REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF POOLED PURCHASING ARRANGEMENTS FOR SMALL EMPLOYERS, COMMUNITY HEALTH CENTERS AND FREE CLINICS PURSUANT TO HJR 202/SJR 124

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

Senate Joint Resolution (SJR) 124 and House Joint Resolution (HJR) 202 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics.

Specifically, SJR 124/HJR 202 directed the Joint Commission's study to include: (i) evaluating the pooled purchasing arrangements operating in California, Florida and other states; (ii) assessing the level of interest among Virginia's small employers in participating in a pooled purchasing arrangement; (iii) analyzing the key elements of such a purchasing pool to maximize the number of participating employers; and (iv) identifying health insurance market reforms or other actions necessary to ensure the success of a purchasing pool.

Based on our research and analysis during this review, we concluded the following:

- small employers (groups of 2-50 employees) traditionally have had a more difficult time purchasing coverage for their employees than larger employers primarily due to cost;
- small employers have a significantly higher percentage of employees who are uninsured than larger employers;
- pooled purchasing arrangements, such as health insurance purchasing cooperatives (HIPCs), provide a means for aggregating purchasing power and spreading risk for small employers;
- HIPCs can offer several advantages for small employers, including more stable premiums, lower administrative costs, and a greater choice of plan options for employees;
- while pooled purchasing arrangements can be defined in many ways, there appear to be 11 HIPCs across the country which offer multiple benefit options and standardized benefits;
- the success of HIPCs has been mixed; some (e.g., California, Connecticut and Florida) have been very successful, while others have not had the market impact that was anticipated;

- there are several key elements to the success of a HIPC, including: (i) market rules inside and outside of the HIPC must be identical; and (ii) insurance agents and brokers must support the plan and play a key role in marketing the HIPC's products;

- Virginia does not require modified community rating in the small group market except for the Essential and Standard plans; if a Virginia HIPC were to use modified community rating, legislation would be needed to require the same rating methods for all products in the small group market;

- small businesses in Virginia support the *concept* of a HIPC; however, without an actuarial analysis of the cost of coverage inside and outside of a HIPC, it is difficult to gauge whether employers actually would purchase coverage through the HIPC;

- the Code of Virginia does not prohibit the private formation of a HIPC by interested parties leading some to believe that if there is a need for a HIPC in Virginia, the private sector should respond to this need rather than the Commonwealth;

- while THE LOCAL CHOICE (TLC) program has functioned successfully as a HIPC for local governments and school divisions, expanding eligibility for the program to small businesses likely would create a number of administrative difficulties which could increase administrative costs and potentially injure the program; and

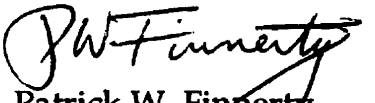
- based on TLC rates calculated for a sample of Free Clinics and Community Health Centers (CHCs), only a handful of the Free Clinics and CHCs indicated that the program would result in any significant savings in insurance premiums.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 31-32.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at

Appendix C) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Bureau of Insurance, the Department of Personnel and Training, the Department of Business Assistance, the Virginia Hospital and Healthcare Association, the Virginia Chamber of Commerce, the Virginia Association of Health Plans, Trigon Blue Cross Blue Shield, Blue Cross Blue Shield of the National Capital Area, the Virginia Manufacturers Association, the Virginia Chapter of the National Federation of Independent Business, the Virginia Primary Care Association, the Virginia Association of Free Clinics, the Independent Insurance Agents of Virginia, the Virginia Association of Health Underwriters, the Virginia Association of Life and Health Underwriters, and the Association of Health Insurance Agents for their assistance during this study.



Patrick W. Finnerty
Executive Director

February 3, 1999

TABLE OF CONTENTS

I.
Authority for Study/Organization of Report

Senate Joint Resolution (SJR) 124 and House Joint Resolution (HJR) 202 of the 1998 Session of the General Assembly directs the Joint Commission on Health Care to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics.

In conducting its study, the Joint Commission was directed to coordinate its review with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, the Virginia Manufacturers Association, the Virginia Chapter of the National Federation of Independent Business, the Virginia Primary Care Association, the Virginia Association of Free Clinics, and the Department of Personnel and Training. In addition, the resolutions directed the Joint Commission to consult with consumer advocates.

Specifically, SJR 124/HJR 202 required that the Joint Commission's study include, but not be limited to:

(i) evaluating the pooled purchasing arrangements operating in California, Florida, and other states;
(ii) assessing the level of interest among Virginia's small employers in participating in a health insurance purchasing pool;
(iii) analyzing the key elements of such a purchasing pool to maximize the number of participating employers; and
(iv) identifying health insurance market reforms or other actions necessary to ensure the success of a purchasing pool.

SJR 124/HJR202 also directed the Joint Commission to study THE LOCAL CHOICE program and its potential as a model for pooled purchasing of health insurance for small employers, community health centers and free clinics. (THE LOCAL CHOICE is a program administered by the Department Personnel and Training which allows local school divisions, local governments, and other governmental entities to purchase health insurance through the state employee health benefits program.)

A copy of SJR 124 is attached at Appendix A.

This Report Is Presented In Six Major Sections

This first section discusses the authority for the study and organization of the report. Section II provides background information regarding the structure, operation and objectives of pooled purchasing arrangements. Section III presents information about the pooled purchasing arrangements that have been established in other states. Section IV identifies a number of key issues that must be considered in establishing a pooled purchasing entity in Virginia. Section V describes THE LOCAL CHOICE program and presents information on the potential use of this program as a model for pooled purchasing. Lastly, Section VI presents a series of policy options the Joint Commission may wish to consider in addressing the issue of pooled purchasing arrangements for health insurance.

While there are several terms used to describe the concept of pooled purchasing arrangements for health insurance, for the purposes of this report, the term "health insurance purchasing cooperative" (HIPC) will be used to describe these entities.

II.
Background: Pooled Purchasing Arrangements For Health Insurance

Small Employers Face More Difficulties Purchasing Health Insurance Than Larger Employers

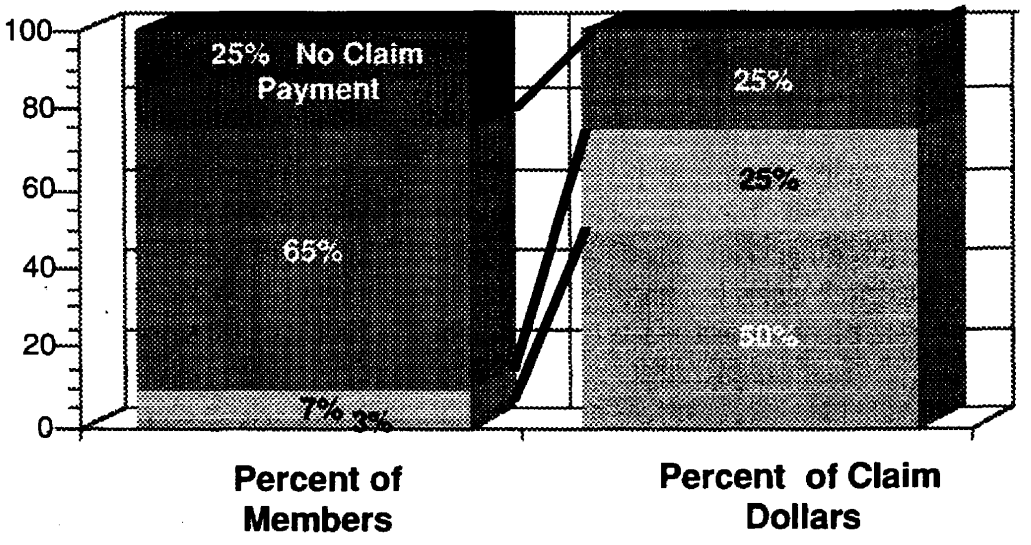
Historically, small employers, typically defined as groups of between 2 and 50 employees, have faced the greatest difficulties in purchasing health insurance for their employees. Small employers generally are viewed as higher risks by health insurance carriers because of the small number of employees across which insurance risk can be spread. With a limited number of employees, carriers often calculate premiums very conservatively as a precaution against a member of the group incurring an unexpected level of claim expenses. For instance, a single premature birth can cost as much as $500,000 - $1,000,000. Because a small group has so few members, insurers often add a significant risk charge to the premiums for the group to help cushion the financial loss of this size claim.

Even those 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 often faces a significant premium increase the next year. The next year may be a small increase; and the succeeding year another significant increase. Many small groups describe this experience as being on the "premium roller-coaster."

Figure 1 presents actual claims data from a large employer group and illustrates the impact that a relatively small number of high risk enrollees can have on the cost of health insurance. Moreover, when applied to a small employer with only a few employees to absorb the costs associated with a high risk person, the data show why carriers often rate small groups so conservatively. As seen in Figure 1, 3% of the group members incurred approximately 50% of the claims; 10% of members accounted for 75% of the claims, and 25% of members had no claim payments.

Figure 1

Distribution of Claims Expense Among Enrollees



Source: William M. Mercer, Inc., 1994

The high cost of health insurance and instability in rates from year to year are the major reasons why many small employers do not offer health insurance to their employees. This difficulty in being able to afford health insurance is illustrated by results of the Health Care Access Survey conducted in 1996. This statewide survey estimated the number of uninsured Virginians to be approximately 858,000. The survey data was analyzed by size of employer group. Figure 2 illustrates that small employers (under 50 employees) have a significantly higher percentage of employees who are uninsured than larger employers. As seen in this graphic, 28% of employees in firms with five or fewer employees are uninsured. The percentage of uninsured employees in larger firms is substantially less.

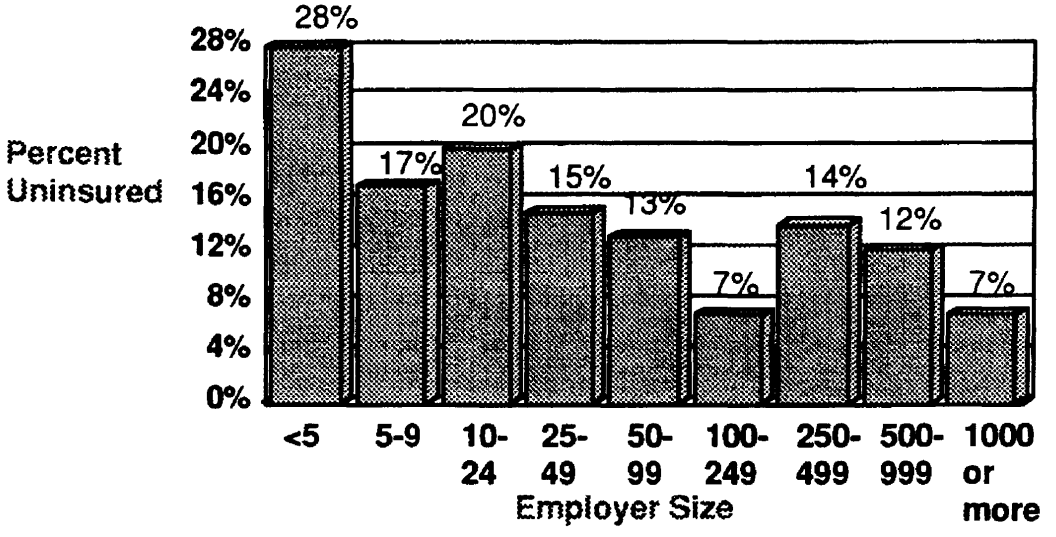
The Great Majority Of Small Employers Offer Health Insurance, But A Significant Number Do Not

According to a 1997 health insurance survey conducted by the Virginia Chamber of Commerce, approximately 86% of small firms (2-25 employees) offer health insurance to their employees. However, given the fact that small businesses comprise a significant percentage of the private

workforce, the 14% who do not offer coverage represent a significant number of employees. A greater percentage of larger employers (98-99%) offer health insurance to their employees.

Figure 2

Percentage of Uninsured Employees By Size Of Employer



Source: JCHC Staff Analysis of 1996 Health Care Access Survey

HIPCs Are A Mechanism For Aggregating Purchasing Power And Spreading Risk For Small Employers; While Similar In Some Respects To Association Plans, There Are Key Differences

A HIPC is a mechanism for small employers to join together in a larger pool of purchasers thereby aggregating purchasing power and generating a larger number of persons (i.e., employees and enrolled dependents) in the group for risk-spreading. Joining a HIPC provides a number of purchasing advantages that are outlined below.

HIPCs are similar in some respects to other types of group purchasing, such as association plans, but also offer significant advantages not available through association plans. In an association plan, only those members of the association are able to purchase insurance as part of a

larger group. In a HIPC, eligibility is open to any small employer. Association plans typically contract exclusively with one health insurance carrier, thus, the enrollees do not have a choice of different carriers. In a HIPC, several carriers are offered to the participating groups/enrollees promoting competition among the carriers and allowing the enrollees to choose the carrier which best suits their needs.

HIPCs Offer Several Advantages To Small Employers

More Stable Premiums: Pooled purchasing offers a number of advantages for small employers. Within a HIPC, small employers aggregate their purchasing power so that each group's claims experience is spread across a larger group. This "spreading of risk" helps to stabilize premium increases from year to year. The larger the HIPC, the more evenly it can distribute insurance risk among its members.

Lower Administrative Costs: The percentage of a small employer's premium that pays for administrative costs (e.g., marketing, enrollment, collection/disbursement of premiums) can be reduced. Several of the HIPCs currently in operation report administrative costs between 3% and 8%, whereas insurers report administrative costs between 25-40% for groups under 50 people. ("States of Health," Vol. 7, #8, Dec.,1997).

Choice of Coverage Options For Employees: Another key advantage of a HIPC is that it allows small employers to offer employees a choice of coverage options. Due to the small number of employees, small employers typically are not able to offer a choice of plans, because to do so would reduce the number of employees in each plan option which further increases the risk of each plan, resulting in even higher premiums. The structure of most HIPCs is such that employees are able to choose their health plan. This feature not only provides the important advantage of allowing employees to have their choice among plan options, it also promotes competition among plans. In a HIPC, the plans have to compete on the basis of price and quality of services.

A HIPC May Help To Reduce The Number Of Uninsured Virginians

From a public policy perspective, the most important aspect of a HIPC is the potential for reducing the number of uninsured persons in Virginia. To the degree that a HIPC can lower costs and stabilize future premium increases, such an entity holds some promise for increasing the number of small employers offering coverage, and, thus, reducing the number of uninsured Virginians.

As will be discussed in Section III of this report, some states have reported that between 20 and 50 percent of their participating groups previously were uninsured. While some question the true impact of HIPCs in this respect, the potential reduction in the number of uninsured is nonetheless noteworthy. Moreover, to the degree that HIPCs can hold down future cost increases, the HIPC may prevent further increases in the number of uninsured that would have occurred in the absence of the HIPC.

HIPCs Perform Several Basic Functions And Contract With Health Insurance Carriers To Provide Coverage; HIPCs Do Not Assume Risk

While the HIPCs that have been established across the country have various administrative and legal structures (see Section III), virtually all of these entities perform some basic operational functions in making coverage available to small employers. Figure 3 identifies these basic HIPC functions. While the HIPC has responsibility for performing a number of administrative functions, they typically subcontract these services to a third party administrator or other vendor.

Figure 3
Basic Functions Performed By HIPCs

- ***Selecting, negotiating and contracting with health plans*** and other vendors to provide services to participating groups
- ***Enrolling employees*** in health plans through a centralized process, generally through a third party administrator
- ***Collecting and distributing premiums*** from each participating employer to the health plans
- ***Collecting, analyzing and publishing*** consumer information on plans' characteristics and performance and customer satisfaction to assist in enrollees' plan selections
- ***Marketing*** the HIPC to prospective employer groups, and working with insurance brokers and agents

Source: JCHC Staff Analysis

HIPCs contract with insurance companies and/or health maintenance organizations (HMOs) to provide health insurance coverage. HIPCs do not assume insurance risk; the risk of insuring the participating

groups remains with the carriers and HMOs. All HIPCs offer some choice of benefit plans. A number of HIPCs require the carriers to offer a standardized set of benefits so that enrollees can make "apples to apples" comparisons of the carriers, select a carrier on the basis of price and quality, and not have to worry about variation in benefit designs that may be causing price differences.

Provisions To Establish "Healthmarts" Are Included In Health Insurance Legislation Being Considered By Congress

While HIPCs have been established in a number of states across the country, there currently is no federal legislation that establishes any requirements, minimum standards, criteria or other direction to the states as is the case with the health insurance reforms contained in the 1996 Health Insurance Portability and Accountability Act. However, Congress currently is considering legislation which includes provisions to establish "Healthmarts" as a type of pooled purchasing arrangement.

H. R. 4250 would establish Healthmarts as non-profit organizations offering multiple health plans to small employers (2-49 employees). A Healthmart would have to offer coverage to employees of all small firms within the Healthmart's geographic area that were willing to enter an exclusive contract with the Healthmart for employee insurance.

Like state level HIPCs, Healthmarts would provide administrative services for purchasers such as accounting, billing, enrollment, coverage status reports, consumer information, etc. Group participation in Healthmarts would be voluntary. Multiple Healthmarts can be established in a given region.

Healthmart Insurance Coverage: The health insurance coverage offered by a Healthmart would be fully insured products offered by state-licensed issuers (i.e., insurance carriers). However, in contrast to policies sold in the current small-group insurance market, a Healthmart's products would not have to comply with state benefits mandates (except for state mandates to cover a specific disease).

Healthmart Premiums: Premiums would be determined by the carrier on a policy or product specific basis and would have to be calculated in accordance with any applicable rate setting requirements imposed under state law. As such, in those states which require some form of community rating, or limits on experience rating, the rates charged by health plans within the Healthmart would have to be rated in the same manner.

The Final Status Of Federal Healthmart Legislation Is Unknown At This Time

H.R. 4250 has been passed by the House and now is awaiting Senate action. It is unclear at this time whether this legislation will be passed by Congress. H.R. 4250, called the "Patient Protection Act of 1998," includes a number of other health insurance-related provisions, including an external appeals process, a point-of-service mandate, and other patient protections. President Clinton has indicated he will veto the legislation due to concerns that the patient protection provisions are inadequate. At this time, it is unclear if and when final Congressional action will occur on this legislation.

The Feasibility Of Implementing A HIPC In Virginia Has Been Studied Several Times In The Recent Past

HIPCs are not a new idea. The concept of pooled purchasing was debated vigorously as part of President Clinton's health care reforms proposed in 1994. The Joint Commission has examined the feasibility of implementing a HIPC in Virginia in 1993 (Joint Commission's 1993 Annual Report, 1994 Senate Document 60) and again in 1994 (1995 Senate Document 21). Most recently, the Joint Commission's 1997 "Point-of-Service" (POS) Task Force looked at HIPCs as a means of expanding employee choice of health plans. This current study is being conducted as a follow-up to the work of the POS Task Force.

III.
Pooled Purchasing Arrangements In Other States

Various Forms Of HIPCs Have Been Established Across The Country

Various forms of HIPCs have been established in a number of states. There are no strict criteria by which to judge whether a certain form of pooled purchasing is or is not considered a HIPC. Therefore, it is difficult to determine the exact number of such entities which are operating across the country. However, the Academy of Consumer-Choice Health Purchasing Groups, which is a national organization that promotes pooled purchasing and conducts annual conferences on the subject, has established the following working definition of a HIPC as an entity which: *". . . has a Board of Directors with conflict of interest provisions and members who represent small employers; offers a choice of multiple competing health plans, and has standardized benefits."* The Academy has identified 11 HIPCs across the nation that meet this definition, but also notes that their list may not include all such HIPCs. Figure 4 identifies those states in which these 11 HIPCs are operating.

It is important to recognize that there are many other pooled purchasing arrangements in existence today that are not reflected in Figure 4.

While There Are Variations In How Each HIPC Is Organized And Operated, There Also Are A Number of Similarities

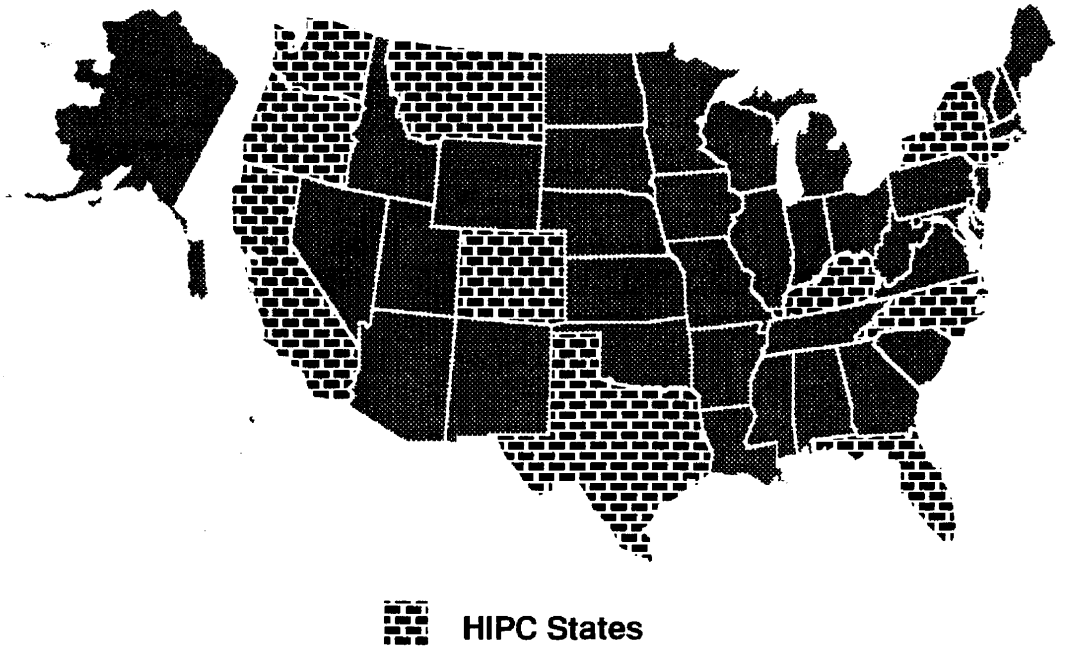
Each HIPC has certain aspects or features that distinguish it from the other HIPCs operating across the country. While there are organizational and operational variations among the HIPCs, there also are a number of similarities.

All HIPCs Are Voluntary; Most Serve The Entire State: All of the HIPCs are voluntary; employers choose whether or not to purchase coverage from the HIPC. Most of the 11 HIPCs identified by the Academy of Consumer-Choice Health Purchasing Groups provide coverage throughout the state through one statewide HIPC. The LIA Health Alliance (Long Island, New York) serves only the Long Island area. In Florida, 8 Community Health Purchasing Alliances (CHPAs) provide services across

the state. In North Carolina, pooled purchasing is offered through four regional organizations.

Figure 4

Consumer Choice Health Purchasing Groups



Source: Academy of Consumer-Choice Health Purchasing Groups

All HIPCs Include Small Employers, Some Include Individuals and Other Groups: All of the 11 HIPCs provide coverage to small groups, typically defined as 2-50 employees. In Florida and North Carolina, coverage is offered to self-employed persons. In Connecticut and Washington, the minimum employer size is 3 employees. Individuals are eligible to participate in the Kentucky and North Carolina HIPCs. The Colorado HIPC offers coverage to any size group.

Several HIPCs Are Private, Non-Profit Entities: There is considerable variation among the HIPCs with regard to their legal structure; however, several are private, non-profit entities. In California and Kentucky, the HIPC is a state agency. In Florida and North Carolina, the HIPCs are state-chartered, private, non-profit entities.

All Offer Multiple Health Plans And Standardized Benefits: All of the HIPCs offer multiple, competing health plans (carriers) with various levels/types of benefits. The number of plans being offered ranges from only two in Montana to as many as 34 in Florida. Most of the HIPCs offer three or four competing plans. All of the HIPCs require the carriers to offer at least some standardized benefit options which enables enrollees to make "apples to apples" comparisons when choosing between the carriers.

HIPCs Rate Groups On A Modified Community Rating Basis: Virtually all of the HIPCs rate groups on a modified community rating basis. In each of these states, modified community rating laws exist in the small group market which helps protect the HIPC from adverse selection.

All HIPCs Provide Some Level Of Employee Choice: While there is some variation among the HIPCs, all provide some level of employee choice of health plans. A few HIPCs place limits on the degree to which employees can choose their plan (e.g., the employer chooses the benefit level and the employee selects the plan). However, the vast majority of HIPCs have no restrictions; the employee is free to select the level of benefits and the plan in which he/she enrolls.

All HIPCs Required Start-Up Funding; Sources Of Funding Vary: Start-up funds are needed to establish a HIPC. The source of the funding varies. California, Florida, Texas, Kentucky, and North Carolina all received at least a portion of their start up funding from their respective states. Start-up funds in the other states came from various sources, including the sponsoring employer groups, foundation grants, and the participating health plans. The actual amount of start-up funds was available from only a few states. In Florida, each of the CHPAs received $275,000 from the state; in Texas, the state provided $250,000 for the statewide HIPC.

Most Services Are Contracted Out; HIPC Staffing Is Minimal: All of the HIPCs contract out most of their administrative functions to a third party administrator or other vendor. The HIPC in Connecticut appears to be an exception; it performs most functions in-house. The number of staff employed by the HIPCs ranges from 2 to 14. As one would expect, the size of the staff depends in large part on the number of participating groups.

There Is Significant Variation In The Number Of Participating Groups And Employees

The number of participating groups and employees varies widely depending on: (i) the size and population of the states, (ii) the length of time the HIPC has been operational, and (iii) the eligibility criteria which determine who is eligible to participate. As an example, Montana, which has a very small population and became operational on January 1,1998, reports only 30 groups and 150 covered lives (i.e. employees and dependents). On the other hand, Florida, which is heavily populated and began operations in 1994 covers 22,500 groups and 90,100 covered lives. California, another heavily populated state which has been operational for several years, covers 7,321 groups and 136,471 covered lives.

Figure 5 provides detailed information about the 11 HIPCs identified by the Academy of Consumer-Choice Health Purchasing Groups.

The Success Of HIPCs Has Been Mixed; Some Have Been Very Successful; Others Have Not Had The Market Impact That Was Anticipated

HIPCs have had varying degrees of success in enrolling small employers and expanding health insurance coverage to this segment of the market. California, Florida and Connecticut are the states most often cited as having had the most success. As noted above, California currently provides coverage to approximately 7,300 groups and 136,500 covered lives. Most notably, California officials indicate that approximately 20% of their employer groups were uninsured prior to joining the HIPC. (Some have argued that a portion of these groups would have purchased coverage from somewhere else if the HIPC had not been available. Nonetheless, the 20% figure is significant.)

California's HIPC originally was established as part of a state agency. However, the enabling legislation required that after five years, the HIPC be operated by a private firm. California just recently completed a procurement process in which a private firm was selected to take over operation of the HIPC.

Florida enrolls the greatest number of groups (22,500) of any of the 11 HIPCs identified by the Academy of Consumer-Choice Health Purchasing Groups. This probably is at least partially due to the fact that self-employed persons (i.e., groups of 1) are eligible in Florida, and not in California. Whereas California has one statewide HIPC, Florida has eight

community-based HIPCs or Community Health Purchasing Alliances (CHPAs). However, the Florida CHPAs do not compete with one another. Each has a specific region of the state in which it operates.

Figure 5
A Comparison of Consumer Choice Health Purchasing Groups

	The Kentucky Health Purchasing Alliance	The Cooperative for Health Ins. Purchasing	Carolliance	HealthChoice	Associated Oregon Industries	Community Health Options
Geographic area	State of KY with 7 rating regions	State of Colorado	State of North Carolina with 4 regional org.	State of Washington with several rating regions	State of Oregon with several rating regions	State of Montana
Size of employers	2-50, indiv. and govt. emp. Mandatory: state emp. Voluntary: local govt.	Any size	Self-employed, individuals and businesses with fewer than 50 employees	Employers with more than 3 employees with focus on those with ≤100	2-50 Oregon employees	Employers with 2 or more employees
Number of employer groups	See Below	Average group size is 10. 1,100 employers.	971 as of 4/1/98	623 groups as of 4/22/98	90 as of 4/98	30
Number of covered lives	Total of 150, 444 public emp. and 14,000 indiv. and comm. emp	17,770	3,947 as of 4/1/98	7,796 employees as of 4/22/98	Approximately 1,500 as of 4/98	150
Legal structure	Independent government agency	Private, cooperative	State chartered, not-for-profit	Information not obtained	Private, non-profit	Taxable, state not-for-profit mutual benefit corporation
Number of participating health plans	13 health plans/ total of 21 different products	4 health plans each offering an HMO and POS plan	3 health plans offering HMO, PPO, and POS plans	4 health plans, each offering all products	3 health plans	2 participating health plans
Standardized benefits	Yes. 18 different plan options that vary in services, delivery model, and co-pay levels	Yes. Employers have a choice of three benefit levels standard, basic, and standard with a POS option	Yes. Three benefit levels: Standard, Basic, and Select	Yes. An HMO product and a POS high and POS low product	Yes. HMO with high and low options and a POS	Yes
Employer or employee choice	Employee	Employee (Employer chooses the benefit level and employee chooses the plan)	Employers who pay 70% or more of the lowest cost plan may choose only 1 plan	Employee choice of health plan and benefit level	Employee (Employer chooses the benefit level and employee chooses the plan)	Employee choice
Start up finding	State funding and grants	A grant from the Hartford Foundation, other grants, and employer contribution	Varies by region State funding	Funding provided by the Association, the participating healthplans, and the Administrator	Funding provided by the Association	Founding large employer members and potentially by participating healthplans
Number of FTEs	9	Not available	All regions have between 2 or 3 employees	The Administrator employs 5-6	Currently 2 FTEs	Currently 1 FTE

Note: Alliances on this chart have a Board of Directors with conflict of interest provisions and members who represent small employer consumers, offer a choice of multiple competing health plans, and have standardized benefits. All alliances meeting these requirements may not be included.

Source: Institute for Health Policy Solutions

Figure 5 (cont'd)
A Comparison of Consumer Choice Health Purchasing Groups

	Health Insurance Plan of California	Florida Community Health Purchasing Alliances (CHPA)	Texas Insurance Purchasing Association	CBIA Health Connections (Connecticut)	The LIA Health Alliance
Geographic area	State of California 6 rating regions	8 CHPAs cover the entire state of FL	State of Texas with 7 service regions	State of Connecticut with 4 rating regions	Long Island, N.Y.
Size of employers	2-50 employee firms	1 to 50 employee firms	2-50	3-50	2-50
Number of employer groups	7,321. Avg. group size is 10 emp	22,500 groups	936 groups. Avg. group size is 6.2 employees	3,800. Avg. groups size is 8 employees	2,500. Average size group is 6-10
Number of covered lives	136,471	90,100	10,131	55,700	16,000
Legal structure	Part of the Managed Risk Medical Ins. Board which is a state agency	State chartered, private, not-for-profit	Private, not-for-profit	Subsidiary of private association of employers	Private, not-for-profit
Number of participating health plans	20 HMOs and 2 POS options	Statewide 34 AHPs offering 75 product options	4 health plans representing HMO, PPO and Indemnity delivery options	4 health plans each offering 2 HMO and 2 POS plans	6 health plans offering 3 versions of an HMO and 2 versions of a POS
Standardized benefits	Yes. A high and low option for each HMO and POS plan	Basic , standard, Plus & Flex options	Yes. 2 Alliance-developed benefit plans, plus 2 state-mandated plans	Yes. Each ins. company must offer a high and a low option HMO and POS. Emp. have a choice of 16 std. insurance products.	Yes. High, low and value HMO options. High, low POS options
Employer or employee choice	Employee	Employers choose plans from which emp. then choose	Employee (Employer chooses benefit level and employee chooses carrier and delivery)	Employee	Employee
Start up funding	Loan from state repaid with a surcharge on premiums	$275,000 per alliance provided by state. State funding ended in 1997.	$250,000 provided by state in 1993	CBIA Service Corp., a for-profit subsidiary of CBIA provided start up funds	Funding provided by the Association and participating insurers
Number of FTEs	14 (All employees also work on 2 other programs)	All CHPAs have 2 or 3 employees	2	12	9

Note: Alliances on this chart have a Board of Directors with conflict of interest provisions and members who represent small employer consumers, offer a choice of multiple competing health plans, and have standardized benefits. All alliances meeting these requirements may not be included.

Source: Institute for Health Policy Solutions

While in Florida and California, the respective state government took an active role in establishing their HIPCs, Connecticut's success has been due to the Connecticut Business and Industry Association (CBIA). The Connecticut HIPC is not supported by the state of Connecticut in terms of legislative action or financial backing. It has been the actions of the CBIA and the business community as a whole which initiated, implemented, and now operates the HIPC. Currently, the CBIA HIPC covers 3,000 groups and 55,700 lives.

The Connecticut HIPC is an example of how a HIPC can be established and maintained successfully through efforts of the business community with limited involvement by state government.

North Carolina officials report less than anticipated results from their HIPC, called "Caroliance." In North Carolina, the State Health Plan Purchasing Alliance Board charters non-profit organizations as an "alliance" to provide health insurance purchasing services to member employers in a market area. Each state-chartered alliance has one or more "community sponsors" which assume responsibility for serving as a host for the alliance. Only one alliance is chartered in each market area. The State Health Plan Purchasing Alliance Board authorizes start-up funding for each alliance. The current enrollment in the North Carolina alliances has been less than expected. Even with individuals and self-employed "groups of 1," the total number of covered lives is only 3,947.

There have been some pooled purchasing arrangements which have failed and had to cease operations primarily because of adverse selection to the HIPC. Adverse selection occurs when a group attracts a disproportionately large number of high risk persons. When this occurs, the HIPC must raise its rates to meet claim expenses. The higher premiums result in the healthier groups disenrolling, leaving behind an even higher risk pool. Eventually, the HIPC can no longer be sustained.

While There Is No Guarantee Of Success For HIPCs, There Are Several Critical Elements That Must Be Addressed

There is no guarantee of success for HIPCs or any other type of pooled purchasing arrangement. And, while there are many important considerations that must be addressed in establishing a HIPC, the experiences and advice of other state HIPC officials, consultants and actuaries have identified several critical elements that must be addressed for the HIPC to have a reasonable chance of success.

Market Rules In And Out Of The HIPC Must Be The Same: Without question, the most critical element is that the insurance market rules the HIPC is required to follow must be the same as those that apply to coverage sold outside of the HIPC. If a HIPC is truly going to "spread risk" among participating employers, the HIPC will need to set premium rates on some form of modified community rating. "Modified community rating" means that the premium paid by an individual group is based, for the most part, on the claims experience of the entire pool, and not just the individual group's experience. This necessarily means that healthier groups will pay a somewhat higher premium to subsidize the less healthy groups. Conversely, because of the healthier groups' subsidies, a less healthy group will pay a lower premium.

If the coverage offered through the HIPC is rated on a modified community rating basis, all products sold outside of the HIPC must be subject to the same rules. If the same rating rules do not apply on <u>all</u> products offered outside of the HIPC, the healthier groups in the HIPC will disenroll resulting in the HIPC having a greater proportion of the "sicker," more expensive groups. The HIPC then has to increase its premiums leading to further "adverse selection." Eventually, the HIPC prices itself out of the market, and no longer can survive.

Brokers/Agents Play A Critical Role In Selling HIPC Products: In the small group market, insurance agents and brokers provide important services to the vast majority of small employers. In order for a HIPC to be successful, the broker/agent community must be involved in the marketing and sale of the HIPC products. Commissions paid to brokers and agents must, at a minimum, provide no disincentive to marketing HIPC products. In addition to commission payments, the HIPC must provide as much support as possible (e.g., training, marketing materials, etc.) to brokers and agents. It also would be very advantageous to involve the broker/agent community in the development of any legislation or other start-up activities.

Start-Up Funding Is Needed: To begin a HIPC, start-up funding is necessary to pay initial costs of development and operation until a premium base is established to provide continuing support. As previously noted, start-up funding in other states has come from multiple sources, both public and private. In many instances, the start-up funding is repaid to the funding source within a given amount of time.

There Must Be A "Champion" For The HIPC: Starting and maintaining a HIPC is difficult. It requires a great deal of work in

marketing and promoting the HIPC, and energizing the small group market, including both employers and carriers. As with any new large scale program, it is essential to have one or more individuals or organizations who "champion" the cause. With respect to HIPCs, it could be business coalitions, several individual businesses, and/or state government. However, whatever other "champions" there may be, the support and commitment of the business community, particularly small employers, is critical. In some states (e.g., Connecticut), it has been the business community alone which has been the catalyst in starting the HIPC. Inasmuch as HIPCs are intended to benefit small employers, there must be strong business support.

The National Association Of Insurance Commissioners Has Adopted Model HIPC Legislation

As with many complex insurance-related issues, the National Association of Insurance Commissioners (NAIC) has adopted model HIPC legislation that states can use when drafting such legislation. The NAIC developed three separate HIPC models: (i) The Single Health Care Voluntary Purchasing Alliance Model Act, (ii) The Regional Health Care Voluntary Purchasing Alliance Model Act, and (iii) The Private Health Care Voluntary Purchasing Alliance Model Act. The NAIC does not express a preference for one model over another. Each of the model acts assumes that the state has enacted substantially the same small group reforms as contained in NAIC's model act for small group reforms. Included in these reforms is modified community rating in the small group market.

The Single Health Care Voluntary Purchasing Alliance Model Act: This act would allow for the establishment by the state of a centralized purchasing entity (HIPC) through which eligible small employers, and self-employed individuals can purchase health coverage. It also clarifies the respective roles and jurisdiction of existing regulatory agencies and the HIPC.

The Regional Health Care Voluntary Purchasing Alliance Model Act: This act provides for a state oversight board that establishes regional purchasing entities (HIPCs) through which eligible employers and self-employed persons can purchase health coverage.

The Private Health Care Voluntary Purchasing Alliance Model Act: This act establishes private competing purchasing entities (HIPCs) through which eligible small employers and self-employed persons can purchase health coverage. The most notable aspect of this model is the "competing

plan" provision. In the other model acts, only one HIPC would be operating in a given area. This model provides for multiple HIPCs in an area.

IV.
Key Issues For Establishing A HIPC In Virginia

As noted in the previous section, there are several critical elements that must be in place in order to successfully establish a HIPC. This section of the report addresses the current small group market reforms in Virginia, the interest of Virginia businesses in establishing a HIPC, and key issues that would need to be addressed prior to establishing a HIPC in the Commonwealth.

Currently, Virginia Does Not Require Modified Community Rating On All Insurance Products Offered In The Small Group Market; If A Virginia HIPC Used Modified Community Rating, Legislation Would Be Needed To Require The Same Rating Method On All Products Offered In The Small Group Market

HIPC officials across the country, as well as health insurance consultants and actuaries, all agree that the single most critical element of a successful HIPC is to have the same rating rules apply to coverage offered inside and outside of the HIPC. To accomplish one of the primary goals of a HIPC, which is spreading insurance risk across a larger number of covered lives, the HIPC must utilize some form of modified community rating when calculating a participating group's premium.

To assure that a Virginia HIPC would not be selected against, the same rating requirements would have to exist throughout the Commonwealth's small group market. However, in Virginia, the only products that are rated on a modified community rating basis are the Essential and Standard Plans marketed to groups of 2-50 employees. Section 38.2-3433 of the Code of Virginia requires health insurance issuers to calculate premium rates for these two plans on a modified community rating basis in which the rate for a given group can deviate 20% above or below the community rate due to claims experience.

In order to have modified community rating in a Virginia HIPC, and to prevent the HIPC from being selected against, legislation would have to be enacted that expands the current modified community rating provisions beyond the Essential and Standard Plans to all products offered in the 2-50 small group market. Historically, with rare exception, the insurance industry has opposed such legislation citing fears that it would help only a few groups and would increase the cost of coverage for many more groups.

In the HIPC states that have required modified community rating across the small group market, there has not been any severe market injury. While the rates for healthier groups will increase somewhat to subsidize the rates for less healthy groups, these states have not reported any significant reduction in the number of small groups purchasing coverage. Where there has been some market disruption, it has been in other states which attempted pure community rating where there are no adjustments allowed to account for differences in health status, etc.

It is not absolutely necessary that a HIPC rate groups on a modified community rating basis. Groups can be experience rated just as they are currently. However, as previously noted, to experience rate small groups in a HIPC does nothing to spread the risk among groups in the pool, thus eliminating one of the primary goals of a HIPC. If groups were experience rated in the HIPC, groups would still have the advantage of increased choice of plans and some administrative efficiencies; however, the overall value of the HIPC is significantly lessened.

Virginia Business Groups Support The HIPC Concept

Through staff interviews, the Virginia Chamber of Commerce, the Virginia Chapter of the National Federation of Independent Business, and the Virginia Manufacturers Association all indicated strong support for the concept of a HIPC.

While these groups support the establishment of a HIPC, there is little or no solid evidence on the number of small employers that would purchase coverage through the HIPC. The concept of a HIPC is relatively unknown to most businesses. Thus, it is difficult to accurately gauge the true level of interest in such an enterprise. Moreover, because the price of coverage is the most critical factor small employers consider in purchasing health insurance, until there are specific products with concrete rates that can be reviewed by businesses, there will always be some degree of uncertainty regarding how many employers would join the HIPC.

While Virginia business groups support the HIPC concept, the business community would have to play a major role in establishing, marketing, and supporting a HIPC for it to be successful.

Small Businesses Express Interest In Purchasing Health Insurance Through A HIPC

The Virginia Department of Business Assistance contacted its Small Business Development Center Network, which includes 24 local sites to gain some insights into small employers' interest in a HIPC. The local small business development centers report that many small employers are interested in purchasing coverage for their employees as a means of attracting and retaining employees. Cost was identified as the main reason why employers do not now offer coverage. The majority of these local sites indicated that employers likely would be interested in pooled purchasing. However, participation in the HIPC would depend on its ability to reduce premiums well below the amount small employers now have to pay. Until specific information on the benefits and costs of a product are available, it is very difficult to get a clear understanding of how many employers would participate in a HIPC.

A HIPC In Virginia Would Require Start-Up Funding

If it is decided to establish a HIPC in Virginia, the HIPC would require start-up funding to cover initial expenses until such time that premium income could support its operation. If the HIPC is administered by a state agency, general funds and perhaps other sources of revenue would need to be provided.

Another possible action for the Commonwealth would be to foster the development of private HIPCs by providing start-up or seed money for any HIPC(s) which met certain criteria established by the Commonwealth. As has been the case in some states, the start-up funds could be in the form of a loan which would be paid back by the state-run or private HIPC.

In The Past, Virginia's Insurance Broker/Agent Community Has Not Supported A HIPC

During past studies of HIPCs by the Joint Commission, the insurance broker/agent community has not supported the establishment of a HIPC. In recent discussions, the broker/agent community did not indicate a clear opposition to HIPCs; rather concerns were expressed about whether a HIPC actually can deliver the benefits and advantages they portend to offer.

As stated in the previous section of the report, to have a successful HIPC in Virginia, it will be crucial to gain the support and active

participation of the broker/agent community. Involving the broker/agent community in any potential legislation that may be drafted may help to alleviate some of their concerns. Without their support, a Virginia HIPC would face a certain and significant uphill battle.

The Code Of Virginia Does Not Prohibit The Private Formation Of HIPCs

Whereas some states have had to enact legislation to allow the formation of HIPCs by private entities, the Bureau of Insurance has indicated that the Code of Virginia does not contain any such prohibitions. As such, if the business community feels strongly that such a purchasing pool would be of significant value, there does not appear to be any provisions in the Code to prevent the establishment of a private HIPC.

A Number Of Association Plans In Virginia Currently Offer Pooled Purchasing To Their Members

As discussed in the background section of this report, association plans offer pooled purchasing of health insurance coverage to their respective members. The key difference between an association plan and a HIPC is that only those association members are eligible for coverage. In a HIPC, any small employer is eligible which expands the potential size of the pool. Another key difference is that in an association plan, one carrier has an exclusive contract to provide coverage to the plan members. In a HIPC, several carriers contract with the HIPC administrator thereby promoting competition among the plans and providing the enrollees a choice of carriers.

"Chamber Select" Plan: There are a number of association plans operating in Virginia. One example of a successful association plan is the Hampton Roads Chamber of Commerce plan, called "Chamber Select." The program began in 1992 and originally served only the members of the Hampton Roads Chamber of Commerce. It has since expanded to include the Chambers of Commerce in many other Tidewater and eastern Virginia localities. Groups up to 99 employees are eligible to join. Currently, there are about 500 groups and 5,000 covered lives in the plan.

In the "Chamber Select" plan, the rates are calculated in the same way that rates are calculated throughout the rest of the small group market. However, if the plan's experience at the end of the rating period is less than the experience of the carrier's overall book of small group business, the difference is returned to the participating employers on a pro rata basis as a

credit on their renewal rates. As an incentive to join the plan, groups are provided "added value benefits" at no extra cost. These benefits include wellness benefits, vision discounts, lower hospital co-pays and free pre-employment drug testing.

V.
THE LOCAL CHOICE Program

THE LOCAL CHOICE Program Was Established in 1989 To Provide An Additional Health Insurance Option For Virginia Localities

Responding to concerns voiced by local school divisions and local governments about the increasing difficulty in purchasing health insurance for their employees, the 1989 General Assembly passed legislation (HB 1116) enabling these groups to purchase health insurance coverage through the auspices of the state employee health benefits program. The program, which is called THE LOCAL CHOICE (TLC), was implemented in 1990.

The Department of Personnel and Training (DPT) administers TLC. Section 2.1-20.1:02 of the Code of Virginia provides statutory authority for the program. All school divisions, local governments, constitutional officers, and other governmental entities established by an Act of the General Assembly are eligible to participate.

DPT has promulgated regulations regarding the administration of the program and the requirements groups must meet in order to participate in TLC. Premiums are calculated based on the size of the participating group. The smallest groups (1-49) are 100% community rated based on the pool's rate; groups of 50-299 enrollees are rated on a combination of the group's experience and the experience of the pool; and the largest groups, over 299 are rated entirely on the group's own experience.

Participating groups are offered the same menu of insurance offerings made available to state employees. Participating groups select the plans they wish to offer their employees; the employees then choose the plan in which they want to enroll. Groups are required to pay a minimum contribution to the cost of coverage on behalf of the employee and any covered dependents. If 75% or more of eligible employees participate in the program, the required contribution to dependent coverage is waived.

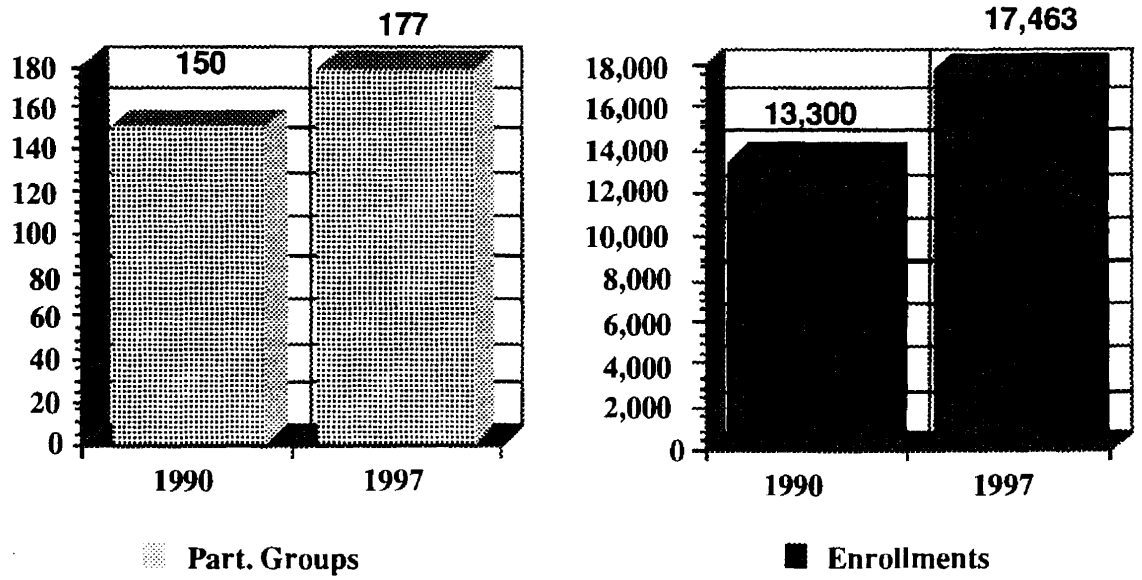
Participation In THE LOCAL CHOICE Has Remained Relatively Stable Since 1990

As seen in Figure 6, the number of groups participating in TLC has grown from 150 in its inaugural year (1990) to 177 in FY 1997. Enrollments have increased from 13,300 in 1990 to 17,463 in FY 1997. Overall, group

participation and enrollment have remained relatively steady in the intervening years.

Figure 6

TLC Participation: 1990 - 1997



Source: Senate Document #21, DPT 1997 Annual Report for THE LOCAL CHOICE Program

Much Of The Success And Stability Of TLC Is Due To The Size And Financial Strength Of The State Employee Program

The financial viability of the state employee program provides a crucial fiscal foundation for TLC. Many of the cost-saving efficiencies of the program are due to the size and fiscal strength of the state employee program. DPT's administration of the program along with the TLC regulations and participation requirements also contribute to the success of the program.

While the TLC program could be used as a model for other HIPCs, without the enrollment base and financial strength of the state program, the likelihood of success is lessened.

Expanding TLC To Include Small Employers Would Result In Administrative Difficulties For DPT

The experience of insurance carriers indicates that administering benefit programs for some small employers creates administrative difficulties due to businesses closing or being unable to meet premium payments. Although some states allow private companies to join their HIPC along with government workers, adding small employers to those eligible for TLC would create a number of administrative difficulties at DPT which would increase administrative costs and potentially injure the existing program. Also, many small employers likely would not be able to meet the premium contribution requirements of the program.

Community Health Centers And Free Clinics Provide Valuable Services To Virginia's Indigent And Uninsured Population And May Benefit From Participation In TLC

Virginia's Community Health Centers (CHCs) and Free Clinics play a critical role in providing health care services to Virginia's indigent and uninsured populations. Virginia's 45 CHCs provide care to approximately 130,000 patients. According to the Virginia Primary Care Association, 21% of the CHCs' patients were in families with income below the federal poverty level and one-third of their patients were uninsured. Virginia has 32 Free Clinics which provide free medical and dental care and prescription medications to indigent and uninsured persons. In 1997, the Free Clinics provided $17.4 million of health care to nearly 37,000 Virginians. Without the CHCs and Free Clinics, thousands of indigent and uninsured Virginians likely would go without proper medical care or would access care in expensive emergency room settings.

The CHCs and Free Clinics indicated last year during the Joint Commission's study of Virginia's indigent and uninsured populations that they face difficulties in providing affordable health insurance for their employees. These groups also expressed interest in the possibility of participating in TLC. While adding small employers in general to TLC would cause administrative difficulties, staff at DPT indicated that expanding eligibility for the program to include the CHCs and Free Clinics would not pose the same difficulties. The key reasons are: (i) there is a limited number of CHCs and Free Clinics (approximately 75); (ii) CHCs and Free Clinics have greater permanence and longevity than some small employers; and (iii) each of the CHCs and Free Clinics has a Board of Directors to which the individual centers and clinics are accountable.

DPT officials indicated that if eligibility were to be expanded to CHCs and Free Clinics, a separate rating pool would be established which would prevent any possible negative affect on the rates being charged existing TLC groups.

After Reviewing TLC Premium Estimates, Only A Few CHCs and Free Clinics Indicated Interest in the Program

DPT calculated premium rates for the CHCs and Free Clinics to ascertain whether TLC would be beneficial to the groups in terms of the coverage available and the premiums. After reviewing the premium estimates, only a few of the CHCs and Free Clinics indicated a continuing interest in the program. Most of the CHCs and Free Clinics stated that the TLC premiums did not represent any significant savings over their current plans.

VI.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue. Also, in some instances, the policy options may not be mutually exclusive of one another; combinations of certain options can be implemented.

Option I. **Take no action**

- This option is offered due to the fact that current Virginia statutes do not prohibit employer groups from forming a HIPC. Also, this option is offered in light of Congress' consideration of legislation that would create private Healthmarts.

Option II. **Introduce a joint resolution to form a task force comprised of representatives of the insurance industry, the business community, consumers, and the broker/agent community to draft a bill for introduction during the 2000 General Assembly Session which would establish a statewide HIPC.**

- This task force would not be charged with further study of the issue. Instead it would be charged with determining the most appropriate provisions to be included in the legislation and actually drafting a bill.
- Pursuing this option would reflect a decision to establish a HIPC in Virginia.

Option III. **Introduce legislation to extend the existing modified community rating requirement for the Essential and Standard plans to all products sold in the small group (2-50) market.**

- This option could be pursued this year or could be part of the legislation that would be introduced in 2000 should Option II be pursued.

Option IV. **Introduce legislation to amend §2.1-20.1:02 to make Community Health Centers and Free Clinics eligible to participate in THE LOCAL CHOICE program in accordance with the current program regulations. The legislation would include a three-year sunset provision.**

Option V. **Introduce legislation and accompanying budget amendments to establish a state fund which would provide start-up funding to assist private HIPCs that are established in Virginia and meet certain criteria and requirements.**

APPENDIX A

Appendix A

SENATE JOINT RESOLUTION NO. 124

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training, to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics.

Agreed to by the Senate, March 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, pursuant to Senate Joint Resolution No. 298 of the 1997 Session of the General Assembly, the Joint Commission on Health Care recently completed a comprehensive study of how to reduce the number of uninsured persons in Virginia; and

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, the percentage of Virginia's uninsured adults who are employed full time has increased from 41 percent in 1993 to 57 percent in 1996; and

WHEREAS, when purchasing health insurance coverage, small employers generally pay higher administrative costs, have less negotiating power with insurance carriers, often are considered a greater insurance risk, and pay higher premiums than large employers; and

WHEREAS, because of the difficulties small employers face in purchasing health insurance coverage, the percentage of employees who are uninsured is much greater among small employers than large employers; and

WHEREAS, there are 42 community health centers and 30 free clinics across the Commonwealth which provide valuable health care services to many of Virginia's uninsured and indigent persons; and

WHEREAS, through the Joint Commission on Health Care's study of the indigent and uninsured, it was determined that the community health centers and free clinics have encountered many of the same difficulties as other small employers in purchasing health insurance coverage for their employees; and

WHEREAS, health insurance purchasing pools enable small employers to "pool" their purchasing power, a practice which provides them with many of the same purchasing advantages of large groups; and

WHEREAS, at least 20 states have enacted laws to establish state-sponsored health insurance purchasing pools or encourage the development of private pools; and

WHEREAS, Virginia's business community has expressed significant interest in pursuing the possible development of a health insurance purchasing pool for small employers; and

WHEREAS, detailed study and analysis are needed to determine more definitively the type of pooled purchasing arrangement that would be of the greatest interest to small employers and the key elements that would need to be included for such an arrangement to be successful in Virginia; and

WHEREAS, pursuant to §2.1-20.1:02 of the Code of Virginia, the Department of Personnel and Training administers THE LOCAL CHOICE program as an optional health insurance program for local governments, school divisions, constitutional officers, and other governmental entities which can elect to purchase health insurance coverage for their employees through the program; and

WHEREAS, THE LOCAL CHOICE program functions in many respects like a pooled purchasing arrangement and provides many purchasing advantages for small governmental entities; and

WHEREAS, THE LOCAL CHOICE program has been successful since its inception in 1990, is financially strong, and currently provides health insurance to approximately 190 groups and 22,000 eligible employees; and

WHEREAS, additional study of THE LOCAL CHOICE program is needed to determine the advantages and disadvantages of expanding the program to include small employers, community health centers, and free clinics, without causing any adverse impact on the groups currently participating in the program; 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, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training be directed to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics. The Joint Commission also shall consult with health care consumer advocates in conducting the study. The Joint Commission's study shall include, but not be limited to, (i) evaluating the pooled purchasing arrangements operating in California, Florida, and other states; (ii) assessing the level of interest among Virginia's small employers in participating in a health insurance purchasing pool; (iii) analyzing the key elements of such a purchasing pool to maximize the number of participating employers; and (iv) identifying health

insurance market reforms or other actions necessary to ensure the success of a purchasing pool; and, be it

RESOLVED FURTHER, That, as part of its study, the Joint Commission shall study THE LOCAL CHOICE program and its potential as a model for pooled purchasing of health insurance for small employers, community health centers and free clinics. In conducting this portion of its study, the Joint Commission on Health Care shall also consult with the Department of Personnel and Training, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Manufacturers Association, the Virginia Chapter of the National Federation of Independent Businesses, the Virginia Primary Care Association and the Virginia Association of Free Clinics. Actuarial work, estimated to cost $50,000, will be required for the Joint Commission on Health Care to complete the study.

The Joint Commission on Health Care shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 202

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training, to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics.

Agreed to by the House of Delegates, March 12, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, pursuant to Senate Joint Resolution No. 298 (1997), the Joint Commission on Health Care recently completed a comprehensive study of how to reduce the number of uninsured persons in Virginia; and

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, the percentage of Virginia's uninsured adults who are employed full-time has increased from 41 percent in 1993 to 57 percent in 1996; and

WHEREAS, when purchasing health insurance coverage, small employers generally pay higher administrative costs, have less negotiating power with insurance carriers, often are considered a greater insurance risk, and pay higher premiums than larger employers; and

WHEREAS, because of the difficulties small employers face in purchasing health insurance coverage, the percentage of employees who are uninsured is much greater among small employers than larger employers; and

WHEREAS, there are 42 community health centers and 30 free clinics across the Commonwealth which provide valuable health care services to many of Virginia's uninsured and indigent persons; and

WHEREAS, through the Joint Commission on Health Care's study of the indigent and uninsured, it was determined that the community health centers and free clinics have encountered many of the same difficulties as other small employers in purchasing health insurance coverage for their employees; and

WHEREAS, health insurance purchasing pools enable small employers to "pool" their purchasing power which provides them with many of the same purchasing advantages of larger groups; and

WHEREAS, at least 20 states have enacted laws to establish state-sponsored health insurance purchasing pools or encourage the development of private pools; and

WHEREAS, Virginia's business community has expressed significant interest in pursuing the possible development of a health insurance purchasing pool for small employers; and

WHEREAS, detailed study and analysis is needed to determine more definitively the type of pooled purchasing arrangement that would be of the greatest interest to small employers and the key elements that would need to be included for such an arrangement to be successful in Virginia; and

WHEREAS, pursuant to §2.1-20.1:02 of the Code of Virginia, the Department of Personnel and Training administers THE LOCAL CHOICE program as an optional health insurance program for local governments, school divisions, constitutional officers, and other governmental entities which can elect to purchase health insurance coverage for their employees through the program; and

WHEREAS, THE LOCAL CHOICE program functions in many respects like a pooled purchasing arrangement and provides many purchasing advantages for small governmental entities; and

WHEREAS, THE LOCAL CHOICE program has been successful since its inception in 1990, is financially strong, and currently provides health insurance to approximately 190 groups and 22,000 eligible employees; and

WHEREAS, additional study of THE LOCAL CHOICE program is needed to determine the advantages and disadvantages of expanding the program to include small employers, community health centers, and free clinics, without causing any adverse impact on the groups currently participating in the program; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Association of Health Maintenance Organizations, the Virginia Hospital and Healthcare Association, and the Department of Personnel and Training be directed to study various issues regarding pooled purchasing arrangements for health insurance for small employers, community health centers, and free clinics. The Joint Commission shall consult with health care consumer advocates in conducting the study. The Joint Commission's study shall include, but not be limited to, (i) evaluating the pooled purchasing arrangements operating in California, Florida, and other states; (ii) assessing the level of interest among Virginia's small employers in participating in a health insurance purchasing pool; (iii) analyzing the key elements of such a purchasing pool to maximize the number of participating employers; and (iv) identifying health insurance market reforms or other actions necessary to ensure the success of a purchasing pool; and, be it

RESOLVED FURTHER, That, as part of its study, the Joint Commission shall study THE LOCAL CHOICE program and its potential as a model for pooled purchasing of health insurance for small employers, community health centers and free clinics. In conducting this portion of its study, the Joint Commission shall consult with the Department of Personnel and Training, the Department of Business Assistance, the Virginia Chamber of Commerce, the Virginia Manufacturers Association, the Virginia Chapter of the National Federation of Independent Business, the Virginia Primary Care Association and the Virginia Association of Free Clinics. Actuarial work, estimated to cost $50,000, will be required for the Joint Commission on Health Care to complete the study.

The Joint Commission shall submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: POOLED PURCHASING STUDY (SJR 124/HJR 202)

Individuals/Organizations Submitting Comments

A total of 12 individuals and organizations submitted comments in response to the draft issue brief on pooled purchasing for small employers.

- Trigon, BlueCross BlueShield
- Blue Cross Blue Shield of the National Capital Area
- Virginia Association of Health Plans
- American Association of Retired Persons (AARP)
- Virginia Hospital and HealthCare Association
- Virginia Chamber of Commerce
- Independent Insurance Agents of Virginia
- Judith Clarke Consultants
- Virginia Manufacturers Association
- Virginia Association of Free Clinics
- Virginia Primary Care Association
- Virginia Association of Health Underwriters, Virginia Association of Life Underwriters, and Association of Health Insurance Agents (combined response)

Policy Options Included in the Pooled Purchasing Issue Brief

Option I. **Take no action**

Option II. **Introduce a joint resolution to form a task force comprised of representatives of the insurance**

industry, the business community, consumers, and the broker/agent community to draft a bill for introduction during the 2000 General Assembly Session which would establish a statewide HIPC.

Option III. **Introduce legislation to extend the existing modified community rating requirement for the Essential and Standard plans to all products sold in the small group (2-50) market.**

Option IV. **Introduce legislation to amend §2.1-20.1:02 to make Community Health Centers and Free Clinics eligible to participate in THE LOCAL CHOICE program in accordance with the current program regulations. The legislation would include a three-year sunset provision.**

Option V. **Introduce legislation and accompanying budget amendments to establish a state fund which would provide start-up funding to assist private HIPCs that are established in Virginia and meet certain criteria and requirements.**

Overall Summary of Comments

Overall, the comments reflected a clear difference of opinion between insurance companies and insurance agents and the business community regarding the most appropriate approach for the Commonwealth to take regarding pooled purchasing. Each of the insurance companies/associations and insurance agent associations expressed concern about establishing a health insurance purchasing cooperative (HIPC) and any further small group insurance reforms (i.e., modified community rating). These groups question whether a HIPC will be able to do anything that improves the affordability and availability of coverage for small employers. These groups also commented that, since there is no prohibition in the Code to prevent private entities from establishing a HIPC, the Commonwealth should let the private sector respond to the demand for pooled purchasing.

On the other hand, the business groups which submitted comments support establishing a HIPC and urge the Joint Commission to pursue Option II to set up a task force to draft legislation for the 2000 Session. The Virginia Hospital and Healthcare Association, AARP and Judith Clarke also supported Option II. The Virginia Association of Free Clinics and the Virginia Primary Care Association commented that their organizations continue to have an interest in participating in THE LOCAL CHOICE (TLC) program. However, subsequent to their review, only a handful of their respective members expressed a continuing interest in the program.

Summary of Individual Comments

Trigon BlueCross BlueShield

Leonard Hopkins, Vice President, Public Policy Officer, commented that given the understanding there are no prohibitions in the Code against the formation of HIPCs by private entities, and given the complexity, expense, and bureaucracy incident to establishing a government run HIPC, it would seem most appropriate to let the private sector determine and respond to the demand for HIPCs. Mr. Hopkins also noted that if start-up money for private HIPCs proves to be a problem, the Commonwealth could consider at a later date the advisability of establishing a state fund to provide start-up money.

Mr. Hopkins commented in support of allowing the Community Health Centers and Free Clinics to participate in THE LOCAL CHOICE program. Lastly, Trigon commented that it continues to have significant concerns about any extension and expansion of modified community rating.

Blue Cross Blue Shield of the National Capital Area

Gail M. Thompson, Director of Government Affairs, commented in support of Option I (Take No Action). Ms. Thompson commented that it may be prudent for the Joint Commission to defer any recommendation to support the development of a HIPC until the employer community develops a specific proposal. She also noted that BCBSNCA is concerned that a significant bureaucratic structure is generally necessary to support pooled purchasing arrangements. Ms.

Thompson also commented that BCBSNCA believes that a modified community rating reform represents a significant change to the existing small employer market and merits careful study and discussion.

American Association of Retired Persons (AARP)

Norma L. McDonough, William L. Lukhard, Jack R. Hundley, and Mary H. Madge commented on behalf of AARP and stated that AARP supports purchasing cooperatives when they are established to enhance access to health coverage and expand choice of health plans for individuals. They also commented that HIPCs should not restrict participation on the basis of demographic characteristics, health status or source of employment. HIPCs also should provide consumer access to grievance and appeals procedures. They noted that AARP supports Option II and that regional HIPCs should be considered. AARP also supports Option III but believes it should be an integral part of Option II if pursued in 1999. Otherwise, Option III should be pursued independently.

Virginia Association of Health Plans (VAHP)

Mark C. Pratt, Executive Director, commented that while pooled purchasing for small businesses may make sense on a conceptual or voluntary basis, VAHP is not convinced that a state-mandated HIPC is the appropriate solution for addressing the problem of the affordability and availability of health insurance for small employers. Mr. Pratt also noted that VAHP opposes Option III because of concern that the cost of coverage would increase for many groups. He also noted that because the Code of Virginia does not prevent private entities from establishing a HIPC, it may be prudent to let the private sector respond before putting in place a government-run program.

VAHP believes it is premature for the Joint Commission to recommend Option II; however, if a task force is formed, it would like to participate. Lastly, the VAHP has no position on Option IV and that Option V is a decision the General Assembly can make only after deliberating over budgetary constraints and priorities.

Virginia Hospital and HealthCare Association (VHHA)

Christopher S. Bailey, Senior Vice President, commented that the VHHA believes there is evidence that supports the notion that, if properly structured and managed, pooled purchasing arrangements hold much promise for improving the availability and affordability of health insurance for small employers. Accordingly, the VHHA supports Option II. Mr. Bailey noted that Option II would clearly express the Commonwealth's intent to implement a pooled purchasing arrangement, but would do so in a way that would allow stakeholders time to craft the important supporting policies (e.g., small employer market reform), and design an approach that best fits the Virginia context.

Virginia Chamber of Commerce

Sandra D. Bowen, Senior Vice President, commented that the Chamber has experienced frustration at the inability of the Joint Commission to advance a concrete proposal for pooled purchasing. Ms. Bowen stated that the Virginia Chamber supports pursuit of Option II. She noted that the Task Force must be composed of technical experts in insurance and actuarial science, including benefits consultants, brokers and agents, actuaries, and others with specific technical expertise. She also suggested that the Task Force report to the Joint Commission by September 1, 1999 and that the report include draft legislation.

Ms. Bowen indicated that the Virginia Chamber does not support legislation in 1999 to extend modified community rating to all products in the small group market. Any proposals should await the recommendations of the Task Force. Lastly, Ms. Bowen indicated the Chamber is ready to "champion" new pooled purchasing arrangements.

Independent Insurance Agents of Virginia (IIAV)

Mr. Theodore L. Smith, President, commented that the IIAV challenges the underlying assumption that small employers are uninsured due to the failure to find adequate or affordable coverage. He stated that while some are uninsured, many small employers

choose to be uninsured due to the associated costs. Mr. Smith noted that the IIAV is not convinced that HIPCs will do anything to reduce the population of uninsureds. He commented that IIAV does not believe the Commonwealth should be involved in funding HIPCs; this would lead the Commonwealth into the insurance business in direct competition with the private market.

Mr. Smith commented in opposition to modified community rating as it will drive up costs for the healthy groups. Lastly, he stated that HIPCs will have an adverse impact on the individual market and that there is a high probability that poor service may result from pooling groups.

Judith Clarke Consultants

Judith T. Clarke, President, commented that to take no action (Option I) would not be in the best interests of small employers and that the state of Virginia would benefit from establishing a purchasing pool for the indigent and working poor. She noted that a state-owned statewide HIPC may further reduce its premiums through a merger with a private, statewide HIPC. Ms. Clarke commented that modified community rating of all small group products is widely accepted in other states and is critical to the survival of a HIPC. She also noted that the insurance industry is familiar with this idea and willing to accept this change.

Ms. Clarke commented in opposition to allowing Free Clinics and Community Health Centers in THE LOCAL CHOICE program. Lastly, she stated that she is interested in forming a HIPC and would like to have support from the Commonwealth in the form of a loan which would be paid back over a number of years.

Virginia Manufacturers Association

Robert P. Kyle, Vice President, commented that the threshold question is posed by Option III. He noted that the HIPC cannot survive if better risks are skimmed out of its membership. He also commented that unless the General Assembly is willing to "level the playing field," it should discard the concept of pooled purchasing arrangements. Mr. Kyle commented in support of Option II not as a

vehicle for further study but as a commitment by the Joint Commission to produce legislation for an "up or down" vote by the Commission in 1999, and surviving that, for introduction in the 2000 Session.

Virginia Association of Free Clinics

Mr. Mark Cruise, Executive Director, commented that approximately one-half of the 32 Free Clinics report that they provide no health insurance benefits. Mr. Cruise indicated that the Free Clinics are reviewing premium estimates from the Department of Personnel and Training for THE LOCAL CHOICE program and will provide additional comments to the Joint Commission following their review.

Virginia Primary Care Association (VPCA)

Mr. John B. Cafazza, Executive Director, commented that the proposed inclusion of Community Health Centers in THE LOCAL CHOICE (TLC) program has the potential to help health centers provide their employees with quality benefits at a possible savings over current benefits. The VPCA's initial review of TLC rates indicates that a number of centers are offering similar benefits at costs equal to or less than TLC. Mr. Cafazza noted, however, that until their review is complete, VPCA continues to be interested in this option.

Virginia Association of Health Underwriters, Virginia Association of Life Underwriters, and Association of Health Insurance Agents (combined response)

Ms. Susan Maley Rash and Mr. Richard Herzberg commented that, as noted in the issue brief, insurance agents have concerns about whether a HIPC actually can deliver the benefits and advantages they portend to offer. One such concern is about standardizing benefits. Another concern pertains to legislated modified community rating. Ms. Rash and Mr. Herzberg noted that the market has already begun to adopt a modified community rating approach. The agent associations oppose Option III. Ms. Rash and Mr. Herzberg noted they cannot support Option II as presently worded because it suggests a commitment to establish a HIPC from the outset. They would like to

be included, however, if a task force is created. Lastly, they noted that studies have shown states with aggressive small group reforms have increased the number of uninsured persons.

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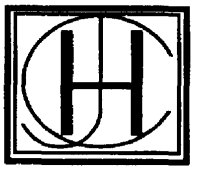

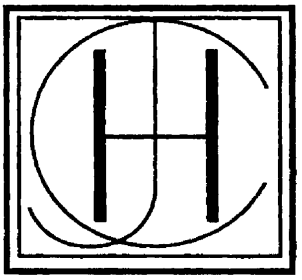

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