Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution
Perspectives

Design Of Health Insurance Purchasing Cooperatives
by Paul Starr

At the pivot of the managed competition approach to health care reform is a new and distinctive organization: the health insurance purchasing cooperative (HIPC). To turn managed competition from a set of principles into a national program requires spelling out the basic methods of operation of the purchasing cooperatives, their organizational structure, and a plan for their development across the country.

The purchasing cooperatives are not intended to provide insurance, much less medical care. Instead, they contract with health plans and offer consumers a choice. HIPCs are the managers of managed competition—a phrase that refers not to managed care, but to the HIPCs’ role in maintaining a framework of choice that holds all plans accountable for their performance and rewards the more efficient ones with more enrollees.

The HIPC’s Role

In the approach taken here—managed competition under a cap—there are three new or strengthened lines of defense against high costs and low quality, and three corresponding roles for the HIPCs. The first line of defense is an empowered consumer. Many principles of managed competition (the standard benefit package, open enrollment, data on quality of care, and contributions pegged to the benchmark plan) reflect an interest in promoting informed, cost-conscious choice by consumers. One job of the HIPC is to support that consumer decision making.

A second defense against high costs and low quality is the management of the HIPC itself, which, wields the combined purchasing power of its large blocs of consumers in negotiations with plans. The HIPC’s access to aggregate data and sophisticated analytical tools puts it in a strong position to act as consumers’ agent in monitoring plan performance. If the individual’s capacity to “exit” represents the force of the market at work, the purchasing

Paul Starr is a professor of sociology at Princeton University. He is a staff member of President Clinton’s health care reform interdepartmental working group.
cooperative’s capacity to bargain with plans represents another, no less powerful check—that of a countervailing institutional power.

The third line of defense is “upstream” regulation at the national level—much of it under a new National Health Board—including technology assessment for cost-effectiveness, development of practice guidelines, changes in training to favor primary care, and global limits on expenditure growth. Besides supporting consumer decisions and performing their own countervailing role, HIPCs would be responsible for keeping spending within global budgets and adapting national policy to local circumstances.

In carrying out these functions, the purchasing cooperatives should be principally what their name says: purchasing, not planning, organizations. The United States has had much dismal experience with communitywide planning in health care. Planning agencies typically have been asked to do too much with too little—to make planning decisions of enormous complexity with little of the necessary information and no control over the flow of funds. The purchasing cooperatives are different. For one thing, they have more financial leverage than any community health planning agency ever had. Moreover, in this model, they are not the chief health planners—the health plans are. In effect, just as the HIPC buys health services, it buys health planning services. And in this system, unlike traditional health planning, funds follow consumers as they “vote with their feet.”

Because the HIPC’s role is limited, it need not be a large bureaucracy. The cooperative deals only with health plans; it need have no direct role in setting or negotiating provider rates. The core function that its managers must perform directly is negotiating and monitoring contracts with health plans. As part of that function, the HIPC should have special responsibility for assuring service to vulnerable populations and resolving consumer complaints. Most of its other operations—operating a clearinghouse; enrolling employee groups and individuals; and collecting, analyzing, and distributing data on plan performance—can be contracted out to private firms.

Active versus passive HIPCs. Although managed competition proposals call for purchasing cooperatives on an unprecedented scale, we do have examples of organizations that closely approximate HIPCs. These are the health benefits programs for public employees, especially the state programs in California and Minnesota and the Federal Employees Health Benefits Program (FEHBP). All contract with multiple plans, although none of them yet risk-adjusts premiums. In recent years, under the California and Minnesota programs, employees have had to pay the marginal cost of more expensive plans. Price competition has intensified, and rate increases have slowed.

Both state programs bargain aggressively over rates.

Some would have the purchasing cooperatives assume a more narrow and less active role, others a broader and more powerful one, than this model
offers. Managed competition bills introduced in Congress in 1992 appear to give the cooperatives little discretion, requiring them to offer all federally certified health plans, except in special circumstances. The result might be that cooperatives would act merely as price takers instead of aggressively jawboning plans, and consumers would lose the benefit of a powerful agent acting in their behalf. If this were the outcome, we would have an arrangement that might be described as passively managed competition.

At the other extreme are those who would make the purchasing cooperative a risk-bearing insurer and community health planner. A proposal by a state commission in New Mexico, for example, calls for a HIPC that would become the state’s “primary payer.” In general, reformers should be mindful of the dangers of entangling the HIPC in provider payment and making it directly responsible for the financial health of hospitals and physicians. Rationalizing the health system requires reducing hospital capacity and reforming overspecialized, resource-intensive patterns of medical practice. It will be difficult for a purchasing cooperative-as it has been for public planning agencies-to bring about the necessary changes. Private health plans are far more likely to be able to carry out the necessary consolidation and reorientation. But where there is no prospect of effective competition, self-insurance by the cooperatives may prove to be the most workable alternative (perhaps with point-of-service options that allow consumers to choose among different modes of care); Congress should at least create such an option for states to experiment with.

Agents of the purchasers. One reason to resist generally transforming the HIPCs from purchasing into planning organizations is that it will jeopardize their special role as the agents of the purchasers. A purchasing cooperative ought to be recognized, first and foremost, as the arm of the purchasers—that is, consumers and employers. Control of the purchasing cooperative should rest with them. If, by contrast, the HIPC is turned into a comprehensive financing and planning organization, demands for provider representation will be difficult to deny, and, if the past is any guide, capture by provider interests will be hard to avoid. To keep the HIPC a cooperative of and for the purchasers, its relation with both insurance and provider interests should be at arm’s length. Strict conflict-of-interest rules should bar any provider or insurer from serving on the cooperatives’ policymaking boards. In this respect, structure should follow function.

Throughout this essay I refer to purchasing cooperatives rather than to pools. In connection with health insurance, the term pool suggests a high-risk pool and rightly has very negative connotations. No one wants to be in a pool that is certain to be high in cost. Moreover, the word pool does not convey the idea that consumers would have a choice of plan or that an active, powerful management organization would negotiate on their behalf.
Pool is, therefore, an inadequate and misleading term—worse, it is a political mistake. I also eschew the phrase business cooperative because it suggests that the cooperative would represent only employers. The term purchasing cooperative, on the other hand, properly points to the broader group in whose interests the cooperative should be organized to act—all of those who pay for health care.

Thinking Through Organizational Structure

Proposed models for purchasing cooperatives range from the single-sponsor plan of California Insurance Commissioner John Garamendi, embracing all employee groups, to the Jackson Hole Group’s initiative, which would mandate participation only of employers with 100 or fewer workers. The Conservative Democratic Forum (CDF) bill would set the cutoff for mandatory participation at 1,000 employees and allow states to raise it to 10,000. These varying degrees of inclusiveness—roughly two-fifths of the employed population under Jackson Hole, three-fifths under the CDF plan, and 100 percent under Garamendi—would significantly affect the organization as well as the function of purchasing cooperatives.

Yet while varying in their implications, all of these models are fundamentally different from the voluntary small-employer purchasing groups much touted by the Bush administration, such as Cleveland’s Council of Smaller Enterprises (COSE, pronounced “cozy”). COSE is not a HIPC in the sense used here. As a voluntary cooperative, vulnerable to adverse selection, COSE does not accept high-risk groups. In fact, it underwrites 20 percent of applicants. Moreover, it does not offer competing plans but rather several different flavors of Blue Cross. On the enrollment side, it is not universal; on the delivery side, it is not procompetitive. If COSE exemplifies anything, it is the limitations of the voluntary model of the purchasing cooperative.

It is essential to managed competition—particularly as a strategy for universal health insurance—that participation be mandatory for employers or at least a broad base of employers. Without mandated membership, high-cost employee groups will be attracted to the purchasing cooperatives, low-cost groups will stay away, the growth of the cooperatives will be slow, and they will never reach the size they require to function effectively. The cooperatives will have to devote resources to marketing; the entry and exit of member groups will raise administrative costs. There are a thousand ways to kill a good idea. The surest way to kill managed competition is to make the purchasing cooperatives voluntary or to create loopholes that allow low-risk employee groups or associations to self-insure. Such provisions design in adverse selection and ultimately failure.
Inevitably, whatever the formal structure of the HIPC and its relation to expenditure limits, the larger and more inclusive its mandated membership, the more likely the HIPC is to acquire the color of a public authority. A Garamendi HIPC would be a public body; even a Jackson Hole HIPC would likely evolve in that direction. The CDF bill calls for a mixed structure by requiring the states to establish the purchasing cooperatives as not-for-profit corporations with gubernatorially appointed boards. Otherwise, the legislation leaves the structure of the cooperative and the composition of its board to the states.

In principle, there is nothing wrong with letting the states shape the governance of the cooperatives. But past experience suggests caution because of the dominant influence of provider interests in state health policy. Federal law should at least stipulate that the HIPCs' governing boards should represent employers and consumers; the exact methods for representing them can be left to the states. In one approach that I favor, states would create two statewide councils: one to represent employers by size and industry, the other to represent major labor and consumer organizations. Governors would appoint individuals nominated by these councils to serve on the regional HIPCs.

Curiously, while current proposals call for monitoring of the health plans, they fail to provide for monitoring of the HIPCs. But because they hold a regional monopoly, the purchasing cooperatives need especially to be held accountable for their performance in a variety of areas, including containing costs, assuring care to vulnerable populations, informing consumers, and responding to questions and complaints about both their own services and those of the health plans. Such evaluation should be built into the federal information systems and regulatory boards. Even if the HIPCs are constituted by the states and accountable to the governors, there might well be some mechanism for federal decertification of a board that was failing in some critical responsibility, such as living within budgetary limits.

Developing HIPCs On A National Scale

Edward Zigler, one of the early figures in Head Start, recalls in a recent book that from President Johnson's first public announcement of Head Start in 1965, its administrators had just twelve weeks before the first programs were to be up and running. How the world has changed! Managed competition, we are often warned, will require years to develop. Indeed, for a full-scale development of accountable health plans across the country, a decade would be a modest estimate of the time required. But to establish the purchasing cooperatives, the time needed is far shorter. From the point of enacting legislation, the target for operational HIPCs might
well be set at eighteen months—six months for the states to designate HIPC areas and constitute the purchasing cooperatives, another year for the cooperatives to enter into contracts with employers and health plans and set up enrollment procedures. Beginning at that point, the entry of employee groups into the system could be phased in.

To get cooperatives up and running in eighteen months will be feasible if the federal government and private foundations provide the necessary help and if the HIPCs are built using existing organizational bases. One element should be the development of national resources to aid the HIPCs. These might include the following.

Curriculum and training for purchasing cooperative managers and boards. Paul Ellwood suggests the need for a “HIPC academy;” Alain Enthoven foresees the formation of a national association of HIPCs. Such developments need not wait on federal legislation. Private foundations, for example, could fund curriculum development and training programs and begin identifying a corps of professional cooperative managers.

Development of standard contracts. There is no reason why each cooperative must develop standard contracts on its own, and every reason why it should avoid depending on insurers and health plans. A National Health Board that sets a standard benefit package and practice guidelines will be setting terms for standard contracts. A national resource center also should be funded—first by private foundations, then by the federal government—to provide technical advice. Once in operation, the purchasing cooperatives can finance such services out of their own budgets.

Software and network development. Today, in creating a new type of organization, developing the necessary software and network systems is as essential as defining the structure of authority. The purchasing cooperatives should be planned from the outset to be thoroughly electronic organizations. By that I do not simply mean that they need to use computers. The most critical step is to link HIPCs electronically to all the other organizations with which they will need to communicate, especially employers, health plans, and national and state agencies. As part of the infrastructure of an information society, we should be investing in the technologies that will make enrollment, payment, and communication in the new system of health coverage as little dependent on paper as possible—and as friendly and accessible as possible to consumers and employers.

Building on existing organizational bases also can help facilitate the transition to the new system. While the states could create new organizations from scratch, they might also draw on existing ones: large, multiple-choice employee benefit plans and even the flawed voluntary employer purchasing groups; existing state employee health insurance programs; or even the FEHBP, which might be given authority to act as a bargaining
agent for the new purchasing cooperatives during a transitional period.

Even in the absence of federal legislation, states could put their own employee benefit plans on managed competition principles as Minnesota and California have done. Following California's example, they could also open the state plan to local and county employee groups. Many localities, water and school districts, and even county governments are suffering severely from the current insurance market. The states could act immediately to establish comprehensive public-sector purchasing cooperatives. As in Minnesota, the same structure could be used as a purchasing cooperative for small private employers.

Ironically, while some state and national legislators may balk at managed competition because of its alleged novelty, they actually have had this solution under their noses for years. After all, it is how they provide health coverage to public employees. Imagine if every member of Congress and every state legislator had to seek health insurance for their staff; they would face the same problems as small business faces today. Instead, they belong to a purchasing cooperative that gets them a far better deal than they could get on their own. That cooperative generally provides their staff with a choice of health plans (although it does not yet manage competition as actively as it should). Universal health insurance through managed competition involves extending essentially the same mechanism. In that light, managed competition is a far more familiar and appealing alternative than some of its critics, and even some of its friends, have made it out to be.

NOTES

1. For a general description, see P. Starr and W.A. Zelman, “Bridge to Compromise: Competition under a Budget,” in this volume of Health Affairs.