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HEALTH REFORM

Purchasing Cooperatives Have an Increasing Role in Providing Access to Insurance

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here to testify on our report on health insurance purchasing cooperatives, a study that we undertook at your request.[1]

One of the few facts agreed upon by all sides in today's health reform debate is that small businesses and other small organizations have had a tough time buying and keeping health insurance for their employees. Some small groups cannot obtain insurance at any price because of the health status of just one of their employees. Even those able to secure coverage may face very high premiums because their health costs are unpredictable and the costs attributable to one sick person must be borne entirely by each small group. Because risk can't be spread and because of relatively higher overhead, it can cost up to 40 percent more for a small firm to get the same coverage as a larger firm.

One response to this problem is to pool the buying power of individual small firms. Just as hardware store owners, farmers, and other small business owners have formed cooperatives and other associations to use joint purchasing power to buy merchandise at a lower price than they could do individually, so too have we seen the rise of insurance purchasing cooperatives around the country. The basic principle of such cooperatives is that large numbers of relatively small organizations can join together to reduce their administrative expenses, pool their insurance risk, and increase their clout in the market to get a better deal.

The original Clinton administration proposal called for mandatory cooperatives, called alliances, but sentiment in the Congress is now clearly toward voluntary cooperatives. While the Congress has been deliberating health care reform, including the role of cooperatives, state governments and private organizations throughout the nation have been forming and operating such cooperatives. Increasingly, voluntary purchasing cooperatives will be the vehicle by which small business provides health insurance. Therefore, you asked us to examine the operation, authority, and accountability of existing cooperatives. Our objective was to inform the Congress on issues that might arise as it moves toward enacting legislation that could make such cooperatives a much more important part of the health care environment.

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[1]Access to Health Insurance: Public and Private Employers' Experience with Purchasing Cooperatives (GAO/HEHS-94-142, May 31, 1994).

BACKGROUND

Cooperatives can be public, private, or state chartered systems that include public and private employers, and potentially Medicaid recipients.[2]

- **Private cooperatives** are voluntary associations of employers who band together to purchase insurance for their employees. Although pooled purchasing is generally discussed in the context of assisting small businesses, in fact, large firms have also organized cooperatives. Examples of private cooperatives are the Business Health Care Action Group, a relatively new association of large Minneapolis-based firms, and the Council of Smaller Enterprises (COSE), a small employer association founded in 1973.

- **Public cooperatives** were originally established by state governments to purchase insurance for state employees and were subsequently expanded to allow voluntary participation by county and municipal workers or other public entities. The largest public cooperative we visited, the California Public Employees' Retirement System (CalPERS), began offering health insurance over 30 years ago and now has nearly 1 million covered lives.[3] Recently, several states have again expanded public programs by creating voluntary cooperatives targeted at small businesses.

- Finally, **statewide systems of cooperatives** being established in some parts of the country are an amalgam of public and private cooperatives. They will eventually embrace state employees and Medicaid recipients and are open on a voluntary basis to a wider spectrum of groups, including private firms, the self-employed, and low-income individuals. The farthest along is Florida's statewide system of 11 regional cooperatives that began enrolling members in May 1994.

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[2]The 11 purchasing cooperatives we visited and some of their characteristics are listed in table 1.

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

Table 1: Membership and Enrollment of Purchasing Cooperatives GAO Visited

Public Cooperatives		
California Public Employees' Retirement System (CalPERS)	State and local government employees	**930,000**
Washington State Health Care Authority		
Public Employees Benefit Board	State and school district employees	265,824
Basic Health Plan	Individuals on subsidies and those willing to join on a nonsubsidized basis	32,697
Caregivers	Caregivers	50
Total		**298,571**
Health Insurance Plan of California (HIPC)	Firms with 5-50 full-time employees	**44,000**
Minnesota Department of Employee Relations		
State Employee Insurance Program	State employees	144,000
Public Employee Insurance Program	Local government employees	5,000
Minnesota Employers Insurance Program	Private employers with two or more employees	1,000
Total		**150,000**
Wisconsin State Employee Group Health Benefits Program	State and local government employees	**195,000**
Private Cooperatives		
Business Health Care Action Group (BHCAG), Minnesota	Firms with more than 500 employees	**45,000**
Council of Smaller Enterprises (COSE), Ohio	Firms with fewer than 151 employees	**200,000**
Employers Association Buyers' Coalition, Minnesota	Small- to medium-sized firms	**13,000**
Employers Health Purchasing Cooperative, Washington	Small and large firms	**1,050**
Statewide Cooperative Systems		
Florida	Firms with fewer than 51 employees, state workers, and individuals eligible for subsidies	Enrollment began mid-May 1994
Washington	Individuals and any size firm	Not yet enrolling

Regardless of the outcome of the current national health reform debate, the growing number of states and businesses forming cooperatives suggests they are here to stay. We found that pooled purchasing is both a tested and effective mechanism to address recognized problems in the insurance market--especially for small employers.

EXISTING COOPERATIVES HAVE BROAD AUTHORITY OVER HEALTH INSURANCE ADMINISTRATION AND BENEFITS

Purchasing cooperatives have several administrative functions in common including enrollment, premium collection, and contracting with health plans. These functions are similar to those being considered for voluntary cooperatives by the Congress. But existing cooperatives are also empowered to perform additional policy and management functions. Notable among the broad policy functions assigned to existing cooperatives are the ability to (1) define benefits packages, (2) include or exclude individual health plans, (3) negotiate contracts, and (4) develop and analyze quality data.

Benefits Package

Existing cooperatives often play an active role regarding benefits. The state legislature gave the Health Insurance Plan of California (HIPC) responsibility for developing the benefits package offered to small employers. Using health maintenance organization licensing standards and information gathered during a series of public hearings, HIPC created a standardized benefit structure. Other cooperatives have also standardized benefits in order to (1) prevent plans from using the benefit structure to deter bad risk enrollees, (2) make it easier for consumers to compare plans, and finally (3) enable the cooperative staff to more easily evaluate each plan's efficiency. Private cooperatives generally work with insurance carriers to develop benefit structures that reflect the needs of their membership.

Contracting Authority Affects Consumer Choice

Cooperatives have significant power over the type and number of participating health insurance carriers and thus over consumer choice. Although states allow public cooperatives to exclude carriers, they tend to be inclusive. Thus, HIPC offers enrollees a choice of 18 competing carriers. Especially for small businesses, the broad choice of plans offered by public cooperatives expands the options available to their employees. On the other hand, COSE, typical of the private cooperatives we visited, contracts with only two carriers.

Because they believe managed care is more effective at controlling costs, both the private and public cooperatives we visited generally offer managed care options to enrollees. In

1983, the Wisconsin cooperative announced that, with the exception of its two self-funded fee-for-service (FFS) plans, only health maintenance organizations (HMO) would be allowed to participate. Enrollment in HMOs more than tripled to 65 percent the next year. Officials at Cleveland-based COSE told us that their members prefer FFS plans and that this preference has limited the cooperatives' ability to more actively encourage enrollment in plans with stronger cost control features. Only 21 percent of COSE members are enrolled in HMOs.

Negotiating Authority

A particularly controversial issue in the consideration of cooperatives is whether they should negotiate premiums with insurance carriers. Some versions of managed competition view cooperatives as more neutral, with competition between health plans serving to hold down prices. Most existing cooperatives, however, view their ability to negotiate with carriers as a critical tool for restraining growth in health insurance premiums.

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

Although CalPERS had long discussed premium increases with health plans, pressure to contain costs became critical in 1991 when California froze the state contribution to premiums, magnifying the impact of rate increases on state employees. As a result, CalPERS began aggressive negotiations with health plans in 1992 and had held premium increases to well below the national average. Another California cooperative, HIPC, recently achieved a 6-percent reduction over premiums offered in 1993, its first year of operation.

The private purchasing cooperatives we visited believe that their negotiating hand is strengthened by severely restricting the number of participating carriers. Although they may solicit bids from a number of competitors, private cooperatives approach negotiations with the implicit caveat that they will award the contract to a single competitor. For example, COSE, a private

small business cooperative, contracts with only two carriers to obtain a volume discount. Constituting about 15 percent of Blue Cross's business in the Cleveland metropolitan area, COSE is the carrier's single largest customer. According to COSE officials, Blue Cross knows that the cooperative could "shop around" when the current contract expires.

Quality of Care

Reflecting the state of the art, programs to measure, improve, and report on the quality of care delivered by participating health plans are in their infancy. Compared to the public cooperatives we visited, however, private purchasing pools placed more emphasis on such programs. For example, the Business Health Care Action Group sponsored creation of a $2 million institute to develop practice guidelines and a system to monitor treatment and patient outcomes. Public cooperatives are now beginning programs that focus on the quality of the services obtained. Officials at the Minnesota State cooperative told us that they intend to create a new unit to collect and analyze quality outcomes data. Florida's statewide system of cooperatives will issue report cards on quality using health plan data analyzed by a state agency.

EXISTING COOPERATIVES OPERATE WITH MODEST BUDGETS AND STAFFS

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

CONCERNS REMAIN REGARDING GOVERNING STRUCTURES

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

believe that the experience of Florida cooperatives identifies some of the potential pitfalls.

- Although the Florida law requires that cooperative boards reflect the demographics of the population served, that goal has been difficult to achieve. Political rivalry among the three appointing officials has impeded the coordination needed to meet the law's goal.

- The "consumer" representatives on the boards--defined in the law as "an individual user of health care services"--are virtually indistinguishable from the 11 statutory "business" representatives.

- According to a Florida official, inadequate screening resulted in board members whose appointments could be challenged--for example, appointees with prohibited affiliations such as health care consulting.

Politicization, with the potential to undermine public confidence in purchasing cooperatives, suggests that serious attention should be paid to provisions regarding the composition and appointment of boards. Florida's experience suggests that in providing for cooperatives the Congress should include a mechanism to ensure achievement any representational goals.

CONCLUSION

Regardless of the outcome of the debate over cooperatives in national reform proposals, pooled purchasing appears to be an increasingly accepted mechanism to address insurance market shortcomings. Our work suggests that the criticism of purchasing cooperatives as too regulatory and too bureaucratic has been overstated. Cooperatives are a proven and economical way for firms, especially small employers, to purchase insurance. If cooperatives become a national vehicle for expanding insurance coverage, however, the Congress may want to give greater attention to the selection, composition, and accountability of cooperative governing boards.

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

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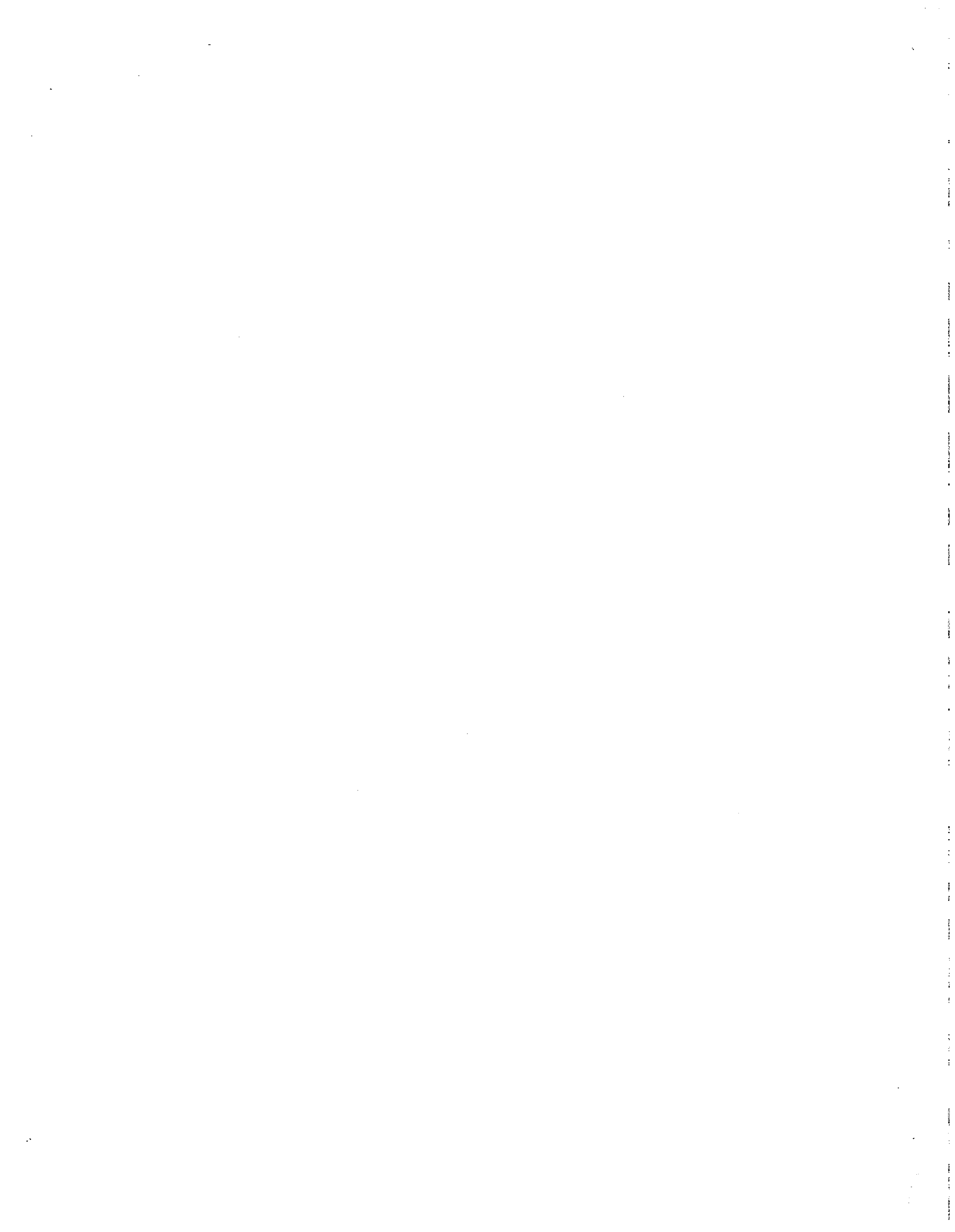

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