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HEALTH CARE REFORM

Implications of Geographic Boundaries for Proposed Alliances

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SUMMARY

A common feature of many health reform bills is the creation of health purchasing groups, commonly called alliances, which pool risks and have the market power of a large group of purchasers. Various health insurance plans would compete within these alliance areas. Three major bills incorporate alliances: the Clinton bill, the Chafee/Dole bill, and the Cooper/Breaux bill.

Decisions on alliance boundaries are left to the states except for provisions in all three bills that require that Metropolitan Statistical Areas (MSAs) remain intact. There is some potential that procedures for defining MSA and alliance boundaries could become political decisions that might affect existing health markets. Approaches taken by Florida and Washington to resolve boundary issues in their state reform efforts may be instructive as to different points of view regarding the size, number, and boundaries of alliances.

There are three issues that are often raised regarding the drawing of boundaries for alliances:

-- Impact on the provision of care. Concerns have been raised about the ability of individuals to get care and regional hospitals to provide care if alliance boundaries split current medical service areas. However, health plans may well operate in contiguous alliances and alliances and plans could coordinate trans-alliance care. About 40 MSAs cross state lines, and individuals frequently get care across state lines. Avoiding disruption of care will depend on coordination between states, alliances, and plans.

-- Potential concentration of higher-risk populations. The extent to which some alliances within a state will have a disproportionate share of the state's high-risk population depends on the number of alliances in a state and whether states have MSAs that have very different demographic profiles. Smaller alliances may tend to concentrate risks and reduce competition among health plans. Another concern is whether rural areas will be isolated in their own alliance with inadequate service as is now the case in many rural regions. However, all three plans require alliances of such size that the segregation of rural areas is unlikely. The issue of service depends less on alliance boundaries than whether health plans will offer adequate choice and service in rural areas.

-- Redistribution of health care costs. In all three proposals, some people may pay more for insurance than they do now, and those payments will indirectly subsidize other people who will pay less than before. In general, however, such redistribution is less a consequence of how boundaries are drawn than of other features of health reform. Any reform plan that enables higher-risk individuals or previously uninsured individuals to get affordable insurance will necessarily entail costs for those who previously paid the lowest premiums.

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 (1) provisions of major health 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

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[1]Two proposals refer to purchasing cooperatives or purchasing groups. For our discussion, we will refer to these entities as alliances.

[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).

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]

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

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
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[a]	Minimum 250,000 individuals residing in alliance area

[a]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

[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).

(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).

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[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.

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 legislation. 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 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.

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[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.

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.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

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.[1] 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.[2] 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

[1]These totals include 3 MSAs, 3 PMSAs, and 1 MSA in Puerto Rico.

[2]OMB establishes definitions for metropolitan areas based on criteria developed by a 15-member federal interagency committee.

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 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	
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