REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF HEALTH INSURANCE PURCHASING COOPERATIVES PURSUANT TO SJR 132 OF 1994

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 21

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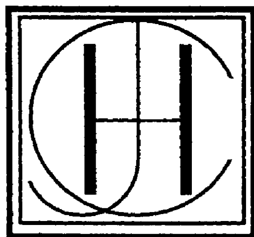

Preface

Senate Joint Resolution (SJR) 132 of the 1994 Session requested the Joint Commission on Health Care to continue its study of health insurance purchasing cooperatives (HIPCs). The study requested the Joint Commission to address a number of specific planning and operational issues regarding HIPCs.

Ten states have enacted legislation to establish HIPC(s) to improve the affordability and accessibility of health insurance primarily for small groups. It is generally agreed that HIPCs can lower administrative costs and stabilize premiums for small groups; and, as such, they can expand coverage to uninsured groups which previously were unable to afford coverage. However, because states have enacted their HIPC legislation only recently, there is limited data available to substantiate the long-term benefits of HIPCs.

Based on the HIPCs that have been established thus far, there appear to be several common features: (i) HIPCs typically are implemented following small group insurance reforms (Virginia passed similar reforms in 1993 and 1994); (ii) participation in HIPCs is voluntary; (iii) HIPCs offer standardized benefit plans so that insurers compete on cost and quality and not benefit design/risk selection; (iv) most HIPCs are private, non-profit entities which selectively contract with health plans; and (v) HIPCs contract out administrative functions.

HIPCs were included in most of the national health care reform proposals debated in the 1994 Congress. While no national reforms were passed this year, a number of different types of purchasing cooperatives and coalitions are being formed by private groups without enabling legislation.

This study offers three policy options for consideration in Virginia. In Option I, the impact of the recently enacted small group insurance reforms would be analyzed prior to establishing a HIPC. Option II would revise THE LOCAL CHOICE program, which is administered by the Department of Personnel and Training for local schools and governments, to allow small employers to join the program. In Option III, legislation would be introduced to create a public entity to administer a HIPC, or to encourage or permit a private entity to develop one.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

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December 30, 1994

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Authority for Study

Senate Joint Resolution (SJR) 132 of the 1994 Session requests the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, to continue its study of Health Insurance Purchasing Cooperatives (HIPCs). The study continues the work completed in 1993 under the authority of SJR 332 of the 1993 Session.

Background

In its 1993 study, the Joint Commission found that establishing and implementing a HIPC is a significant undertaking requiring a substantial amount of advanced planning. In its 1993 Annual Report, the Joint Commission outlined the major operational functions of a HIPC; identified the key features of a HIPC; and summarized the role that HIPCs would play in each of the major federal health care reform proposals. The Joint Commission concluded that further analysis and study were necessary prior to making any final recommendations to the General Assembly.

SJR 132 requests that the Joint Commission address specific planning and operational issues regarding HIPCs, and make recommendations to the General Assembly. These issues include:

- the potential for HIPCs to expand coverage to the working uninsured, uninsured children and others;
- the potential to serve Medicaid and state employee plans;
- the appropriate organizational model and governance structure;
- whether participation should be mandatory or voluntary;
- the appropriate rating, underwriting, risk adjustment and open enrollment requirements;
- the anticipated costs of establishing cooperative(s); and
- the pertinent legal issues surrounding the creation of cooperatives.

In addition, the resolution requires that the Joint Commission obtain information on the target population's interest in purchasing coverage through a cooperative.

This paper provides an overview of the principles which support the establishment of a HIPC; summarizes the status of the major national health care reform proposals with respect to HIPCs; outlines the experiences of other states which have established a HIPC; and identifies options for establishing a HIPC in Virginia.

Health Insurance Purchasing Cooperatives

A Health Insurance Purchasing Cooperative (HIPC) is a mechanism for aggregating purchasing power and spreading risk for small employers and for individuals purchasing coverage on their own.

HIPCs Are Not a New Idea

Pooling the purchasing power of small employers and individuals is not a new idea. Multiple Employer Welfare Arrangements (MEWAs) and other similar joint-purchasing arrangements (e.g. trade association insurance plans) have existed for some time. However, the inclusion of HIPCs in several federal health care reform proposals has prompted new interest in HIPCs.

HIPCs Can Provide Important Benefits for Small Groups

By pooling small groups and individuals into a larger purchasing entity, or HIPC, these persons are able to receive many of the same financial benefits of belonging to a larger employer group. For example, because large groups represent a substantial number of employees and dependents, they are able to negotiate better contractual provisions with carriers and demand better service for their employees.

HIPCs Can Lower Administrative Costs and Stabilize Premiums

Administrative costs comprise a smaller percentage of the total premium for larger groups because carriers can pass along their cost savings that result from economies of scale. Many services provided by a carrier have fixed costs that are the same whether the group has 10 employees or 1,000 employees. Larger groups are able to spread these costs across a greater pool of employees which results in lower per enrollee administrative costs.

Perhaps the greatest advantage of pooling small groups into a HIPC is the spreading of risk across a greater number of insureds. The principal reason that small employers often pay such high health insurance rates (or cannot afford insurance at all) is because the group is so small that the carriers have to calculate the rates very conservatively as a precaution against a member of the group incurring an unexpected level of claims. For instance, a single premature birth can cost as much as $500,000 to $1 million. Because the group is so small, insurers add a significant risk charge to the premiums for the group to help cushion the financial loss of this size claim.

Even small groups which have had favorable claims history can become a "high risk" group very quickly if only one member experiences a serious illness or injury. When a group incurs high claims costs, it generally faces a significant premium increase the next year. The next year may require a small increase; and the succeeding year another significant increase. Many small groups describe this experience as being on the "premium roller-coaster."

When small groups pool their risks into a HIPC or similar arrangement, the risk charge built into the premium can be minimized because there is a larger pool of insureds to absorb unexpected claims costs. As a result of lower administrative costs and risk charges, premiums can be held to a minimum. Small groups' premiums also become more stable and less susceptible to the "roller-coaster" phenomenon.

THE LOCAL CHOICE Program Has Been a Successful HIPC for Virginia's Local Governments

As previously noted, pooling arrangements are not a new phenomenon in the health insurance marketplace. In Virginia, THE LOCAL CHOICE (TLC) program administered by the Department of Personnel and Training functions as a voluntary HIPC for local governments, school divisions, constitutional officers, and other governmental entities. TLC was established pursuant to House Bill 1116 of the 1989 Session.

Eligible groups who elect to join the TLC program choose among several benefit plans, including the state's Key Advantage plan, to offer their employees. Employees then select among the plans offered by their respective employers. Participating groups enjoy the benefits of a large employer including greater benefit plan selections, lower administrative costs, more stable premiums, and enhanced service levels.

Participation in TLC has grown from 150 groups and 13,300 enrollees in its inaugural year, 1990, to 186 groups and 17,500 enrollees in 1994. More information regarding the TLC program is provided later in this paper.

Status of Health Insurance Purchasing Cooperatives In National Reform Proposals

HIPCs have been included as key elements of the three major national health care reform proposals. In the President's proposal, participation in HIPCs would be mandatory for groups under 5,000 employees. Under the proposal sponsored by Congressman Cooper, participation in HIPCs would be

mandatory for groups with 100 or fewer employees. In Senator Chafee's proposal, participation in HIPCs would be voluntary.

Mandatory HIPCs Unlikely in National Reform

The 1994 Congress did not pass any health care reform legislation. Currently, most industry analysts and national reform experts report that "mandatory" HIPCs will not be included in any reform package that may eventually be passed by the Congress. Voluntary HIPCs are still being discussed as a possible component of reform. However, even if included in a future reform package, HIPCs likely will not play the major role as originally envisioned in the Clinton proposal. Some observers note that Congress likely will let the states decide what role, if any, HIPCs will play in health care reform.

Health Insurance Purchasing Cooperatives: Other States' Programs and Virginia's Local Choice Program

Ten States Have Passed HIPC Legislation

Currently, there are 10 states which have passed legislation to establish Health Insurance Purchasing Cooperatives (HIPCs). The states are at various stages of implementing their respective HIPC(s). Figure 1 identifies the 10 states which have passed HIPC legislation.

Figure 1

States Which Have Passed Legislation Establishing HIPCs

California	New Mexico
Florida	North Carolina
Iowa	Ohio
Kentucky	Texas
Minnesota	Washington

Source: Institute for Health Policy Solutions

The following analysis provides an overview of how the various states' HIPCs are established and administered. Information regarding THE LOCAL

CHOICE (TLC) program, administered by the Department of Personnel and Training (DPT) also is provided.

Small Employer Groups Are The Primary Target Population of HIPCs

Other States. The size of an eligible "small employer" varies from state to state. The threshold size in five states is 50 or fewer employees. Others have set the threshold at 100 and 150. Three states allow any size employer to participate in their HIPC(s).

Three states allow individuals to participate in their HIPC(s); and four states have included state employees in their HIPCs. Medicaid populations are "potential" future participants in three states.

TLC Program. There is no limitation on the size of the local government groups who are eligible to participate in TLC. The size of participating groups currently ranges from 2 employees to 945 employees. However, a large majority of the participating groups have 100 or fewer employees.

Participation in Nearly All HIPCs is Voluntary

Other States. In each of the states that have passed HIPC legislation, participation in the HIPC is voluntary. Eligible groups may choose whether to purchase coverage through the HIPC or directly from a carrier. However, in Kentucky, participation in the HIPC will be mandatory for state employees, and local government and school employees.

TLC Program. Participation in the TLC program also is voluntary. The governing body of each governmental entity must approve the group's participation in the program. Groups decide each year whether to continue their participation in the program.

HIPCs Offer Standardized Benefits

Other States. All states that have established HIPCs have developed or are in the process of developing standardized benefit plans to offer through their respective HIPC(s). Five states have established 2 standard plans (e.g. a basic and a standard plan). These standardized plans are similar to Virginia's "Essential" and "Standard" plans. Other states have established between one and five standard benefit plans.

Most states allow carriers to offer other plans in addition to the standard plans that must be offered. Conversely, Kentucky prohibits insurers from offering benefit plans other than the five standard plans.

Three states have developed different cost sharing provisions (e.g. high/low deductibles) or different service delivery designs (e.g. fee-for-service and HMO/PPO) for each of their standardized benefit plans.

TLC Program. The same benefit plans offered to state employees are available to groups who participate in the TLC program. In addition to the state benefit plans, other lower cost benefit plans (e.g. a comprehensive plan with 20% coinsurance for enrollees) are available to TLC groups.

Many HIPCs Are Private, Non-Profit Entities With A Governing Board

Other States. All 10 states which have passed laws to establish HIPCs have done so since 1992. Most states are still in the development phase of implementing their HIPCs. Typically, the HIPCs are private, non-profit entities which are chartered or licensed by the state. In most states, the HIPCs are governed by a Governing Board, whose members often are appointed by the Governor and Legislature.

In seven states, a state agency (e.g. executive branch or independent agency) provides oversight of the HIPC(s). In the other three states, the Bureau of Insurance oversees the HIPC(s).

TLC Program. The TLC program was established in 1989 pursuant to § 2.1-20.1:02 of the Code of Virginia. As provided in statute, DPT administers the program with the assistance of the Local Health Benefits Advisory Committee.

Most HIPCs Selectively Contract With Certain Health Plans

Other States. Most states selectively contract with health plans and offer only those selected through the procurement process. However, in North Carolina and Washington, the HIPCs must contract with all qualified or certified health plans.

Some states have placed certain requirements on insurers to encourage their participation in the HIPC. In Florida, insurers cannot offer health insurance to state employees without offering coverage to small businesses through the HIPCs. In New Mexico, insurers who bid on the state employees' program must participate in the HIPC.

TLC Program. The Department of Personnel and Training (DPT) selects the health plans that are offered to participating groups in accordance with the Virginia Public Procurement Act.

Choice of Benefit Plans is Provided Either Directly to Employees or Through the Employer

Other States. A key decision that must be made when establishing a HIPC is where the choice of benefit plan resides. There is general agreement that in order to encourage competition among health plans, individual employees must be able to choose among different plans. However, the manner in which this choice is provided to employees varies by state.

Three states require that individuals be given the opportunity to select <u>any</u> of the benefit plans offered through the HIPC. In three states, the employer chooses the plans to be offered to its employees, and the employees then choose among the plans selected by the employer. In two of the states that have multiple HIPCs, the HIPC decides whether the employee or the employer chooses the benefit plans. In the remaining two states, the legislation is not clear as to whether employees have the choice of all available plans or only those plans selected by their employer.

TLC Program. Employers participating in the TLC program select among the benefit plans offered by DPT. Employees then can choose among the plans selected by their employer. Some employers select only one plan; and, thus, the employees have no choice of benefit plans.

Single, Statewide HIPCs and Regional HIPCs Have Been Established

Other States. Four states administer a single statewide HIPC. Of the six states which administer regional HIPC(s), four states permit one HIPC per region; one state permits two per region; and one state has no constraint on the number per region.

In three of the six states that developed regional HIPCs, the law requires the governing board to establish the number and composition (i.e. geographic boundaries) of the regions. Florida has established 11 regions based on their health service planning districts. Iowa has established 8 regions. Ohio has no specific constraint on how the geographic composition is determined.

TLC Program. The TLC program is a statewide HIPC. However, the TLC program divides the state into three geographic regions (Northern Virginia,

Central Virginia/Tidewater, and All Other Areas) for the purpose of setting premium's for TLC groups.

Initial Financing of HIPCs is Provided through Start-Up Loans or Appropriations; On-Going Financing of HIPCs is Provided through Premium Surcharges or Membership Fees

Other States. Start-up financing typically is provided through state loans, grants, or a direct appropriation. In California, the HIPC received a $3 million loan; in Florida, each HIPC received state funds up to $275,000; and in Texas, each HIPC receives up to $250,000.

In each state, the on-going administrative functions of the HIPC(s) are financed through premium surcharges or monthly membership fees. In California, each group pays a $20.00 per month fee, plus $2.50 per month per enrolled subscriber. In Kentucky, administrative fees are limited to 1.5% of annual premiums.

TLC Program. The start-up of the TLC program as well as DPT's operating costs for the first year were financed through a general fund appropriation provided to DPT. Currently, the on-going administrative costs of operating TLC, including Blue Cross and Blue Shield of Virginia's costs and DPT's costs, are financed through a premium surcharge that is paid by the participating groups.

Functions of Health Insurance Purchasing Cooperatives

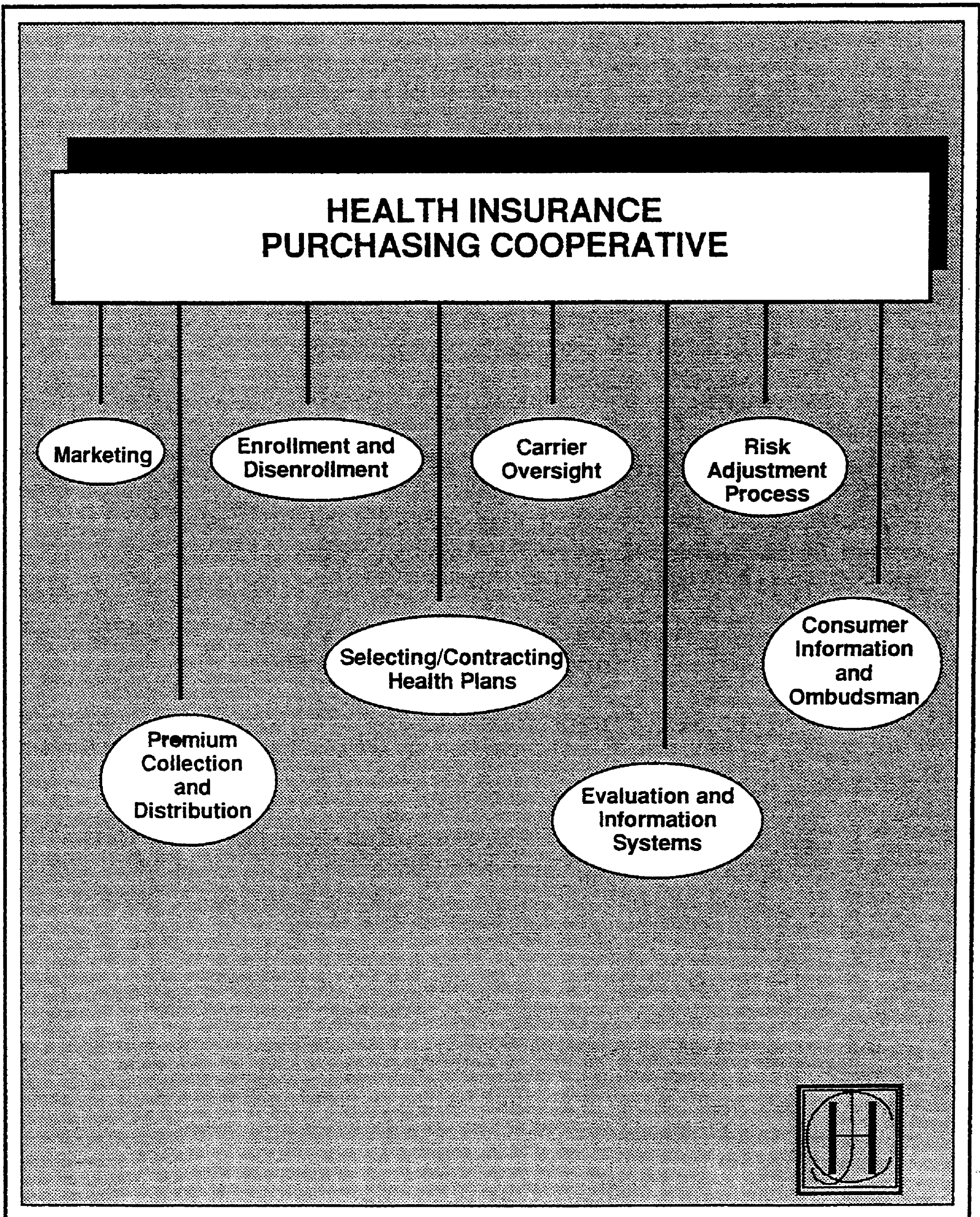
All Health Insurance Purchasing Cooperatives (HIPCs) perform basically the same administrative functions. Figure 2 illustrates the primary functions of HIPCs.

HIPCs Contract Out Many Administrative Functions

Other States. In most states, various administrative functions are contracted out to private vendors. The California HIPC, which serves approximately 2,100 employers and 36,000 enrollees, has 13 full-time staff members. It contracts out nearly all administrative functions to one private vendor.

While most functions are contracted out by the HIPC, the HIPC selects and contracts with the health plans, and performs the carrier monitoring and oversight role.

Figure 2



TLC Program. Several administrative functions, including premium collection, marketing, and enrollment are contracted out. DPT staff procures and contracts with the health plans; monitors the performance of the health plans; and provides administrative assistance (e.g. claims payment resolution, eligibility determinations, and training) to the participating groups.

Risk Adjustment is Critical to the Success of a HIPC

An appropriate risk adjustment process is critical to the long-term success of a HIPC. One key objective of a HIPC is to have the participating health plans accept risk for a wide range of enrollees. In an environment where the health plans must guarantee issue of coverage for all groups, and must rate these groups through modified community rating rather than experience rating, an effective and equitable risk adjustment process is critical.

The risk adjustment function attempts to equalize the risks assumed by the health plans participating in the HIPC. Those plans with higher-than-average risk receive a financial transfer or adjustment, funded by an assessment on those plans with a lower-than-average risk. This risk adjustment process eliminates the financial incentive for plans to attract low-risk groups through other means (e.g. marketing practices or benefit design). The risk adjustment process is still being developed by most of the states.

Results of Health Insurance Purchasing Cooperatives

While There Is Limited Data Available from Other States, Initial Results Look Promising; the TLC Program Has Been Successful and Has Shown Moderate Growth

Other States. Because the legislation establishing all of the state HIPCs has been enacted since 1992, there is little data available to evaluate the success of HIPCs in reducing premiums or in expanding health insurance coverage to groups and individuals who previously were uninsured.

The California HIPC is entering its second year of operation. In its first year, the HIPC enrolled 2,100 employers and approximately 36,000 enrollees. California reports that approximately 22% of the employer groups participating in the HIPC were uninsured prior to the HIPC being formed. Another encouraging result is that the premiums charged for the plans offered through the California HIPC will be reduced by an average of 6% for the next plan year which begins July 1.

The Florida HIPC currently is implementing its HIPC, and does not yet have enrollment data to analyze its impact on the uninsured population. However, the initial bids received by Florida from health insurers interested in participating in the HIPC indicate that premiums for some groups may be reduced substantially.

TLC Program. Enrollment in the TLC program has increased slowly, but steadily since the program's inception. The groups participating in the program were providing insurance coverage to their employees prior to TLC. Therefore, TLC has not expanded coverage to previously uninsured groups. However, the program has provided enhanced benefit options for groups, and has stabilized or lowered the premiums for many groups. The vast majority of groups has remained with the program for several years, which is an indication of the groups' satisfaction with the program.

DPT reports that renewal premiums for the 1995 plan year (July 1, 1994 - June 30, 1995) have been reduced for 35% of the participating groups. Premiums for another 25% of the groups will remain unchanged. Thirty-five percent of the groups' premiums will increase less than 10%. Based on this information, the TLC program is succeeding in holding down health care costs for its groups.

National Association of Insurance Commissioners' Model Legislation for HIPCs

The National Association of Insurance Commissioners (NAIC) currently is developing model legislation for states to follow when establishing HIPCs. The NAIC is expected to develop model legislation for four types of HIPCs. Three of the models will be for voluntary HIPCs: 1) Single, Statewide HIPC; 2) Regional, Non-Competing HIPCs; and 3) Private Competing Alliances. The fourth model will be for a mandatory HIPC. The model legislation is scheduled to be available in late 1994.

NAIC reports that it likely will recommend the following provisions be included in each of the four legislative models:

- carriers must guarantee issue of all products available through the HIPC, not just a basic or standard benefit plan;
- premiums should be calculated on a modified community rating basis;
- HIPCs should be able to contract selectively with health plans, and be able to exclude certain plans from participating in the HIPC;
- employees should be able to choose among plans offered through the HIPC; and

- several standardized benefit plans should be offered; however, there should be a limit on the number of plans that are offered.

A number of key issues regarding the establishment of a HIPC have yet to be resolved by NAIC, including:

- whether individuals should be able to purchase coverage through the HIPC;
- what type of risk adjustment process should be used;
- whether all benefit plans offered inside or outside the HIPC should be standardized; and
- whether there should be a minimum employer contribution toward the cost of employees' coverage.

Staff will monitor the NAIC's work in this area, and will review its final recommendations.

Health Insurance Reform in Other States and Virginia

Most industry analysts agree that a critical step in establishing a HIPC is to have the necessary health insurance reforms already in place. All of the states which have passed legislation to establish a HIPC indeed have enacted insurance reform legislation. The reforms passed by all of the states apply to coverage purchased both inside and outside the HIPC.

Most States' Insurance Reforms Apply to Small Employers

With the exception of the state of Washington, the insurance reforms enacted by the states apply to small employers. In these states, the definition of a "small employer" ranges from a minimum of 2 employees to a maximum of 50. In four of these states, the reforms apply to groups with a maximum of 25-29 employees. The reforms enacted by Washington apply to all employer groups and individuals.

Insurance Reforms Include Guaranteed Issue and Renewability, and Modified Community Rating

Except for Ohio and North Carolina, the reforms require carriers to provide guaranteed issue and renewability of all products offered to small employers. In Ohio, carriers must accept small employers and individuals up to an annual "new business" threshold. In North Carolina, only two products are guaranteed issue products.

Insurance reforms in the states also require insurers to use a modified community rating methodology for the plans offered to small employers. Rating factors include health status/claims history, industry/occupation classification, geography, age, gender, and family composition.

Five states permit limited use of health status/claims history in their rating methodologies. Four states include an industry or occupation rating factor. Tobacco use is included in two states' rating methodologies.

In most states, there are limitations on the degree to which certain factors can affect a small employer's premium. (For example, California limits premium adjustments due to health status to no more than 20%.)

Virginia Has Enacted Small Group Health Insurance Reforms Similar to Other States

The General Assembly passed SB 505 in 1992 which enacted several reforms in the small group market. The legislation required guaranteed renewable coverage; disallowed the practice of excluding individuals within groups; and placed limits on pre-existing condition exclusions. SB 505 also established the Essential Health Benefits Panel to develop an essential health benefits plan and a standard plan for the Commonwealth.

Legislation sponsored by the Joint Commission and passed by the General Assembly (HB 2353 in the 1993 Session and HB 1345 in the 1994 Session) enacted several additional reforms which impact the small group market. The key provisions of these two measures included:

- directing the State Corporation Commission to adopt regulations establishing the "essential" and "standard" health benefits plans as recommended by the Essential Health Services Panel;
- requiring all carriers who transact business in Virginia with small employers (2-49 employees) to guarantee issue of the essential and standard benefit plans to any primary small employer (2-25 employees);
- modifying the definition of primary small employer to include "mom and pop" operations which have just two related employees;
- exempting the essential and standard plans from having to include mandated health benefits;
- requiring small employer carriers to calculate premium rates for the essential and standard benefit plans on a modified community rating basis for primary small employers based on the carrier's claims experience in <u>all</u> products sold to the primary small employer market;
- establishing geographic area, age, and gender as the rating factors; and

- permitting carriers to deviate from the community rate by not more than 20 percent based on the group's claims experience.

The insurance reforms enacted by Virginia have established a good foundation for establishing a HIPC to serve the small employer community. Should the Commonwealth move toward implementing a HIPC in Virginia, legislation may be needed to "fine-tune" the existing insurance statutes to coincide with the design and implementation of the HIPC.

"LESSONS" OF OTHER STATES

There is general agreement among representatives from other states which have implemented HIPCs, as well as national health reform analysts, that certain steps must be taken to implement and administer a successful HIPC. These "lessons" from other states are enumerated below.

- "Make sure you know who you are serving through the HIPC(s). Develop the program for their needs, not the desires of others."
- "If you are serving small employers through HIPC(s), the three top priorities of these employers are: 1) price, 2) price, and 3) price."
- "Do not place requirements or restrictions on your HIPC(s) that are more restrictive than those that apply to other insurance products or entities outside of the HIPC(s)."
- "To attract good risks into your HIPC, you must offer more than just limited benefit plans. HIPCs that offer only limited benefit plans will attract primarily poor risk groups/individuals."
- "Benefit plans offered through your HIPC(s) should be standardized so that the health plans (i.e. insurers and HMOs) cannot tailor their benefit design to attract only good risks."
- "To be successful, you must offer something inside the HIPC(s) that is not available outside of the HIPC (e.g. lower price, lower administrative costs, employee benefit choices)."
- "In the past, many purchasing groups have tried to limit or eliminate the role of insurance agents/brokers as a means of lowering administrative costs. However, to be successful in the small group market, a HIPC needs to involve agents and brokers in the process. Get the agents/brokers to work for you, not against you!"

Options for Implementing a HIPC in Virginia

A HIPC could be implemented in Virginia in several different ways. The principal decision that drives how the HIPC would be formed is the "target population" (i.e. which groups and/or individuals) that the HIPC would serve.

Small Employers Likely Would be the Primary "Target Population" of a Virginia HIPC

Inasmuch as small employers represent a significant portion of Virginia's uninsured population, and given that all of the other states which have established HIPCs have included small employers in their purchasing pools, Virginia's "target population" likely would include at least small employers. Because Virginia's small group insurance reforms define "primary small employer" as 2-25 employees, and define "small employer" as 2-49 employees, it may be appropriate to use either or both of these terms in defining "small employer" for a Virginia HIPC.

Assuming small employers would be the primary target population for a Virginia HIPC, there are various options for implementing such a program in Virginia. Three such options are presented in the following paragraphs.

Option I: Analyze Impact of Small Group Market Reforms Prior to Establishing a HIPC

Many of the small group insurance reforms discussed earlier became effective July 1, 1994. This option would involve analyzing the impact that these reforms have had on improving access and affordability of health insurance for small groups prior to implementing a HIPC. It may be that these small group reforms have a significant impact on the market, and mollify the need to take further reform actions. Analysis also may show that additional steps, such as the formation of a HIPC, may be needed to provide affordable health insurance for these groups.

By analyzing the impact of the small group market reforms for one year, the Commonwealth would have additional information and experience with which to design a HIPC that meets the needs of the small group market. Moreover, this approach also would allow any further refinements to the small group insurance reforms to be developed at the same time the HIPC legislation is developed.

Option 2: Revise THE LOCAL CHOICE Program to Allow Small Employers to Be Eligible for the Program

The TLC program has been successful in providing pooled purchasing of health insurance for local governments. This option would involve amending §2.1-20.1:02 of the Code of Virginia to permit small employers to participate in the program. The TLC program would provide a strong base upon which to establish pooled purchasing for small employers.

Concern may be expressed about expanding the program to private employers. However, as noted previously, other states have included state and local government employees in their HIPCs. If this option is pursued, provisions would be needed to ensure that current TLC groups are insulated from any potential adverse impact on their premiums. There also may be some concern regarding the Commonwealth's personnel agency (i.e. DPT) administering a health insurance program for private businesses. These and other related issues would need to be analyzed carefully.

Option 3: Initiate Steps to Create a Public Entity to Administer a HIPC or Enact Legislation that Encourages or Permits A Private Entity to Develop One

This option would involve developing legislation this year that would: 1) create a separate public entity to implement a HIPC in Virginia; or 2) allow for a private entity to develop a HIPC. Should a public entity be created to establish a HIPC, all of the key decisions and issues presented in this paper would need to be fully examined and addressed in the enabling legislation.

The second approach under this option would involve enacting legislation that encourages or permits private entities to establish a HIPC. The legislation involved in this approach would need to provide a legal framework within which the HIPC would be required to operate.

Next Steps

Staff will continue to analyze the various issues regarding the establishment of a HIPC in Virginia. Staff also will work with the Bureau of Insurance, the business community, health insurance carriers, employers, insurance agents, selected state agencies and other interested parties to determine whether a HIPC should be established in Virginia, and, if so, how best to accomplish this task.

Staff will analyze the advantages and disadvantages of the various options for implementing a HIPC in Virginia, and will continue to monitor the implementation of HIPCs in other states and the potential role of HIPCs in national health care reform.

APPENDIX A

SENATE JOINT RESOLUTION NO. 132

Requesting the Joint Commission on Health Care in cooperation with the Bureau of Insurance and other state agencies and private groups, to continue its study of health plan purchasing cooperatives.

Agreed to by the Senate, March 1, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, a lack of insurance coverage continues to be a major problem in Virginia; and

WHEREAS, the Commonwealth has enacted various programs and policies designed to expand access to health coverage for the uninsured; and

WHEREAS, the Commonwealth makes major expenditures for the purchase of health care coverage for state and local public sector employees; and

WHEREAS, health plan purchasing cooperatives could enable small businesses, individuals, families, and other groups to benefit from the power of large purchasing cooperatives that negotiate and contract with competing partnerships of health care providers and insurers; and

WHEREAS, other states and the U.S. Congress are considering health plan purchasing cooperatives as major elements of health care reform; and

WHEREAS, the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, has initiated a study of the feasibility of creating health plan purchasing cooperatives to increase access to affordable health care coverage for small businesses, individuals, families, and other groups that would benefit from the economics of cooperative purchasing; and

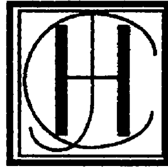
WHEREAS, the results of this study indicate that there are a number of complex operational issues involved in the creation of health plan purchasing cooperatives; and

WHEREAS, there is a need for additional public discussion and analysis before the General Assembly makes final decisions about the creation of health plan purchasing cooperatives; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, continue to study the feasibility of creating health plan purchasing cooperatives. In this regard, the joint commission is requested to make recommendations in the following areas regarding health plan purchasing cooperatives (cooperatives): (i) the potential of cooperatives to expand access to necessary health coverage for the working uninsured, uninsured children, and other uninsured individuals; (ii) the potential of cooperatives to serve state employee benefit plans and the Virginia Medicaid program; (iii) the appropriate employer size threshold; (iv) the appropriate organizational model and governance structure for cooperatives; (v) whether participation in cooperatives should be mandatory or voluntary; (vi) the appropriate role of state employee benefit plans and the Medicaid program; (vii) the appropriate number of cooperatives and the corresponding regional responsibilities; (viii) the appropriate role of cooperatives in setting prices, certifying health plans, and extending access to underserved areas; (ix) the types of plans which should be offered through cooperatives; (x) the appropriate degree of employee and employer cost sharing and choice; (xi) appropriate rating, underwriting, and open enrollment requirements for participating health plans; (xii) the appropriate risk adjustment methodology to be used in cooperatives; (xiii) the appropriate use of private administrators in carrying out the responsibilities of cooperatives; (xiv) the anticipated costs of creating cooperatives; and (xv) the pertinent legal issues surrounding the creation of cooperatives; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private organizations, shall: (i) gather information on the target population's interest in and views on purchasing health care through a health plan purchasing cooperative, (ii) identify legislation that may be required for the Commonwealth or other entities to establish health plan purchasing cooperatives, (iii) and report its findings on health plan purchasing cooperatives to the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B



Joint Commission on Health Care

Comments on Draft Issue Brief 1:
Health Insurance Purchasing Cooperatives

Comments regarding the Health Insurance Purchasing Cooperative (HIPC) Issue brief were received from the following organizations:

* Blue Cross and Blue Shield of the National Capital Area,
* Blue Cross and Blue Shield of Virginia,
* Golden Rule Insurance Company,
* The Independent Insurance Agents of Virginia, The Virginia Association of Life Underwriters, The Virginia Chapter of the American Association of Health Insurance Agents, and The Virginia Chapter of the National Association of Health Underwriters,
* Kaiser Permanente,
* The League of Virginia Health Systems,
* The Virginia Chamber of Commerce,
* The Virginia Farm Bureau,
* The Virginia HMO Association,
* The Virginia Association of Health Insurance Agents, Virginia Association of Health Underwriters, and the Big I, and
* The Virginia Hospital Association.

Policy Options Presented in Issue Brief

Three policy options were presented in the Issue Brief for consideration by the Joint Commission on Health Care.

Option I: Analyze Impact of Small Group Market Reforms Prior to Establishing a HIPC

Option II: Revise THE LOCAL CHOICE Program to Allow Small Employers to Be Eligible for the Program

<u>Option III</u>: Initiate Steps to Create a Public Entity to Administer a HIPC or Enact Legislation That Encourages or Permits a Private Entity to Develop One

Summary of Comments

There was general agreement among those commenting on the issue brief that the impact of the recently enacted small group insurance reforms should be analyzed prior to establishing a HIPC in Virginia. There also was general agreement that, should a HIPC be formed in Virginia, a private, non-profit entity should be created to establish the HIPC. Three organizations specifically stated that they opposed expanding THE LOCAL CHOICE program to include small businesses.

A majority of those submitting comments suggested that, if the HIPC concept is approved, there should be regional HIPCs, and that participation in the HIPCs should be voluntary.

Summary of Individual Public Comments

Blue Cross and Blue Shield of the National Capital Area

David F. Peters, of the law firm of Hunton & Williams, commented on behalf of Blue Cross and Blue Shield of the National Capital Area (BCBSNCA). He identified several questions which they believe need to be addressed. These questions include: (i) whether a HIPC should be a federal agency, a state agency or a private agency, (ii) whether participation in the HIPC would be mandatory or voluntary for employers and health plans, (iii) whether there are any antitrust implications associated with the formation of a HIPC, and (iv) how various interstate issues/concerns will be addressed.

Mr. Peters referenced a briefing paper prepared by the Blue Cross and Blue Shield Association, and noted that the small group reforms that have been enacted in Virginia will achieve the goals of a HIPC without the additional bureaucracy of mandated and government-controlled HIPCs.

Blue Cross and Blue Shield of Virginia

Mr. Roderick B. Mathews, Senior Vice President and Corporate Legal and Government Affairs Officer for Blue Cross and Blue Shield of Virginia (BCBSVA) suggested that authorization for a public or private entity to develop a HIPC should be postponed until the impact of the small group health insurance

reforms enacted pursuant to HB 2353 of the 1993 session and HB 1345 of the 1994 session is analyzed.

Mr. Mathews indicated that without a review of the impact of the small group market reforms, it is questionable whether the expense and bureaucracy associated with the establishment of an untested HIPC organization could be justified. Mr. Mathews suggested that the HIPCs established in other states should be monitored closely before Virginia embarks on such an endeavor.

Golden Rule Insurance Company

Suzanne, E. Katt, Vice President for Government Relations, stated that Golden Rule believes that HIPCs should remain voluntary to allow consumers as much choice as possible. She suggested that the Commonwealth consider allowing the HIPCs to offer both guaranteed issue and underwritten products.

Independent Insurance Agents of Virginia, Virginia Association of Life Underwriters, Virginia Chapter of the American Association of Health Insurance Agents, and the Virginia Chapter of the National Association of Health Underwriters

Mr. Ted L. Smith, President of the Independent Insurance Agents of Virginia, submitted comments on behalf of the organizations identified above.

Mr. Smith stated that these groups do not believe in the concept of HIPCs, and do not believe that there will be economies for small businesses by the introduction of voluntary purchasing cooperatives through legislative or regulatory constructs. He stated that the agent community believes a voluntary HIPC will increase administrative costs, and that while a mandatory HIPC has the potential to reduce administrative costs, it is both politically and structurally unacceptable.

He stated the small group reforms in progress have been significant and that the best course of action now is to "sharpshoot" at a few more targeted issues, and give current reforms a chance to work in the marketplace. He identified the following areas as specific targets for further reform:

* expand portability of coverage to groups of all sizes,
* reform conversion policies to make this coverage more available and affordable, and require carriers offering group coverage to offer equivalent individual policies,
* review the impact of the small group market reforms enacted by the 1993 and 1994 sessions of the General Assembly, and

* examine the feasibility of expanding guaranteed issuance and modified community rating to all health insurance policies in the 2-25 group market.

Mr. Smith indicated that HIPCs are not viewed as a threat to the existence of the agent/broker community, but rather as a "costly and unnecessary layer of bureaucracy that will impede innovation in health care reform."

Kaiser Permanente

Kathleen McNalty, Government Relations Representative for Kaiser Permanente, stated that Kaiser Permanente supports the implementation of a Health Insurance Purchasing Cooperative (HIPC) targeting the small group market. She recommended that the HIPC include groups with 2-200 employees. Ms. McNalty recommended that, in order to avoid significant adverse selection, participation in the HIPC should be mandatory. She recommended that all qualified health plans be offered through the HIPC.

Ms. McNalty agreed that a HIPC can provide advantages to small businesses including lower administrative costs, greater rate stability, broader choice of health plans for employees and fair competition through market conduct monitoring and application of risk assessment and risk adjustment.

Ms. McNalty recommends that Option 3 (enact legislation that either creates a public entity to implement a HIPC or permits a private entity to develop a HIPC) be adopted. She states that Option 1 (study impact of small group reform prior to implementing a HIPC) also is a viable "first step." Lastly, she states that Kaiser Permanente is opposed to Option 2 (expanding THE LOCAL CHOICE program to small businesses).

League of Virginia Health Systems

D. Patrick Lacy, Jr., of the law firm of Hazel & Thomas, commented on behalf of the League of Virginia Health Systems. He indicated that the League supports the second approach under Option 3 in which legislation is enacted that encourages or permits private entities to establish a HIPC. The League believes the establishment of a HIPC should be a private, and not a public, initiative.

Mr. Lacy commented that HIPCs should be targeted to small employers with 50 or fewer employees, and that there should be multiple HIPCs with at least one HIPC in each region of the Commonwealth. Lastly, the League believes that the governing body of a HIPC should be composed of representatives of interested parties, as well as stakeholders.

Virginia Chamber of Commerce

Sandra D. Bowen, Senior Vice President of the Virginia Chamber of Commerce, offered preliminary comments and indicated that more definitive comments will be submitted later in the summer. She indicated that there is some skepticism within the Chamber of Commerce about the need for legislation at this time until the effects of the small group market reforms and the indigent health care trust fund pilot projects are known. She stated that if HIPCs are seen as a means of attracting small businesses and individuals into the market, consideration should be given to legislation which will encourage and facilitate the formation of private, voluntary HIPCs.

Virginia Farm Bureau

C. Wayne Ashworth, President of the Virginia Farm Bureau, commented that the concept of pooling small groups and individuals into a large purchasing entity has merit. To ensure that rural Virginia does not "slip through the cracks," the Farm Bureau supports regional HIPCs.

Mr. Ashworth stated that participation in a HIPC should be voluntary, and that both small employers and individuals should be eligible to participate. Employers should be able to select health plans to make available to their employees. He also noted that if Virginia establishes a HIPC, it should be formed as a private, non-profit entity that is controlled solely by its members. Cooperatives should not have exclusive state-granted franchises.

Mr. Ashworth commented that it would be prudent to analyze the impact of the small group market reforms prior to establishing a HIPC. If it is determined that a HIPC is needed, the Farm Bureau believes that enacting legislation which permits private entities to establish a HIPC (Option 3) would be appropriate. He stated that the Farm Bureau is concerned that an expansion of THE LOCAL CHOICE program to include small businesses would not provide adequate service to rural Virginia.

Virginia HMO Association

Mr. Reginald N. Jones, an attorney with the law firm of Williams, Mullen, Christian & Dobbins, commented that the Virginia HMO Association (VAHMO) supports Option I, and suggests that enactment of legislation creating or enabling the creation of HIPCs would be imprudent at this time. VAHMO indicated that if a HIPC is implemented, it would oppose any proposals that would give HIPCs significant regulatory or market power.

The Virginia Association of Health Insurance Agents, Virginia Association of Health Underwriters, and the Big I

Mr. Richard Herzberg, Vice President of the Frieden Agency, commented that these groups of insurance agents support Option I, and recommend that the impact of the small group market reforms be analyzed prior to establishing a HIPC.

Virginia Hospital Association

The Virginia Hospital Association (VHA) supports Option 1, and suggests that the impact of the small group market reforms be analyzed prior to establishing a HIPC in Virginia. The VHA indicated that Option 3 (enacting legislation to create a public entity to administer a HIPC or encouraging/permitting a private entity to develop a HIPC) may eventually be an appropriate course to follow after assessing the impact of the small group reforms. If Option 3 is pursued, the HIPC should be established according to the following principles: (i) pluralism in both financing and delivery of care, (ii) local control of any reform approach that includes community health networks or HIPCs, (iii) competition among local or regional HIPCs to avoid the creation of a "super-HIPC," such as a statewide HIPC, (iv) assurances that payments to health plans are the same whether the enrollee is funded from the public or private sector, and (v) participation in the HIPC is limited to small employers. The VHA does not support expansion of THE LOCAL CHOICE program.

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