Development and Role of Purchasing Coalitions

5

As was previously discussed, many employers in the Twin Cities have begun to restructure the way in which they purchase health care (60). Their actions have had a major influence on health plans and have contributed to the ongoing reconfiguration of the health care delivery system in the Twin Cities. In this chapter, several of these efforts are addressed. First, the development of the Business Health Care Action Group (BHCAG), a consortium of major employers in the Twin Cities, and the implementation of its purchasing approach are discussed. Second, the ● 'managed competition" approach used by the State of Minnesota Group Insurance Program to purchase health care for 144,000 individuals in Minnesota is described. This program has been cited as one example of how a "health alliance" might function under the Clinton Administration's health care reform proposal. Finally, two approaches--one public and one private--to the formation of insurance pools for health care purchasing are examined.

BUSINESS HEALTH CARE ACTION GROUP

Formation

During 1988, several large private-sector firms headquartered in Minneapolis/St. Paul formed a coalition called the Business Health Care Action Group to lobby for health care reform. During the fall of 1991, the coalition decided to create a health plan for their employees and dependents. All of the firms were self-insured, and they ranged in size from 8,000 to 200,000 employees nationwide. BHCAG contracted with a benefit consulting firm to develop a request for proposals (RFP) that could be circulated to potential provider groups and third-party administrators. The resultant RFP was a very detailed document in which potential bid-

rs were asked to identify the specific sources of high-cost, complex technological services such as MRIs, lithotripsy, and hemodialysis, and to specify the volume of services provided by those sources during the past year. Bidders were also requested to submit the credentials of the physicians providing these services along with any available information on clinical outcomes. The benefit package included in the RFP was based on the existing programs offered by the sponsoring firms and, consequently, included an extensive array of services consistent with the traditionally generous health care benefits of these firms.

Six health care provider groups bid on the BHCAG request for proposals. These firms included two large HMOs (MedCenters Health Plan and Group Health, Inc.) that joined together to respond to the RFP, Medica health plan (a large independent practice association HMO), Blue Cross and Blue Shield of Minnesota, and Preferred One (a hospital-owned PPO). The MedCenters/Group Health coalition (HealthPartners) was the successful bidder, although at least one other bidder offered the services at a lower price. However, Health Partners and its providers were judged to be In a position to provide services that were more appropriate and accessible while still assuring that complex technological procedures were appropriately limited to settings with highly qualified personnel, extensive experience, and sufficient volume to assure quality of care.

The network offered by Health Partners includes approximately 1,000 primary care providers practicing in over 175 primary care clinic sites. The network's primary care physicians are supported by more than 4,000 specialty physicians, nearly 30 community hospitals and specialty hospital "centers of excel lence." When enrollees join the pian, they must select a primary care clinic within the network. However, each member of the family may choose his or her own clinic and can choose a physician from among those practicing at the selected clinic. The clinics have different policies concerning access to specialty care. Most c1inics require that a patient receive a referral by a primary care physician before making an appointment with a specialist. If enrollees seek care outside the network, they have a lower level of benefit coverage and must submit claims forms.

| Implementation

At the firm level, the Health Partners product is being offered as the basic self-insured plan. Most employers offer employees an option to enroll in this plan or select one of the other plans offered by their employer. Currently, employers are offering their employees two or three competing plans, but it is generally assumed that these plans will be replaced over time with new health plans that contract with BHCAG. In most cases, the employer's contribution to an employee's health plan is 1imited to the contribution that would be made to the BHCAG plan.

During the first year of operation, 10 of the 14 coalition members offered the BHCAG health plan. During 1993, an additional eight employers joined the coalition, bringing total membership to 22 companies. While interest was reported to be high, many of the firms had employee and union contractual agreements and commitments to other providers that made it difficult to shift to the BHCAG plan. During 1992, the first year of' the Health Partners' contract, 55,000 employees enrolled, with about 70 percent of these being previous MedCenters or Group Health members. It is anticipated that enrollment will grow to 85,000 enrollees during 1994, representing about 30 to 35 percent of the eligible employees.

Although the BHCAG plan is modeled on the HMO concept, it is not currently operating on a c:apitation basis. Instead, providers are paid on a fee-for-service basis. Each employer has a contract with the providers. To do otherwise would violate the self-insured provisions of ERISA and would place the program under the supervision of the state insurance commissioner. This reportedly would limit the flexibility of employers in structuring their benefit package. Currently, there is no standard fee schedule. Rather, fees are negotiated, often resulting in discounts of 20 to 30 percent. BHCAG is experimenting with severity measures to adjust fees, and is attempting to implement the Johns Hopkins Ambulatory Care Groups method-

ology for selected cases. Health Partners is paid a set fee (currently 8 percent of total expenditures) to administer the program. BHCAG employers estimate that the plan reduced their expected health care costs for the enrolled employees by about 10 percent during 1993 compared with similar coverage available through competing managed care products.

Programs for Quality Improvement

The BHCAG quality improvement program consists of both clinical guidelines focused on cost-effective modalities and clinical outcomes assessment programs. Eight of the provider medical groups have volunteered to serve as pilot sites for testing and implementing guidelines. Sixteen guideline topics were selected for the initial program, and installation of these guidelines is now under way at pilot medical groups. In total, 18 medical groups will participate in guideline development and implementation, representing about 88 percent of the volume of care delivered by participating providers in the BHCAG health plan.

Six clinical indicators have been identified to begin benchmarking quality across the BHCAG provider network (table 5-1). Joint purchaser/provider assessment of new and emerging technologies is another key quality control initiative. During 1993, a joint purchaser/provider group was established to review the effectiveness of certain medical technologies. The scientific assessment of these technologies will be linked to benefit coverage decisions. Topics reviewed to date include: cochlear (ear) implants, bone marrow rescue with chemotherapy for breast cancer, laser surgery to correct vision problems, pancreas transplants, chest compression devices for cystic fibrosis, immune globulin for neurological conditions, lung transplantation, and PSA for prostate cancer screening. Development of a prototype automated medical record will be completed by the end of 1993.

Implications

The employers who formed BHCAG feel that knowledgeable purchasing groups are the key to restructuring the health care system. To that end, they believe BHCAG has the responsibility to develop quality assurance programs, structure health plans, and use its purchasing power to create competing cost-effective provider systems. From this perspective, they view BHCAG as a community service as well as a service to the member firms. Consequently, although BHCAG plans to invest at least $30 million in the development of practice guidelines, these guidelines will be available at no cost to non-BHCAG health care providers as well as competing health insurance plans.

According to BHCAG'S annual report, the average cost to employees for single coverage is $1,200, while family coverage is $2.500. BHCAG estimates its savings in the first year to be about 11 percent. However, it cautions that approximately 2 percent of these savings are due to higher copayments and another 2 percent are due to state taxes and fees not payable under self-funded plans.

BHCAG has expressed strong support for competitive markets for health services. However, its actions helped precipitate the merger of two large HMOs—MedCenters and Group Health. In response to criticisms that it has not promoted a competitive health plan market in the Twin Cities, BHCAG has stated its intention to offer other products in the near future to member firms in competition with the current health plan--HealthPartners. These products presumably will offer more choices with respect to benefit coverage, providers, and coinsurance and deductible provisions.

THE STATE OF MINNESOTA GROUP INSURANCE PROGRAM

The State of Minnesota Group Insurance Program (or State of Minnesota Employees Health Benefit Program) covers 57,000 employees. Along with dependents and retirees, the number of lives covered by the program is approximately 144,000, making it the largest employer-based health insurance group in the state. State employees work in every county in Minnesota and,

TABLE 5-1: BHCAG Clinical Indicators for Quality Indicators

Breast cancer
% of women with mammogram ordered
% of women aged 50-74 with mammogram
% of newly diagnosed cases stage I or less
% of diagnosed cases stage II or less
Total hlp replacement
Measure of functional status before and after surgery
Childbirth
Vaginal birth after C-section rate
C-section rate
% of deliveries that occur at <37 weeks
Heart disease
30-day mortality following Coronary Artery Bypass Graft
Childhood infectious disease
% of children aged 27 months who have had lmmunizations recommended by the Minnesota Department of Health
Asthma in children
Rate of hospital admssion for asthmatic children aged 0-18 years

SOURCE Business Health Care Action Group, *7993 Annua/Repor,* Mmnetonka, MN, 1993

therefore, the state's health benefits program must serve the needs of people in urban and rural areas, and in areas with and without HMOs.

| Eligibility

Employees and their dependents are eligible to enroll. However, spouses of eligible employees who can participate in their own plan, but who have received cash or credit not to participate, are ineligible for state health benefits. There is a 28-day wait for eligibility from the point of hiring. Upon becoming eligible, the employee has an open enrollment choice of plans. Moving to an area where the employee's plan is not available is the only situation in which the employee is allowed to change plans between scheduled annual open enrollment periods. If the employee moves to a county where the present plan is offered but where the employer's premium contribution is different, the contribution is frozen at the previous level for the rest of the year.

| History -

The original health plan offered to state employees before the advent of HMOs, and the only plan available to employees statewide, was a fee-for-service, Blue Cross and Blue Shield of Minnesota product. During most of the 1980s, this plan enrolled half or more of the State of Minnesota group. By state law, any HMO that wished to be offered to state employees was allowed into the state employees' program. As a result, the state offered a large number of HMOs--at times as many as 10. Under the same law, the state's contribution toward the cost of health insurance was tied to the fee-for-service premium--100 percent contribution for employee coverage and 90 percent for dependent coverage. Employees did not receive a premium rebate if they picked an HMO that cost less than the fee-for-service plan, but they had to pay the difference if they picked a more expensive plan. HMO rates tended to cluster near the fee-for-service rate. The rates submitted by the HMOs and Blue Cross/Blue Shield were not examined criticall y by the state. In other words, the State of Minnesota was a fairly typical large employer offering multiple health plans.

During 1985 the state consolidated its HMO offerings and changed the basis for determining its premium contribution. The number of HMOs participating in the state employee's program fell from a high of 10 to 6 at the beginning of 1990. This reduction occurred for a variety of reasons, including: the 1985 repeal of the law requiring an open-door policy toward HMOs; HMO attrition and mergers; rejection of applications to join the plan submitted by HMOs that did not meet the state's criteria and objectives; departure of an HMO that could not maintain reasonable premium rates; and, an insurer or HMOs no longer being allowed to offer more than one option to employees or to add plans at its own initiative. Offering fewer HMOs resulted in larger market shares for the remaining plans and provided a chance for them to gain even more enrollees by offering an attractive, well-managed plan. Offering fewer HMOs also diminished the prospects for biased selection and eliminated the possibility that health

plans could add options to undercut a competitor's position and/or to ● *shore up" an existing plan.

The most significant reform during this period was changing the formula for determining the employer contribution. The state, through collective bargaining with 10 unions that represent state employees, replaced the formula based on the fee-for-service plan with one based on the low-cost carrier (health plan) serving a given county. Under the new formula, which was adopted in October 1985 for the 1986 contract year, the state continued to pay 100 percent of the premium for employee coverage and 90 percent for dependent coverage, but the contribution was based on the low-cost carrier in each county rather than the fee-for-service plan premium. To be eligible to be the low-cost carrier, health plans were required to serve the entire county.

In the first few years after the low-cost carrier formula was introduced (from 1986 through 1988), the fee-for-service plan continued to have the lowest rate and remained the basis for the employer contribution. (From 1985 to 1988, the state continued to contract with an outside vendor for its computerized payroll systems, and this vendor had difficulty implementing the low-cost formula. For that reason, HMOs may not have fully reacted to the low-cost carrier program until the computer system was changed in 1989.) Over time, however, the HMOs were able to offer lower rates despite offering better coverage. In 1989, seven different HMOs were low-cost carriers in at least some part of the state. (Plans submit one statewide premium, but not all plans are offered in all count ies, so d ifferent plans are the low-cost carrier for different counties.)

Introduction of the low-cost carrier formula led to striking changes in the pattern of health plan premiums, as shown in tables 5-2, 5-3, and 5-4. HMO premium rates in 1988 (the last year before the formula began to have an impact) still tended to cluster around the fee-for-service rate. Premiums for the four largest HMOs (Group Health, Share, MedCenters, and Physicians Health Plan) averaged 112 percent of the low-cost fee-for-service plan sponsored by BCBSM. Table 5-5 shows the trend in average total premiums (the portion paid by both the employer and employee) for single and family contracts for all state employees (not just Twin Cities' employees) from 1980 to 1994. These average premiums reflect not only changes in premiums from year to year, but also changes in the health plans' market shares. The transition period to the low-cost program (1985-1988) was chaotic, characterized by wild swings in premiums. During much of this period, the premium growth rate was above the national average. Since 1989, however, the percentage increase in total expenditures on health insurance by the state and its employees has fallen steadily to less than 3 percent in the period 1993 to 1994 and has been below the national average (62).

The low-cost carrier formula created a substantial incentive for plans to submit the lowest possible rate regardless of the fee-for-service rate. Holding the premiums of other plans constant, each health plan knows that a $1.00 increase in its premium will *reduce* the employee's out-of-pocket premium differential between itself and higher cost plans by $1.00 and *increase* the premium differential between itself and lower cost plans by $1.00. The effect of both types of changes resulting from a premium increase will be to decrease the health plan's market share. The new formula enhances regional competition among HMOs even if a plan is not the low-cost carrier in the Twin Cities, it may be low-cost in another area.

Since 1989 Group Health, a staff model HMO, has been the low-cost carrier in every county in which it was offered with family premiums sometimes $1,500 per year below those of competing plans. In contrast, independent practice association-model HMOs with open networks, and plans that allow out-of-network coverage, have had the highest premium rates. This pattern was not evident until the low-cost carrier formula took effect. Over the period 1988 to 1994 it is interesting to note the experience of the two largest plans: BCBSM, which evolved into the "State Health Plan" option, and Group Health. The BCBSM plan typically was the most expensive or second most expensive plan during that period, while Group Health was consistently the lowest cost

TABLE 5-2: Annual Premium For Family Health Coverage in Minnesota State Program, 1986-94

	1986	1987	% Increase	1988	% Increase	1989	% Increase	1890	% Increase	1991	% Increase	1992	% increase	1993	90 Increase	1994	% Increase
Group Health[a]	$2118	$2173	26%	$2315	65%	$2662	15 o%	$3050	14 6%	$3492	145%	$3715	64%	$3919	55%	$4205	7 3%
First Plan HMO[b]	2008	2059	25	2228	82	2759	238	3182	153	3822	201	4257	114	4450	4 5	4735	6 4
Share[b]	2142	2010	-62	2394	191	2848	190	3273	149	3665	120	3891	62	4274	9 8	4290	04
Central MN Group Health[b]	2361	1990	-157	2293	152	3031	322	3343	103	3834	147	—	—	—	—	—	—
MedCenters Health Plan[b]	2142	2207	30	2363	70	2834	191	3655	290	4087	118	4537	110	4603	15	5127	114
HMO Gold[c]	—	—	—	24(X)	—	3241	350	—	—	—	—	—	—	—	—	—	—
Physicians Health Plan[d]	2309	2076	-101	2481	195	3398	370	3909	150	4405	127	4790	87	5422	132	5497	1 4
Mayo Health Plan[e]	—	—	—	2397	—	3655	525	—	—	—	—	—	—	—	—	—	—
Blue Cross/Blue Shield[f]	1998	1908	-45	2128	115	3461	62.6	—	—	—	—	—	—	—	—	—	—
State Health Plan[g]	—	—	—	—	—	—	—	4037	—	4263	56	4477	50	4710	52	4759	10

a staff-model health maintenance organization (HMO)

b network-model HMO

c network-model HMO with out-of-network coverage

d independent practice association (I PA) with out-of-network coverage

e IPA-model HMO

f fee-for-service plan

9 preferred provider organization with out-of-network coverage

KEY — indicates that a plan was not offered

SOURCE: J Klein, State Employee Insurance Group Program Manager, Department of Employee Relations, State of Minnesota, Minneapolis, MN, personal communication, 1994

TABLE 5-3: Seven–County Metropolitan–Area Yearly Enrollment and Out–of–Pocket Premiums State Employees, Single Coverage Health Plans

Health Plan	988	989	990	99	992	993
State Health Plan	3,259	2,114	1,050	1,040	**1,079**	1,201
% of total	42.53%	23 49%	12,0170	11,97'?40	12.19%	13 65%
premium	$0	$40.06	$4676	$39,72	$4016	$4188
Group Health Inc	1,894	3,320	**3,900**	3,936	4,178	4180
% of total	24 72%	36.89%	44.59%	45.31 %	47 20%	47 51%
premium	$048	$0	$0	$0	$0	$0
Medica Choice	1,082	1,391	2,006	1,997	1,879	1,653
% of total	14.1270	15 46%	22.94%	22.99?4.	21 .23%	18 79%
premium	$2.22	$19.58	$22.88	$24.10	$2898	$4248
MedCenters	586	1,022	990	946	893	917
% of total	7.65%	11,3670	11.327.	10.89%	10.09%	10 42%
premium	$0	$2.92	$19.08	$18.70	$2668	$2200
Medica Primary	290	722	800	767	823	848
% of total	3.78%	8.02%	9.15%	8.83%	9.30%	9 64%
premium	$318	$218	$2.78	$0.54	$0.28	$580
Coordinated Health Care	114					
% of total	1 49%					
premium	$4.28					
HMO Gold	437	431				
% of total	5.70%	4,79%				
premium	$428	$2486				
Total	7,662	9,000	8,746	8,686	8,852	8,799
% of total	100%	100%'0	100%	100'XO	10070	1 00%

SOURCE J Klein State Employee Insurance Group Program Manager Department of Employee Relations, State of Minnesota Minneapolis, MN personal communication **1994**

plan. Group Health's market share rose from 18.7 percent for employee contracts (18.7 percent for family contracts) to 36.3 percent for employee contracts (29.5 percent for family contracts) from 1988 to 1994, while BCBSM's market share fell over the same period from 56.0 percent for both single and family contracts to 43.9 percent (50.4 percent for family contracts).

Feldman and Dowd evaluated the State of Minnesota's low-cost carrier formula by simulating the expenditures that. would have occured if the plan switching had not taken place and enrollment by plan had remained constant. They found that health plan switching saved the state employees $3.8 million dollars in 1993 alone (24).[3]

Evolution of the Fee-For-Service Plan

After the low-cost carrier system was installed, the BCBSM plan incurred a $9 million deficit and announced it would no longer offer the high-coverage option. Several options were considered, including limiting open enrollment to once every three years to discourage "hit and run" utilization,

[3]The authors caution that their estimate does not consider how premiums may have changed as a result of the reforms to the state employee program and, if plan competition increased, maybe too small. In addition, they note that the low-cost plans may have enjoyed favorable selection compared with the high-cost plans, m which case their estimate would be too large because it would include favorable selection as well as efficiency.

TABLE 5-4: Seven–County Metropolitan–Area Yearly Enrollment and Out–of–Pocket Premiums
State Employees, Family Coverage Health Plans

Health Plan	1988	1989	1990	1991	1992	1993
State Health Plan	4,452	2,757	1,526	1,618	1,733	1,957
% of total	41.8870	23.60%	13.81%	1 4,47%	1 5.37%	17.1 o%
premium	$9.96	$79.82	$97.28	$81.58	$81.90	$85.30
Group Health Inc	3,064	4,837	5,576	6,798	6,020	6,221
% of total	28.25%	41 .41%	50.46%	51 .84%	53,39°A	54.37%
premium	$25.52	$13.18	$15,10	$17.32	$18.42	$19.44
Medica Choice	1,284	1,122	1,669	1,538	1,384	1,113
% of total	11 .84%	9.60%	15,10%	1 3,75%	12.27%	9.73%
premium	$3940	$74.62	$86.62	$93.44	$107.98	$144.70
MedCenters	665	1,427	1,284	1,267	1,170	1,210
% of total	6.12%	12.22%	11 .62°A	11.33%	10.38%	10.5770
premium	$29.58	$27.54	$65.56	$66.94	$86.92	$76.42
Medica Primary	384	813	996	963	968	942
% of total	3.54%	6.96%	9.01%	8.61%	8.59%	8.23%
premium	$32.12	$28.72	$33.64	$31.80	$33.08	$49,02
Coordinated Health Care	190					
% of total	1 ,75%					
premium	$27.66					
HMO Gold	717	726				
% of total	6 581%0	6.21%				
premium	$32.66	$6146				
Total	10,846	11,682	11,051	11,184	11,275	11,443
% of total	100'%0	100%	100'%0	100%	10070	100%

SOURCE J Klein State Employee Insurance Group Program Manager, Department of Employee Relations, Stateof Minnesota, Minneapolis, MN, personal communication **1994**

dramatic increases in the plan's deductibles, gatekeeper systems and conversion of the fee-for-service plan to a preferred provider organization (PPO). The state felt that three-year "lock-ins" would decrease price competition among plans and the unions were not amenable to a "gatekeeper" system at that time. Large deductibles, on the other hand, had the potential to affect risk selection among the health plans. Ultimately, the state chose to replace the fee-for-service plan with a preferred provider organization. The specifications for the fee-for-service plan were revised according] y and the plan was put out for competitive bids. Because the plan had to be a PPO and cover providers statewide, BCESM was the likely choice and, in fact, was awarded the contract.

In 1994, further changes were made to the PPO and IPA plans (the State Health Plan and Medica Choice Select, respectively). Medica Choice Select was experiencing rapid premium increases relative to the other plans and responded with the installation of a gatekeeper system. The State Health Plan, fearing adverse selection, also installed a gatekeeper system. The effect of those changes was to hold the premiums virtually constant for the State Health Plan and the products offered by Medica. The family coverage premiums for Medica Choice (renamed Medicare Premier) and the State Health plan increased 1.0 and 1.4 percent, respectively.

Managing Open Enrollment

In February of each year, the state assembles information for the health plans, which it mails to the plans in March. This information includes full specifications for proposals from the health plans. In late April or early May, the plans submit their

TABLE 5-5: Average Premium* and Percentage Change in Premiums for Minnesota State Employees: 1980-1994

Year	Average premium for single coverage	Average premium for family coverage
1980	$ 37.93'	$96.45
1981	45.62	110.23
1982	54.21	130,79
1983	60.32	140,51
1984	68.32	156.67
1985	7276	17019
1986	73,31	171,71
1987	71.06	165,90
1988	78.37	186,03
1989	11146	262.99
1990	126.67	304.34
1991	138,82	333.04
1992	14758	352.81
1993	156.21	372.33
1994	160.36	38347

Year	Percent change in average premium for single coverage		Percent change in average premium for family coverage	
1980-81	2026		1428	
1981-82	1883		1866	
1982-83	1129		744	
1983-84	1326		11.50	
1984-85	650		8.63.	
1985-86	**0.75**		0.89	
1986-87	**-3.07**		-3.39	
1987-88	**10.28**	**12.54'"**	12.13	12.75"'
1988-89	**42.22**		41,37	
1989-90	1365		1572	
1990-91	9.59		943	
1991-92	631		5.94	
1992-93	5.85		5.53	
1993-94	2.66		2.99	

*Includes both the employer- and employee-paid portion of the premium

** Average over four years

SOURCE J Klein State Employee Insurance Group Program Manager, Department of Employee Relations, Stale of Minnesota, Minneapolis. MN, personal communication, 1994

proposals in two parts during meetings with the state. The first part lists participating providers along with the capacity of each provider. The health plans inform the state whether their networks are expanding or contracting. Plans have to indicate not only their participating providers, but also which providers are accepting new patients. Complaints registered by employees assist the state in determining if there are capacity problems with particular provider groups. In the past, there have been problems with providers not accepting new patients from particular health plans. A meeting is then held where the state entertains suggestions from the plans for plan design changes.

Rate requests submitted by health plans must be supported by demographic information on the state group and special categories of early retirees, the disabled, and COBRA continuations as well as key assumptions and methods used to project utilization and price trends. In evaluating the rate information, the state has found it necessary to develop a format to frame the discussion. The state's actuaries provide corridors for expected trends in various factors in a cost "grid" format of inflation rates, cost per service, and number of services. When this format was first instituted, deficiencies in HMO data systems made it difficult for them to comply. Now, however, the state describes the process as approaching a "partnership." During the process of rate negotiation, each plan remains unaware of the other plans' submitted prices. The state uses an independent actuary to help evaluate the proposed premiums, and premiums are finalized each year by June 30.

Collective Bargaining Considerations

It remains important for employee and union perceptions that a single plan be available on a statewide basis with uniform benefit levels and premium rates---criteria that no HMO has been able to satisfy. Blue Cross/Blue Shield played this role before 1990, with its statewide fee-for-service plan. However, cost increases forced the state to drop the BCBSM plan in 1990. In order to offer a statewide plan, the state and the unions negotiated reforms that substituted a preferred provider organization (PPO) administered by Blue Cross/Blue Shield. Aggressive management of the new PPO held its premium increases to 5.6 percent in 1990- 1991,5.0 percent in 1991-1992, and 5.2 percent in 1992-1993. These percentages compare favorably with premium increases posted by other plans, including HMOs. However, many state em-

ployees have expressed dissatisfaction with the PPO'S limited provider network.

The collective bargaining agreement specifies a certain percentage increase in total compensation for each year of the biennium. Health plans know that increases in benefit costs will cut into the increase in compensation, and that the state's negotiators will adopt a tougher stance when the increase in annual compensation is small. Every second year, when union contracts are being negotiated, meetings with unions begin in December, and contracts are settled by July 1 of the following year. The printing deadline for the fall open enrollment information distributed to employees is mid-August. Thus, health plans must project their costs as much as 18 months into the future. On September 15, information is mailed to state employees. Open enrollment takes place during October. There is no official grace period during which enrollees can change their mind with respect to their choice of health plan, but they are allowed to change during November and December if they offer a convincing rationale.

Current Strategy for Selecting Health Plans

The state has targets for participation by different types of plans. In general, the state has no wish to limit the number of "integrated" plans (e.g., Group Health, Share, First Plan, and Central Minnesota Group Health) in the state program. Nor does the state object to two *different types* of plans (e.g., an IPA and a network HMO) offered by the same corporation. However, the State is not interested in "look-alike" plans offered by the same corporation, including plans that vary only in the amount of coverage offered.

Summary

The performance of the State of Minnesota Group Insurance Program can be attributed to several factors. An important factor appears to be limitation of the employer's premium contribution to the lowest cost plan. Another important factor may be the size of the plan and its goals. At 144,000 covered lives, the program is large enough to elicit swift response on the part of health plans to demands for better products and lower prices. However, the program is not so large that its decisions have become politicized and subject to regulatory capture. The program's administrators expressed concerns about becoming too large or influential in the market (34). Rather than trying to reform the entire system, they have directed their efforts at providing the best possible products and prices to state employees.

THE MINNESOTA EMPLOYEES INSURANCE PROGRAM

Motivation for Formation

To understand the need for the Minnesota Employees Insurance Program, and the key role of insurance pools versus simple underwriting reform, it is useful to first discuss the nature of the problems faced by individuals and small groups in markets for health insurance. Consumers in this market may face higher administrative expenses (insurer overhead) than consumers in large groups and they have higher search costs. Most importantly, however, it has proven difficult for consumers in the individual and small group market to prevent having their risk redefined by their insurer after the occurrence of a serious illness or injury with lingering effects (15).

Insurers are often blamed for medical underwriting which results in high-risk consumers paying higher premiums but, in fact, the need for risk-rating arises not from insurer greed, but from consumer behavior. If an insurer offers a health insurance product that charges a single ● *community-rated" premium, enrollees are likely to be individuals with expected health expenditures above the premium. In order to keep premiums from rising, low-risk individuals and businesses must subsidize the costs of higher risk individuals and businesses. In the past, that sort of altruism has not been the norm. The response of insurers has been to risk-rate applicants, so that individuals in the same risk class pay the same premium, resulting in high-risk consumers paying higher premiums.

This problem cannot be solved by requiring everyone to purchase insurance. Suppose that consumers in the same risk class pay the same premium in the first contract period. During that first period, some people experience illness or injury that changes their risk going into the second contract period. When premiums are quoted for the second period, the insurer could continue to charge everyone the same premium, but only if the people who remained healthy during the first time period agreed not to switch to another insurer offering them a lower rate due to their low-risk status. In order to prevent the good risks from being picked off by competitors, insurers have had to protect the good risks within their own pools by putting them into a separate policy with a lower premium. Of course, that leaves the high-risk individuals paying a higher premium.

One approach to the problem of risk redefinition is simply to prohibit insurers from raising premiums when an individual or group of individuals become ill. However, at least one health economist has noted that forcing insurers to charge the same price to individuals in different risk categories may exacerbate, rather than alleviate, discrimination against high-risk individuals (56). Under these circumstances, insurers may find covert, nonprice ways to discriminate against high-risk individuals.

Employees of large firms, even those offering multiple health plans, do not face the problem of having their risk redefined, as long as they remain employed. Large employers offer employees a multiperiod contract that protects them against risk redefinition in exchange for the employees' willingness to remain in the "pool. " The employee contracts are with the *pool*, however, not with a single insurer. That arrangement allows employees to change insurers if they become dissatisfied with the service they are receiving, even if they are in poor health. Increases in an employee's premium are based on the experience of the pool, not the individual's experience. Insurance pools may have other advantages, including lower administrative costs, better consumer information on health plan choices and greater purchasing "clout" in the health insurance and health care services markets.

| Implementation

In Minnesota, the state legislature responded to the problems in the individual and small group market by creating the Minnesota Employees Insurance Program (MEIP) as part of the 1992 Minnesota Care legislation. Private businesses with two or more employees and 95 percent of their employees working in Minnesota are eligible to enroll all their employees in MEIP (but eligibility is not limited to small employers). Minnesota employers with less than 95 percent of their employees working in Minnesota may enroll their Minnesota employees in MEIP. Employees must work at least 20 hours per week for the business, and 75 percent of the business' employees must enroll in MEIP, not including those employees who have insurance through another source.

MEIP offers a choice of up to four health plans, depending on the county in which the employee lives. All plans have restricted access to specialists, with two offering some coverage of self-referral services not approved by the designated primary care (gatekeeper) clinic. Employers must pay at least 50 percent of the premium for single coverage but cannot pay more than 100 percent of the cost of the lowest priced plan in each market area. There is no requirement that employers contribute to the cost of dependent coverage. Employers must sign up for two years, but open enrollment among health plans is held every year, and employees have unrestricted access to health plans in their market area during open enrollment. Premiums are guaranteed for 12 months and policies are sold through private insurance agents or directly through a MEIP agent. The MEIP pool is designed to be self-financed, with no public subsidy of premiums or administrative costs. MEIP began taking applications in July 1993 and is just beginning to enroll firms in the pool.

MEIP is a blend of two programs started earlier and operated by the same group of administrators in the Department of Employee Relations. The

first is the State of Minnesota Group Insurance Program, which was described earlier in this section. The MEIP pool resembles this program in that multiple health plans are offered to consumers (statewide, when available), and consumers face the marginal cost of choosing more expensive plans. The second previous program is the Public Employees Insurance Program (PEIP), a pool started for the employees of small government units in Minnesota. PEIP also required employees to sign two-year contracts with the pool and the PEIP pool has remained stable through its renewal periods.

If the MEIP pool is successful, it has the potential, along with the Minnesota Care (subsidized premium) pool, to dramatically affect the market for health plans and health care services in the Twin Cities. A substantial portion of medical underwriting costs are eliminated by purchasing insurance through MEIP. Many people who previously purchased individual and small group insurance policies at high prices, and often found themselves in high-cost health plans with little management of care, may have the option to purchase lower cost coverage.

EMPLOYERS' ASSOCIATION HEALTH CARE BUYERS COALITION

Motivation for Formation

The Minnesota Employers' Association (EA) is a nonprofit association of approximately 1,300 businesses that provides its members with various training and management services (17). in late 1991, the EA began to develop a health insurance purchasing strategy in response to a survey of EA members that identified health care as a priority area for the provision of assistance by the EA. Members were experiencing yearly double-digit increases in their health insurance premiums that showed few signs of abating. Working with a consulting firm, the EA developed a joint purchasing strategy that resulted in the implementation of Innovation, a health insurance program made available to members beginning on January 1, 1993, through a contract with the Prudential Insurance Company.

Membership

In late 1991, the EA held a series of informational meetings for its members in which the outlines of the joint purchasing arrangement were explained and membership in a Health Care Buyers Coalition was solicited. By June 1993, a total of 363 companies representing about 160,000 employees and dependents had joined the coalition effort. These companies, which were mostly small to medium-sized, contributed between $300 to $600 each to cover the startup costs of the coalition. About 325 companies supplied data that were made available to insurers wishing to be offered to coalition members. Of these 325 firms, between 90 and 100 chose to offer the Innovation insurance product to their employees during the first year of the program, with about 90 percent of these located in the Twin Cities area. First year enrollment in Innovation consisted of 5,000 employee enrollees and their dependents. By the third year of the program, it is expected there will be 10,000 enrollees in Innovation.

Approach to Joint Purchasing

In designing its contracting approach, the coalition concluded that managed care itself was not sufficient to control costs. It identified the problem as a lack of competition among managed care plans on the basis of both price and quality (17). A strategy was developed that would pool the purchasing power of coalition employers, increase the amount of information available to providers, payers, and consumers about health care outcomes and qualiity of care, and provide consumers with a financial incentive to act on the information. The coalition viewed continuous quality improvement as the process by which cost increases could be restrained.

In the spring of 1992, a meeting was held with provider representatives to assess their interest in bidding for a contract to serve the coalition. A coalition committee was formed to develop a Request for Proposals. The RFP was issued in the summer of 1993 and responses were received from three organizations. (The scope of nonmetropolitan provider coverage requested of

bidders ultimately limited the number of organizations able to respond to the RFP.) After hearing presentations from each bidder, a coalition steering committee selected Prudential. Prudential offered premium increases guaranteed to be 10 percent or less a year over a three-year period, as well as access to data desired by the coalition.

Innovation is designed as a preferred provider model health plan. The preferred provider network in the Twin Cities consists of 865 primary care physicians, 1600 specialists, 18 urgent care facilities, 27 hospitals, and a large number of area pharmacies. If an enrollee seeks care within the network, all care is coordinated by a primary care physician and preventive care is provided without any copayment on the part of the enrollee. The primary care physician authorizes all specialty care. Enrollees who seek care from non-network providers must pay a higher share of the costs and also face a deductible.

Innovation network providers are involved in developing clinical "pathways" that contain criteria for physicians to use when making decisions relating to certain types of medical treatment. The coalition intends to develop data on outcomes, costs. and patient satisfaction for pathway conditions so that ● 'continuous quality improvement" can be achieved over time. A "quality council," consisting of physician, employer, consumer, and Prudential representatives, and chaired by EA professional staff, meets regularly to discuss pathway development and other quality-related issues. Also during the first year of Innovation, an array of wellness progams and health education materials were made available to enrollees.

A four-tiered premium structure was established for Innovation, based on previous expenditures and/or the demographics of each group. During the three-year contract period, an employer can move to a less expensive tier, if that is justified, but cannot move to a more expensive tier. Prudential is responsible for marketing the Innovation health plan, but employers who are prospective purchasers frequently indicate an interest in dealing directly with EA staff. Therefore, the EA has a staff person who assists with marketing, often accompanying the Prudential representative when an initial presentation is made to a firm.

1 Outcomes to Date

Prudential guaranteed it would not increase rates by more than 10 percent during any year under the three-year contract. At the end of the first year it increased rates by 8 percent. The rates paid by firms offering Innovation averaged 14 percent below the rates paid by the same companies for 1991 and 1992.

Initial data on enrollee satisfaction and patient outcomes are now being examined by the coalition's board, but no analyses of these data have been published as yet.

SUMMARY

The restructured State of Minnesota Group Insurance Program has increased the level of competition among health plans in the Twin Cities and reduced the costs of care for its enrollees. However, its effects on the reconfiguration of the health care delivery system in the Twin Cities are unclear. The largest coalition formed by private employers the Business Health Care Action Group (BHCAG) appears to be playing a more direct role in restructuring health care delivery. BHCAG was formed both as a mechanism to purchase health insurance in a more effective manner and as a way to leverage purchasing power to effect change in the health care delivery system. As stated by one health plan CEO, "We believed that this was just the beginning of a massive concentration of enrollees and felt that if we were not responsive at the front end we would be left out ." In contrast, the emphasis of the State of Minnesota Group Insurance Program was on creating and maintaining competition among health plans at the enrollee level.

In summary, the organization of the demand side of the market was both a response to health plan strategies and an important factor in shaping those strategies. First, some of the larger HMOs that offered IPA or point-of-service programs pressed employers to designate them as the sole

HMO offering. The justification for this was the potential for adverse selection if multiple plans were offered. In return for being designated the exclusive HMO, these plans promised to make available multiple options, with one option being a more restrictive set of providers similar to a staff or network HMO. This accelerated the trend toward multi-option plans among all HMOs. To achieve the levels of access and overall capacity needed to compete in this arena, some of the HMOs began to explore mergers. The formation of the BHCAG accelerated this process, since BHCAG contractual requirements included broad-based geographical coverage for providers under the contract. This, coupled with proposals for the development of Integrated Service Networks (ISNS) in Minnesota, with antitrust exemptions to facilitate that development, and national health care reform proposals, caused all of the major health care provider organizations in the Twin Cities to begin to explore ways to link hospitals, physicians, and health insurance plans more closely.