatly different in two contiguous areas, it might be disadvantageous.

Senator BRADLEY. So you are saying that if it is more expensive to get an open heart surgery in New York than it is in New Jersey that the New Jersey health alliance might say, no, we do not pay for the heart surgery?

Ms. JAGGAR. It is a plan process.

Mr. CURTIS. Again, Senator Bradley, it is the health plan that is reimbursing the hospital and it is the health plan that is contracting with the hospital, not the alliance.

Today health plans increasingly have incentives to find the most cost effective hospitals to contract with. With this kind of structure, presumably there are going to be more cost pressures and more price competition. So those pressures might increase.

But that does not relate to the purview or the functions of the alliance, except, that the Clinton plan does have alliances negotiating fee schedules for providers that then would be paid by the fee-for-service plans.

Now if the State or alliance is doing that, obviously that has implications. Because then, no matter who the health plan is, they are paying that provider just as Medicare does on a DRG basis, an amount determined by an alliance in negotiation with providers who are representatives of those providers in that area. Then you get into that kind of an issue.

Again, that function of alliances is an artifact of a specific component of the Clinton plan that does not have anything to do with the core alliance functions of contracting with integrated health plans. The question is, do you want states or alliances setting provider fee schedules.

Senator BRADLEY. Well, I think this is going to have to be a subject that we come back to, just because I am not exactly clear on it. Could I ask one more quick question?

The CHAIRMAN. Please.

Senator BRADLEY. How would you weigh the advantages of having competing alliances in a kind of designated area versus having an exclusive alliance within a designated area? What do you see as pros and cons?

Mr. CURTIS. The pro is an obvious one, I think. People feel like they have some choice. And presumably if there is choice that is an incentive for individual alliances to perform better because there is some place else for people to go.

Now the fact of the matter is, consumers could have choice in the things they see and experience with one alliance. If you are on the roll of an alliance, what you see is pieces of paper and whatever

mechanisms are used for you to choose a plan and get the payment to an alliance.

In fact, a single alliance could have alternative ways to do that and competing vendors to do those things. So you might be able to—that they could fire. And in most States where alliances are going up, they, in fact, are hiring a contractor to do these things.

The most obvious example is again in California. You can use an agent and pay more or you can directly enroll. So there is already choice even thought it is only one alliance, in this case competing with the rest of the market.

The big con that people worry about, including I know Enthovin worries about this, you might inevitably have alliances interested in risk selecting who they enroll.

Senator BRADLEY. If you had a single alliance?

Mr. CURTIS. Not if you had a single alliance. If you have more than one.

Now some people, for example, big employers who have been reviewing this, think, gee, maybe you should have competing alliances so that they are able to be purchasers. They should be able to selectively contract. That gets you into a whole different range of issues and none of the three bills before this committee allow an alliance to do that.

But many of the people who seem to be most interested in the idea of competing alliances, want them to be able to choose the most cost effective plans that they would contract with.

Now the Chafee bill allows there to be more than one alliance, allows there to be multiple employer welfare arrangements, allows there to be a variety of other ways in which people can get coverage. And the alliance in that context simply becomes a way to access all of the plans in the market for an employer's individual employees and to give them choice. And it is not playing any of these other kinds of functions.

In that context, as long as those plans are community rated, I am not sure it matters if there's only one.

The CHAIRMAN. Thank you, Senator Bradley.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Mr. Curtis, I do not know whether I am amused or amazed, but alliances I think probably because of the design of some people, have taken on a bad name to some. It is perfectly clear to me that you cannot have a health care plan that works in this country without an alliance. And that anybody who thinks you can have a health care reform plan without an alliance is living in thin air.

Now I happen to think that somebody—I think you have to have a single alliance, for reasons which you have just given, and one which you did not, and that is if you have multiple alliances you double or triple, whatever it is, the bureaucracy.

But alliances are far more efficient. There is nothing else that has been devised by mankind so far within the North American continent at least that brings down cost, that gives, you know, FEHB one-tenth of 1 percent. Everything else, premium dollar, goes to health care. Nothing else gives the consumer the power that the consumers never had before.

Right now the consumer—let us say the consumer works for business. The business negotiates with an insurance company. Whatever the result of that negotiation is, that is what he or she lives with, no particular choice of plans, no choice of anything, no choice of how much you have to pay the next year to increase premium. It just goes. It just happens. And that alliances not only reduce the bureaucracy it reduces the costs of all of this relative to the present circumstance.

I have heard no arguments from either of you that cause me to think anything different. So my question of you is, why is it that we are having this argument over whether alliances are useful or not. I mean, they are manifestly useful. People who want to undo health reform or slow it down or change it to their own advantage are raising these questions, but they are manifestly inappropriate.

There cannot be health care reform that is efficient, that gives consumers power that they do not have in this country without alliances. Am I right? [Laughter.]

The CHAIRMAN. Now, Mr. Curtis, careful. [Laughter.]

And, Ms. Jaggar, remember you are a government employee.

Ms. JAGGAR. Yes, sir. [Laughter.]

Or I was. [Laughter.]

The CHAIRMAN. Well, thank you very much. [Laughter.]

Senator ROCKEFELLER. It seems to me a fairly basic question.

The CHAIRMAN. Please go ahead and give your own judgment.

Mr. CURTIS. If we are going to have systems reform that at least eventually covers the uninsured and does so by giving people a choice of competing private plans rather than through a single payer system. I do not care what the name of the organization is, or whether you divvy these functions up a bit, but something is needed that very efficiently gives people a choice of these plans, especially in the smaller employer and individual market, and provides evenhanded information and is easy to use.

And again, people can disagree on some of these other issues, whether these things should have some regulatory powers or not. That is a legitimate point of dissension and disagreement. But the core functions that I talked about in my testimony, again, somebody needs to do these things if this kind of reform is going to work.

I think the fact that all three of these bills have these functions included and have somebody doing them recognizes it. My own view is, at least for small employers and individuals, the only way to do it efficiently and effectively in a user friendly way is through these organizations that we can call cooperatives or alliances or groups. I do not care what the name is.

Senator ROCKEFELLER. Well, there is a difference between mandatory and voluntary.

Mr. CURTIS. Yes. [Laughter.]

But again, these are vehicles to get people to health plans. And the important thing is the competition among health plans and people's choice of plans and finding the best way to do that. People can legitimately disagree about the best way. But it seems to me that the real debate should be an honest debate about what is the best, most efficient, user friendly way to do that.

Senator ROCKEFELLER. But then if one is honest in this discussion and one—I mean, you know, there are people in the Congress who do not like the word alliance because it connotate government or something or regulatory or whatever.

On the other hand, that is not an excuse it seems to me for saying, oh, gee, then let us just make them voluntary because if we make them voluntary then we do not have to worry about any of these other words which we are embarrassed to explain to our constituents because they are all just voluntary. And if it is voluntary then what difference does that make?

Well, that is the same thing as saying, well, I will just offer—you are saying it to a business—that you can offer your employees a health care plan but you do not have to pay for it. So I mean, yes, of course, you can have a voluntary alliance and you can also make the statement I think quite fairly that that represents no significant change from the health care system than we have today. Am I right, Mr. Curtis?

The CHAIRMAN. The Chair rules that you are right. [Laughter.]

Senator ROCKEFELLER. Mr. Chairman, I was asking Mr. Curtis because I think this is an important point. I think this is a very important point. I think voluntary alliances are a dodge on the part of those who wish to sort of strip away from their own arguments, their own causes the words bureaucracy and other things which are unpleasant for them to explain to their constituents.

But if we are talking about serious health care reform, I do not think competing alliances which bring you right back to the situation we have today in terms of aversion to risk and all this kind of thing work. I really want to have your view on that.

The CHAIRMAN. I only wish to make the point that individuals and organizations are free to establish "alliances" today if they wish to do. But the question of requiring them is what we are talking.

Senator ROCKEFELLER. Exactly. And they are free to do that today and for the most part they choose not to, which is why we are going from a trillion dollars in 1994 to $2 trillion in the year 2000, which is less than 6 years ago. I mean, this is quite my point.

Mr. CURTIS. I do not want to, of course, attribute motives. If you look at the Chafee-Dole bill, again, most of these functions are there. They have tried to find a way to make it work without requiring people to go to purchasing alliances.

I have spent a lot of my time over the last 5 or 6 years in a variety of places working on rules for the small employer market to try to fix it. In my view, that part of the market is so broken and so dysfunctional that you do need a different structure.

I do not think there is a way to efficiently solve these problems without a structure that is something like an alliance. Again, in the small employer market under the size of 25, it is not like most people are getting coverage, through direct employer contracts now. It is only 28 percent.

The CHAIRMAN. We are going to have to keep moving.

Mr. CURTIS. All right.

The CHAIRMAN. We have a panel still to come.

Senator Rockefeller,is that all?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman and thank the panel as well.

I want to return to the issue that Senator Breaux has raised, because in reading the Congressional Budget Office review I must say I come away very concerned with the notion of how we structure these purchasing pools or alliances or purchasing cooperatives or whatever they are called.

It does seem quite clear that we need those functions performed. That raises the question of how they get performed. And when I read the Congressional Budget Office study it seems to me that they make quite clear that there is great doubt about how a whole new institution could take on those functions versus using existing enterprises and entities.

Let me just say, my own conclusion is we would have chaos if we went around the country and established whole new institutions that had to secure office space, hire staff, develop systems and then take on these very complicated functions.

I mean, it reminds me a little of the RTC situation, where instead of using existing institutions to perform functions, we went out and created a whole new structure, all across the country, and I think it was a fiasco. My own view is, it is one of the biggest mistakes that has ever been made by a government.

I am very concerned that we are going to repeat that exercise if we create new institutions to carry out these functions. So my question to you is, is it possible to use existing institutions to carry out these functions and what most logically would those existing institutions be?

Mr. CURTIS. I am just going to talk about the core functions of a purchasing cooperative or alliance that get people a choice of plans and enroll them in the plans, just those core functions.

I think the best example we have is the one in California, which is voluntary. But in terms of getting the infrastructure up, what they did is instructive for what is going to happen in most parts of the country as cooperatives or alliances are being implemented. For the core administrative functions, they had competitive bids from private sector vendors that have relevant experience.

They ended up with bids for the core functions like enrollment and premium collection that were far under what people in the industry said was possible. And they were from institutions that now perform similar functions. The fact of the matter is, they could be done for less when there are these kinds of economies of scale.

Senator CONRAD. But existing institutions——

Mr. CURTIS. As vendors.

Senator CONRAD.—bid on taking on the responsibilities for these functions. And they came in with very dramatic reductions in the cost of carrying out such functions.

Mr. CURTIS. Yes.

Senator CONRAD. What were those? Can you give me some flavor for what those existing institutions were that made these bids?

Mr. CURTIS. They varied from insurance companies that had experience in collecting premiums from individual small employers to

data firms. The next panel has someone from California and she can give you far more detail.

Senator CONRAD. Yes.

Mr. CURTIS. We are finding that there are a large number of organizations from data firms to American Express to computer companies like EDS to companies you have heard of like Mercer-Meitin. There are a large number of companies that are starting to look at what is happening here and gearing up to be able to perform these functions.

What I would anticipate will be true, even if you do not do anything as the States begin putting these up, is that companies like these will be performing the administrative functions. The nice part about that is, number one, it can be done quickly and inefficiently. Number two, they can be fired if they do not do a good job.

We are not talking about the establishment of huge new government bureaucracies with employees who are vested who cannot be fired. We are talking about, for most of the functions, private sector organizations who are competing against others and are submitting competitive bids and will get fired if they do not perform.

Senator CONRAD. And they are operating. You do not have to go create whole new institutions.

Mr. Chairman and other members of the committee, I hope we will concentrate on this point very carefully. I think this is awfully good advice that is coming our way. I think we would have the potential for chaos if we were to have these whole new institutions created. I just think it invites very serious trouble.

I thank the Chairman for the time.

The CHAIRMAN. I thank Senator Conrad.

Mr. CURTIS. Can I clarify one point?

The CHAIRMAN. Please, sir.

Mr. CURTIS. Just to make sure I was not misheard. These are alliances or cooperatives that are new organizations, but they have very limited staff and then they are contracting these administrative functions out.

The CHAIRMAN. Right. Fine. May I say we have a panel that has been very patiently waiting. The hour of noon has arrived.

Senator Roth, you are going to be last, but you can be next if Senator Durenberger does not mind, and do not forget Senator Chafee. Yes, this is right. It has been a long time since you have spoken.

Senator Roth, do you want to just ask a few questions?

Senator ROTH. Yes. I have some concerns with the structure and size of health alliances. I represent Delaware, a very small State where the majority of people do live on the borders. We could end up with a situation where the State health alliance has a larger budget than the entire budget under the jurisdiction of the Governor.

This brings up, it seems to me, a whole series of questions regarding who is appointed or elected to run the alliance, and to whom are they accountable.

Frankly, the decision on exclusive alliance would be making you could have tremendous repercussions it would seem to me on our economy, our State's economy, as well as our health care.

Have you had the opportunity to determine what would be the effect of a State's ability to govern itself if alliances budgets are bigger than higher State budgets?

Mr. CURTIS. The alliance is a conduit. The health plans and the providers get the money and the alliance is an intermediary and would deposit the funds in banks. It is not as if alliances is an organization like State Government that has an Appropriations Committee or other ways of subjectively deciding how the money is spent.

There will be large amount of money, involved even if alliances only serve smaller employers and individuals, I think. It is going to be very important that you make sure that this system has a high degree of financial integrity.

Ms. JAGGAR. And perhaps, Senator Roth, I could add that in Florida where they are beginning to set up their 11 alliances, the budget for each of the alliances as appropriated by the State at this point is $275,000 a year at this time. They are not considering the premiums that will flow through the alliance to be part of their budget. It is not their money to deal with.

The CHAIRMAN. May I make this point, since Ms. Jaggar mentioned Florida once again, that Governor Chiles, our former colleague, has a letter on this subject which he would like to place in the record and I will do so at this time, not interfering with your questions, sir.

[The letter follows:]

STATE OF FLORIDA, OFFICE OF THE GOVERNOR,
Tallahassee, Florida, February 24, 1994.

Hon. GEORGE MITCHELL,
Majority Leader,
U.S. Senate,
Washington, DC.

Dear Leader: I've read recent articles in the *Washington Post* and *New York Times* that call into question the soundness of health care purchasing alliances envisioned in the President's reform initiative. Since Florida has moved from the drawing board to the front lines of health care reform, I thought you might be interested in our early experiences with our own purchasing alliances.

We have established eleven Community Health Purchasing Alliances (CHPAs) with exclusive geographic territories. Each is governed by a 17-member board of directors made up of business, consumer, and government representatives. Membership is open to businesses with 1–50 employees and the state will be purchasing health care for its employees as well as Medicaid recipients through the alliances. Large businesses are joining as "associate members" to gain access to the outcome data being collected by each CHPA from the Accountable Health Partnerships (AHPs). This year we have proposed to the Legislature that membership in CHPAs be expanded to individuals, businesses with up to 150 employees, and local governments.

One criticism of purchasing alliances is that they will become huge bureaucracies that will increase administrative costs. Florida's experience has been quite the opposite. Our purchasing alliances became effective October 1, 1993 and, in four short months, have organized their boards, hired an executive director, located office space, and most importantly, issued requests for proposals to AHPs for our standard and basic benefit plans, and to Third Party Administrators (TPAs) that will provide member services. Bids by the AHPs were opened in each CHPA region on February 10. The alliances are now in the process of selecting TPAs to develop AHP comparison sheets for members, collect premiums, and market to potential members. We expect health plan coverage to CHPA members will begin on May 1. These accomplishments were realized by volunteer board members with a skeletal staff. When the CHPAs are fully operational, they will have no more than three staff each.

Our alliances have not added administrative costs to the system. In fact, they have already made substantial progress toward their goals of stimulating competi-

tion in the health care market, pooling the purchasing power of businesses, and providing members with a choice of plans, lower premiums, and high quality health care.

When the AHPs' bids were opened on February 10, consumers across Florida got a late Christmas present. In every region of the state, CHPA members have a wide variety of plans to choose from, including HMCs, PPOs, and indemnity plans. Throughout Florida, alliance members will be able to purchase health care coverages that are comparable or better than their existing coverages at lower prices. In most cases, members will enjoy substantial reductions in the premiums by purchasing health care through the CHPAs. We have also experienced an interesting phenomenon I call the "sentinel effect" where progress of the CHPAs has had a constraining effect on the outside market. Each CHPA is currently analyzing the flurry of bids they received and I will provide you with more detailed results as soon as they become available.

While we think we are on the road to success, I must note that we are concerned about the potential for AHPs to "game" the system. We are anticipating, based on our experience prior to our insurance reforms taking effect, that companies not participating in the CHPAs will use marketing methods that steer potential members away from the CHPAs and steer risk into the CHPAs. Without mandatory AHP participation in the alliances, we will need to be vigilant to protect the CHPAs from these manipulations.

Mr. Leader, I hope this information will be useful to you as you deliberate the merits of the president's legislation. If I can provide further information, please don't hesitate to call me at (904) 488-2272.

With warm regards, I am

Sincerely,

LAWTON CHILES

Senator ROTH. I am finished.

The CHAIRMAN. Thank you.

Senator Durenberger?

Senator DURENBERGER. I just will lay a question on the record and perhaps it will be responded to. But I do not want to miss the opportunity as others may have in my absence to compliment Rick Curtis on his professional commitment to this very, very difficult area.

I think when I came here you were here, Rick, and I have admired your work for the 16 years I have been here, out there in a very difficult area. So I am really grateful to the staff for having asked you to come today. I want to say to all of my colleagues that this is a person of great professional skill. He may not have all the right answers. [Laughter.]

Senator DURENBERGER. But he is very good. I guess the question that I wanted to ask because the problem that I think is escaping us here a little bit is the distinction between accountable health plans and the alliances as you both pointed out.

The concern that a lot of people have about going right away to a defined alliance, prescriptive borders with exclusive powers and so forth, is that the accountability function that current alliances perform, like General Mills for its employees or the FEHBP or all of us may be curtailed.

A lot of those accountability functions in a changing accountable health plan market might be limited by the degree to which we set one set of rules or particularly if we allow States to start to negotiate. So I come down on the—and I know these terms are confusing; and I am in both camps. Like I am over here in the exclusive mandatory camp with John Breaux. Then I am over here in the competing voluntary camp with Chafee-Dole.

But suppose we have a system that would require everyone to buy accountable health plans through a coop, alliance, whatever

you want to call it. In other words, that is the mandatory part of it. But it would allow competing alliances to exist, so that General Mills could be an alliance, the Implement Dealers Association in Kansas can be an alliance. You can have various of these choices. I do not know whether competing is the right word. It happens to be the one that is used in Chafee-Dole.

If all of the alliances were required to enroll everybody who came forward, and in effect, you know, play by the same rules, might this not be a good middle ground solution to some of the debate that has been going on here this morning?

Mr. CURTIS. It may well be. There are problems. For example, if you were trying to mainstream the Medicaid population through alliances. If there are a large number of alliances, only some of them are likely to have plans that actually serve the geographic areas with large proportions for poor folks. So you would end up with maybe Medicaid II: a poor person's alliance.

Senator DURENBERGER. One of the defects, I think, in Breaux-Breaux-Breaux-Durenberger is that in effect we put the low-income Medicaid population right in with small groups. That probably is a defect that we need to try to deal with.

The CHAIRMAN. By small groups you mean small firms?

Senator DURENBERGER. Yes, small firms and individuals.

Mr. CURTIS. Well, the population in that bill may be big enough. This depends on whether you are paying full freight for the population or cost shifting to the other members of the alliance. If you are paying market rates for the plans, I think that you have enough people in those structures that it is really not a problem. You are talking about close to half the working population.

Senator DURENBERGER. But the problem is that we didn't know a lot about these new people, these low-income people. We do not have a lot of information about estimating costs of absorbing that particular population under these groups at least in the beginning.

Mr. CURTIS. From what we know about these populations—and you are right, it is imperfect knowledge—I am not particularly worried, other than the chronically disabled population and the frail, elderly population and other institutionalized populations that, in fact, the average per capita age adjusted expenditure is going to be all that much different.

Again, I think in that bill if you have one alliance per area they are probably big enough. It is a matter again of whether you pay market rates. But if you had a large number of competing alliances, it would be more problematic. Maybe if you had a few it would be more workable.

Senator DURENBERGER. Thank you.

The CHAIRMAN. You said that it was not clear that the per capita costs of Medicaid individuals was that much different from the population generally controlling for age, arrangements, and such.

Mr. CURTIS. Well, obviously, the developmentally and physically disabled, the frail elderly in nursing homes.

The CHAIRMAN. Controlling those.

Mr. CURTIS. Physically those populations cost more.

The CHAIRMAN. Yes.

Mr. CURTIS. And medically needy people who are on Medicaid because of their high medical expenses, of course, are expensive by

definition. But the other (far more numerous) populations, and I was also talking about the uninsured low-income workers of whom there are many. I do not think from what I know—this is a very complex subject—that the per capita costs, across all those kinds of people once they are in the system is going to be higher on an age adjusted basis.

The CHAIRMAN. That makes perfect sense actually.

Senator Durenberger, thank you, sir.

And now our last question of this distinguished panel from Senator Chafee of Chafee-Dole.

Senator CHAFEE. Thank you very much, Mr. Chairman. This will be brief. Mr. Curtis, if there is one mandatory alliance, I think we agree that the possibilities of risk selection can be severely curtailed.

Mr. CURTIS. Yes.

Senator CHAFEE. But there are down sides of this. As I understand it, you testified to some of those down sides, which I certainly think exist, and I think you phrased them as what happens if it is not user friendly, this mammoth alliance.

We, as you know, in our legislation, strongly believe that risk selection can be limited in a voluntary alliance arrangement. We believe that if you have these ingredients there which are—you require community rating, and you have designated enrollment offices, and you apply risk adjustment—if you have those features in there, then you can, in the voluntary alliance arrangement, severely limit risk selection. Do you agree with that?

Mr. CURTIS. You can certainly substantially reduce it. I do not believe you would be as assured that it was reduced to levels you would want it reduced. And with an alliance structure I think you can. This issue of the designated enrollment office and what those look like, how easily accessible they are, who is monitoring plans to make sure they do not serve people who cost more less well. There are a lot of those kinds of things that someone needs to do.

I know in your bill you tried very hard to think through who could do those things. I understand that you are revising your bill to try to solve some of the problems that were still there.

I think ultimately, again, when you are talking about small employer and individual part of the market, in order to do those things well you will end up with something that is administratively far more expensive and cumbersome than an alliance, whether it is exclusive or one of several competing alliances would be. I think that is the single biggest down side.

Senator CHAFEE. But there are down sides to the other approach likewise.

Mr. CURTIS. Yes.

Senator CHAFEE. What happens if they are not user friendly if you have a single one?

Mr. CURTIS. True. That would present problems.

Senator CHAFEE. Good. Thank you very much.

The CHAIRMAN. Thank you, Mr. Chafee. Let me echo Senator Durenberger's thanks to Mr. Curtis who has obviously made such a deep study of this for so very long. We thank you, sir. We thank Ms. Jaggar and all those good citizens at the General Accounting

Office. You are not quite finished yet. Steady on. And again, our appreciation.

Now we have our concluding panel of the "morning." Four very able and learned persons. We will ask people to come forward. You are all very welcome. We want to thank you for your patience.

Now our four witnesses are Lisa Carroll, who is a registered nurse and vice president of Health Services of the Small Business Service Bureau, Inc. of Worcester. Ms. Carroll, good morning to you.

Lesley Cummings is Deputy Director for Administration and Fiscal Integrity—I am glad to hear that—for the State of California Managed Risk Medical Insurance Board. Ms. Cummings, good morning and welcome.

Kevin Flatley, who is Chairman of the Board of Directors of the Association of Private Pension and Welfare Plans of New York City.

And finally, a good friend of this committee, Cathy Hurwit, who is Legislative Director of Citizen Action.

I am going to regretfully have to state that we must be finished by 1:00. So would each of you keep at 5 minutes. Unfortunately, we will put the bell on so you will know. Then we will have a chance to talk.

So, Ms. Carroll, good morning. Go right ahead.

STATEMENT OF LISA M. CARROLL, R.N., VICE PRESIDENT OF HEALTH SERVICES, SMALL BUSINESS SERVICE BUREAU, INC., WORCESTER, MA

Ms. CARROLL. Good morning, Senator. Thank you. I am the other person from the provider community that is now working on the access and affordability issue for small employers. The Small Business Service Bureau is a national membership organization which actually was started by my father over 25 years ago.

So not only am I from the provider community, but I have grown up with this business and am the second generation working in a family-owned small business.

Thousands of small business employers and employees participate in over 170 group Blue Cross/Blue Shield and HMO programs in 14 States that Small Business Service Bureau sponsors. These States include New York, Massachusetts, and Rhode Island.

We develop, market and administer these fully insured plans for firms with 1 to 10 employees. Basically, Small Business Service Bureau is a private sector purchasing group, and contracts with the health plan to establish both benefits and rates. We also encourage the health plans to check us out. That is one issue that I do not think has been addressed in any of the debates.

We encourage health plans to know who they are dealing with as far as an intermediary. Health plans want to be sure they get their payments on time, and their members are also our members. We market based on a sophisticated, direct mail and telemarketing system. We do offer both employer and employee choice of health plans. We act as an employee benefit specialist by helping the employers select the plan that best meets their needs.

We bill, collect and remit premium, and we require our staff to go through very intensive training programs including a licensing program so that they can best service and educate the members.

Purchasing alliances themselves, especially those developed under the Clinton plan, I believe, are overrated in their ability to both lower premiums and administrative costs in the small group market.

Alliances or purchasing groups are really nothing more than distribution channels. Alliances themselves are limited in their negotiating ability by the small group reform elements of community rating and the guarantee issuance of coverage.

Small business premiums themselves under the Clinton health alliances will increase substantially because small groups will be responsible for subsidizing the cost of uninsured workers, Medicaid recipients, early retirees and older and sicker workers from large corporations and union trusts which are dumped into the alliance pool.

Alliances are nothing more than a big business solution to a small business problem which they, themselves, created when they pulled out of the fully insured community rated market after the passage of ERISA. Alliances are also a vehicle by which big businesses, auto manufacturers and unions can relieve themselves of obligations they have made to employees and retirees.

Right now American businesses want to opt out of the alliance structure, regardless of their size. It is interesting that the same businesses that pulled out of the fully insured market are the ones that want to opt out of the alliance structure. It is unfair to the small business community to force them into a system that larger firms want to escape from.

The majority of small firms are in fully insured health plans. Alliances only restructure the same population and give them a different name. It does not resolve the problem of inequitably allocated health care costs.

Government payers and self-insured companies are exempt now from paying for uncompensated care and benefit mandates. In our estimation the only impartial method of truly spreading across the largest base is to require all businesses, regardless of size, to community rate, such as they do in Rochester, NY.

Purchasing groups also do not eliminate any of the activities necessary to enroll an individual in a health insurance program. Most administrative costs in the small group market are related to both processing applications and the billing of collection of premium.

The Federal Employee Health Plan has been used as an example of pooling and negotiating for favorable rates at a low administrative cost. However, I would like to point out that this program does not bill and collect premium. The majority of the payments are made based on payroll deduction directly from Federal employee payrolls.

Organizations which do sponsor purchasing groups in the private market add value to both the plan and the members, and they compete for membership. Usually health plans contract with a purchasing group or intermediary because they are the most successful at reaching out and attracting businesses, servicing those businesses and competing to keep their administrative costs low.

A large exclusive mandatory alliance, by virtue of its own bureaucracy, will result in higher prices and inferior services for small employers because they lack the incentive to do otherwise. Where will the Federal Government generate the revenue to support the infrastructure and operation of these alliances? Through higher taxes, fees, and premiums that are charged to small employers.

The method of enrolling people itself will be a waste of time and money. Will small employers and their employees be expected to wait in line outside of their local alliance office, such as Medicaid, Social Security, unemployment office or the Registry of Motor Vehicles?

Reform proposals provide for subcontracting many services with the private sector. This only affirms that the existing structure is both acceptable and effective in reaching the small employer community. The cost of re-enrollment itself under a mandatory system will amount to billions of dollars. Billions will be wasted that could be better used to help purchase coverage for the uninsured population instead of being squandered on already insured businesses.

The CHAIRMAN. I am going to ask you to leave off there, but we will get back to you. I want to get back to that ERISA point. You may help me on that.

Ms. CARROLL. Thank you.

[The prepared statement of Ms. Carroll appears in the appendix.]

The CHAIRMAN. Now, Ms. Cummings, who is Deputy Director for Administration and Fiscal Integrity.

Ms. CUMMINGS. That is right, Senator.

The CHAIRMAN. You are going to tell us what that means. I am glad to hear there is lots of it in California. Good morning to you.

STATEMENT OF LESLEY S. CUMMINGS, DEPUTY DIRECTOR FOR ADMINISTRATION AND FISCAL INTEGRITY, STATE OF CALIFORNIA MANAGED RISK MEDICAL INSURANCE BOARD, SACRAMENTO, CA

Ms. CUMMINGS. Thank you very much. Senator, I am here to talk about the Health Insurance Plan of California. The plan was authorized in legislation.

The CHAIRMAN. Cal PERS.

Ms. CUMMINGS. No, actually this is called the Health Insurance Plan of California, HIPC. Cal PERS is sort of our big sister, which negotiates for public employees in California.

The CHAIRMAN. Oh, I see. This is HIPC.

Ms. CUMMINGS. We are simply for small employers.

The CHAIRMAN. Right.

Ms. CUMMINGS. The pool is administered by our Board, the Managed Risk Medical Insurance Board. The board was established prior to the HIPC and also administers California's medically uninsurable pool as well as an insurance program for uninsured pregnant women.

We received the authority for Health Insurance Plan in California in legislation which was bipartisan in nature. It was authored by Assemblyman Burt Margolin in California. But the impetus for passage was also very influenced by the Governor himself, Pete

Wilson, who came out and said that he thought there needed to be a small market reform.

The CHAIRMAN. So this is relatively new.

Ms. CUMMINGS. Yes, it is new. The HIPC itself and the market reforms, which are the environment in which the HIPC was authorized, took effect July 1st and the HIPC itself opened July 1st.

I want to state for the record that our Board is an independent agency and the views that I reflect are ours and not necessarily those of the Governor. It reflects our experience with our programs.

The market reforms included guarantees issue, guaranteed renewability of coverage for all products in the market, pre-existing condition exclusions, and portability of coverage. It also authorized this voluntary purchasing pool.

Our Board was given broad authority in designing the purchasing pool. When it made its decisions about what sort of purchasing pool it wanted to have, it looked to the principles of managed competition as its inspiration.

We have in the HIPC employee choice of health plan. We use a standardized benefit plan design and we encourage employers to give their employees a share of cost in the health plans by setting up participation standards for them at the lowest cost plan.

We opened July 1st. We have contracts with 18 health plans. We have state-wide coverage in most areas of the State. Employees have a choice of health plans. For example, in Sacramento, employees can choose from 14 health plans there.

The CHAIRMAN. Can I just say, you mentioned employees, but you also said uninsured pregnant women.

Ms. CUMMINGS. Yes, and that is a separate program.

The CHAIRMAN. Who would not necessarily be employees.

Ms. CUMMINGS. Well, there are employees who can be uninsured pregnant women.

The CHAIRMAN. Yes.

Ms. CUMMINGS. Which is why we have this second program. Hopefully, with the reforms in California there will be less of them.

We are a negotiating alliance in California and we negotiated rates with our health plans, which are lower than the market rates for equivalent benefit package. Carriers have said that the emergence of the HIPC on the scene influenced a general market decrease in the rates.

We are in the process now of negotiating rates for our fiscal year that will begin July 1st. I wanted to comment on a couple of the issues that I have heard here today about concerns about alliances being bureaucratic.

We have 13 employees in the Managed Risk Medical Insurance Board (MRMIB). We do contract out, as has previously been said, for our operational functions and we use performance contracts when we do that. The contractor that we have hired to do the collection of premiums and enrollment functions is obligated to process an application within 4 days, enroll a person within 2 weeks, answer 80 percent of the phone calls within 15 seconds, and they actually exceed that.

The CHAIRMAN. Fifteen seconds?

Ms. CUMMINGS. Yes. And they exceed that and answer 90 percent of cells within 15 seconds. So we are advocates of using performance contracts in an alliance structure.

The second thing I want to comment on is the issue of purchasing pool administrative costs. Our costs are about 3 percent of premium in the HIPC. Our big sister, Cal PERS, costs are about 0.5 percent of premium. These are not, in our case, add-ons to what employers pay for coverage because we manage to get health plans to reduce their rates to reflect the fact that we are doing the enrollment functions, and premium collection.

So our lowest rates are below market rates by about 15 percent, and the fact that our 3 percent administrative costs are on top of that, still provides a net savings to employers who purchase through the pool.

We are advocates for a negotiating purchasing pool. We have seen the benefits of this approach in California. We know health plans gave us lower rates because we can chose not to contract with them. We saw 30 percent of health plans lower their rates in our negotiations last year.

Another point I want to make is that we believe that the environment in which you best rearrange competition to have it function on price and quality rather than risk selection is one that occurs in an exclusive environment.

We have seen how risk selection works in California with our medically uninsurable pool. We are aware that when there is an outside market and an inside market, there are many ways that risks can be segmented and fragmented, and we are concerned about the long-term fate of a voluntary pool.

There are things you can do to mitigate that risk. But the best way, we think, to take the issue of risk selection off the table and restructure competition to work for the consumer is in the context of an exclusive environment.

The CHAIRMAN. Very concise and straightforward, very impressive.

[The prepared statement of Ms. Cummings appears in the appendix.]

The CHAIRMAN. Mr. Flatley, speaking on behalf of the Association of Private Pension and Welfare Plans.

STATEMENT OF KEVIN P. FLATLEY, CHAIRMAN, BOARD OF DIRECTORS, ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, WASHINGTON, DC

Mr. FLATLEY. Thank you, Mr. Chairman and members of the committee. I am Kevin Flatley, vice president of Employee Benefits of American Express Co., New York, NY. However, today I am here in my capacity as chairman of the Association of Private Pension and Welfare Plans and offering testimony on their behalf.

Our members include employer sponsors of both health and retirement plans, insurers, financial institutions and firms that design and administer benefit programs. Altogether our members sponsor or directly provide services to plans which cover more than 100 million Americans. We are glad to testify here today because we think the best legislative starting point are the bills that have

been introduced by four members of this committee—Senators Chafee, Dole, Breaux, and Durenberger.

While we applaud President Clinton for putting health care reform at the forefront of our domestic agenda and while the President's proposal has some commendable features, we think that the bill is flawed in certain areas.

The Chafee-Dole HEART Act and the Breaux-Durenberger Managed Competition Act and the comprehensive proposal that the APPWP itself developed more than a year ago represent a better base from which to correct the weaknesses of the current system and build on its strengths.

We would like to see a merger of the best elements of Chafee-Dole and Breaux-Durenberger along with some modifications set forth in our own policy. We adopted this policy back in 1992 following a rather intensive 18 months of work. Our comprehensive health care proposals ensure coverage for all Americans and incorporate aggressive mechanisms for controlling costs.

Mr. Chairman, I would ask permission to have our complete proposal entered into the record.

The CHAIRMAN. It most certainly will and a very handsome production this is.

Mr. FLATLEY. Thank you very much.

[The prepared statement of Mr. Flatley appears in the appendix.]

Mr. FLATLEY. As part of its plan, the APPWP became the first business organization to endorse employer and individual mandates. As you might suspect, it was very hard for a business organization like us to embrace such mandates.

We did so only after analyzing all other options and in conjunction with conditions to lessen the financial burden on workers and employers and to ensure the rigorous cost management is applied to both private and public programs. The details are set forth in our proposal.

We support a mandate because we believe in universal coverage and an active employer role. While we agree with the President on the principle of universal coverage, the Health Security Act is misdirected in that it excludes employers from any meaningful role in designing or delivering health benefits.

We do not support such a role for the sake of tradition or philosophy. Rather, we are motivated by economics and experience. The truth is, employers have been leading the fight for health care quality, accountability and cost management.

For example, our written testimony cites innovative purchasing by employers, both individually and collectively, around the country. These are the representatives of the success stories in today's health care system.

There are several issues that are fundamental to an improved system. Many of these, such as the absolute imperative for Federal rather than State-by-State rules to govern the system, are not topics of the hearing today. So I will confine the balance of my remarks to the purchasing arrangements.

Our conclusion is that——

The CHAIRMAN. But you did state the absolute need for a national standard?

Mr. FLATLEY. Yes.

Our conclusion is that Chafee-Dole comes closest to creating a workable and effective purchasing group arrangement. The strength of the HEART Act is its reliance on multiple, voluntary purchasing groups and an option for employers to purchase insurance directly from insurers.

We believe that the goals of a single mandatory purchasing group would be achieved more effectively by multiple, voluntary purchasing groups and a direct purchase option, without the serious risk created by a mandatory purchasing group approach.

Mandatory groups do not give small employers market clout to control costs. In fact, in all likelihood, they will prevent small employers from banding together to selectively contract with a limited number of health plans. The ability to steer a volume of business to a limited number of health plans is essential to controlling costs and ensuring quality.

Mandatory exclusive alliances are not needed to control risk selection or achieve risk adjustment. In fact, it might promote increased risk selection by allowing unrestricted individual choice among health plans. Risk selection can be effectively controlled by requiring each voluntary purchasing group and insurers to operate under the same market conduct rules, such as open enrollment.

Nor is a single mandatory purchasing group necessary to achieve administrative savings. Next week we will be formally releasing a study prepared by Lewin-VHI on health costs by employer size. This study projects that small firms would realize large administrative savings through insurance reforms without any need for risk pooling. Therefore, mandatory exclusive purchasing groups are not needed.

In many respects, an exclusive mandatory purchasing arrangement is counterproductive to achieving these desired goals. While many of the same flaws and structure of mandatory exclusive alliances are found in the Breaux-Durenberger Mandated Competitive Act, its overall emphasis on market-driven health reform suggests it could be modified easily to provide for a competitive non-mandatory purchasing system.

One of the most problematic aspects of the Health Security Act is the corporate alliance structures. The rules governing the corporate alliances are so onerous that the APPWP has yet to identify a single one of our eligible Fortune 500 companies that would establish a corporate alliance.

While the Managed Competition Act is a substantial improvement over the Health Security Act, we have concerns about its purchasing group structure. Exclusive purchasing groups for employers with fewer than 100 workers would still encompass about 45 percent of the employment based market. Added to those would be employers of two-worker families and certain others that would lead to over one-half of the market being covered in this manner.

It seems highly unlikely that a government enforced huge monopoly will ever be run as efficiently as a private entity, even though that is the initial intent. Over time, such purchasing groups would all become de facto government-run entities.

The HEART act requires each voluntary purchasing group to offer each qualified plan in its region, which desires to be——

The CHAIRMAN. Sir, I did not hear. The HEART Act?

Mr. FLATLEY. Yes. That is the Chafee-Dole bill, sir.

Senator CHAFEE. Mr. Chairman, we started with the acronym and then we worked backwards. [Laughter.]

H-E-A-R-T. After considerable study, we then converted that to Health Equity and Access Reform Today.

The CHAIRMAN. HEART Act. Thank you, sir.

Mr. FLATLEY. Chafee-Dole.

This makes it impossible for purchasers to selectively contract with a limited number of health plans. It would be impossible for large firms to adopt aggressive cost control strategies which structured their worker's choice among health plans if workers in small firms were given unrestricted choice.

In conclusion, the APPWP supports universal coverage achieved through a combined employer and individual mandate. We support the market-based and generally national reform rules of the Breaux-Durenberger and Chafee-Dole bills and the voluntary nonexclusive purchasing structure of the Chafee-Dole bill. We look forward to working with the committee to fashion legislation that combines the best elements of each of these measures.

Thank you, sir.

The CHAIRMAN. We thank you, sir.

And now for our concluding testimony of the morning. Cathy Hurwit of Citizen Action.

STATEMENT OF CATHY HURWIT, LEGISLATIVE DIRECTOR, CITIZEN ACTION, WASHINGTON, DC

Ms. HURWIT. Thank you very much, Mr. Chairman. I want to express our appreciation for the opportunity to testify today.

As you know Citizen Action is a strong supporter of the Wellstone bill, the American Health Security Act, because we believe that a single-payer system is the best way to meet the goals of universal, comprehensive and affordable coverage.

If, however, Congress does not enact single-payer reform on a national level, we believe it should do two things. First, it should give States the ability to adopt single-payer reform at their own discretion. And second, it must protect the interests of consumers in States which do not enact single-payer reform by establishing a powerful entity to represent them in dealings with the health insurance industry.

In the Clinton plan, the health alliance is that entity. I must say that I think Senator Breaux was correct in his comments earlier, that the issue is not whether to have a purchasing group, but what that purchasing group should do.

We believe that the question in this debate is whether there should be a multiplicity of purchasing arrangements with replication and duplication through individual businesses and purchasing groups or whether functions should be handled through a single purchasing group. We support a single purchasing group.

The question for consumers also is whether they are better off under a system where purchasing groups merely accept premium bids by insurers or whether they are better off under purchasing groups which have some cost containment authority. We believe the latter is better for consumers.

We also believe that consumers are better off under purchasing groups which do not limit eligibility, but under a purchasing group which accepts all residents.

Finally, we believe that consumers are better off in terms of enforcing the rules of competition with a single exclusive purchasing authority. For those reasons, we believe that the health alliance system in the Clinton bill is the preferred solution if you are going to rely on private insurance and premiums.

We believe there are six essential benefits for consumers under the structure in the Clinton plan. The first and I believe perhaps the most important is the fact that the health alliances can break the link between employment and insurance, allowing individuals and families, not employers, to select coverage.

Now this is a very interesting issue, the choice issue, particularly given the discussion which occurred earlier. There are several levels of choice for consumers. One could be to choose among competing purchasing groups or health alliances. I would contend that consumers really have very little interest in that.

What they are more interested in is selecting plans and particularly being able to select providers within those plans. What the health alliance does is to give consumers the ability to choose plans, not necessarily the ability to choose providers or facilities, such as going to the Mayo Clinic.

I would say that if this committee is interested in giving consumers a full range of choice in both areas, there are certain requirements that should be made, such as a point of service option, which is available under the Clinton plan, and rules to determine who gets to decide medical necessity and appropriateness, whether physicians and their patients get to determine that or whether the insurance companies do.

We do think the Clinton plan can be improved in terms of consumer choice by eliminating the corporate opt out and allowing all individuals and workers, not just those in smaller businesses, a full choice of plans.

Breaking the employment insurance link not only expands consumer choice, it protects portability. Changes in employment from large employer to small employer do not necessarily mean that consumers would have to change plans. Again, we think that the Clinton plan can be improved by limiting or eliminating the differences among plans. Even within the Clinton plan portability may still be a problem if changes in income require that consumers have to move from a fee-for-service plan or a higher cost managed care plan into a lower cost plan.

Third, we believe that the regional health alliances under the Clinton plan, by being able to negotiate on behalf of a very large percentage of residents, would be able to use purchasing power effectively on behalf of all consumers.

We also believe that the cost containment provisions in the plan, such as the lower administrative costs, the ability to enforce premium caps and fee schedule setting authority will improve affordability.

Fourth, because of community rating within the plan, we believe all consumers will be protected. Also, as you heard Rick Curtis talk about earlier, the large regional alliances give the alliances the

ability to blend private and Medicaid payment rates to ensure that there are no obstacles to low-income people getting access because of differentials in payments to providers.

Fifth, we believe, as I alluded to earlier, that the regional health alliances are best able to monitor and discipline insurers enforcing the rules on behalf of all consumers. It is far easier to achieve this function through a single alliance than attempt to track individual insurers selling separately to individual employers and families or to track purchases through competing alliances.

And finally, and this is the point that I really want to stress, the regional alliances as they are constituted in the Clinton plan give consumers for the first time in many places the ability to participate effectively in the decision making process. By having regional health alliances that are comprised equally of consumers and employers, for the first time consumers will be able to participate and affect the implementation of the health care system.

We believe that there are other ways potentially to achieve the functions and the goals that I just laid out. We are looking forward to working with this committee in the months to come as we wrestle and you wrestle in particular with these very difficult questions.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Hurwit appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Hurwit. Thank you all.

I am going to do something which I have not so far had to do this year, which is say that the New York State delegation is meeting over in EF-100 and Governor Cuomo has come down with his health advisers and all. That started 15 minutes ago. So, if it is possible, Senator Breaux, would you chair the remaining of the hearing with Senator Chafee.

I mean this has been such a—we have heard so many nice things about Chafee-Dole and Cooper-Breaux, I think I would not want to deny you the pleasure. [Laughter.]

Senator BREAUX. Could we have a vote while you are gone? [Laughter.]

The CHAIRMAN. With great appreciation. Thank you for this. This is very well written.

Ms. Carroll, will you tell me more in writing when you have a chance, tell the committee, about what happened with the opt out of community rating under ERISA. That is one of those unanticipated consequences that I would like to know more about. I will give you that charge, and I will give you this.

Senator BREAUX. I will just stay here. I also want to thank the panel.

Ms. Carroll, I got the impression that your testimony indicated that the folks that you represent support the employer mandate.

Ms. CARROLL. No, I did not address the employer mandate in the testimony, sir.

Senator BREAUX. You said on page 4, that is what confused me, "the only impartial method of spreading costs across the largest base is to require all businesses, regardless of size, to participate in fully insured community rated plans."

Ms. CARROLL. That was addressing the ERISA issue and how self-insured plans really do not pick up their burden of uncompensated care. So as an alternative to forcing all small groups into a

new entity, I would recommend looking at regulating self-insured plans so that they participate in fully community rated insured plans instead of self-insured.

Senator BREAUX. You do not support a Congressional mandate on employers to provide or to offer insurance?

Ms. CARROLL. When we have polled our members, they are pretty split on the employer mandate issue. The majority are opposed to the employer mandate. You will find that different types of businesses have been struggling due to the bad economic conditions that they have had to live with over the last few years.

The employer mandate would put a significant strain on them, especially those with very limited cash flows.

Senator BREAUX. I think I would probably have less of a reluctance to support that if we had a chance to reform the system before we started talking about an employer mandate. That is just an editorial comment.

You also point out that small employers with fewer than 100 workers account for over 95 percent of the business community. That is the threshold for the Cooper-Breaux plan. But that is not to say that 95 percent of the workers. Are you just talking about the number of companies?

Ms. CARROLL. I am talking about the number of employer groups, correct.

Senator BREAUX. Our number is probably around, what, 35 to 50 percent of the number of employees.

Ms. CARROLL. Individuals.

Senator BREAUX. Do you support the concept of alliances or do you not? I am trying to figure out exactly where you are coming from.

Ms. CARROLL. I do not think that alliances themselves are necessary in all markets. When I have talked to representatives from different States, they have told me that they do not have any existing purchasing type of arrangements. That is why an alliance would serve the function of a purchasing entity or intermediary for them.

If there are alliances, I think that they should be voluntary, so that you give small employers a choice of where they obtain their insurance. Because of insurance market reform itself, all insurers should be on a level playing field when it comes to guarantee issue coverage and community rating.

And the alliance itself or purchasing group is only a vehicle to add value really to the employer, and to take some of the administrative and distribution responsibilities off the insurer.

Senator BREAUX. Ms. Cummings, let us talk about that a minute because many of the people who advocate voluntary alliances look to what you all have done in California. An argument against it is that if you have voluntary alliances you will have alliances that may end up only insuring sick people, who move to the alliance because they think they can get a better deal, which could have the potential of wrecking the alliance and having more healthy people stay outside because they do not think they have a problem.

Can you comment on that? I mean, is that not a legitimate and real problem?

Ms. CUMMINGS. It is a legitimate and real concern. Yes, it is. We are hoping that we have by-passed that concern for now, at least in California. Under our market rules carriers still have the ability to give low-risk groups lower rates than high risk groups. We do not do that in the purchasing pool and we have taken a risk in not doing it.

But because our rates are so low, and because we are the only place where there is an employee choice option, we think we are bringing in enough low risk to offset that problem. But it is a problem with voluntary pools that you always have to look out for, how they can, over the long term, avoid this problem of attracting high risk into the pool.

The market rules have to be very, very close to community rating and very uniform at the minimum and even then you may experience problems.

Senator BREAUX. I want to ask you about the type of alliances. Is the alliance you all have, can you classify it as being more of a purchasing cooperative or more of a regulatory agency?

Ms. CUMMINGS. It is a purchasing cooperative and it is not a regulatory agency. As I said before, we are aggressive negotiators for rates and we think that it is difficult to have people who regulate companies and people who negotiate with them in the same house. We have other regulatory agencies in California—our Department of Insurance and our Department of Corporations.

Senator BREAUX. So I guess your opinion is that the experience you have had so far is that you have been able to accomplish the goals of reduced cost and other things without being a regulatory agency partially because of the market place and partially because other existing agencies provide that type of function?

Ms. CUMMINGS. Yes. Yes, we have. I mean, the degree to which purchasing pools produce rate savings and savings in administrative costs is all a matter of a continuum. We have done it in our voluntary mechanism in California, in both lower rates and lower administrative costs.

The issue I think facing you is the extent to which we have done that to the extent necessary to meet the need of national reform.

Senator BREAUX. Let me ask one other question of Mr. Flatley. I got the impression from your testimony that your organization has endorsed employer mandates and you strongly oppose employer mandates. I am trying to figure our which it is.

On the first page of your summary, you say that your Association was the first national organization to endorse a requirement that employers offer health benefits to their employees and pay most of the premiums. In the second paragraph you say your Association strongly opposes a mandate.

Mr. FLATLEY. We are in favor of employer mandates and individual mandates for coverage. What we are not in favor of is a mandatory exclusive alliance.

Senator BREAUX. So you would favor just a mandate that they provide insurance but not mandated through a health alliance?

Mr. FLATLEY. Through a single health alliance, yes, we would prefer a voluntary and competitive market place for the alliances, as well as a corporate direct purchase option.

Senator BREAUX. Is your concern about the alliances the fact that it is regulatory or just the principal of a purchasing cooperative.

Mr. FLATLEY. Principally, one of its ability to function as a purchasing cooperative if it was given a monopoly and the inefficiency of that setup.

Senator BREAUX. But would not as I think our alliance and perhaps all of the alliances are structured, would allow the competition within one alliance? You would have one alliance, but you could have several different providers competing to offer their plans through that alliance. That the alliance is just a purchasing cooperative that the competition comes through, because you could have 25 different programs being offered in that alliance, each competing with each other for the best price and the best services.

They would just be offering it through a single alliance. It would not be one alliance offering one plan, but several providers offering their proposals through a single purchasing cooperative.

Mr. FLATLEY. I guess that we feel that if it is good on the provider side, the competition would be good on the alliance side as well. That having the ability for purchasers, whether they be small groups, large groups or individuals, to have a range of choices of alliance that would have in turn contracted with a range of choices of plans would be a better setup than giving a certain geographic monopoly to a particular negotiator, alliance or aggregator of purchasing power.

Senator BREAUX. I would hope you all would take a look. I think it goes to the function of the alliance. If the alliance like in our bill is merely a purchasing cooperative as opposed to a regulatory body, I think that another purchasing cooperative could reduce the benefits received through economics of scale. I am not sure there is a real need for competition between purchasing cooperatives, but rather competition among those who offer their different plans through that mechanism. But anyway.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Ms. Carroll, I was interested in what you said in the middle of page 3 of your testimony where you say, "Alliances are a vehicle by which big business, auto manufacturers and unions can relieve themselves of obligations made to employees and retirees"; I think you are particularly thinking really of retirees, are you not? Where those retirees can all go—they are shuttled off into an alliance.

But the big company, by virtue of having more than 5,000 employees, can go into self-insurance and they do not have to bother with alliances. Is that the point you are making?

Ms. CARROLL. Yes, that is the point I am making. In addition, sir, concessions are being made now to employer groups of less than 5,000 that they, too, can opt out of the alliance.

However, I think the possibility is still open that if an employee group does have—a large employer group has an older, sicker work force they can still participate in the alliance because self-insurance probably would not be a cost-saving vehicle for them.

Senator CHAFEE. In your particular group, the Small Business Service Bureau, do you have any risk selection or how does that work?

Ms. CARROLL. The membership in the Small Business Service Bureau is open. It is available to all employer groups. There is no risk selection that occurs to be a member of the Small Business Service Bureau. As for the health plans themselves, the majority are offered on a guaranteed issue with some type of community rating, consistent with the small group reform initiatives in the given State where we market the health plan.

Small employers themselves, when they select a health plan, select first based on whether their doctor is a member of the network. Second, they select based on price.

Senator CHAFEE. That is a service you provide?

Ms. CARROLL. Right. Correct.

Senator CHAFEE. In other words, your——

Ms. CARROLL. We are just an intermediary.

Senator CHAFEE. You are an intermediary. You then make available to them several plans?

Ms. CARROLL. Yes.

Senator CHAFEE. Do you all agree to have the system work, there has got to be a uniform benefit package? Ms. Cummings, you were pointing out that in effect people have got to know that they are choosing on the basis of price and quality and they are comparing apples to apples in making their selection.

Ms. CUMMINGS. Yes. We think that is very important and we think that another benefit of a standard benefit plan design is that then carriers cannot risk select based on benefit plan designs. Risk selection based on benefit design is clearly a feature of the market. We have seen that as we implemented small group reform in California certain groups that had benefited from special carriers deals for their groups tried to maintain those deals in the last legislative session.

Senator CHAFEE. Mr. Flatley, I want to thank you for the kind words you had to say about our legislation. We hope you will come back frequently. [Laughter.]

Mr. FLATLEY. We will be happy to, Senator.

Senator CHAFEE. I am not sure, Ms. Cummings, how you are able to compete in California in your group because you have community rating within your group, but there is not community rating in California.

Ms. CUMMINGS. There is, Senator. In the small group market there was a general market reform. It was only in the context of that market reform that the HIPC was authorized. There is guaranteed issue, guaranteed renewability.

Senator CHAFEE. In California?

Ms. CUMMINGS. Yes. Modified community rating.

Senator CHAFEE. So if AETNA offers a uniform benefit package within your group for $150 and I did not want to belong to your group, but I wanted to go to AETNA and get the same package, would they have to offer me that package at $150, or would they charge me $200?

Ms. CUMMINGS. That is a very interesting question because I think it underscores again the difficulties for a voluntary purchasing pool. What we did in our contracts with the health plans that came into the pool was include a contractual provision which said

that they could not underprice us out in the market for the same benefit package.

The open market is an environment of diverse benefit packages. We were concerned that carriers could sell our product for a cheaper price or the equivalent price outside in the market, the risk selection dangers were immense to us.

Senator CHAFEE. Well, I would think they would be. But you have that covered.

Ms. CUMMINGS. We have it covered in that way. The fact that there are so many benefit plan designs in the market and the HIPC functions in a voluntary environment, I again think that the dangers of risk selection are still there.

Senator CHAFEE. Well, we have a single price in our plan in a voluntary market. You know, you always worry if they have an open enrollment office but it is on the 72nd floor of the Empire State Building with no elevator. [Laughter.]

Ms. CUMMINGS. That is exactly a concern with that approach. We have seen that in Medicaid. In the HIPC we have mail-in applications. Actually, in all of our programs we have mail-in applications. This makes a great deal of difference in terms of the accessibility of being able to get in. So that is a problem when you have a place where you have to go to apply.

Senator CHAFEE. Well, we believe we have that covered. In our plan, you can get the same price for, let us say AETNA, regardless of whether you go through the purchasing cooperative or purchasing alliance or not.

I want to thank you all very much for your testimony. It has been very helpful. We particularly encourage those who come here who have kind words to say about our plans.

Senator BREAUX. And on behalf of the committee and Senator Moynihan, we thank all of you for being with us and for your testimony. The committee will stand adjourned.

Mr. FLATLEY. Thank you, Senator.

[Whereupon, at 1:02 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF LISA M. CARROLL

Good morning Senator Moynihan and members of the Senate Finance Committee. I appreciate the invitation to speak to you today on the issue of health alliances.

My name is Lisa Carroll. I am Vice President of Health Services for the Small Business Service Bureau Inc. (SBSB). SBSB is a national small business membership organization which has met the health insurance needs of small firms for over 25 years. Thousands of small business employers and employees participate in 170 group Blue Cross Blue Shield and HMO plans sponsored by SBSB in 14 states and the District of Columbia. From our National Operations Center in Worcester, Massachusetts, SBSB staff plan, develop, market, and administer fully insured health programs for firms with 1–10 employees.

I. SMALL BUSINESS SERVICE BUREAU—FUNCTIONS AND ROLE

SBSB's ability to meet the special needs of small employers through its communication and distribution network, pooling mechanisms, and educational efforts has also helped our participating insurers. SBSB offers a competitive choice of local and regional health plans which are carefully screened for structural quality, financial stability, customer satisfaction, including the extent of its practitioner network. We work with the health plans to design the benefit package, premiums, and enrollment guidelines to be offered to SBSB members. The administrative functions we perform include verification of eligibility and processing of applications, billing, collection and remittance of premiums to insurers, processing all coverage adjustments, conducting open-enrollment, and acting as an advocate for members to resolve complaints. The SBSB small group program is a model private sector, voluntary purchasing group.

II. PURCHASING ALLIANCES—ROLE AND PARTICIPATION

The cornerstone of many health reform proposals are purchasing alliances. Fundamental principles supporting creation of these entities include enhancing the negotiating ability of small firms to get premium rates comparable to large employers, decreasing administrative costs in the small group market, and offering choice to employees. In reality, the ability of alliances to lower both premium and administrative costs is highly overrated. Alliances may actually increase the prices paid by small firms for health insurance.

The small group reform elements of community rating and guarantee issue limit the ability of an alliance (the distribution channel) to negotiate favorable premiums. The distribution channel (how insurance is sold and administered) is irrelevant to how rates are determined, and thus negotiated, because risk pooling does not occur at this level. Rather, risk pooling is an activity of the health plan. And, state law regulates how a health plan calculates rates offered in the small group market.

In addition, small employers participating in the Clinton alliance model would pay higher rates because they would be responsible for subsidizing the cost of uninsured workers, Medicaid recipients, and early retirees and older, sicker workers from larger corporations and union trusts "dumped" into the alliance pool.

Alliances are a big business solution to a small business problem which they themselves created by pulling out of the fully insured, community rated market following the passage of ERISA. Alliances are a vehicle by which big business, auto manufacturers and unions can relieve themselves of obligations made to employees and retirees. Obligations which last year amounted to over $8 billion dollars, and

which the Congressional Budget Off ice (CBO) estimates will cost $15 billion per year by 2004. Even now, medium sized firms are fighting for an exemption from alliance participation. The business groups which pulled out of the fully insured market are the same ones that want to opt-out of alliances.

It is unfair to the small business community to force them into a system larger firms want to escape from. There are 2,400 companies in this country that employee over 5,000 workers, ⅘ths of them are self-insured. Yet there are over 7 million small firms with fewer than 100 employees and only about ⅓ are self-insured. Restructuring the identical population of small employers and renaming them an "alliance" doe's not resolve the fundamental problem of inequitably allocated health care costs. Small business premiums are already inflated due to cost-shifting from Medicaid, Medicare, and self-insured companies exempt from paying for uncompensated care and benefit mandates. Alliances only institutionalize this cost-shift; they do not eliminate it. The only impartial method of spreading costs across the largest base is to require all businesses, regardless of size, to participate in fully insured, community rated plans.

III. PURCHASING ALLIANCES—ADMINISTRATION

Purchasing groups do not eliminate activities necessary to enroll an individual in a health insurance program. Pooling small employers (especially those with 1-10 employees) into larger groups can be effective in streamlining certain activities related to enrollment, billing, collection, and remittance of premium. This liberates health plan resources to concentrate on larger sized groups. But the potential for these economies of scale to result in significant savings is limited. Enrollment and maintenance activities between the purchasing group and health plan are coordinated and sometimes duplicated. The purchasing group collects applications and forwards them to the health plan. The health plan, then enters the applications into their system and produces identification cards. A fully functional purchasing group will also issue thousands of bills to multiple employers, so that the health plan only has to issue one bill to the purchasing group. In this case, the group functions as a common employer account.

Organizations which sponsor such purchasing groups compete for membership, which creates incentives to be:

1. innovative in developing and providing services for members,
2. responsive to member needs including prompt problem resolution, and
3. meticulous about keeping administrative fees low.

A large, exclusive, mandatory alliance will have the opposite effect. By virtue of its own bureaucracy it will result in higher prices and inferior service for small employers, lacking incentive to do otherwise. Alliances under the Clinton plan are estimated to cost $6 billion a year to operate. If Medicaid administrative costs, which have increased 45% over the last 10 years, are any indication of the ability of the government to control overhead expenses, then one may conclude this $6 billion estimate is too low. And where will the federal government generate the revenue to support the infrastructure and operations of the alliance? Through higher taxes, fees, and premiums charged to small employers.

In addition, money and time will be wasted if employees are forced to wait in line outside their local alliance office to enroll in a health insurance plan. This situation is analogous to waiting in line at the local Medicaid or Social Security office, unemployment office, or registry of motor vehicles. If the alliance subcontracts for marketing and enrollment activity, it simply uses the existing distribution system, affirming that the existing structure is both acceptable and effective.

The cost of re-enrolling a large segment of the population into a mandatory alliance is also a waste of money and effort. If the group size is fewer than 5,000, 97-100% of all employers, their employees and dependents in every state will be forced to choose a new health plan and complete new enrollment forms. Even if the group size were decreased to 100, more than 95% of all employers would be impacted. Computer programming time, staff resources, preparation of marketing materials, processing enrollment forms, shifting and accounting for payments between and among insurers and alliances, issuing new I.D. cards, reconciling accounts, resolving complaints and transaction problems, and educating the employer community will cost billions of dollars at the outset. Billions that could be better used to help purchase coverage for the uninsured population, instead of squandered on already insured businesses.

The Clinton Plan Alliances will also be responsible for determining subsidy levels. Small employers will be required to enroll new employees within the first 30 days of hire. The federal government cannot guarantee the small business will receive its

subsidy within the same time frame. The result is a serious cash flow crisis for the small firm. Once in the system, coverage may not be cancelled for non-payment of premium. The alliance will pick up the financial burden for non-payers by shifting this cost to the health plans, small employer premiums, and tax payers. Providers will deliver services to people utilizing the system who have not paid into it, resulting in the 21st century version of uncompensated care.

IV. RISK SELECTION ISSUES

Selection of healthy risk by health plans and insurers has been based on the health status of employers, employees and dependents, industry classification, and eligibility criteria such as date of hire. Small firms representing healthier risk were also rated more favorably, whereas companies with older or sicker workers, or those experiencing a large claim because of pregnancy or illness would be penalized by higher premiums. This risk selection behavior by insurers is declining in part because of small group reform and subsequent enforcement by state insurance departments.

Concerns about health plans selecting risk based on service area should be addressed directly. Alliance service areas should not be used as an excuse to manipulate and regulate HMO service areas. If regulating HMO service areas to prevent "red-lining" and assure all geographic areas of coverage is the intent of Congress, it can certainly be accomplished with intervention by' state regulators. If a purchasing group is voluntary, risk selection based on health plan service area is irrelevant because the purchasing group markets to the area defined by the plan.

"Cherry picking" behavior in the small group market will continue if self-funded MEWAs and METs are exempt from guarantee issue and community rating requirements. This risk selection problem could be resolved by requiring these groups to comply with small group reform rating and underwriting restrictions.

Small employer resistance. to purchasing health insurance through a centralized entity is underestimated. In any give state, small employers of fewer than 100 workers account for over 95% of the business community. Most of these employers are already offering health insurance benefits to their employees, through distribution networks which they have voluntarily chosen. These distribution networks include association programs such as SBSB, agents and brokers, or direct enrollment. The very essence of any cooperative or alliance relationship is based on a group voluntarily choosing to participate in such arrangement. The small business community does not want to be coerced or forced into a situation they cannot get out of. Alliance or purchasing groups should be voluntary, with implementation of market reforms based on health insurer rating and underwriting practices.

I appreciate your time and attention, and will be happy to answer any questions you have on how SBSB operates in specific states or other issues of voluntary purchasing groups.

Attachment.

SMALL BUSINESS SERVICE BUREAU INC.,
Washington, DC, March 11, 1994.

Hon. DANIEL PATRICK MOYNIHAN,
U.S. Senate,
Committee on Finance
Washington, DC.

Dear Senator Moynihan: At the conclusion of the Senate Finance Committee hearing on Health Alliances, February 24, you requested a follow-up to my ERISA comments.

Prior to the passage of the Employee Retirement Income and Security Act of 1974, ERISA, the majority of Americans enrolled in employer-sponsored health plans were pooled into large groups which received community rates. The risk of medical care expenses was shared across a broad community of individuals, regardless of the size of company they worked for. The health plans themselves were fully insured and subject to state laws and regulations. These state laws include mandated benefits, premium or provider taxes to pay for uncompensated care, and reserve requirements to ensure plan solvency.

Large employers, especially those operating in multiple states, found it frustrating to deal with inconsistent and varying state regulations related to employee health benefit plans. And, as overall health care costs increased, large companies wanted premium rates to reflect the risk of their **own** employee populations and not the community at large. ERISA presented an opportunity for large companies to avoid

state regulations and cross-subsidization by allowing them to self-insure their health benefit plans.

By 1986, 46% of all employers were self-insured. This figure increased to 65% by 1991. As company size increases, it is more likely a firm will self-insure. Recent figures released by A. Foster Higgins, Co. demonstrate that in 1993, 80% of companies with over 1,000 employees self-insured, whereas only 6% of companies with less than 50 employees participated in this type of health benefit funding. It is important to note that self-insurance is only a viable option for small firms if they can afford to take on this financial The Honorable Daniel Patrick Moynihan risk, which implies they must also have a healthy employee population. The success of self-funding in the small group market is dependent upon risk-selection practices such as medical underwriting, industry exclusions, and experience or risk rating.

As large companies with their substantial employee populations pulled out of the fully insured market, the base across which risk could be spread steadily shrunk. Fewer individuals from smaller companies were left in pool, and insurers competed fiercely for the best remaining risk. Premiums for this smaller base of fully insured individuals escalated as the pool became fragmented. In addition, premium loads to finance uncompensated care, mandated benefits, and insurer reserve requirements were increasingly paid for by smaller and fewer employers. Self-insured companies on the other hand, were (and still are) exempt from these financial obligations.

In effect, small employers and employees remaining in the fully insured market have been subsidizing large, self-insured companies and union trusts as a result of federal law. ERISA has insulated big business and big labor from society's health costs which then must be borne by the dwindling number of small employers able to afford current health insurance premiums. Large businesses, union trusts, and insurance companies (for which administering self-insured plans represents over 50% of business) do not want to lose the advantages ERISA has given them in controlling their own health care dollars. But, is it fair to expect the small employer community to bear the cost for what large businesses don't want to pay for?

The key to the anticipated success of alliances is based in prohibiting companies from self-funding their health benefit programs. However, *this can be accomplished without the alliance structure by simply amending ERISA.* The health care system in Rochester, New York illustrates the success which can be achieved in controlling health insurance costs and decreasing the number of uninsured when all local companies' health insurance is community rated. This system has operated for years because of cooperation among all employer groups. Formalized alliances were never necessary.

Even decreasing the size of employer groups required to purchase through an alliance does not solve the fundamental problem of cost-shifting from self-insured groups onto small business premiums, unless the alliance itself is self-insured. And, as I mentioned earlier, to successfully self-fund in the small employer market only the best risk can be included in the pool. Older and sicker workers and dependents would still have an access problem.

I am aware that amending ERISA is almost as politically volatile as health reform itself. However, I would encourage the U.S. Congress to at least fix some of what they (unintentionally) created in 1974 by giving states more flexibility to regulate self-funded plans, especially in the area of premium taxes to fund uncompensated care.

Thank you again for allowing me to present my views to the Committee and for the opportunity to offer some additional thoughts on ERISA.

Sincerely,

LISA M. CARROLL, *R.N., Vice President, Health Services*

PREPARED STATEMENT OF LESLEY CUMMINGS

Mr. Chairman and Members of the Committee: My name is Lesley Cummings. I am the Deputy Director of the Managed Risk Medical Insurance Board, commonly known as MRMIB, a state board which recently opened a purchasing pool for small employers in California. The Board also administers two subsidized health insurance programs, one for medically uninsurable people and one for uninsured pregnant women.

California was the first state to establish a statewide purchasing pool for small employers using managed competition principles. We believe that alliances which use these principles can provide their enrollees with more affordable coverage and increased levels of satisfaction with their health plans. We have worked through a

number of the issues intrinsic to the health alliance construct while designing and implementing California's purchasing pool and hope that our experience and views will be useful to you as you consider the various proposals on alliance roles, structures and responsibilities.

MRMIB is an independent state board whose membership is appointed by both the Governor and the Legislature. Our views are based on the experiences we have had operating the HIPC and our other two programs. They do not necessarily reflect the positions of either our Governor or Legislature.

BACKGROUND ON THE HIPC

The Health Insurance Plan of California,or the HIPC, opened on July 1, 1993 and in its first seven months, has enrolled over 2,100 small employers and 36,000 people.

Authorization for the HIPC occurred in legislation which reformed the small employer health insurance market in California. The legislation, requested by Governor Pete Wilson and authored by Assemblyman Burt Margolin (D–LA), enacted market reforms which ensure guaranteed issue and renewable coverage for all products sold in the market, establish rate bands which limit rate differentials for low and high risk groups, provide for portability of coverage and place limits on pre-existing condition exclusions. Additionally, the legislation authorized MRMIB to establish a statewide, voluntary, purchasing pool in the reformed market. The legislation gave the Board broad authority to establish the HIPC's design. While the reforms did not provide an environment in which strict adherence to all managed competition principles was feasible, the Board drew from as many as it could when structuring the HIPC. Principles the Board used include:

- Use of an "employee choice" model in which the employee chooses annually from among the participating plans.
- Use of a standardized benefit plan design which must be offered by all participating health plans.
- Use of participation requirements which encourage employers to provide employees with fiscal incentives to choose lower cost plans.

MRMIB contracted with one company (Employers Health Insurance) to perform enrollment, premium collection and marketing functions for the HIPC, and with 18 companies (15 health maintenance organizations and 3 preferred provider organizations) to provide health coverage. We have statewide coverage. In the vast majority of the state, employees can choose from numerous health plans. For example, in Sacramento, employees can choose from among 14 plans. We have major "name brand" plans and regional HMO's with limited service area. I have attached to my testimony a list of plans participating in the HIPC (Attachment A).

The initial rates that we negotiated with plans are extremely competitive with those available outside the HIPC. Our lowest rates undercut the market by approximately 15%. Additionally, private health carriers have acknowledged that the HIPC's emergence, coupled with the small group reforms, caused actual rate reductions in the market at large. We are in the process now of negotiating rates for the HIPC's second year, which will begin July 1, 1994.

With this background, I would like now to discuss some of the lessons we have learned which may be relevant to the issues facing you about health alliances. I will then comment on some alliance structural issues.

POSSIBLE LESSONS FOR HEALTH ALLIANCES

The Employee Choice Feature has Proven to be Extremely Marketable and is Valued by our Enrollees

Employee choice is an essential element of the managed competition approach to health care. Placing the ability to elect a health plan at the consumer level, rather than at the employer level, increases the number of people who can make "price elastic" health plan choices. Many people will choose to maintain coverage in a higher priced plan because their own physician is with that plan. When an employer chooses to do so, his or her entire group is precluded from making price conscious health plan decisions. Under the employee choice model, all members of the group are free to make individual decisions. Thus, those who are willing to join a lower cost plan are free to do so without obligating those who are not.

Another advantage of the employee choice model is that when the focus of competition is moved to the consumer, health plans have increased incentives to address consumer quality issues. Health plans know that employees dissatisfied with their phone response time or the length of time it takes to obtain appointments can choose a different plan during the annual open enrollment period.

The HIPC's success shows that the employee choice model is acceptable to small employers and valued by employees.

It is Important for Alliances to Offer a Standard Benefit Package

In the present market, there are multiple thousands of benefit plan designs, many of which have only slight differences from one another. Carriers use these design differences to segment the market into different strata of risk. The "all product" guarantee we enacted in California has made this more difficult to do. As the law has taken effect, we have clearly seen carriers eliminating designs which they were willing to sell to a particular group but which they are unwilling to sell when a product can be purchased by anyone.

The managed competition approach calls for alliances to use a standardized benefit plan design so that when employees choose which health plan they want, their choice is governed by price and quality issues rather than a confusing array of products with slight benefit design differences—differences which carriers can use for risk selection purposes.

The HIPC has adopted this approach. We believe it has succeeded allowing consumers to choose based on price and quality.

Further, it is hard for an alliance to sell multiple benefit plan designs simply on a logistical level. In the HIPC, we sell one design with high and low cost sharing options. These options vary depending on whether a carrier is an HMO or PPO. We have 18 carriers products to describe and rates for 4 family sizes, 6 regions and 7 ages. This results in over 800 rate cells in a given region, even with these very limited choices. Adding more designs needlessly increases marketing and administrative costs—not to mention how much harder it makes the choice for the consumer.

Another note on the composition of a standard benefit plan design. Before our Board established the HIPC's benefit plan design, it was urged to select a catastrophic design with very high deductibles. The Board does not view this type of coverage as real insurance and chose a design with quite comprehensive coverage. The HIPC's success supports the Board view that small employers want to purchase meaningful coverage like that available to large employers.

In a Voluntary Environment, it is Essential to Have Very Strong Market Reform Rules or an Alliance Will Quickly Become a Dumping Ground for High Risk

THESE REFORMS DO NOT HAVE TO MEAN HUGE INCREASES IN PREMIUMS FOR THE ALREADY INSURED

California has some of the strongest reform rules in the country. But these rules still allow carriers to charge different rates to employers depending on perceived health status. It is next to impossible to do this type of underwriting in an employee choice environment and the HIPC has chosen not to do it. However, we take the risk that agents and other carriers might send high risk groups into the pool. We believe that our low prices and the desirability of our employee choice feature will draw in lower risk groups to balance out our costs. But it is exactly this type of dynamic that makes successful operation of an alliance difficult in a voluntary environment. *The stronger the marketing rules are and the closer rating rules are to community rating, the likelier it is that an alliance can operate successfully.*

During negotiations on our market reform, carriers in California argued successfully for a phased in implementation of certain of the reforms. They argued that the premium increases which would result from the reforms needed to be gradual or many employers would drop coverage altogether. However, as I mentioned above, market prices not only did not increase, they decreased.

Alliances can reduce administrative and marketing costs

In the small employer market in which the HIPC operates—and in which the vast majority of the uninsured work—administrative costs are up to seven times higher than those of very large employers. Thus, it seems apparent to us that concentrating functions in one location does in fact reduce administrative costs—costs that we have required our contracting health plans to remove from their premium prices.

In the HIPC, we charge employers an administrative fee of $20 per group and $2.50 per enrollee per month, fees equal to 3% of our average premium. Included in these amounts are the costs of enrollment, premium collection, and marketing (absent agent fees) as well as MRMIB staff costs. Our costs represent the high end of what an alliance's administrative costs would be. This is because:

- Our market is comprised of very small groups with virtually no in-house employee benefit staff. This type of business is relatively expensive to administer compared to large groups with in house benefits staff.

- When we negotiated our administrative prices, we had no enrollment. The higher the number of enrollees, the less administrative costs are as a percentage of premium. The next time we renegotiate our administration contract, we will be able to obtain lower prices, assuming our enrollment has reached sufficiently high levels.
- Because the HIPC is voluntary, we market to attract business. We are spending about 1% of our administrative costs for direct sales staff and advertising.

At 0.6% of premium, our big sister, the CAL-PERS program, probably represents the lower end of administrative costs for an alliance. Because all state employees receive coverage through CAL-PERS, it is, in large measure, an exclusive (eg. mandatory) alliance. It enrolls some smaller groups but also has other extremely large groups to balance out its costs, does not have to market itself, and benefits from the economies of scale which come from being a mandatory pool. It also is an established (rather than new) pool and uses staff in the various personnel offices of state and local government offices to assist in the processing of enrollment paperwork.

We think that alliances will produce significant administrative savings over the current system and, depending on their structure and function, will probably cost somewhere in between CAL-PERS and the HIPC. The degree of administrative savings depends on the type of structure used.

Exclusive alliances clearly can reduce administrative costs to a far greater degree than voluntary alliances because they do not have to market themselves, use standardized enrollment materials and can take advantage of the economies of scale which result with large numbers of enrollees.

I should say a word about another major component of the higher administrative costs in the small employer market—agent compensation. The issue of agent compensation proved to be a significant issue for us and may prove to be so for you. Agents are a major presence in the small employer market. They are the primary way by which coverage is now sold in the marketplace. Many small employers want to take advantage of agent services because they lack in house benefits staff. However, agent commission costs are a significant factor in the higher administrative costs of small employers.

In the voluntary environment of the HIPC, we have created a "value added" agent reimbursement system. The costs of agents are not included in our premium prices. Employers choosing to use agents (and 75% of our employers do) pay fees as a specific add on to premium, in amounts set by the Board. By allowing employers who wish to purchase directly to do so and by reducing the amount of compensation agents receive through the set fee, we have reduced the cost of coverage for employers significantly.

Alliance Operations can be Streamlined, Responsive and Unbureaucratic

Our Board views the role of MRMIB staff as that of policy makers, negotiators, contract monitors and ombudsman. All operational functions, such as collection of health premiums, enrollment, and the provision of health services, are contracted out, using contracts with terms allowing for financial penalties or contract cancellation if performance becomes unsatisfactory. For example, we require our enrollment contractor to process applications for coverage within 4 days of receipt, enroll groups no later than 2 weeks after receipt of application, and answer 80% of all phone calls within 15 seconds—a standard that our contractor surpasses by answering 90% of all phone calls within 15 seconds.

Because we rely on contractors to perform operational functions, MRMIB presently operates the HIPC and its two others programs with just 13 staff. Even though the HIPC's enrollment is growing at the high end of our enrollment estimates, we intend to add only one position through 1994–95.

We think that use of performance based contracts would help alliances achieve high levels of performance, keep the in-house staff small in number and allow the staff to remain focused on essential tasks.

Alliances Alone Will not be Able to Make Significant Progress in Covering the Uninsured

Enacting market reform and establishing alliances provide *access* to coverage. But, as the Robert Wood Johnson Foundation studies have shown, access alone does not result in a significant expansion of coverage for the uninsured.

Our experience supports this finding. Approximately eighty percent of the employers purchasing coverage through the HIPC were previously insured and changed coverage because the HIPC was a better deal for them. We expected to have a significant number of uninsured come into the market last July 1 when the guarantee issue requirements took effect. It is unclear to us what the percentage of uninsured will be when the market settles down a bit.

There are 8,000,000 lives associated with the small employer market in California, half of whom are uninsured. If we have 70,000 enrollees in the HIPC by the end of the present fiscal year and double enrollment the next year, the HIPC will be covering only 0.7% of the uninsured at the present rate.

OBSERVATIONS ON ALLIANCE STRUCTURAL ISSUES

Because of the experiences we have had in drafting California's market reforms and then designing and implementing the HIPC, we are often asked our views on a number of alliance structural issues.

We prepared a chart for our Board which has helped us think through some of the issues about alliance structure. The chart, Attachment B, details a number of the objectives of health reform and looks at how different alliance structures satisfy these objectives. We acknowledge up front that the ratings are subjective and we do not maintain that the ratings we have assigned represent absolute truth. In fact, we think people snould do their own ratings. But the point the chart makes is that there are trade offs involved in the different choices. If policy makers select a voluntary, multiple, regional alliance structure, they will have to develop different mechanisms to accomplish cost containment, subsidy administration, Medicaid administration, risk adjustment and coverage of part-time or seasonal employees.

Below I discuss our opinions on some of these structural issues.

An Exclusive Alliance Structure Would Benefit the Purposes of Health Reform the Most

We believe that health reform should restructure the market so that competition is over price and quality, not risk selection. We also believe it should reduce the cost of coverage, particularly in the small group and individual markets where the cost of coverage is inflated by excessive administrative and marketing costs.

In our view, an exclusive structure best accomplishes these objectives. For managed competition to be effective, coverage must be provided in an exclusive environment. It is only in an exclusive environment that a single administrator can array for the consumer a standardized benefit package from a broad choice of health plans. It is in the exclusive environment that employer and employee cost sharing can be standardized. It is in an exclusive environment that marketing and administrative costs can be reduced the most. And it is in an exclusive environment that competition based on risk selection can best be eliminated.

Alliances Should be Able to Negotiate the Best Deal for Their Enrollees

The president's proposal, as well as most of the other proposals before you, envision a "price taking" alliance with very limited ability to negotiate with health plans. We think this is a mistake, particularly in a voluntary environment—but even in an exclusive one.

We believe that the managed competition model will deliver on its promise to hold down health care costs over time. However, we think that managed competition, on its own, has a limited ability to effect prices quickly. We appreciate that carriers and health plans feel uncomfortable with the idea that an alliance could refuse them participation if their prices are uncompetitive. However, we know from our own experience that active negotiation will result in better prices and products for our members.

In a voluntary market, plans rejected by an alliance could continue to sell in the open market. In a exclusive environment, the model might have to provide for a couple of alliances in an area so that a carrier or plan rejected from an alliance has another opportunity to compete. But, prohibiting a structure intended to provide affordable, high quality coverage from negotiating with carriers for better prices is to establish a structure which requires employers to pay more for coverage than they have to. It is difficult to imagine any other purchasing environment where the purchaser is not allowed to negotiate for the best value.

The HIPC Structure of a Statewide Alliance With Regional Rates and Offerings Reduces the Bureaucratic Complexities of Regional Alliances

Most of the bills establishing alliances—whether voluntary or exclusive—conceive of regional alliances overseen by a state entity. The structure we have established in California is one which allows for regional rates and offerings without requiring multiple, duplicative and costly numbers of boards, staff, data systems, enrollment materials etc. Also, the HIPC structure eliminates the problems that might occur for employers with employees in different parts of a state—interrupted coverage, benefit differences etc. We think that if this structure works in a state as large as California, it is certainly feasible for other states.

CONCLUSION

To summarize, the experience we have had in establishing the HIPC shows that alliances are not just theoretical constructs. The HIPC, even in its modest form, has shown that employee choice is valued in the private market, more affordable rates can be achieved, administrative savings are attainable, and efficient operation is possible. An alliance operating in an exclusive environment could better protect consumers from risk selection practices, further reduce marketing and administrative costs, and negotiate for even better rates with health plans.

ATTACHMENT A

PARTICIPATING HEALTH PLANS

PPOs	HMOs
Aetna	Aetna
Employers Health	CIGNA Healthplans of CA
John Alden Life	Contra Costa Health Plan
	FHP, Inc.
	Health Net
	HMO California
	Kaiser Foundation Health Plan North
	Kaiser Foundation Health Plan South
	Life Guard Group Health Care
	National Med
	PruCare of CA
	QualMed CA
	SCAN Health Plan
	Sharp Health Plan
	TakeCare
	United Health Plan

ATTACHMENT B

ALLIANCE STRUCTURE RATINGS

Ratings: 1=Most, 7=Least

Ratings Based on Judgments Made by MRMIB Staff

OBJECTIVE	Exclusive Statewide Single	Exclusive Statewide Competing (appx. 3-5)	Exclusive Regional Single (appx. 6)	Exclusive Regional Competing	Voluntary Statewide Single	Voluntary Regional Single	Voluntary Competing
Cost Containment Potential	1	2	3	4	5	6	7
Ability to manage within budget cap	1	2	3	4	5	6	7
Reduction of marketing costs	1	2	3	4	5	6	7
Reduction of administrative costs	1	2	2	4	5	6	7
Encourages Quality of Care	4	1	3	2	5	6	7
Establishes Competition on Price & Quality	4	1	3	2	5	6	7
Reduces Competition on Risk Selection	1	3	2	4	5	6	7
Facilitation of Consumer Choice	1	3	2	4	5	6	7
Maximizes Negotiating Power	4	1	3	2	5	6	7
Maximizes Purchasing Power	1	2	3	4	5	6	7
Efficiencies of Scale	1	2	3	4	5	6	7
Least Administrative Overhead	1	2	3	4	5	6	7
Standardazation of Enrollment	1	2	3	4	5	6	7
Standardization of Data Rqmnts	1	2	3	4	5	6	7
Availabiity of Qualified Staff	1	2	3	4	5	6	7
Availability of Qualified Board Members	1	2	3	4	5	6	7
Sensitivity to Community Input	7	6	5	4	3	2	1
Ability to Administer Low Income Subsidies	1	2	3	4	5	6	7
Ability to Sponsor Medicaid Recipients	1	2	3	4	5	6	7
Ability to Sponsor Part-time & Seasonal Employees	1	2	3	4	5	6	7
Ease of Performing Risk Adjustment	1	2	3	4	5	6	7
Amount of Change From Existing System	1	2	3	4	7	7	7
Long Term Vitality of Organization	7	1	6	2	3	4	5

1/4/94

PREPARED STATEMENT OF RICHARD E. CURTIS

Mr. Chairman and members of the committee, I am Richard E. Curtis, President of the Institute for Health Policy Solutions. I greatly appreciate the opportunity to testify before the Senate Committee on Finance's hearing on Health Purchasing Alliances. The Institute is a not-for-profit, non-partisan organization established to identify, analyze, and develop policies to address access and cost problems; the Institute does not advocate specific legislation. Much of the Institute's work has focused on analyzing and developing alternative approaches to health insurance market restructuring and health purchasing alliances. We have worked with states and employer health coalitions with the immediate objective of bringing equity, efficiency, and choice of health plans to small-firm employees and the longer term objective of building an infrastructure for implementing systems reforms.

The purpose of my testimony today is to briefly compare the roles and policies for similar purchasing organizations established under three key bills: the Chafee/Dole bill ("purchasing groups"), the Cooper/Breaux bill ("health plan purchasing cooperatives"), and the Clinton Administration's Health Security Act ("health alliances"). To simplify my narrative, I generically refer to these organizations as health purchasing alliances. I will begin by briefly discussing the bills' assignments of basic roles pertinent to these organizations.

All three of these bills strive to create a system in which people are covered through private health plans that, compete for enrollees on the basis of cost-effectiveness, quality, and service rather than risk-selection. To achieve such a system, a number of functions need to be carried out. As with other such reform proposals, the three bills include a role for health purchasing alliances. While they agree on some functions that alliances (versus government agencies or commissions) would perform, they disagree on others.

All three proposals, as well as virtually all other proposals that incorporate alliances, include the following alliance roles for the populations they serve:

- *Contracting with health plans.* The alliance contracts with health plans that it then makes available to its enrollees, spelling out the conditions under which plans provide services and for what price.
- *Enrolling people in plans.* The alliance makes certain that people's choice of individual plans is translated into actual enrollment in that plan.
- *Collecting and distributing premiums.* Premiums will typically be paid by both employees and employers. The alliance collects the money and makes certain it is distributed in proper amounts to each plan. (The Chafee bill permits, but does not require, the alliance-like structure to perform this function.)

For the following functions, *alliances* would play a key role under the Clinton and Cooper/Breaux proposals. As we discuss later, both the Clinton and Cooper/Breaux proposals make alliances the exclusive vehicle for the population they serve; the Chafee/Dole bill would allow multiple voluntary alliances as an option to conventional individual and employer-based coverage. Reflecting this, The Chafee/Dole bill would make state government primarily responsible for the following functions which would have purview across the small employer and individual markets.

- *Providing consumers with comparisons of plan features and performance.* If consumers are to make wise choices—that is, choosing the plans that offer them the best combination of price and service—they need accurate information to compare plans. Someone has to collect the data, do the analysis, and publish the results in a form that is usable by consumers.
- *Risk-adjusting premiums.* If plans are to compete fairly and equitably on a price basis, cost differences among plans must be attributable to differences in their relative efficiencies and levels of service and amenities, not to differences in the risk profiles of the people they enroll. The cost advantage of plans with enrolled populations of lower-than-average risk must, therefore, be offset by having them transfer funds to plans with enrolled populations that have higher-than-average risk. Some entity has to assume the responsibility of making the proper risk adjustments.
- *Enforcing rules of competition.* Someone has to make certain that competing plans play by the rules and compete fairly.

There is one other function that a number of states believe is important to giving alliance the capacity to reduce health care costs or to at least protect small firms and individuals from cost shifts from larger purchasers:

- *Negotiating and selectively contracting with health plans.* In order for alliances to contain costs, a number of states that have already established alliances allow them to negotiate prices and to selectively contract with plans that are

judged to offer good value. Some states view this function as central to the alliance's role.

Finally, there is a group of functions that alliances could be assigned but that involve policy judgments that are separable from the core alliance functions that restructure the way private plans compete and people access them. They include setting and enforcing expenditure or premium budget limits, establishing provider fee schedules or limits, and determining eligibility for subsidies. The Clinton Administration's proposal assigns such functions to the alliance. Other proposals incorporating such functions typically assign them to government.

There is a broad range of policy issues that need to be addressed in the design of health purchasing alliances. For example, the inclusion of most employers within the alliance structure is directly related to other roles that the Clinton Administration proposal assigns to alliances. The use of premium limits as a mechanism for expenditure control would be difficult if many people were covered by plans outside the alliance. The alliance's role in providing subsidies for low-income people would also be more complicated if substantial numbers were covered outside the alliance.

This testimony concentrates on the core functions often assigned to alliances under a variety of systems reform scenarios. But before we turn to a description of what the bills propose on these dimensions, it is useful to briefly review current problems in the private health insurance market alliances are designed to address. As the Committee considers alternative roles and policies for alliances and other organizations performing similar functions, it may prove useful to assess how well they might solve these problems.

The administrative costs in small-employer and individual health insurance are typically very high. They average between 25 and 40 percent of premiums for very small employers under size 25 and individuals.[1] Some inefficiencies and inequities may be endemic to a marketplace where each small employer group and self-employed individual separately contracts with a health carrier. In such a highly fragmented market, it would be virtually impossible to regulate the broad range of tactics that could be used for selective marketing and servicing to attract and retain only lower risk persons. It is also notable that most small-firm workers do not now obtain coverage through their job. (Only 28 percent of workers in firms with under size twenty-five and 22 percent of workers in firms under size ten currently receives coverage through their employer.) And for those who do, there is a significant probability that their employer will change health plans or drop coverage in the coming year.

There is high turnover of both small firms and their workers, making place of employment a particularly unstable source for this coverage. Even in firms with between twenty-five and ninety-nine employees, the average job tenure is only half that of larger firms.[2] And job turnover is higher still for the currently uninsured, small-firm workers that will hopefully be able to obtain coverage through health care reforms.[3] To the extent that these populations are enrolled in integrated health plans which have limited provider panels, their high rate of job mobility creates yet another problem with employment-based health care coverage. As they frequently change employers and, therefore, health plans, they would typically have to change physicians.

Compounding the high administrative costs and employee turnover found among small firms are the low average wages. For example, the per-worker payroll level for establishments under size twenty is approximately half that of establishments with one thousand or more workers.[4] The subsidies needed to achieve coverage for these populations will disproportionately go toward coverage of small-firm workers. Because small firm employees have relatively low average family income, this will be true regardless of whether employer- or individual-based financing is used to cover the uninsured. The Congress would be understandably reluctant to invest many billions of subsidy dollars or require the purchase of coverage in such an unstable and administratively inefficient market.

While most health systems reform issues have direct or indirect implications for alliance design, there are key issues specific to alliances. These include: a determination of what populations are to be served by alliances, whether alliances are an optional or exclusive vehicle for these populations, whether there is one or more alliance per area, what roles alliances have in negotiating with and selecting health plans, and to what degree states should have flexibility on these and other issues. We now turn to a brief description of the approaches taken by the three bills on these issues:

THE CHAFEE PROPOSAL

The Chafee proposal would permit non-profit organizations to seek charters under state law to become "individual and small-employer purchasing groups." No state or region is required to have a purchasing group, but there is no limit on the number that could be established within a region. No group or individual is required to buy coverage through the purchasing group; participation is wholly voluntary. Participation is limited to employers with 100 or fewer employees (although larger employers could form separate purchasing groups). Each purchasing group must contract with all certified health plans that seek to offer coverage through the purchasing group; selective contracting, in other words, is not permitted.

This proposal assigns alliances (purchasing groups) a relatively minor role and limits their powers more than those of other purchasing entities that the bill recognizes. Alliances offering coverage to individuals and small employers cannot bargain with health plans or deny a contract to a plan because it is too costly or for any other reason. But neither multiple employer welfare arrangements (MEWAs) for small employers nor purchasing groups representing larger employers and self-insured employers are denied such power.

THE COOPER PROPOSAL

The Cooper bill requires employers with 100 or fewer employers to offer alliance-based coverage (though they are not required to pay for any portion of coverage). The private, non-profit alliance is, thus, the region's exclusive source through which small firms purchase coverage (with states having the option to raise the size threshold for employer participation as long as no more than 50 percent of workers in the state-are covered through the alliance). Larger firms continue, as now, to purchase coverage on their own, but they must offer a qualified health plan to their employees. Alliances do not compete; only one operates in each region. But alliances are required to contract with all certified health plans that wish to offer coverage through the alliance; the alliance cannot negotiate with health plans.

THE CLINTON PROPOSAL

The Clinton proposal assigns alliances (which can be a private non-profit entity or a state agency) a very large market share, requiring participation of all but the very largest employers (those with more than 5,000 employees). The sole alliance in a region can—in fact, is required to—negotiate with health plans, but its ability to negotiate is circumscribed because it is prohibited from denying a contract to any plan except those whose premium is 20 percent or more above the area weighted average. However, plans do have incentives to negotiate to help ensure that the alliance's coverage premium is within federally set limits. If the average weighted premium in an area exceeds this target limit, health plan premiums are automatically lowered under a formula specified in the legislation.

None of these bills allows states to give alliances more authority to negotiate or selectively contract with health plans (with the arguable exception of the Clinton bill's single-payor option for states.) Further, the Chafee/Dole bill would not allow states to make alliances exclusive vehicles for small group and individual coverage. As this Committee is frequently reminded, population and health care delivery systems characteristics vary widely from state-to-state and area-to-area. Final decisions on the purchasing role of alliances might take into account this diversity. If a state has neither urban population centers nor competing integrated plans, it may be unrealistic to expect an alliance to contain costs solely on the basis of individuals' choosing among fee-for-service plans that include largely the same providers. The Committee, therefore, might consider giving states the option to give alliances more of a role as purchasers.

While the states that have authorized health purchasing alliances to date have made them voluntary, some states have developed plans that envision alliances as exclusive vehicles for small-firm and individual coverage. It is pertinent to not that federal legislation prohibiting states from making alliances the exclusive vehicle for individuals and small firms would constitute a new preemption of state authority. A state can now use its regulatory power over insurers, which ERISA specifically authorizes, to require that carriers make coverage available only through an alliance. (However, because ERISA would apparently preclude a state from requiring self-insured employers to purchase coverage through a specified structure, states could not require employers large enough to self-insure to use an alliance.)

There is, of course, a broad range of issues and implications that I have not covered in this brief testimony. We are including the following table which briefly summarizes the three bills across the dimensions I have discussed, as well as some oth-

ers. We are now finalizing a more in-depth analysis for the Henry J. Kaiser Family Foundation that also identifies possible hybrid policies for the role of alliances. We will be happy to share that document with the Committee. Again, we greatly appreciate the opportunity to participate in this hearing.

ENDNOTES

1. For example, see Hay/Huggins estimates reported in Congressional Research Service report, *Health Insurance and the Uninsured: Background Data and Analysis,* 1988.
2. E. S., Andrews, "Pension Policy and Small Employers: At What Price Coverage?" Employee Benefit Research Institute, 1989.
3. Steven Long and Susan Marquis, "Gaps in Employment-Based Health Insurance: Lack of Supply or Lack of Demand?" in *Health Benefits in the Workforce* (U.S. Department of Labor, 1992).
4. Source: U.S. Bureau of the Census, County Business Patterns, 1988.

The Alliance/HPPC Role in Three Federal Reform Proposals

	Chafee /Dole (S. 1770)	Cooper (H.R. 3222) Breaux (S. 1579)	Clinton (S. 1757, H.R. 3600)
KEY ALLIANCE/HPC DESIGN ISSUES			
Optional or exclusive vehicle through which coverage is purchased?	Optional; firms can continue to buy coverage outside the alliance.	Exclusive.	Exclusive.
Size cut-off for participating employers	100 employees.	100 employees; larger firms at state option up to 50% of workers.	5,000 employees.
Opt-in for larger employers?	No opt-in, but can form their own alliances.	No opt-in.	Yes, on one-time basis.
Health plan choice: employees or employer?	Generally employer chooses, but individual employees may opt for another plan, and if 50% of employees select a plan, employer must offer.	Individuals choose health plans.	Individuals choose.
Multiple competing alliances per region?	Competing purchasing organizations permitted.	Competing HPPCs not permitted.	Competing alliances not permitted.
Limits on alliance bargaining or selective contracting authority?	Must contract with all certified plans; no bargaining.	Must contract with all certified plans; no bargaining.	Can deny contract only if premium is 20% above the alliance area average.
Are alliances public or private entities?	Private not-for profit corporation (may not be formed by an insurer).	Private not-for-profit corporation.	Can be either public (an existing state agency or a new independent state entity) or private not-for-profit corporation.
How are alliances governed?	By a board composed of representatives of small employers, their employees, and insured individuals. The board is elected by members (small employers, employees, individuals).	By a board that is initially appointed by Governor but thereafter elected by people enrolled in HPPC plans.	By a board composed of equal numbers of consumers and employers (no providers or health plan representatives permitted). State determines how chosen.
How are geographic boundaries defined?	No apparent restrictions.	May have more than one region per state, but must include entire metropolitan statistical area and at least 250,000 people. May have HPPC that includes area in more than one state.	States decide whether more than one, but must include entire metropolitan statistical area and sufficient population to give alliance negotiating power with health plans. May not discriminate on race, socio-economic status, disability, religion, language. Multiple-state alliances not permitted.

	Chafee /Dole (S. 1770)	Cooper (H.R. 3222) Breaux (S. 1579)	Clinton (S. 1757, H.R. 3600)
ALLIANCE/HIPC FUNCTIONS			
Provide information to compare plans — "Report Cards"	Yes, but state initially collects and prepares such information on all plans.	Yes.	Yes.
Enforce rules of competition — monitor marketing, prevent risk selection	Not specifically mentioned as alliance functions.	Not clear who does this. HPPC may terminate plans that violate federal commission rules.	Yes.
Enroll people in plans	Yes.	Yes.	Yes.
Collect premiums	Optional.	Yes.	Yes.
Distribute premiums	Optional.	Yes.	Yes.
Administer risk adjustment	No; state would do this.	Yes, under provisions set by federal commission.	Yes, under provision set by National Health Board (waivers possible)
Negotiate with and select plans	No; must contract with all willing qualified plans.	Prohibited.	Negotiating required but prohibited from denying a plan a contract (unless its premium is 20% above area average).
Act as ombudsman	Not a specified function.	Yes.	Yes.
ADDITIONAL FUNCTIONS			
Establish/apply criteria for certifying plans	State government responsibility.	Federal commission responsibility but may certify that a state can do it.	States do this under procedures they establish.
Oversee resource planning and allocation	Not a specified function.	Not a specified function.	Not a specified function.
Enforce budgets; negotiate/set provider rates	Not applicable.	Explicitly prohibited.	Major responsibilities.
Improve access	Plans could have obligation to serve underserved areas, but alliance is not given responsibility.	HPPC may require health plans to provide services in underserved areas.	Alliance may organize providers to serve underserved area and require plans to do so.
Administer subsidies	No. Appears to be federal responsibility.	No. Responsibility of federal commission.	Alliance responsibility.
Ensure quality	Not a specified function.	No. Responsibility of federal commission.	States have primary responsibility; alliances provide information.

	Chafee /Dole (S. 1770)	Cooper (H.R. 3222) Breaux (S. 1579)	Clinton (S. 1757, H.R. 3600)
HOW THE REFORM PROPOSES TO MEET SPECIFIED OBJECTIVES			
Spread risk and costs more broadly	Modified community rating and insurance reforms help to spread risk for those employed by small firms.	Requires community rating for all employers with 100 or fewer employees, who must get coverage through the HPPC; states have the option to require larger firms to participate, up to half of all employees in the state.	Risk spread among all employers with 5000 or fewer workers, who must participate in the alliance; each participating plan must use community rating.
Restructure competition among health plans	Primarily based on insurance market reform, modified community rating, and tax cap on premiums above the 50 percentile premium for the region. Participation in alliance/HIPC is voluntary.	Participation in HPPC is compulsory for firms with 100 or fewer employees and states have option of including larger firms; restructured competition thus mandated for this group. Tax cap on premiums above lowest in each region.	Competition is restructured through mandatory participation in alliances by all but the very largest firms but with regulatory backup. No tax cap on premiums.
Reduce administrative costs	With respect to marketing and insurer administrative costs, economies of scale would be limited to those participating in multiple voluntary alliances. As with all proposals, includes standardization of reporting forms, electronic reporting, etc.	Economies of scale resulting from inclusion of all small groups and individuals. As with all proposals, includes standardization of reporting forms, electronic reporting, etc.	Economies of scale since alliance is vehicle for coverage for most people. As with all proposals, includes standardization of reporting forms, electronic reporting, etc.
Enhance consumer choice of plans and improve continuity of coverage and care	Those in new purchasing groups would have expanded choice, but these are voluntary. Employees can opt out of employer-selected plan, but not clear whether employer would continue to contribute the same amount (if any) in this instance.	Choice is expanded for all individuals and employees in firms of 100 or fewer, since HPPC is vehicle for all small groups and individuals.	Choice would be expanded for all employees in firms of 5000 or fewer employees. Individuals could keep same health plan as job status changes.

PREPARED STATEMENT OF KEVIN P. FLATLEY

I. INTRODUCTION

Mr. Chairman, members of the Committee, I am Kevin Flatley, Vice President for Employee Benefits of the American Express Company. This morning, I am testifying in my capacity as Chairman of the Board of Directors of the Association of Private Pension and Welfare Plans (APPWP). The APPWP appreciates the opportunity to comment on the purchasing group provisions of the President's Health Security Act (HSA), the Chafee-Thomas Health Equity and Access Reform Today (HEART) Act, and the Cooper-Grandy-Breaux-Durenberger Managed Competition Act (MCA).

APPWP is the national association of firms and individuals concerned about federal legislation and regulation affecting employee health and pension benefits. APPWP's members include principally Fortune 500 companies, some small and mid-size firms, banks, insurers, and consulting, accounting, actuarial, and investment firms.

In December 1992, APPWP became the first national organization of employers to endorse a requirement that employers offer health benefits to their employees and pay most of the premiums. This employer mandate would be coupled with an individual mandate. APPWP's members adopted this position after eighteen months of intensive debate for two reasons: First, we concluded that a restructured employment-based health benefits system offers the best prospect of controlling costs and improving quality. The employer mandate is the only way to organize and pay for health benefits that is consistent with maintaining an employment-based system. Second, a **well-designed** employer mandate is the best way to cover most uninsured Americans and reduce various forms of cost-shifting.

APPWP's support for an employer mandate is conditioned on five factors. First, employers must have the opportunity to be active purchasers of health benefits, i.e., to adopt effective purchasing strategies that save money and improve quality, and to receive the savings generated by those initiatives. **APPWP strongly opposes a mandate, such as the one included in the Health Security Act, that reduces the employer's role to writing checks.** Second, all aspects of the mandate must be designed prudently, so that it is affordable and does not interfere with workplace arrangements that should be driven solely by productivity. Third, government subsidies should be carefully targeted to low wage jobs, without regard to the size of the employer creating the job. Fourth, very importantly, it is crucial that health care reform be achieved in a federal, uniform approach rather than a state-by-state piecemeal to ensure efficient operation and to recognize the reality that business operations and individual consumer action transcend state borders. Fifth, the other features of APPWP's policy proposal (e.g. intensive application of managed care to public and private programs, etc.) must also be enacted.

APPWP also has endorsed measures that would constrain costs by promoting the development of more efficient health care delivery systems and encouraging consumers to choose between competing health plans on the basis of cost and quality. Finally, APPWP has endorsed setting expenditure targets to serve as a benchmark for the success of aggressive, market-driven programs and the need for additional cost containment steps in the future.

This morning, I will explain APPWP's position on purchasing groups. I will then discuss the purchasing group arrangements in the Health Security Act, the Health Equity and Access Reform Today Act, and the Managed Competition Act. **APPWP concludes that the purchasing group structure in the HEART Act comes closest to creating workable and effective purchasing group arrangements. That said, we believe that the HEART Act's purchasing group structure requires considerable work so that its potential effectiveness is realized in practice. While the HEART Act provides a very useful starting point for the purchasing group portion of a health reform bill, the Health Security Act's purchasing group provisions are fundamentally unsound and should be rejected.**

II. THE ROLE OF PURCHASING GROUPS IN HEALTH REFORM

APPWP evaluated the issues raised by purchasing groups throughout our year and a half of deliberations on health reform. We chose to oppose mandating employer participation in purchasing groups, since such a requirement would undermine cost control by creating barriers to effective health care markets and almost certainly evolve into a government-administered system. While APPWP opposes mandatory purchasing groups, it supports establishing a framework under which employers could choose to (a) form multiple, voluntary purchasing groups that would be required to adhere to fair market conduct rules; or (b) purchase insurance

directly from insurers required to operate under fair market conduct rules. In addition, retaining a viable self-insurance option under ERISA will assure continued quality-improving and cost-cutting innovation.

A. The Myths of Mandatory Purchasing Groups

Advocates of a single mandatory purchasing group in each region for all businesses up to a specified size often justify their position with four arguments. First, a single mandatory purchasing group is needed to give small employers the same "market clout" as large employers. Second, a single mandatory purchasing group is needed to assure elimination of adverse and favorable selection by individuals and risk selection by health plans (and to permit "risk adjustment"). Third, a single mandatory purchasing group is necessary to achieve administrative savings. Fourth, a single mandatory purchasing group is needed to assure that all individuals have the opportunity to choose among competing health plans. These arguments lack merit. While APPWP supports each of the four goals, they can be achieved without mandatory purchasing groups and the many risks and problems mandatory purchasing groups would create.

1. Market Clout

Mandatory purchasing groups do not give small employers market clout. All mandatory purchasing group proposals require the purchasing groups to contract with all health plans wishing to participate in the purchasing group (HSA includes limited exceptions to this rule). A purchasing group which neither selectively contracts with a limited number of health plans nor negotiates the terms of coverage with health plans will not have useable market clout.

Market clout results when a purchaser selectively contracts with a limited number of health plans. In return for the purchaser's steering a large volume of its business to the selected health plans, the plans agree to meet the purchaser's standards. For instance, the Business Health Care Action Group (BHCAG) in Minneapolis-St. Paul, a coalition of over 20 large firms, selectively contracted with a consortium of three provider systems. The systems agreed to implement the Action Group's standards in areas such as development and implementation of practice guidelines and creation of a single medical record for all patient encounters.

Mandatory purchasing group proposals should not be modified to allow the purchasing groups to selectively contract with a limited number of health plans and to negotiate the terms of coverage. As recognized by the mandatory purchasing group proposals, it is wholly inappropriate for any single entity-particularly an entity which, in practice, would be government run to exercise absolute control over the market. Establishing monopsonies would destroy the opportunity to create a more efficient and higher quality health care system by virtually eliminating the type of innovation generated by BHCAG and many other purchasers. It is folly to believe that any single entity knows enough to fix all of the health system's ills, or would be motivated to try very hard in the absence of competition. Moreover, government-run monopsonies are unlikely to make and stick to the often unpopular choices that many private purchasers have made over the last few years.

The best way to create real market clout for small employers is to allow employers to negotiate and selectively contract with a limited number of health plans, either independently or collectively through multiple, voluntary purchasing groups. A purchasing group should be permitted to exercise market clout by selectively contracting with a limited number of health plans if it is not the sole purchaser of health insurance for small employers because other purchasing groups are permitted to operate and employers can buy coverage directly from insurers.

Some critics of multiple, voluntary purchasing groups claim that none of the purchasing groups would have enough volume to effectively negotiate with health plans. This view misreads the facts. If all workers in private firms were covered through their own employers, workers in firms with fewer than 25 employees would account for over 28 million insured workers (approximately 32 percent of all workers in private firms). This provides a more than adequate base for multiple, voluntary purchasing groups with market clout and a direct purchase option in each region.

Effective negotiation and selective contracting does not require large market share. Purchasers controlling much less than half of their local market have implemented successful initiatives.

- A single firm, the Digital Equipment Corporation, obtained agreement from three Massachusetts HMOs to meet Digital's comprehensive quality standards.
- Four Cincinnati employers accounting for 10 percent to 15 percent of the Cincinnati market persuaded all greater Cincinnati hospitals to install a standardized system for comparing cost and quality. The system is driving down costs.

- BHCAG accounted for roughly 5 percent of the Minneapolis-St. Paul market when it negotiated agreements under which well-established health care delivery systems, such as the Mayo Clinic, will dramatically restructure their operations.

Establishing one purchaser with a very large market share, rather than multiple purchasers with modest market shares (even if they cumulatively equal the total market share of one dominant purchaser), is the real threat to effective purchasing.

2. Risk Selection and Risk Adjustment

Single, mandatory purchasing groups are often touted as necessary to eliminate risk selection[1] among health plans. In fact, single, mandatory purchasing groups might increase rather eliminate risk selection. Increased risk selection could be caused by (a) switching tens of millions of Americans from employer or combined employer and individual choice of health plan to pure individual choice and (b) vastly increasing-at least initially-the number of health plans available to each individual. This possibility, which has been all but ignored by advocates of single, mandatory purchasing groups, requires further analysis.

Multiple, voluntary purchasing groups and a direct purchase option would retain an element of group choice. It is likely that this would help to control risk selection. Additionally, these arrangements would permit contracting with a limited number of health plans. Offering individuals a choice among a reasonable number of health plans rather than an unrestricted number of plans is likely to reduce risk selection.

Voluntary purchasing groups should be required to adhere to strict market conduct rules designed to minimize risk selection. For instance, all purchasing groups serving small employers could be required to offer open enrollment, cover a specified geographic territory, offer actuarially equivalent benefit packages with identical core benefits, and report uniform cost and quality data. Additionally, all health plans serving the small employer market should be required to adhere to the same market conduct rules (e. g., open enrollment and rating rules), whether they are operating inside or outside of a purchasing group.

Finally, it is important to recognize that a single, mandatory purchasing group is irrelevant to the operation of an effective "risk adjustment" system. Most health reform proposals intend to adjust for risk selection through a risk adjustment formula that would transfer premium dollars among health plans based on the riskiness of each plan's enrollees in relation to a standard risk population. Since risk adjustment occurs among health plans, it would work just as well between health plans in different purchasing groups or outside of any purchasing group as among health plans in the same purchasing group.

3. Administrative Savings

Single, mandatory purchasing groups are not needed to drive down small groups' administrative costs. APPWP has commissioned a study by Lewin-VHI that examines health benefit costs by size of employer. As one part of this project, Lewin-VHI projected the administrative savings which small groups would realize assuming comprehensive insurance market reforms without any purchasing group structure. According to Lewin-VHI, elimination of underwriting expenses, reduced costs of changing coverage, and restricting preexisting condition limitations would cut administrative expenses as a percentage of claims from (a) 40 percent to 18.9 percent for groups with 1–4 employees, (b) 35 percent to 18.9 percent for groups with 5–9 employees, and (c) 30 percent to 18.4 percent for groups with 10–19 employees. We will be pleased to make this study available to the Committee when it is released within the next week.

4. Choice Among Plans

Effective cost control requires cost conscious consumer choice among competing health plans, in addition to aggressive group purchasing by employers. As a result, consumers must be able to choose among competing health plans. A single, mandatory purchasing group is not needed to extend a choice among health plans to workers in small firms. Multiple, voluntary purchasing groups and the direct purchase option can both be organized to assure that all workers have a choice among competing health plans.

---

[1] For purposes of this statement, we use the term "risk selection" to refer both to favorable and adverse selection among health plans by individuals and risk selection by health plans.

III. EVALUATION OF PURCHASING GROUPS IN THE LEADING HEALTH REFORM PROPOSALS

A. The Clinton Administration's Health Security Act

1. HSA's Regional and Corporate Alliances Eliminate Employment-Based Health Benefits

The Health Security Act would end employment-based health benefits, while requiring employers to pay the large majority of workers' health benefit costs. Firms accounting for a large majority of all workers would be legally required to join regional alliances, each of which would have a monopoly within its territory. Regional alliances would exclude employers from playing any direct role in purchasing health benefits. HSA nominally allows some private firms with more than 5,000 full-time employees to manage their health benefits by forming corporate alliances rather than joining regional alliances. However, HSA's rules are so dramatically stacked against the corporate alliance option that few, if any, eligible firms would form corporate alliances. Instead, they would join regional alliances.

Many analyses of the corporate alliance option have mischaracterized the factors that would influence an employer's choice between corporate and regional alliances by focusing solely on the direct financial penalties imposed for forming a corporate alliance. These financial penalties, including a 1 percent payroll tax[2] and denial of government-funded subsidies for low wage workers, are sufficient, even when standing alone, to force many eligible firms into regional alliances. However, numerous other HSA provisions also make the corporate alliance option untenable. Just a few examples from the very long list of such provisions follow:

- Regional alliances and Medicare would control nearly the entire health care market. Assuming the Congressional Budget Office (CBO) estimate that 23 percent of eligible firms would form corporate alliances is correct, corporate alliances would control less than 5 percent of total health spending. As a result, corporate alliances would be unable to effectively negotiate with health plans and would be targets for cost-shifting. Eligible firms evaluating this situation would choose to join regional alliances.
- Corporate alliances could be terminated and forced to join regional alliances due to very small cost trend fluctuations-even if their health benefit costs are lower than regional alliances' costs. Ironically, the result of forcing corporate alliance employers into regional alliances under these circumstances would be higher health care costs.

Corporate alliances would be required to meet the same cost trend as regional alliances. However, each corporate alliances would have to offer a fee-for-service plan regardless of its cost, while regional alliances could drop the fee-for-service option if it becomes too expensive.

- Multistate corporate alliance employers would be required to comply with the differing fee-for-service fee schedules and claims denial standards established by each of the 100 to 200 regional alliances.
- Corporate alliance employers who aggressively manage benefits would face an employee relations nightmare. Full-time employees covered through the corporate alliance could have a limited choice of health plans. Part-time workers in the same workplace could have a broader range of health plan choices

---

[2] The one percent payroll tax on firms forming corporate alliances is a penalty, not a fee which levels the playing between corporate and regional alliances. For instance:

The tax does not compensate regional alliances for higher premiums "caused" by only higher-than-average risk large employers opting to join regional alliances. The tax takes effect in 1996-two years before most regional alliances would begin operation-but large employers choosing to join regional alliances would not be permitted to benefit from community rates until their fifth year in the alliances (and would not be fully community rated until their eighth year in the alliances).

Firms forming corporate alliances would be required to place all employees working fewer than 120 hours per month in regional alliances. The payroll tax would apply to these workers' wages, even though these workers would pay exactly the same premiums as other regional alliance enrollees.

The tax is not needed to assure that corporate alliance firms will absorb part of the large Medicaid cost shift built into regional alliance premiums. Each health plan in a regional alliance would be paid at arbitrarily low Medicaid rates for the same proportion of its enrollees as every other health plan in the regional alliance, regardless of how many Medicaid beneficiaries it enrolls. Unless a corporate alliance manages to avoid contracting with every health plan offered through regional alliances (a virtual impossibility since regional alliances would encompass nearly all of the employed population), the corporate alliance will be faced with the same cost shift as regional alliance employers.

through regional alliances—and, under some circumstances, would receive a higher employer-paid premium subsidy than full-time workers.

2. The Faulty Rationale for HSA's Regional Alliance Structure

Advocates of HSA's regional and corporate alliance structure sometimes contend that all employers with up to 5,000 full-time workers should be required to join regional alliances because it is necessary to include large and small employers in the same pool to make insurance affordable to small employers.

The Lewin-VHI study commissioned by APPWP examined health insurance costs by employer size, assuming universal coverage, a standardized benefit package and rules for distributing members of two worker households. It found that virtually the same premiums would result from (a) pooling only employers with fewer than ten employees and (b) pooling employers with fewer than ten employees with all employers. The study reached the same conclusion when it examined premiums in firms with fewer than 25 workers and firms with fewer than 100 workers. This demonstrates that it is not necessary to force most employers into the same regional alliance to reduce small firms' health insurance costs.

3. The Consequences of HSA's Regional Alliance Structure

HSA's alliance structure would dismantle employment-based health benefits, since employers would no longer play a direct role in purchasing health benefits. Eliminating employers from their role in purchasing health benefits is likely to result in increased costs.

Employers are driving the ongoing revolution in the organization of health care delivery systems and the health care market. There is increasing evidence that these employer-led efforts are beginning to pay off. For instance, a recent study of employer-sponsored health plans by KPMG Peat Marwick indicates that health cost increases, while still too high, are slowing. Employers are limiting cost increases even though Medicaid and Medicare cost-shifting adds several percentage points to the annual increase in employers' health benefit costs.

The administration apparently agrees that there is value to employment-based health benefits. administration officials have repeatedly stressed that they want large employers to form corporate alliances, in order to promote innovative purchasing practices that cut costs. Clearly, though, HSA falls the administration's own test-large employers will not form corporate alliances.

The administration also asserts (Health Security Plan Briefing Book, October 8, 1993) that several state employee health insurance programs and large companies such as Xerox, Digital Equipment Corporation, and GTE have achieved "positive results" by implementing approaches which are similar to mandatory regional alliances. While the administration is correct to point out that these employers have achieved positive results, these results are not attributable to programs that are similar to regional alliances. The programs which the administration identifies as "proven models" work well because employers are involved as active purchasers of health benefits. These programs bear little resemblance to regional alliances, but are closely related to the private, voluntary purchasing groups which APPWP supports.

B. The Managed Competition Act

The Managed Competition Act would require all firms with fewer than 100 full-time workers to join a single purchasing group in each region. Firms also could choose to buy health benefits outside of the purchasing group, but would lose the tax preference for health benefits. MCA does not establish rules governing the market outside of purchasing groups, but does not preclude states from establishing rules governing purchasers under their jurisdiction in this part of the market.[3] Purchasing groups serving small employers also would be the source of coverage for low income persons receiving premium subsidies and individuals without a connection to the workforce.

APPWP believes that MCA's purchasing group structure is an improvement over the Administration plan's purchasing group structure. The somewhat smaller size

[3] Allowing small employers to opt out of the purchasing group into an unregulated market raises important questions about selection effects. Some employers or individuals could realize considerable savings by purchasing through the unregulated market, since they could buy a leaner benefits package, avoid adjusted community rating applicable within purchasing groups, accept medical underwriting, etc. These savings could more than offset the value of the lost tax preference. We assume that most states would respond to these potential problems by regulating the market outside of the purchasing group and that most small groups would come within states' jurisdiction. Therefore, in the remainder of this testimony we treat MCA as establishing the equivalent of a single, mandatory purchasing group in each region.

of MCA's purchasing groups and their non-regulatory nature leave more of the employment-based system intact. Nonetheless, we have serious concerns about MCA's purchasing groups. Some of these concerns are implicit in our earlier comments about single, mandatory purchasing groups. At this time I will focus on a second set of concerns: that MCA's purchasing groups will not perform as intended, resulting in a government-dominated health system that eliminates employment-based purchasing.

MCA's purchasing groups would encompass roughly 45 percent of the employment-based market. This market share could be substantially larger, depending on how two-worker families obtain coverage and the number of large employers electing the option to place units with fewer than 100 workers in a.purchasing group's territory into the purchasing group. This large market share would be supplemented by the other purchasing group populations (low income persons receiving subsidies and persons not connected to the workforce).

APPWP believes that it is highly unlikely a purchasing group which (a) is a government-enforced monopoly for half or more of a region's population and (b) manages a large amount of public funds spent on low income persons will be run as a private entity—even if this is the initial intent. Over time, we believe that such purchasing groups would evolve into de facto government-run entities. A government-managed monopoly would be viewed as responsible for holding down costs, since it would preclude individuals from joining together in groups that could control costs through demand-side pressure on health plans. The likely result is the emergence of highly regulatory purchasing groups over time and large-scale cost shifting to large firms.

Additionally, it probably would not be possible to sustain one set of insurance arrangements for half or more of the employed population and a very different set of arrangements for the remaining employed population. Employers outside of the purchasing group will be able to control costs only if they aggressively manage benefits. This means that workers in large firms will encounter more restrictive health benefit arrangements than workers in small firms (and part-time workers in their own workplaces, who also would be covered through the purchasing group). Large firm workers will not accept this outcome. As a result, large firms would be unable to effectively manage benefits and pressure would build to fold large employers into purchasing groups.

APPWP believes that many of the Managed Competition Act's provisions are sound, despite our concerns about it's purchasing group structure. It would be relatively simple to build on MCA's many strengths by amending it to permit multiple, voluntary purchasing groups and the option for employers to purchase coverage directly from insurers. This would enhance the Act's considerable cost control and quality improvement potential.

C. The Health Equity and Access Reform Today Act

The Chafee-Thomas HEART Act would require all firms with fewer than 100 workers to make health benefits available through a voluntary purchasing group operating under fair market conduct rules or directly through an insurer also operating under fair market conduct rules. This basic purchasing group structure is sound. Nonetheless, the act's details should be changed to assure that this structure will realize its potential effectiveness.

The HEART Act requires each voluntary purchasing group to offer each qualified plan in its region which desires to be offered through the purchasing group. Each qualified plan would be available at the same plan-specific adjusted community-rated premium in each purchasing group through which it is offered and in the direct purchase market.[4] Each small firm employee could obtain coverage through the purchasing group or health plan selected by his or her employer, or could choose to enroll through any other purchasing group or health plan. Other eligible individuals who are not small firm employees, including the Medicaid population at state option, also would be able to choose among all available purchasing groups and health plans.

Taken together, these provisions would make it difficult for purchasers to use multiple, voluntary purchasing groups and the direct purchase option to place demand-side pressure on health plans and health care providers. In effect, it would not be possible for purchasers to selectively contract with a limited number of health plans, since purchasing groups would be required to offer all health plans desiring to be offered and workers would be able to enroll through any purchasing group or in any health plan operating in the direct purchase market. Additionally,

[4] Small differences in premiums would be permitted to reflect differences in purchasing groups' administrative costs.

these rules create many of the same problems as the Managed Competition Act in terms of disparate treatment of workers in small firms and large firms.

APPWP recommends building on the HEART Act's sound structure by permitting selective contracting and negotiation of the terms of coverage between purchasers and health plans. Additionally, all workers should have a reasonable choice among health plans, but that choice should be organized in the context of the purchasing group selected by their employer or the direct purchase market. This would facilitate selective contracting and result in comparable rather than disparate treatment for workers in small and large firms.

IV. PURCHASING GROUPS AND MEDICAID BENEFICIARIES

Medicaid beneficiaries (or beneficiaries of the program which replaces Medicaid) should receive care through the same health plans as individuals covered through their jobs. While care should be delivered through the same health plans, and the level of coverage should, of course, be the same as employment based coverage, it should not be organized through the same purchasing groups. We take this position for the following reasons:

- Organizing Medicaid and employment-based coverage through the same purchasing groups is likely to produce government-administered rather than privately-administered purchasing groups.
- Medicaid beneficiaries should be represented by an advocate who negotiates terms of coverage exclusively on their behalf. Medicaid beneficiaries may have needs which differ in some respects from the needs of most persons with employment-based coverage.
- Separate pooling would promote explicit financing of Medicaid, rather than low visibility, low accountability cost shifting.

V. CONCLUSION

Mr. Chairman and members of the Committee, well-structured purchasing groups and a direct purchase option can contribute to innovation, cost-control and the opportunity for all workers to choose among competing health plans. Both small employers and their workers would be given the tools to make the health care system work better. In contrast, poorly structured purchasing groups would result in higher costs and a government-dominated rather than market-driven health care system.

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Mr. chairman, I just want to observe that many of my constituents have some serious concerns about the type of health Alliances proposed in the Administration's health reform bill. Even though Administration representatives have characterized them as non-regulatory bodies, many people who are writing to me, think they are going to be altogether too powerful.

And, at least up to this point, I agree with them. I was very struck by the characterization of the Alliances in the congressional Budget Office's review of the Administration's reform plan.

For instance, in chapter III they argued that the program was more than just another regulatory program of the Federal Government. They said that the boundaries of regulation had been crossed. They said: "In particular, this appears to be the case with respect to the regional alliances. Federal statute would establish and define these new institutions. The terms and financing of the insurance they offered would be specified by federal law, and their activities would be regulated and monitored by the Departments of Labor and Health and Human Services. "

". . . CBO has concluded that the health alliances would be more like federal agencies than like state or private entities, . . ."

Or: "Although the states and the alliances would have important roles and responsibilities, they would be acting largely as agents of the federal government."

It seems to me that it is extremely naive to think that these Alliances would not be exercising great power in their localities.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Thank you Mr. Chairman. I certainly welcome our distinguished list of witnesses today and commend all of you for your comments regarding the role of regional health alliances in the scheme of health care reform.

As you know perfectly well, a common feature of many of the proposals before Congress addressing health reform is the creation of health purchasing groups, or regional alliances, as a means of pooling risks and improving the marketing power of groups of purchasers.

Indeed, this feature is certainly one of the fundamental components, if not *the cornerstone* of the President's Health Security Act.

It is also a component which for many—including myself—raises serious questions regarding the ultimate impact of mandatory alliances on the provision of quality health care, and its associated distribution of costs.

In other words, just what is the role of federally mandated regional alliances?

Will they function in the same manner throughout the country recognizing the demographic disparities between regions and states?

Can we in the Congress and you, as the real experts, realistically predict the overall impact? Can there be genuine consensus on what that impact will be on *the most important* component of any health care plan—the patient?

And, are there other alternatives to alliances that would essentially accomplish the goals that alliances were designed to address?

Based on what I have heard at previous hearings as well as the briefings from the Administration, and the input and concerns from my constituents, there *is* much confusion and uncertainty as to how these alliances will shape health care delivery in the future.

It is just this simple—the choir is not singing in unison on this one. And, the problem is not the choir—it is the sheet music. And I am not so sure that even Beethoven could fix this score!

That is why today's hearing is so important and critical to the overall health of the President's health reform proposal. If these regional alliances are going to be the "Achilles heel" of health reform, then I certainly want us to know this now, instead of after the fact.

Again, thank you Mr. Chairman for scheduling this hearing.

PREPARED STATEMENT OF CATHY L. HURWIT

On behalf of Citizen Action, I would like to thank Chairman Moynihan and members of the Finance Committee for this opportunity to provide our comments on the role of health alliances in health care reform. The issues which this Committee must address over the next several months are of critical importance to all persons throughout the nation. Citizen Action looks forward to working with you in that effort.

Citizen Action is a federation of state organizations with three million members in 33 states. Our membership is diverse both geographically and economically, including workers and business owners, the insured and the uninsured, rural and urban dwellers. Over the past years, Citizen Action organizations have been active in health care reform efforts at both the state and federal levels. In those efforts, we are committed to passage of legislation which provides universal coverage, comprehensive benefits, fair financing, guaranteed cost savings, consumer choice, and public accountability.

Before stating our views on the role of health alliances, I would like to take this opportunity to reiterate Citizen Action's strong support for single-payer reform, as proposed in S. 491, the American Health Security Act. Under S. 491, the current fragmented financing system of public programs and private insurance would be replaced by a social insurance system.

Citizen Action believes that single-payer reform is the most cost-effective approach to providing universal, comprehensive and affordable care. According to the Congressional Budget Office, S. 491 would reduce annual medical spending by $114 billion in the year 2003, while providing access to a full range of benefits, including long-term care. Americans would be able to choose their own health care practitioners with no financial restrictions and without burdensome cost-sharing requirements that hinder access.

Not only is S. 491 the best way to meet the goals of reducing costs and administrative waste while extending access to the uninsured, it is the best method to protect consumers from insurance company abuses and discriminatory practices that exist today. As I mentioned, many of Citizen Action's members are insured currently. But the bureaucratic hurdles created by their insurance companies are preventing them from getting the health care they need. While it may be impossible to eliminate bureaucracy in today's $1 trillion health care system, it is possible to create publicly-operated and publicly-accountable administrative entities more interested in meeting health care needs than in protecting corporate interests.

Despite our strong support for S. 491, Citizen Action recognizes that this Committee is considering other approaches to health care reform, including the Health Security Act, S. 1757. While we have not endorsed the President's plan, we do support many of the goals contained within its framework.

As written, the President's plan would provide all Americans with access to a relatively comprehensive benefits package by 1998. Employers would have to contribute to the cost of health care, but both employers (as well as individuals and families) would be protected in terms of the amounts they would have to contribute. There is a strong cost control mechanism which the Congressional Budget Office projects would hold health care spending below the baseline, making premiums affordable and providing a certainty of future growth rates. Finally, states are given the option of implementing single-payer plans as an alternative. We believe that inclusion of the state single-payer option is vital. If states are held accountable for meeting strong federal standards of universal, comprehensive health care benefits within a limited budget, single-payer is a choice that will make sense for many states.

Unlike single-payer proposals, the Health Security Act would maintain the role of insurance companies. As long as insurance companies are allowed to remain in the market, consumers need a strong, powerful entity to regulate those companies. In the Clinton plan, health alliances are those entities.

The health alliances in the Health Security Act have been the focus of a great deal of criticism, at times from supporters of alternative proposals which also include alliances. In fact, health alliances—entities which allow all or part of a population to pool risks and achieve economies of scale in the purchase of private insurance—are found in many other proposals, including S. 1579, introduced by Senator Breaux and S. 1770, introduced by Senator Chafee. The differences occur in the functions and role of the alliances.

In my testimony today, I would like to provide Citizen Action's perspective on why the health alliance structure in the Health Security Act is preferable to the structures envisioned under alternative proposals. In doing so, I will concentrate on the functions and goals of the alliances, recognizing that there may be alternative means to achieving those goals.

Health Alliances in the Health Security Act: Under the Health Security Act, most Americans would purchase coverage through regional health alliances. (Other Americans would be covered through corporate health alliances or Medicare). Each alliance would cover a broad geographic region according to borders drawn by the states. Alliance boards would be comprised of equal numbers of consumers and employers, according to procedures again defined by the states.

Under the Health Security Act, health alliances would serve the following key functions:

- Spread risks more broadly through creation of a large purchasing pool. By combining large numbers of persons within the same alliance, the problems of risk selection and avoidance would be avoided. Through community rating, small businesses, individuals and families would be provided with more affordable coverage. Economies of scale are also achieved through the alliances.
- Enrollment. Alliances would enroll individuals and families in state-certified plans with which the alliance contracts. Enrollment would typically occur during an "open season" although changes in enrollment could take place for cause.
- Information collection and dissemination. Alliances would have the responsibility for collecting information on quality and consumer satisfaction. Information would be provided to enrollees through "report cards" or other means to assist consumers in selecting plans.
- Collection and Distribution of Premiums. Alliances would receive premiums from employers and individuals and then use premium dollars and other revenues to pay health plans on behalf of enrollees.
- Enforcement of premium caps and establishment of fee schedules. Alliances would enforce the process to ensure compliance with premium targets and, unless the state established statewide fee schedules, set fee schedules for practitioners within the alliance region.
- Consumer Ombudsman and Appeals Process. Alliances and offices of consumer ombudsman would have the ability to resolve consumer complaints regarding plan practices, including the denial of care.
- Guarantee consumer participation. Alliance boards would be required to include an equal number of consumers and employers, guaranteeing consumer representation in the decisionmaking process.

The benefits of health alliances for consumers: For consumers, health alliances provide a number of gains:

- Regional health alliances provide more consumer choice by breaking the link between employment and insurance. Employers contribute to the cost of coverage, but individuals and families choose their own plans. No longer would employers (except those operating a corporate alliance) make that choice. The greater the number of corporations allowed to opt out of the regional alliance, the greater the reduction in consumer choice.
- Regional health alliances provide greater continuity of care. Through the regional health alliances, consumers have the ability to choose their own plans. A change in employment within the same alliance area, therefore, would allow consumers to remain with the same plan and enjoy continuity of source of care as well as continuity of coverage.
- Regional health alliances make health care more affordable. Because of the size of the alliances, their purchasing power, and lower administrative costs, coverage would be more affordable. Additionally, backup mechanisms ensure that insurance companies would no longer be able to charge unlimited premiums, premiums could not increase faster than inflation, allowing for growth in the population and special health needs.
- Regional health alliances can reduce cost-shifting. With the uniform premiums and rates established through the alliances, the problem of cost-shifting would be greatly reduced, if not eliminated.
- Regional health alliances make the health system more fair. Insurance companies would be prohibited from charging some people more because they have (or may have) health problems, live in certain areas, work in certain jobs, are women or are older. With large numbers of people in each alliance, premiums can be community-rated so that coverage is more affordable. And, in large alliances, Medicaid and private insurance rates can be "blended," eliminating payment differentials that prevent low-income persons from finding care.
- Regional health alliances enforce the rules. Today, consumers have few options when faced with insurance company abuses. The alliance would monitor plans, guarantee truth-in-marketing, and monitor quality. The alliance responds to consumer complaints and can overturn insurance company claims denials.
- Regional health alliances allow consumer participation in the health care system. Regional health alliance boards must be comprised of equal numbers of consumers and employers, ensuring that employers have a voice in the implementation of the system.

Within the framework of the Clinton plan, health alliances are a vital component for ensuring that consumers—not their employers—are able to choose their health care plan, that premiums are affordable, that cost-shifting is avoided, and that consumers have a role in the decisionmaking process. Citizen Action recognizes that there are other mechanisms to achieve many of those goals. Should this Committee decide to utilize the health alliance mechanisms, however, we believe that there are improvements that can be made within that structure to make the alliances more effective. Those include:

- Eliminating the corporate opt-out. The largest problem with the health alliances is the ability of large corporations to opt out. This allows some companies to benefit from a younger, healthier workforce and to save costs by limiting choices to their employees and their families.
- Requiring one alliance per state. One alliance would avoid the possibility that alliance lines can be drawn to segment the population, a segmentation that can result in discrimination either due to higher premium costs or the likelihood that some large insurance companies will avoid some alliances.
- Ensure broad community representation. It should be required that consumers on the health alliances are representative of the community, including persons who are high utilizers of health care, lower-income persons, and persons from underserved areas. Consumer representatives should have access to technical assistance and advisers.
- Allow greater consumer choice. To expand consumer choice, health alliances should ensure affordable access to all plans, including fee-for-service plans.

Health alliances in other proposals: While the health alliance structure contained within the Clinton plan has received the most attention, many of the other proposals introduced in this Congress contain similar structures. Those proposals share with the Clinton plan the belief that there is a need for pooling in order to achieve greater purchasing power and economies of scale. Many of the functions of the Clinton health alliances are also found in those proposals. Health alliances, or purchasing cooperatives as they may be called, would enroll members, provide information on available plans, and collect and forward premiums.

In many other respects, however, these proposals differ significantly from the Clinton proposal. For example, only certain populations such as individuals or small businesses may be eligible to receive coverage through the purchasing group. Alliances may compete with each other or be the exclusive purchasing group for a specified region. Employers are not required to contribute on behalf of their employees nor is participation in the alliance mandatory for individuals. Subsidies may be incorporated into the alliance structure or provided separately to eligible individuals and families. None of the alternative approaches would give alliances any responsibility for controlling premium or other costs.

To take just one example, the Breaux bill, S. 1579, the Managed Competition Act, would establish Health Plan Purchasing Cooperatives (HPPCs). Each HPPC would cover a broad geographic region and may serve interstate areas. The HPPC Boards would be initially appointed by the governor, but within several years would be elected.

Like the Clinton plan, there would be only one purchasing group per region and the region is designed to be sizeable (either the entire state or, at the option of the state, a smaller region but one including at least 250,000 people). The HPPC would enter into agreements with accountable health plans (AHPs), offer information on plans (including the results of enrollee satisfaction surveys), arrange enrollment by individuals, collect and forward premiums to accountable health plans, and reconcile low-income assistance where appropriate. As in the Clinton plan, there is a consumer ombudsman although it is unclear whether this office or the HPPC would have the authority to overturn decisions by health plans. Also, it is apparent that the HPPC election process would allow, although not require, representative consumer participation.

Unlike the Clinton plan in which the majority of Americans would purchase health insurance through the health alliance, the HPPCs in the Breaux bill could only include small employers (up to 100 employees) and individuals. Participation is voluntary, which means that the HPPC might attract a disproportionate number of persons with high health care costs. Because of the limitations on eligibility and the voluntary nature of the HPPC, the purchasing pool will be substantially smaller than the pools in the Clinton plan. There will continue to be risk selection problems and insurance companies may more easily choose to function outside of the HPPC structure. In addition, the economies of scale will not be as large, nor would community rating be required.

The provisions of S. 1579 fail to break the link between employment and insurance, as would be provided for most Americans under the Clinton plan. For those employed in larger firms, coverage and access to group policies would be determined by their employer. The lack of an employer contribution would mean that many small business employees may be unable to afford coverage through the HPPC even with group rates. Additionally, the goal of continuity of coverage is not achieved as changes in employment can eliminate eligibility for coverage through the HPPC.

Finally, unlike the Clinton bill, the HPPCs in S. 1579 have no power to enforce premium rates or provider payment rates to ensure that consumers will be able to afford the policies they sell.

Other purchasing pool approaches vary even more significantly from that in the Clinton plan. S. 1770, the Health Equity and Access Reform Today Act, introduced by Senator Chafee, would create Individual and Small Group Employer Purchasing Groups. Like the health alliances, purchasing groups would enter into agreements with health plans, handle enrollment, collect and distribute premiums, and provide information to consumers comparing plans. Like the HPPCs in the Breaux bill, eligibility is limited to individuals, families and small employers.

While purchasing groups would operate within specified Health Care Coverage Areas (HCCAs)—broad geographic regions that could cross state lines and must include 250,000 people—they could compete with each other within the HCCAs. This creates two levels of choice and two layers of bureaucracy—which purchasing group to select and then which plan to select within the group. In reality, consumers would receive more choice and less paperwork if they were given all choice of plans within the same purchasing group. While the individual mandate in—the bill could result in a majority of Americans achieving coverage through the purchasing groups, the ability for multiple groups to compete within the same area raises the possibility that some groups may be too small to enjoy the benefits of large purchasing pools. Purchasing groups would differ from the alliances also in that they do not serve in an ombudsman function nor do they have any role in ensuring affordability.

From a consumer perspective, the purchasing groups in the Chafee bill present many of the same problems as those in S. 1579. However, because the purchasing groups in S. 1770 may compete with each other, the problems of risk selection, possible discrimination and cost-shifting are increased.

The goals of health alliances: While there are many similarities among the alliances or purchasing groups just described, there are clearly significant differences. Those differences reflect the different goals of their proponents.

Indeed, the recent debate over health alliances has tended to concentrate on matters of implementation rather than on the desired functions to be achieved. Unfortunately, some of the criticisms of the Clinton health alliances have been designed more to confuse or frighten than to raise serious and legitimate questions. Citizen Action believes that the attacks on health alliances by groups like the Health Insurance Association of America have been motivated by the desire to maintain their position rather than to protect the public's interests.

The goal of the Clinton plan is to allow all consumers to benefit from a powerful bargaining authority, representing them in negotiations with insurance companies. If insurance companies are allowed to continue to play a role in our health care system, then consumers are in desperate need of such an authority, with the authority to enforce regulations designed to promote equal access, non-discriminatory practices, and fair pricing.

The goal of the Clinton plan is to eliminate cost-shifting and to allow all consumers to benefit from the creation of an exclusive purchaser, administrative savings, and premium caps.

The goal of the Clinton plan is to break the link between employment and insurance, allowing consumers to choose their plans and avoiding disruptions in care caused by changes in employment.

The goal of the Clinton plan is to provide community rating and uniform payments to plans for all, eliminating the payment differentials which exist in today's system and which create obstacles to access for Medicaid beneficiaries.

The goal of the Clinton plan is to provide a consumer protection mechanism with teeth, allowing arbitrary and unfair denials to be appealed and potentially overturned.

And the goal of the Clinton plan is to give consumers a major voice in decision-making, by ensuring that they have equal representation on alliance boards.

Citizen Action believes that there are alternative means to meeting the goals of the Clinton plan health alliances. If, however, Congress passes health care legislation based on alliances (or purchasing cooperatives), insurance companies and premiums, we believe that it is in the consumer interest to have mandatory, large alliances with the power to achieve those goals. Without them, insurance industries and large health plans will continue to have the upper hand in running the health care system in a manner which is advantageous for them but disastrous for consumers.

Mr. Chairman, we look forward to working with you over the coming months.

RESPONSES OF CATHY L. HURWIT TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. Ms. Hurwit, could you elaborate a bit on your concerns about consumer protection in any health system reform that we do? Why are you concerned about that? After all, the authors of most of these plans say that their plans are designed to enhance consumer choice. And in your view has the Clinton plan done enough to make sure the consumer is protected? What else might we need to do in the context of a managed competition plan?

Answer. Consumer protection encompasses a number of different issues, all of which must be addressed in order to make the promise of health care reform a reality.

Assuming that we are discussing a universal coverage plan, the first question must be whether consumers have the ability to choose the plan which best meets their own needs. In considering the different proposals which have been made, there are several key obstacles to that choice. Proposals such as the Clinton bill, which condition full choice of plans on income (or employment, in the case of companies willing to pay for additional premium costs), limit consumer choice. Even if consumers are given an understandable, descriptive " report card," this may be insufficient to assure choice. In the Administration's plan, individuals and families without the disposable income necessary to pay additional out-of-pocket premiums would be unable to select higher quality, more appropriate plans if they charge premiums above the weighted average premium for the alliance. Therefore, while the Administration's plan may provide more choice than many consumers have today, (and far more choice than proposals which require out-of-pocket premium payments for any other than the least-cost plan in the alliance), there are important restrictions which are likely to force many into managed care plans.

Another limitation on consumer choice of plans occurs when employers—not workers and their families—make choices. In the Clinton plan, large employers can limit

consumer choice by opting out of the mandatory alliance. In other proposals, more employers are given that option either through expansion of the opt-out authority or creation of voluntary alliances, which employers can select on behalf of employees.

Consumer protection is also an issue once a plan is chosen. Particularly in managed care plans, enrollees need to be assured that medically necessary or appropriate care will be available to them whether inside the plan or out-of-network and that the treatment decisions of health professionals are not overruled. While the Clinton plan provides an appeals process for consumers, with assistance through the office of consumer ombudsman and the alliance, more protections are needed. Specifically, we recommend that case-by-case utilization review should be replaced by practice profile review and plans should be required to pay for out-of-network costs if unable to provide covered services in a timely fashion. We also believe that the consumer ombudsman function cannot be implemented to protect consumers unless it is given stable and adequate funding.

Finally, consumers cannot be protected through health care reform unless they have a role in the decisionmaking process. Under the Clinton plan, that role is provided through equal representation on alliance boards. We believe that consumer representation needs to be guaranteed at all levels—including the National Health Board and plan levels. Moreover, we think it is important to require that consumer representation be reflective of the community, including high utilizers of care, persons from rural and urban underserved areas, and vulnerable populations.

Question No. 2. What about the provider incentive plans that some managed care plans use? Would it be your view that we should incorporate some rules into any reform about the size of financial incentives that managed care companies can offer to providers to reduce service?

Answer. While there has been a great deal of discussion about the potential of overutilization in fee-for-service plans, the question of incentives for underutilization in managed care plans has received less focus. In fact, there are a number of potential consumer problems in managed care plans.

Capitated payments themselves create potential for reduced services, unless the payments or risk adjustments to those payments are adequate. Proponents argue that capitation fosters efficiency and the reduction of inappropriate care, since dissatisfied consumers will leave and enroll in other plans. However, in a system in which choice is based on price not just quality, many consumers who are unable to afford higher premiums will be unable to exercise that option. In that instance, there are a number of protections available: guaranteeing enrollees a role in decisionmaking within the plan; reviewing quality standards and requiring remedial action where standards are not met; allowing enrollees to receive out-of-network services at the plan's expense where appropriate care is denied or delayed.

Apart from initial capitation, many managed care plans have instituted "provider incentive plans" which put providers financially at risk for prescribing more than a plan-established level of care or reward them for prescribing less. We believe that such incentive plans should be prohibited.

Question No. 3. Or, should we require insurance plans to outline in detail in their published plan documents the kinds of incentive plans they use that might have an influence on provider treatment decisions?

If incentive plans are allowed to operate (even under limits), then consumer report card and backup plan descriptions should provide information on them. We also believe that the card should include information for each service area on claims or treatment denials, appeals and the percentage of appeals granted, consumer satisfaction, and other information. But again, because consumers may, be required to pay additional out-of-pocket premiums in order to enroll in higher-quality or more appropriate plans, provision of information alone will be an insufficient protection.

PREPARED STATEMENT OF SARAH F. JAGGAR

Mr. Chairman and Members of the Committee: I am pleased to be here today as the Committee continues its deliberations on health care reform. A common feature of many health reform bills is the creation of public or private health alliances[1] that may have the market power and risk-pooling potential of a large number of purchasers. All these bills leave the establishment of alliance boundaries to the states.

Because questions have been raised about the impact of how alliance boundaries might be drawn, you requested that we discuss the (l) provisions of major health

[1] Two proposals refer to purchasing cooperatives or purchasing groups. For our discussion, we will refer to these entities as alliances.

reform bills[2] concerning the configuration of alliance boundaries; (2) experiences of two states that have established entities similar to alliances; (3) features and procedures for establishing a Metropolitan Statistical Area (MSA): and (4) issues relating to the potential effects of alliance boundaries on existing health markets, access to health care, and distribution of health care costs within a state.

Before proceeding, I want to make clear that several geographical issues that I will discuss are issues separate from any health care reform proposal. These include concerns regarding regional differences in the adequacy, availability, and choices of health care providers in underserved rural and central city areas. While some provisions of the various health reform proposals affect these concerns, where or how a geographic boundary is drawn probably cannot correct problems of access to health services for all citizens in a defined alliance area. Nonetheless, care should be taken to assure that the determination of alliance boundaries does not exacerbate these current problems.

BACKGROUND

The health alliance in the Administration's proposal, the health plan purchasing cooperative in the Cooper/Breaux bill, and the purchasing group in the Chafee/Dole bill all draw their basic structure from the managed competition approach to health care reform. They all serve as an organization through which employers or individuals purchase their health insurance. These alliances generally offer purchasers a choice of health plans, help administer subsidies for low-income members, provide members with information on the costs and quality of plans, and allocate collected premiums to health plans.

Each proposal is different in such areas as whether alliances can negotiate premiums, whether the purchase of insurance through the alliance is required, whether employers have to contribute to premiums, and what segments of the population can be covered by alliances. Nonetheless, a substantial share of the population is eligible to obtain its insurance coverage through these alliances. Because all three proposals may place enrollees in the alliance that covers the area they live in, there are concerns that the geographic boundaries defined by the states could affect access to particular providers and the price of health insurance.

To gain an understanding of the potential issues that could arise because of a state's choice of alliance boundaries, we reviewed the legislation on geographic boundary limits in each proposal as well as the literature and positions of interest groups on geographic boundary issues. We also made site visits to Florida and Washington where some decisions regarding the location of alliance boundaries have already been made within the context of state reform efforts. We also drew upon our previous work and current efforts assessing existing public and private alliances that have been in operation for some time.[3]

GEOGRAPHIC BOUNDARY PROVISIONS CONTAINED IN REFORM BILLS

Each of the three health reform proposals we examined gives the states responsibility for and flexibility in establishing alliance boundaries, with only a few constraints (see table 1).

Table 1.—GEOGRAPHIC PROVISIONS OF HEALTH PROPOSALS FOR ALLIANCES

	Clinton Plan (S. 1757/H.R. 3600)	Cooper/Breaux Plan (S. 1579/H.R. 3222)	Chafee/Dole Plan (S. 1770/H.R. 3704)
Alliance can subdivide an MSA.	No	No	No
Number of alliances that operate in each coverage area.	One	One	None, one, or more than one

[2] Three major reform bills establish health alliances. These are (1) the Clinton bill, the *Health Security Act* (S. 1757/H.R. 3600); (2) the Cooper/Breaux bill, the *Managed Competition Act of 1993* (S. 1579/H.R. 3222); and (3) the Chafee/Dole bill, the *Health Equity and Access Reform Today Act of 1993* (S. 1770/H.R. 3704).

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

Table 1.—GEOGRAPHIC PROVISIONS OF HEALTH PROPOSALS FOR ALLIANCES—Continued

	Clinton Plan (S. 1757/H.R. 3600)	Cooper/Breaux Plan (S. 1579/H.R. 3222)	Chafee/Dole Plan (S. 1770/H.R. 3704)
Alliance can cross state lines	No	Yes	Yes
Minimum size requirement for alliance area.	None—National Health Board reviews for sufficient market size	Minimum 250,000 eligible individuals residing in alliance area [1]	Minimum 250,000 individuals residing in alliance area

[1] Individuals, and their families, who are unemployed, self-employed, or employed in firms of fewer than 101 workers, or are Medicaid-eligible, are generally considered to be eligible for coverage through an alliance.

In all three legislative proposals, alliance boundaries are not permitted to subdivide a Metropolitan Statistical Area (MSA)[4] or, in effect, a Primary Metropolitan Statistical Area (PMSA).[5] Both the Chafee/Dole and Cooper/Breaux bills require that designated alliance areas have a minimum population base of 250,000. While the Clinton plan does not specify a number, it does require that the alliance area include a population sufficiently large to provide the alliance with bargaining power with and promote competition among plans.

Both the Clinton and Cooper/Breaux plans specify that a single alliance will operate in each area. The Chafee/Dole plan only requires that the state designate health care coverage area boundaries; if one (or more) alliance forms, then it must serve the entire coverage area.[6] The Clinton plan does not permit alliance boundaries to cross state lines; however, both the Cooper/Breaux and Chafee/Dole plans permit alliance boundaries to cross state lines. All bills permit health plans to operate across state lines or alliance boundaries.

MAINTAINING METROPOLITAN AREAS CENTRAL TO THE THREE PROPOSALS

Each health care proposal requires states to keep MSAs intact when defining alliance boundaries, primarily to prevent discrimination of disadvantaged or high-risk groups by health plans. While some of the largest disparities in income distribution are found between inner city and suburban areas within MSAs, there may also be differences in income and other characteristics among contiguous MSAs and between metropolitan communities and rural areas. While the requirement that MSAs remain intact may prevent some redlining that isolates areas with high-risk populations, potential gerrymandering in defining alliance boundaries could be a problem.

Future issues may emerge if changes in MSA definitions require states to reconfigure their alliance boundaries. Over the past decade, changes in MSA definitions have generally affected only a few areas of the country. Changes were based primarily on a yearly evaluation of statistical criteria by the Office of Management and Budget (OMB). However, in selected cases such decisions have also been based on local opinion or congressional intervention. For example, in 1992, local opinion led to the reversal of an OMB decision to merge Nassau and Suffolk counties into the PMSA that included New York City. Additionally, during the 1980s, four changes in metropolitan area definitions were adopted through federal legislation. Given the potential importance of health alliance boundaries, there are concerns that a change in the definition of an MSA by OMB may require states to reconfigure their alliance boundaries (see appendix I).

RECENT EXPERIENCES IN FLORIDA AND WASHINGTON ILLUSTRATE THE POLITICAL PROCESS INVOLVED IN DETERMINING ALLIANCE BOUNDARIES

Florida and Washington have already faced the difficult decisions required in defining boundaries for alliance-like structures as part of their health reform legisla-

[4] A metropolitan area consists of a large population center and adjacent communities that have a high level of economic and social integration with that population center. Metropolitan areas are classified as a Metropolitan Statistical Area (MSA) or a Consolidated Metropolitan Statistical Area (CMSA). CMSAs, which contain 1 million or more people, consist of at least two separate statistical areas called Primary Metropolitan Statistical Areas (PMSA) (see appendix I).

[5] In the Clinton proposal, an alliance can subdivide an MSA or a PMSA if that area crosses state lines.

[6] Unlike the other two bills, the Chafee/Dole bill permits the creation of competing alliances. A single alliance may operate in more than one coverage area.

tion. Their experiences may be instructive as to the different points of view regarding the size, number, and boundaries of alliances.

Using the existing geographical structure of its Health and Rehabilitative Services (HRS) planning districts, Florida legislators divided the state into 11 separate alliance areas, ranging in population from about 500,000 to over 2 million. Initial legislative proposals anticipated five to six alliances based on health market areas, but market areas are not well-defined and local leaders could not agree on their specific boundaries. Thus, they compromised by relying on existing HRS planning districts. However, the legislators provided for the option of future mergers of up to three contiguous alliances that are not primarily urban into a single alliance.

Florida's alliance boundaries generally conform to the proposed requirements of the national health reform bills. However, portions of the Tampa-St. Petersburg-Clearwater MSA are included in three separate alliances. Also, the smaller alliances in the Florida panhandle may not meet the Cooper bill requirement of a minimum 250,000 eligible individuals.

Alliance boundaries established under the Washington Health Services Act of 1993 also reflected political compromise. The legislation authorized the creation of four alliances and left to the state's Health Services Commission the decision on specific boundaries for these alliances. The legislation also requires that the decision be based on population, geographic factors, market conditions, and other factors deemed appropriate by the Commission. The legislation specified only that the population covered by an alliance should be at least 150,000, which is smaller than the minimum size required under the Cooper and Chafee plans. The Washington Senate would have preferred two alliance areas; the Washington House was concerned about the potential power of larger alliances and wanted 10 areas.

STATES' PLACEMENT OF BOUNDARIES RAISES SOME CONCERNS

The number of alliances that states would ultimately create and the placement of the alliance boundaries have raised questions for consumers, employers, and providers. Questions arise as to whether the creation of alliance boundaries will impact the provision of care in existing health markets, segment and limit access to care for disadvantaged or high-risk populations, and redistribute health care costs among different geographic or socioeconomic groups.

Potential Impact on the Provision of Care

Individuals seeking insurance through the alliance that includes the area they live in may have concerns about whether they will still be able to use physicians, hospitals, and other health care facilities that may be located outside the boundaries of their alliance. Similarly, physicians, hospitals, and other providers may also have concerns as to whether they will be able to maintain the part of their patient base that is located in another alliance area. Whether these concerns are justified depends more on the service areas covered and provider networks and coordination mechanisms developed by health plans than the geographic boundaries of alliances.

Perhaps the more important issue is whether the structure of the alliances will make coordination across areas and development of broad ranging networks by health plans easier or more difficult. On the one hand, the creation of a standard benefits package and the broader coverage expected under these plans could make coordination easier. On the other hand, coordination could be more difficult if states or alliances have different requirements for the collection and dissemination of provider data. This could result in health plans not seeking certification, and thus the permission, to operate in multiple alliances or states. Similarly, if alliance fee schedules are not roughly comparable, providers may avoid serving patients from neighboring alliances.

Obviously, the larger the number of alliances established, the more coordination there will have to be, and, possibly, the higher the administrative costs. Ultimately, plans will have to assess whether the benefits of operating in a different alliance area outweigh the costs incurred in terms of meeting any additional requirements.

Coordination could be most critical in areas where alliance boundaries separate existing health markets. This may be likely in the 41 metropolitan areas that span state boundaries such as in the Washington, D.C., and Philadelphia metropolitan areas.

Administration officials contend that coordination should be no more difficult than it is today, when plans operate across state lines. While the necessary coordination is anticipated under reform, no provisions in the Clinton bill explicitly provide mechanisms or incentives for this coordination.

The Cooper/Breaux and Chafee/Dole bills also contain stipulations to minimize the impact of alliance boundaries on the provision of care for individuals and providers. As with the Clinton proposal, they permit plans to operate in multiple alliances or

states and allow states to coordinate their plan requirements. Further, to keep health markets that span state lines intact, the Cooper/Breaux and Chafee/Dole bills allow multistate alliances. Interstate cooperation would be needed to create these alliances, and additional issues could arise, such as the creation of an adequate oversight mechanism for and the inclusion of Medicaid-eligible populations in multistate alliances. Neither of these bills specifies the mechanisms or incentives to do so.

Potential Risk Segmentation and Limited Access to Care

Other concerns center around whether some alliances within a state will have a disproportionate share of a state's high-risk population. Such alliances could have greater difficulty attracting a sufficient number of health plans that would offer consumers an adequate choice of plans. The extent to which boundaries could cause this to happen depends on factors like the number of alliances in a state and whether states have metropolitan areas with markedly different demographic profiles. For example, some isolation of high-risk communities could occur if states created a number of geographically smaller alliances, such as one alliance for each metropolitan area. Such risk segmentation could occur in areas with specific characteristics, such as unusual industrial, environmental, or epidemiological conditions (for example, the West Virginia coal mining region or areas with large concentrations of AIDS cases). Moreover, risk segmentation could also exist when two adjacent MSAs have different proportions of Medicaid populations, as in the case of two primary metropolitan areas in southern Florida. For example, 16 percent of the population in the Miami PMSA is eligible for Medicaid compared with only 8 percent for the neighboring Ft. Lauderdale PMSA.

Isolation of rural areas depends largely on whether states choose to separate rural areas in establishing alliance boundaries. Because the MSA rule has little relevance to rural areas, states could establish boundary lines to segment rural populations that are potentially high-risk or underserved. The Cooper/Breaux and Chafee/Dole requirements that alliance areas have a population of at least 250,000 and the Clinton requirement that alliance population size be sufficiently large to promote competition among plans make segregation of rural areas difficult or unlikely.

Further, risk segmentation may also occur on the plan level if plans are not required to provide services throughout an alliance or metropolitan area. The Clinton bill contains a provision that allows states to require a health plan to cover all or selected portions of an entire alliance area. The Chafee/Dole bill requires every alliance to service an entire coverage area. However, as with the Cooper/Breaux bill, the Chafee/Dole proposal apparently has no provisions regarding health plan service areas. Minnesota is attempting to address this problem in its reform initiative by dividing the state into 20 health service areas. Any plan operating in a particular service area must demonstrate that it provides a reasonable level of access to care for those in all geographic areas within that health service area.

Providing adequate care in rural areas has long been a challenge, and doubts have been expressed about whether the managed competition concept even has applicability to such areas. For example, the California Public Employees' Retirement System (CalPERs) health alliance serving state and local workers throughout California illustrates the limited choices that can exist in rural areas. While CalPERs offers a fee-for-service plan and over 20 health maintenance organizations (HMO) plans to its members, few HMOs operate in the more rural and remote areas of the state. Thus, rural residents tend to choose the more expensive fee-for-service plan under CalPERs in large measure because their choice is restricted.

Redistribution of Health Care Premiums

Another question that has been asked about alliance boundaries is whether boundaries will be drawn in such a way as to redistribute health costs among different groups. Under each proposal some people may pay more for insurance than they do now and those extra payments will indirectly subsidize other people who will pay less than before. In general, however, such redistribution is less a consequence of new health alliances than of health insurance reform.[7] Currently, most individual firms pay premiums that reflect the health status and medical costs of their workers. Firms with a few high-risk workers may be unable to get insurance unless they exclude those workers. Since a major goal of health care reform is to

[7] The demographics of redistribution can take many forms, for example between high- and low-income groups, between rural and urban populations, between easy and hard-to-serve areas, or between young and old individuals. Exactly which groups are affected by, and the extent of, the redistribution will likely vary across regions according to the representation of the different groups within each region.

provide guaranteed access to affordable insurance, covering these high-risk people will necessarily entail that some of their costs will be paid by others.

While cost redistribution is inevitable under reform, alliance boundaries could affect whose premiums change and by how much. Larger alliances would provide greater risk sharing among a state's population, but this could result in some persons paying higher premiums. Because premiums will be community-rated, persons living in lower-cost areas would pay more and persons in higher-cost areas would pay less if health plans attempt to serve the entire alliance area. For example, persons in Flint or Saginaw, Michigan, would pay more if their alliance included Detroit. At present, average net health insurance claims costs in the Detroit area are about 20 percent higher than costs in Flint and nearly one-third higher than in the Saginaw area.

On the other hand, creation of smaller alliances within a state could also result in higher premiums for some persons as disproportionate shares of high-risk persons are concentrated in some alliances. Citizens in those alliances would pay more because of the greater costs of these high-risk persons.

SUMMARY

Alliances have been proposed as a means for broadening coverage, pooling risks, providing consumers with a choice of health care plans, and disseminating information on the costs and quality of plans. However, the major health reform proposals relying on alliances have various boundary provisions that raise concerns. These concerns include the potential for gerrymandering, changing the provision and receipt of health care, segmenting high-risk groups, and isolating underserved areas.

APPENDIX I—METROPOLITAN AREAS AND ALLIANCE BOUNDARIES

Each health care proposal requires states to keep metropolitan areas intact when defining alliance boundaries, primarily to prevent discrimination of disadvantaged or high-risk groups. The following is a discussion of metropolitan areas and the Office of Management and Budget's (OMB) process for defining them.

The Metropolitan Area Concept

A metropolitan area consists of a large population center and adjacent communities that. have a high number of economic and social factors in common. OMB, responsible for defining metropolitan areas, recognizes three types. The Metropolitan Statistical Area (MSA) must include one city with 50,000 or more inhabitants or an urbanized area of at least 50,000 inhabitants and a total metropolitan population of at least 100,000 (75,000 in New England). Metropolitan areas with more than 1 million people and meeting other OMB standards are referred to as a Consolidated Metropolitan Statistical Area (CMSA). Each CMSA consists of two or more major components recognized as a Primary Metropolitan Statistical Area (PMSA).

As of June 1993, OMB recognized 253 MSAs, 76 PMSAs, and 19 CMSAs.[8] The number of metropolitan areas contained in a state can vary widely; four states have only one metropolitan area, while 10 states have over 10. A sizable number of MSAs and PMSAs, 41, cross state lines (see table I.1).

OMB establishes definitions for metropolitan areas on the basis of a review of population data from the decennial census; intercensal population estimates; commuting patterns; and, for selected instances, local opinion.[9] The latter factor is considered in OMB decisions related to (1) combining two adjacent metropolitan areas of specific sizes, (2) assigning a county or place eligible for inclusion in more than one metropolitan area, (3) identifying PMSAs within CMSAs, and (4) titling metropolitan areas. In soliciting local opinion, OMB urges the appropriate congressional delegations to contact a wide range of groups in their communities, including business and other leaders, the chamber of commerce, planning commissions, and local officials.

Major revisions to metropolitan area definitions are made after each decennial census, when both population and commuting data become current. Nonetheless, OMB updates metropolitan area definitions annually. Intercensal changes, which are based on the Census Bureau's annual population estimates, are used to identify areas that are close to meeting the specifications necessary for revision. PMSAs do not change between the decennial census as data on commuting patterns are needed for those determinations. Metropolitan area definitions stay fairly consistent between decennial censuses. Since the mid-1980s, intercensal changes have consisted

[8] These totals include 3 MSAs, 3 PMSAs, and 1 MSA in Puerto Rico.

[9] OMB establishes definitions for metropolitan areas based on criteria developed by a 15-member federal interagency committee.

chiefly of adding new areas as they reached the minimum required city or area population.

How local opinion affects OMB's decisions on metropolitan area definitions may be of concern as deliberations on health alliances continue. We found instances where local opinion and political intervention played a role in OMB's final decisions. For example, in 1992, local opinion led to the reversal of an OMB decision to merge Nassau and Suffolk Counties into the PMSA with New York City. We found other changes to metropolitan area definitions resulting from congressional action. During the 1980s four changes in metropolitan area definitions appeared in legislation; two were attachments to continuing resolutions for appropriations legislation.

Table I.1: Metropolitan Areas Crossing State Borders

Metropolitan Statistical Areas	Primary Metropolitan Statistical Areas
Augusta-Aiken, GA-SC	Boston, MA-NH
Charlotte-Gastonia-Rock Hill, NC-SC	Lawrence, MA-NH
Chattanooga, TN-GA	Lowell, MA-NH
Clarksville-Hopkinsville, TN-KY	Portsmouth-Rochester, NH-ME
Columbus, GA-AL	Worcester, MA-CT
Cumberland, MD-WV	Cincinnati, OH-KY-IN
Davenport-Moline-Rock Island, IA-IL	Newburgh, NY-PA
Duluth-Superior, MN-WI	Philadelphia, PA-NJ
Evansville-Henderson, IN-KY	Wilmington-Newark, DE-MD
Fargo-Moorhead, ND-MN	Portland-Vancouver, OR-WA
Fort Smith, AR-OK	Washington, DC-MD-VA-WV
Grand Forks, ND-MN	
Huntington-Ashland, WV-KY-OH	
Johnson City-Kingsport-Bristol, TN-VA	
Kansas City, MO-KS	
La Crosse, WI-MN	
Las Vegas, NV-AZ	
Louisville, KY-IN	
Memphis, TN-AR-MS	
Minneapolis-St. Paul, MN-WI	
New London-Norwich, CT-RI	
Norfolk-Virginia Beach-Newport News, VA-NC	
Omaha, NE-IA	
Parkersburg-Marietta, WV-OH	
Providence-Fall River-Warwick, RI-MA	
St. Louis, MO-IL	
Sioux City, IA-NE	
Steubenville-Weirton, OH-WV	
Texarkana, TX-Texarkana, AR	
Wheeling, WV-OH	

SOME FACTS ABOUT STATE BOUNDARIES

- More than 40% of Americans live in cities and counties that border on state lines.
- In 26 states, more than half of the population lives in cities and counties that border on state lines.
- More than 37% of U.S. counties* border on state lines.
- In 8 states, less than 15% of the population lives in cities and counties that do not border on state lines. In 6 states, more than 85% live in cities and counties that do not border on state lines.

States with 0-15% living in border cities and counties:

Alaska
California
Florida
Hawaii
Michigan
Texas

States with 15-50% living in border cities and counties:

Alabama
Arizona
Colorado
Georgia
Indiana
Iowa
Kansas
Louisiana
Maine
Mississippi
New Mexico
North Carolina
North Dakota
Ohio
Oklahoma
South Carolina
Washington
Wisconsin

States with 50-85% living in border cities and counties:

Arkansas
Connecticut
Idaho
Illinois
Kentucky
Minnesota
Missouri
Montana
Nebraska
New York
Oregon
Pennsylvania
South Dakota
Tennessee
Vermont
Virginia
West Virginia
Wyoming

States with 85-100% living in border cities and counties:

Delaware
District of Columbia
Maryland
Massachusetts
Nevada
New hampshire
New Jersey
Rhode Island

*Counties and county-equivalents directly bordering on state lines, or within normal commuting range.

1993 POPULATION IN CITIES AND COUNTIES BORDERING ON STATE LINES

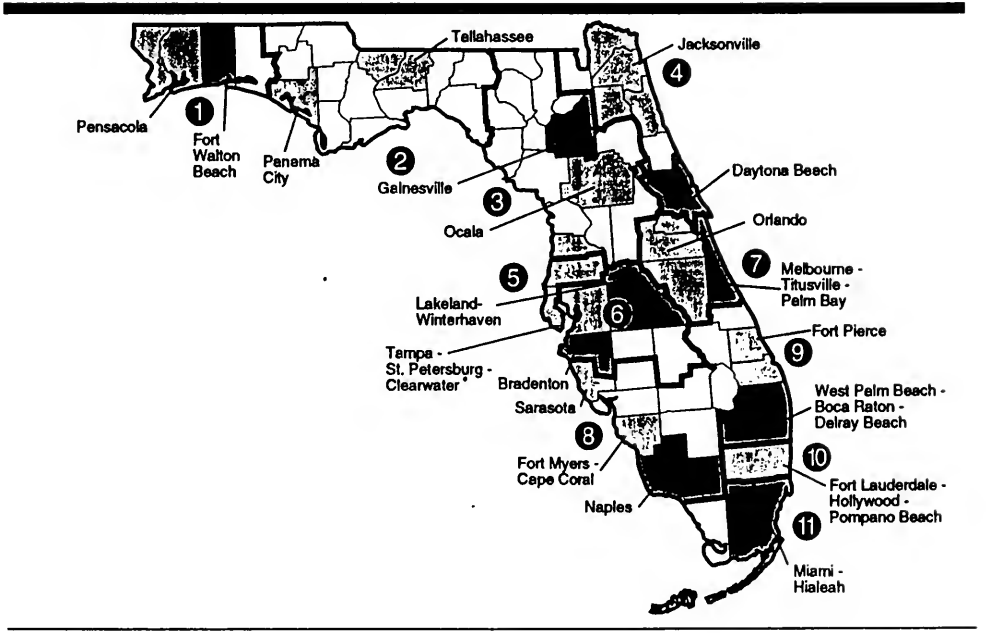
State	Total Cnties	Border Cnties	% Border Counties	(000) Ttl Pop.	(000) Bdr Pop.	% Border Popltion	Notes
AL	64	33	51.6	4040.6	1994.5	49.4	
AK	27	0	0	1477.3	0	0	
AZ	15	9	60.0	3665.2	584.3	15.9	
AR	75	34	45.3	2350.7	1207.4	51.4	
CA	58	12	20.7	23667.8	533.0	2.3	Excl San Bernadino, Riverside & Imperial Cos
CO	64	25	39.7	3294.4	613.7	18.6	
CT	8	6	75.0	3107.6	2339.3	75.3	Excl New Haven
DE	3	3	100.0	666.2	666.2	100.0	
DC	1	1	100.0	606.9	606.9	100.0	
FL	73	14	19.2	12938.0	1366.2	10.6	
GA	159	49	30.8	6478.2	1729.6	26.7	
HA	5	0	0	1108.2	0	0	
ID	44	26	59.1	1006.7	778.9	77.4	
IL	102	27	26.5	11430.6	7272.2	63.6	
IN	87	39	44.8	5544.2	2544.1	45.9	
IA	95	36	37.9	2776.8	1059.7	38.2	
KA	100	40	40.0	2477.6	983.1	39.7	
KY	120	49	40.8	3685.3	1024.6	27.8	
LA	60	29	48.3	4220.0	1738.6	41.2	
ME	16	4	25.0	1227.9	489.3	39.8	
MD	24	19	79.2	4781.5	4128.1	86.3	Incl Baltimore City
MA	14	9	64.3	6016.4	5230.2	86.9	Incl Boston
MI	83	11	13.3	9295.3	662.8	7.1	Excl Detroit
MN	87	33	37.9	4375.1	2915.6	66.6	Incl Twin Cities
MS	82	33	40.2	2573.2	875.5	34.0	
MO	112	47	42.0	5117.1	3481.0	68.0	Incl St. Louis City
MT	56	18	32.1	337.0	261.6	77.6	
NE	93	40	43.0	1578.4	813.8	51.6	

NV	17	11	64.7	1201.8	1129.2	94.0	
NH	10	9	90.0	1109.2	1089.2	98.2	
NJ	21	17	81.0	7730.2	6839.7	88.5	
NM	33	17	51.5	1515.1	648.4	42.8	
NY	62	26	41.9	17990.5	11918.9	66.3	
NC	100	44	44.0	6628.6	2702.5	40.8	
ND	53	19	35.8	638.8	290.3	45.4	
OH	98	27	27.6	10847.1	3306.0	30.5	Excludes Cleveland
OK	77	30	39.0	3145.6	442.0	17.5	
OR	36	20	55.6	2842.3	1698.8	59.8	
PA	67	31	46.3	11881.6	7983.9	67.2	Includes Pittsburgh
RI	5	5	100.0	1003.5	1003.5	100.0	
SC	46	22	47.8	3486.7	1675.4	48.1	
SD	66	29	43.9	696.0	470.3	67.6	
TN	95	43	45.3	4877.1	3137.7	64.3	
TX	254	41	16.1	16986.5	1744.9	10.3	
UT	30	15	50.0	1722.9	289.1	16.8	
VT	13	8	61.5	562.8	286.8	51.0	
VA	110	51	46.4	6187.3	3761.0	60.8	Incl 14 ind cities
WA	39	13	33.3	4866.7	942.3	19.4	
WV	55	30	54.5	1793.5	959.9	53.5	
WI	72	22	30.6	4891.8	1042.2	21.3	
WY	23	15	65.2	453.6	315.3	69.5	
USA	**3108**	**1160**	**37.3**	**246155.2**	**100691.4**	**40.9**	

Definitions: A "border county" is a county or equivalent which directly borders on or is within close land-travel distance of a state line, but excluding counties which are separated from the neighboring state by bodies of water not crossed by accessible bridges. "County" also includes independent cities not under county jurisdiction.

Sources: Bernand's 1993 City and County Directory,
Rand McNalley's 1989 Atlas

GAO MAs and Health Alliances in Florida



PREPARED STATEMENT OF PEDRO ROSSELLÓ

Mr. Chairman, members of the Committee on Finance: My name is Pedro Rosselló. I am the Governor of Puerto Rico.

As a candidate for that office, I promised to reform the Island's health care system.

The voters gave me a mandate to do so.

We took office in January of last year. And health care reform has since become a reality.

Obviously, we acted fast. But we also acted responsibly.

Nearly two decades ago, when commencing my private practice as a pediatric surgeon, I quickly recognized grave deficiencies in Puerto Rico's health care system.

Hoping someday to be able to improve the situation, I went back to school and obtained a master's degree in public health.

In 1985, I accepted the post of Director of the Health Department in our largest city, our capital, San Juan. There, I initiated a reform program and wrote a book on the subject.

The title of that book was *Alliance for Health.*

Upon becoming Governor, in other words, I was no stranger to the concept of health care reform, and no stranger either to the concept of health care alliances.

That explains why we were able to move both quickly and responsibly to address those issues during 1993.

Reform was needed, in Puerto Rico, to ensure equal access to quality care.

A majority of our population was being served by government facilities. Those facilities were overburdened and underfunded. They were victimized by bureaucratic inefficiency, and by partisan politics. Radical change was imperative.

The cornerstones of our reform philosophy have included *choice* and excluded *discrimination,* and we have set those cornerstones within a framework of *managed competition.*

Last September, to implement that philosophy, we created the Puerto Rico Health insurance Administration.

This is a public corporation, endowed with full authority to promote, negotiate, contract and administer comprehensive health insurance coverage, so that every resident of Puerto Rico, of every income-level, can be guaranteed quality medical care.

This public corporation, the Health insurance Administration, is fully operational—functioning, in essence, as the island's first health alliance.

And health care reform is now a reality for the residents of six municipalities, located in eastern Puerto Rico.

Before I summarize the success of this pioneering venture, let me acknowledge that our road to reform has had its share of rough spots.

Like the national program, ours has confronted its share of skepticism, cynicism, criticism, and even occasional mockery.

At one point, for exam pie, political adversaries began joking that our reform-oriented government was launching so many pilot projects that the public thought we were founding an airline.

I responded by saying that my administration refused to ignore urgent priorities; that we refused to simply "wash our hands" when confronted with the island's problems: "Better to be a *project* pilot," I retorted, "than to be a *Pontius* Pilate."

So we persevered, and our perseverance has begun to pay dividends for the Puerto Rican people.

Two months ago, with the approval of the federal Health Care Financing Administration, our Health insurance Administration signed a contract with a private insurance firm.

That company, chosen from among several bidders, agreed to provide health coverage, in a managed-care system, for approximately 46,000 persons, comprising three moor groups of beneficiaries.

The Health Insurance Administration pays the insurer a premium, based upon the contracted benefits, for either individual or family coverage. Those monthly premiums come to $52.76 for Individuals, and $149.45 for families.

Most necessary procedures, including preventive services, are provided under the program's basic-coverage plan, at primary cave centers located in each of the participating towns. Additional benefits are available under special coverage, through a network of providers that are under contract to the insurer.

Health reform is being implemented sequentially, both in terms of geographical regions and in terms of participant-categories. With respect to the latter, three stages are involved.

Stage one took effect on the first day of this month, and applies to persons previously served directly by the island Health Department in public facilities. This category encompasses the following groups:

- Everyone eligible for Medicaid, either federally or locally; plus
- Police officers, military veterans, and their immediate families.

Of the estimated 45,000 individuals eligible, more than 45,000 had been duly certified within just 15 days after the screening process got under way. Of those certified, moreover, 28,490 persons are now enrolled in the plan.

As you can see, therefore, implementation has been both rapid and comprehensive.

We are likewise greatly encouraged by some other surprising data, concerning Puerto RIco's first experience with a health care alliance:

- The price being paid by the Health Insurance Administration, to cover its beneficiaries, is more than 31% lower than the cost of a traditional fee-for-service plan;
- Also, that price is 29% lower than the cost of comparable coverage, supplied by similar health maintenance organizations on the island;
- Despite grumbling, from providers, about how some prefer the traditional fee-for-service approach, we are nevertheless receiving a massive influx of inquiries from providers, asking how they participate in our health reform plan;
- Companies, whose bids for the December contract were rejected, have begun to restructure their hearth insurance plans into managed care systems, so they can be competitive in bidding for the second geographical area, where operations are scheduled to commence this coming June;
- Numerous primary care providers are organizing into groups, with the intention of adopting the managed care concept, so they can compete with established centers in this new health care marketplace;
- Spectacular progress has been made, during the program's very first month, in addressing one of the most critical shortcomings of our public health care system:

  —Under our first health alliance, the primary-care physician-to-patient ratio has improved dramatically—from 1-to-2,505, down to 1-to-835; and

  —Major gains have been recorded, as well, in the ratios applicable to specialists, clinical laboratories, pharmacies and hospitals.

In Puerto Rico, then, health care reform has evolved from a proposal into a program. It is alive and well—or, mom to the point, it is keeping *people* alive and well.

And the alliance concept is at the *heart* of this thriving young initiative, pumping the blood of security, tranquillity and dignity through a society that is eagerly embracing a long-awaited opportunity for health-care equality.

Earlier, I mentioned that Puerto Rico health reform entails three stages, and I described the parameters of Stage One. To supplement that, let me say that we expect to extend this stage, to cover the entire island, during the next four years.

Meanwhile, Stage Two will be getting under way in 1995, to include, under our health alliance, all government employees. During this stage, we shall explore how we can also bring into the program persons currently insured under the government's worker compensation system, known as the State insurance Fund; and those covered by the no-fault injury-protection that is provided by the state's Automobile Accident Compensation Administration.

Stage Three will bring every remaining resident of Puerto RIco into the program, under guidelines that will respond to the provisions of the national health care reform system that you am now considering.

As our program moves forward, the alliance features of our Health Insurance Administration will increasingly mirror the alliance concepts envisioned under the federal proposal.

Near the beginning of my testimony, I mentioned that choice is a cornerstone of our health care reform program. Specifically, in this regard, our reform legislation stipulates the following:

- Participants, except as noted below, must have the option of selecting from among two or more health insurance firms, certified by the Health Insurance Administration;
- The exceptions are these—

  —Implementation complexities have necessitated the temporary designation of a single insurer for the first coverage area;

  —Options will be guaranteed for Stage One participants after they have been in the program for five years.

The second cornerstone of our program, cited earlier, is the absence of discrimination. On this front, the law prohibits contracted insurance firms from issuing two or more types of identification cards for the same class of coverage. In other words, we have ensured that the medically-indigent will never be stigmatized on the basis of the type of card they carry.

Furthermore, the anti-discrimination aspect of our program is reflected in its breadth of coverage, its minimal exclusions, and its total lack of waiting periods or exclusions for pre-existing conditions.

Cornerstone Number Three, for Puerto Rico health care reform, is managed competition as a model for improving services to the medically indigent sector of our population. As noted previously, we are already seeing evidence that managed competition is stimulating a reorganization of delivery systems.

This, in turn, is producing greater efficiency, in the form of tower prices and higher quality.

In the time remaining, I shall review in greater detail exactly how our alliance concept operates.

- Under its organic act, the Health Insurance Administration is empowered to delegate some of its authority to regional or local alliances, thereby maximizing local control and averting the negative consequences of a large, centralized bureaucracy.
- As a state program, rather than a national reform blueprint like the pending federal Health Security Act, our system entrusts to the Health insurance Administration a variety of regulatory and management responsibilities that would be assigned to the states under President Clinton's plan.
- Our program's insurance risk is borne not by the government-owned Health Insurance Administration, but by the private contractor; and the latter, it should be mentioned, will act as a secondary payor when a participant possesses additional health care insurance.
- One duty, of the Health Insurance Administration, is to devise control-mechanisms that will prevent unjustified increases in the cost of health cam services.
- Another of its duties is to protect the rights of both beneficiaries and providers.
- A third demanding task is to evaluate the effectiveness of the system in such areas as ease-of-access, quality of care, and the way in which health care services are actually utilized by the public.

As to the regulatory and management role of the Health insurance Administration, this will consist of several components—

- The agency will monitor insurers, through outcome reporting and analysis, on three levels:

  —One, to allow consumers to make quality-comparisons when choosing a health plan;
  —Two, so that the health plans can establish practice patterns;
  —Three, to assist the Health Insurance Administration in designing future benefit-packages.

- The agency's oversight functions will be extensive. It will:

  —Supervise private-health-plan marketing practices;
  —Investigate allegations of fraudulent reporting;
  —Guard against unacceptable risk-selection activities;
  —Ensure private health plan accountability, and compliance with the norms of managed competition.

- On the management front, the Health Insurance Administration must:

  —Maintain an enrollment database;
  —Certify, to the insurer, the identities of persons eligible for enrollment;
  —Pay appropriate premiums;
  —Keep track of the services rendered by health care providers;
  —Assess the quality of those services;
  —Act as custodian for the resources from which premiums are paid (this entails collecting money from federal, state and municipal institutions);
  —Administer a grievance-resolution mechanism, to protect the rights of both providers and participants;
  —And finally, of course, the Health Insurance Administration must discharge the crucial and fundamental duty of negotiating contracts with health care providers, in accordance with the parameters established during the bidding process.

Another subject, touched upon earlier, was the coverage offered under our health care reform.

- Under *basic* coverage, a participant is entitled to preventive services; visits to physicians; hospitalization; surgical procedures; diagnostic testing; clinical laboratory testing; x-rays; emergency room services; ambulance services; limited mental health services, including detoxification treatment; maternity services; and prescription drugs.
- *Special* coverage expands upon those, by adding procedures of a cardiovascular, neurovascular, and neurosurgical nature; specialized diagnostic tests; the treatment of cancer, acquired immune deficiency syndrome, tuberculosis and leprosy; services pertaining to dialysis and hemodialysis; and neonatal intensive care.

Eligible for coverage, under our health plan contract, are Medicare enrollees who have been certified as medically indigent by our state Medicaid program. For medically indigent persons who have Part A Medicare protection, the insurance plan pays all Part A deductibles and co-insurance fees, as well as all health plan benefits not included under Part A. For medically indigent persons, with both Part A and Part B Medicare protection, the contracted plan pays all deductibles and co-insurance expenses, plus the cost of medications.

The initial pool, of 28,490 health plan beneficiaries, includes 320 persons with Medicare Part A, and 1,186 who have both parts of Medicare.

Currently, funding for Puerto Rico's heath care reform program is being derived, to some extent, from participant-deductibles. Most of its funding, however, comes from state government sources.

As we expand into Stages Two and Three, in the coming years, it will be imperative that we broaden the system's resource base.

Of necessity, truly universal coverage will require contributions from all sectors capable of making such contributions.

A healthier population is a more productive population. A more productive population is a more prosperous population.

A more prosperous population is the *goal* of a free market economy. In the global economy, it is a competitive advantage.

Good health, therefore, is good business.

Because universal health care requires a broad resource base, I strongly support the provisions of the pending Health Security Act, including those involving employer mandates.

As a participant in the Health Core Task Force of the National Governors' Association, it was my privilege last year to work closely with The White House in designing its program.

Moreover, in Puerto Rico, we made certain that our own program would be fully compatible with the national plan.

Puerto Rico's alliance for health is on the books, and is off to a strong start.

I am confident that the President's plan can serve the nation well, just as our plan is serving Puerto Rico well.

Thank you, Mr. Chairman, for offering me the opportunity to testify today, on behalf of the 3.6 million United States citizens of Puerto Rico.

○

ISBN 0-16-046635-0

90000

9 780160 466359