RECORD OF SOCIETY OF ACTUARIES
1993 VOL. 19 NO. 4A

HEALTH PURCHASING GROUPS

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Recorder: JAMES E. DRENNAN

- Purchasing group approach
- Distinctions between health alliances (HAs) and health insurance purchasing cooperative (HIPCs)
- Role in administration's proposal
- Advantages and disadvantages

MR. JAMES E. DRENNAN: We're going to start with the national Clinton health care reform program. We'll discuss a couple of the modifications that have been introduced lately. There may have been a few last minute changes, but this is fairly up-to-date. Then I'm going to go from the national level to the state level to mention a couple of states that have done some unique things with purchasing groups. Then we're going to go to the only state that has a track record of any real experience in purchasing groups, which is California.

Starting off with the Clinton plan, some of this will be old hat to you, but we're going to go through it fairly quickly. Obviously the building blocks are managed competition, a standard benefit package, coverage mandates, who will pay, and the federal and state roles. It is really crucial to the rest of our discussion that you keep in mind the distinctions between a corporate alliance, a regional health alliance (HA) or a health insurance purchasing cooperative (HIPC) (whatever you want to call it), and health plans (HPs), also called affordable health plans (AHPs). Of course, we had to introduce some new acronyms into all this, in addition to health maintenance organization (HMO), preferred provider organization (PPO), and point of service (POS). Then, of course, down at the bottom of managed competition are the providers. Our whole discussion asks, how does this flow, how does this work, will it work? What are the problems inherent in this? We're not going to talk much about the corporate health alliances. We're going to concentrate more on the regional health alliances, our state-only alliances, and the health plans.

As background, the National Health Board will oversee the state systems, set the standards for HAs and HPs, administer the global budget, review national quality data, recommend changes, and then will develop a risk-adjusted system for the health alliances. I'm really interested in the risk-adjusted system. I don't really understand how it's going to work at this point, but I hope they have some actuaries involved.

Going down to the next step, we have the regional health alliances, which are state chartered. They could have one or more per state, exclusive territories, and they compete only with the corporate alliances and bear no financial or insurance risk.

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That is the way they're designed at this point. Their purpose is to cut the administrative costs, spread risk, and increase member buying power. Basically it works like your small employer purchasing groups in a lot of states. Their responsibilities are to qualify the health plans. Whether that qualification will mean a state insurance license or not still has not been decided. Will they have to be licensed? What if you had a physician/hospital alliance (PHO)? Is that going to qualify? In addition, regional alliances negotiate the premiums, monitor the price, quality, and solvency, and that's a big task. They do the risk adjustments, provide consumer information, and meet the global budget. Another big question is, how will the global budget work.

Regional Alliances serve the small employers, part-timers, federal, state, local governments, pre-65 retirees, the unemployed, Medicaid, but not Medicare initially, although that's supposed to be phased in later. Medicare was one of those items that was originally included in the plan. The cost was so difficult to measure and so large that it was pulled out. Now some of the savings from Medicare are proposed to actually pay for the reform plan.

At this point the corporate health alliances are not our primary focus. Corporate alliances basically include over-5,000 employee groups. Who qualifies? Taft-Hartley plans and private employers have been mentioned. What's the definition of an employer with 5,000 employees? At this point it looks like it's anywhere within the U.S., as far as I can tell, although you've got some with foreign locations. All sorts of questions come to mind about corporations. What is the ownership structure? All those things have to be worked out. Corporate alliances would basically select the HMOs and carriers and act like the regional alliance, but they still have to be subject to the global budgets.

Let's do a quick comparison of the regional health alliance, this quasi-government agency, and the corporate health alliance. The regional alliance sets rates to meet the global budget and has community rating. The corporate HA negotiates the best deal; it could have community rating or it could experience rate. The regional alliance has the power to enforce the global budget, whereas the corporate alliance has no unilateral power. It just has to meet the global budget, so it's really subject to the federal regulations at that point. The regional alliance will offer all qualified health plans to all participants, and the self-funded plan may be all that's offered for the corporate alliance, as long as they have the appropriate options. As far as the consumer information, it's the same. They both have to report costs, provider characteristics, access, and quality data.

Now, as we go down one level, the health plans are also called affordable health plans. The delivery system players are vertically integrated medical management groups like HMOs, fee-for-service plans, point-of-service plans, or PPOs. Also, in this vertically integrated system, a physician/hospital organization (PHO) could be a possibility. There could be all sorts of new organizations we have never seen, depending on what the qualifications are and what the requirements are. All are vendors of a standard benefit package and they all have to report outcomes data and other quality information which should give actuaries some interesting things to look at. All the health plans themselves must have a low cost-sharing HMO option, a high cost-sharing indemnity option, and then a combination, (point-of-service or a PPO-type option) with the various co-payments and deductibles.

An employer implication is that the regional health alliance would eliminate the burden of providing directly administered benefits. You have community rating that may be beneficial to some -- obviously it's not always beneficial -- and the premium contributions are limited to 7.9% of payroll, although it's phased in for certain employers. But on the limitation side, the payment will vary state by state if you're a multiple state employer. There's no choice of health benefits by the employer. The employer has no choice at this point, and will lose the flexibility. If the employer doesn't become a corporate alliance initially, he cannot chose that later. Risk-adjusted factors are based on the industry and employee profile, and they're phased out over eight years. Employees may still expect a large employer to intervene and help with their problems, so they may have to still keep a benefits staff.

The standard benefit package has a broad range of covered services, no co-pay for preventive care, no pre-existing condition limitations, and no lifetime limit on benefits. More specifically, the low cost-sharing HMO has no deductible, $10 per office visit, $5 per prescription, and no hospital co-pay, with a $1,500 (times two per family) out-of-pocket maximum. The high cost-sharing HMO has a $200 deductible, times two per family, 20% coinsurance, with no copay on preventive, and the same out-of-pocket maximum as above. The in-network/out-of-network is basically just a combination of those two. The interesting thing is that workers' compensation and auto insurance were thrown in. The patient will seek care through the health plan, but the health plan will then bill the workers' compensation carrier or the auto carrier. So you've got another little complication added in there, another little circle that's created. It makes some sense, but it also adds some complexities as far as the administration costs. In other words, all your medical will be with the same health plan whether it's workers' compensation, auto, or traditional medical. But the method of billing and the procedures are different; in addition, you're splitting up the workers' compensation between the medical and disability portion, which provides some interesting problems.

The eligibility is for employer and individual mandates. In other words, each employer is mandated to offer all the plans, and the individual can pick any one he or she chooses. Employed spouses are subsidized by their own employers. The family, though, will enroll under one plan, which will create some coordination problems there. There's no employer mandate for retirees except for the 55 to 65 year-old retirees. The non-Medicare eligible retirees do qualify for an 80% federal premium subsidy which leads to some interesting results with any *SFAS 106* liability that's been set up. That's not the subject but it really could cause some profits to return from liabilities that have been set up in the past.

The eligibility is full-time status, defined as 30 or more hours per week, part-time between 10 and 30 hours, and those with ten or fewer hours are not considered eligible employees. The employer contribution will vary. It's 80% of the weighted average premium for the full-time employees; that's the weighted average of all the health plans that those employees have chosen within that particular geographical area. The employers may contribute more than the 80%. There's a prorated contribution for part-time employees, and the employers may subsidize the retiree medical if they so wish.

As a quick example, you might have HMO A with a $1,600 premium, HMO B with a $2,000 premium, an indemnity plan with $2,100, and a PPO with $2,300 (see Table

1). If all of them had equal participation from a single-employer group, then your average premium would be $2,000; therefore, the first HMO would require no employee contribution. On HMO B there would be a $400 contribution, the indemnity plan has a $500 contribution, and the PPO would require $700. In theory, people would gravitate towards HMO A, assuming it had appropriate coverage for the network areas. This is what is described as managed competition, and there are some questions about how to measure the quality and things of that nature, which are real unknowns at this point. We'll have to see how the government regulations come out and how adequately all those things are communicated.

TABLE 1
Contributions

	HMO "A"	HMO "B"	Indemnity	PPO
Single Premium*	$1,600	$2,000	$2,100	$2,300
Enrollment	25%	25%	25%	25%
Employer Contribution (average x 80%)	$1,600	$1,600	$1,600	$1,600
Employee Contribution (after tax)	$0	$400	$500	$700

*Average Weighted Premium Cost: $2,000

The revenue sources come from 80/20 cost sharing and some graduated cost savings from Medicare growth. Then $105 billion comes from an undetermined combination of sin taxes and corporate assessments that's sort of a soft number at this point. The administration estimates have no Congressional Budget Office scoring yet to really nail these down because it is still under discussion.

Let's discuss the tax issues. The standard benefit package is deductible and excluded from employee income. The supplemental benefits are also deductible except for any that are adopted after January 1, 1993, and even those that are in effect prior to that time would have their deductibility phased out after ten years. Supplemental benefits include things like dental, vision care, etc., basically a health care flexible spending account that will not be very tax effective. Pretax health contributions to a flex plan will probably cease. The federally enforced caps on the spending are going to be the consumer price index (CPI) plus 1.5 points in 1996, graded down to the CPI only in 1999. This is supposedly how the budgeting will work. There will be caps that will control the premium, but not necessarily control the costs. Federal caps will control the premiums and then it's up to the health plans to make the costs stay in line and to negotiate the appropriate discounts.

The federal role is to set the minimum benefit and contribution levels, to administer this global budget, to specify the information reporting requirements for the states, and to establish -- and this is very key -- a performance-based quality management

improvement system. I'm really interested in seeing this last one, because that could be the key to this whole program.

The state role is to select the health insurance system that will regulate the market competition. A state may create a single-payer system if it wishes. It may regulate providers by setting all payer hospital rates or dictate the physician reimbursements if the state so chooses. The states will have to set up a premium collection mechanism and the territories for the alliances. It might collect taxes, make assessments to the self-funded plans, and set financial solvency requirements for the health plans, especially if they're not subject to the normal insurance department solvency recommendations or requirements.

In the final analysis, the interaction and proportional impact of each building block ultimately determines how the health care reform will affect any organization. Table 2 shows some of the cost factors. An arrow up is an increase in cost, an arrow down is a decrease, and a dot is neutral. The noncovered workers are either up or neutral. Working spouses could go either way. Pre-65 retirees will probably show a cost decrease. The standard package could go either way depending on what the current benefits are. Employer contribution could go either way. Community rates could affect you either way, depending on the population of an individual group. Retirees over 65 will probably have a decrease or break even at best. Global budget should show a decrease. Administration could go either way and workers' compensation could affect costs either way.

TABLE 2
In the Final Analysis

Key Factors	Costs (▲/▼/●)
Noncovered workers	▲ or ●
Working spouses	▲ or ▼
Pre-65 retirees	▼ or ●
Standard package	▲ or ▼
Employer contribution	▲ or ▼
Community rates	▲ or ▼
Retirees over 65	▼ or ●
Global budget	▼
Administration	▲ or ▼
Workers' compensation	▲ or ▼

There has been an additional proposal by the Republicans, from Senators Chafee and Dole. Some of the differences from the Clinton proposal are that there is no employer mandate and the health alliances are voluntary as opposed to mandatory with an employer deduction cap (See Table 3). There's no global budget, however there is a medical savings account, and it does include small group reform. The current feeling is that some of these pieces that are common will probably be passed in one form or

the other. It's hard to tell, though, how strong these alternate proposals are at this point and then there are lots of issues going on about who will be the key Republicans. How many Democrats will support each plan? There was an article in *The Wall Street Journal* about some of the alternate proposals and how strong they're becoming. It indicated that the key in-between groups may be the ones that are for the single-payer system. They may have a swing vote, and if they choose to go one way or the other, then they could pass it. But if they stay on their own with their plan, then there may be too many plans for anyone to have a majority. At some point this will probably be sorted out, and there will be some movement to some common plans, but it's going to be a long, difficult negotiation process.

TABLE 3
The Debate Begins . . .

Reform Provisions	Clinton Proposal	Senate Republicans (Chafee/Dole)
Employer mandate	Yes	No
Individual mandate	Yes	Yes
Employer deduction cap	No	Yes
Employee exclusion cap	Yes	Yes
Health alliances	Mandatory	Voluntary
Standard benefit package	Yes	Yes
Global budget	Yes	No
Pretax health benefits (Cafeteria plans)	No	No
Medical savings accounts	No	Yes
Small group reform	No	Yes
Malpractice (tort) reform	Yes	Yes

Let's discuss a state program. Let's talk about Florida specifically just to give some of the differences being proposed. In fact, there are some meetings in Tallahassee where they're doing some of the actual hands-on work in bringing up the state plan. In Florida, they include Medicaid. They define the employer as under-50 employees. The majority of them have to be in-state, so Florida is basically a small-employer program. They also have a sole proprietor included. A most-favored nation clause is in the legislation. In other words, if you participate in the Florida program, you can't have another program underwritten with lower rates that you're using elsewhere. The rates can vary by contribution levels, and there are some options by age. They do not include workers' compensation or automobile medical. You must use a licensed Florida agent. The proposed legislation actually uses the word "must," for any brokerage-type work in the State of Florida. I think there was a strong lobby at that point.

The Florida legislation defines access, which is a very interesting thing to try to do, because access in one part of the country is different from the other. In cities you find people willing to drive further than you do in the rural areas, but they define emergency services as being 30 minutes away, a hospital in-patient facility should be no more than 45 minutes away, and specialist care as no more than two hours away. I've worked with some groups that tried to define that, and I've never found that it worked very well over a large geographical area. It will be interesting to see how this requirement in their legislation actually works.

One of the other interesting things is the requirement to do a survey of the population health status of the groups using a Rand 36-item questionnaire that's actually specified. There will be some follow-up data gathered on the health status of the groups in this program. It would be very interesting to see how the health status changes from the start of the program to the end.

There are other states that are involved in health reforms. Tennessee, Kentucky, and various other states are doing things, but the two that are furthest along are much Florida and California. To take us in-depth in the California experience we have as a guest speaker Sandra Shewry, Deputy Director for Benefits and Plan Relations for the Managed Risk Medical Insurance Board. This board administers two programs in California which provide subsidized health insurance to Californians. One is for the medically uninsurable and the other is for low-income pregnant women. This board also administers the small employer purchasing pool. Sandra, as deputy director, is responsible for the negotiations between the health plans and the Board for all the services. She has worked for the last 12 years at both the state and county level. Prior to this assignment she was Assistant Secretary for Policy and Fiscal Affairs at the California Health and Welfare Agency. Sandra has a master's in public health and a master's in social welfare from the University of California at Berkeley.

MS. SANDRA SHEWRY: I work for a five-member bipartisan board in the state of California and we're doing something that no other state is doing right now. We're doing a purchasing cooperative, a health alliance, a regional purchasing pool. Call it what you will, we're doing something that is embodied in the Clinton proposal. We're not doing it exactly the way the Clinton proposal suggests, but we are doing a lot of what we consider to be pioneering work to determine how this construct could work. So we are kind of out in the frontier. When you hear some of the choices we've made you might say, "Well, I wouldn't do it that way." I encourage you to think of us as just starting down this path. We've had to make some choices and we'll see how it goes.

In 1992, we obtained small group underwriting reform in our state. We do this a little different than most states do. We have an all-products guarantee issue, which applies to any product sold to any small group of 5-50 this year, 4-50 next, and 3-50 in 1995. If you issue it to one group, you must issue it to anyone else who wants to buy it. It's very different than the way many of the proposals for small group underwriting reform are being looked at. They usually define a basic benefit package. The thinking in our state was that it just leads to a death spiral of that benefit package, because only the sickest of the sick would buy the guarantee issue product. So we do have an all-product guarantee/all-product renewal. We've limited preexisting conditions exclusions in our state to a single six-month period. This reform

probably has the biggest public policy impact on coverage in California because it goes from three to infinity, so there are no more waivers of five years, no more preexisting exclusions of two years every time you change jobs on any coverage for a group above three in our state. We had some underwriting reform as part of this; now there are no more than seven age categories. Those are written down in our law. Everybody uses the same age categories. There are no more than nine geographic areas in our state and four family groupings. Then the insurer can look at the group. No gender rating is allowed, and no health rating is allowed per se. You can look at the groups and then either go up or down 20% from what we call in our state the "standard employee risk rate." The public thinks it's a 20% rate band, but if you think about a $100 rate, you can go from $80-120, depending on your evaluation of the group. It's actually a big band.

In order to make an all-products-guarantee issue work, our legislature felt very strongly that the disclosure requirements had to be very strong in our state. Every carrier has to put a brochure out that describes every single product they've got in the small group market. This was another attempt by our legislature to prevent steering of good risks into one product leaving the guarantee issue business to go to maybe some basic or more standard products.

The final thing our legislature did in this reform was it authorized my board, the Managed Risk Medical Insurance Board, to start a voluntary purchasing pool ("voluntary" meaning no employer has to buy from us and meaning that we are basically competing with the rest of our small group market). Because we have so many players, large companies, that are in our small group market as part of our pool, the idea of competing kind of takes on a different meaning, but some of the large players in our state chose not to be in our pool, and so it is fair to say that we are in competition with them.

I will tell you a little about how the organizational relationships work. My board is responsible for the overall administration and policy development of the pool. We establish the rules, negotiate the contracts with the health plans, and direct the marketing. We contracted with Employers' Health Insurance to be our administrator for the program. This was a competitive bid negotiated kind of process in our state. They administer the enrollment process for us, collect premiums, and provide marketing assistance to the program. In terms of accountable health plans or affordable health plans, we've selected three preferred provider organizations and 15 health maintenance organizations in our state to actually provide the benefits to enrollees (Table 4). The companies range from large national plans like Aetna, Employers' Health, CIGNA, Family Health Plan (FHP), and John Alden Life to small regional plans that you may not have heard of. Scan Health Plan in Long Beach, California has just entered the market for the sole purpose of trying to be part of our pool.

We just looked at what kind of network and price and different components of their service and administrative package a company could offer us and frankly their willingness to sign the contract that we put forth for the pool. We did have 24 companies that were interested in entering into negotiations with us. We got proposals from 22 and we selected these 18. This is something that's very different from the Clinton proposal which is basically a monopoly. If you are in the purchasing alliance, you are the only chance for all persons buying except the corporate alliances.

In our model we could have really restricted the number of plans and it really wouldn't have had that much of an impact on those we did not select. Obviously in the Clinton proposal if you weren't selected to be in California, you would basically have no entry to that market, so that's a crucial kind of policy difference.

TABLE 4
Participating Health Plans

PPOs	HMOs	
Aetna	Aetna	SCAN Health Plan
Employers Health	CIGNA Healthplans of CA	Sharp Health Plan
John Alden Life	Contra Costa Health Plan	TakeCare
	FHP, Inc.	United Health Plan
	Health Net	
	HMO California	
	Kaiser Foundation Health Plan North	
	Kaiser Foundation Health Plan South	
	Life Guard Group Health Care	
	National Med	
	PruCare of CA	
	QualMed CA	

Our employer participation standards are to have 5-50 eligible employees. Those are persons regularly working at least 30 hours a week. After July 1, 1994, it drops to four and the next year to three. We are mimicking our small group underwriting law. At least 70% of the eligible employees in a group have to purchase through the pool in order for the group to be eligible for the pool. Also, the employer has to contribute 50%. The difference here from the Clinton plan is that the employer contribution must be 80%.

We are what is called an employee-choice model. That means the employer makes the decision to buy their coverage through the pool and then the employee chooses everything else. This was very, very hard for the industry to take, because marketing departments are pretty much geared up to sell to employers. We had much public comment in the design of our pool on how to get clients if individual employees have a choice. While our board was sympathetic to the challenge that might be, we thought one of the things that a government-organized purchasing pool should offer was employee choice. Some large plans came in and said, "Oh, but we offer choice. We have a PPO, a point of service, and an HMO. There are choices." And we said, "Yes, but it's all basically the same people who are adjudicating your claims and serving as your customer service people. That's not really choice." So in our plan, individual employees can choose from among those health plans. There are 18 plans, and the way that works out is in one region of our state, there's up to 14 choices an individual can have. The individual employee also chooses from four benefit levels. Basically we have an HMO benefit plan, a PPO benefit plan, and then two levels of cost-sharing. They also can choose what level of family coverage they'd like.

We basically mimic our state's small group underwriting reform rating categories. We use the seven age categories that are provided for in our state law and the four employee family sizes. We divided our state into six geographic areas. Our law says

a company can have up to nine. That doesn't make any sense in California. You can't prove that there's really more than four different cost centers in the state when you look at it in the aggregate. So we compromised with the plans that wanted to do business with us. We said we'd have six. So, we have six geographic rating areas.

Our benefits are comprehensive hospitalization, physician visits, drugs, and medical equipment. Our board promulgated the benefits in a regulation package. So that means things like the definition of medical necessity is standard among all plans. All the plans, when they filed with their regulators their certificates to be part of our pool -- we aren't a regulatory entity -- had to adopt the definitions in our benefit package. We really wanted the option to say to customers, "Adult immunizations are covered in any of these plans. How they're delivered to you, what you'll have to pull out of your pocket, and where you'll have to go to get them varies, and we want you as the customer to make that choice."

I'll summarize our HMO. Basically we have a $2,000 per person/$4,000 per family out-of-pocket maximum on all our benefit designs. Our standard HMO package has a $15 per office visit and a $5 on what we call our preferred plan. Basically the same structure and the same benefits are offered in our PPO option. In this case, the only difference in the benefit package is that our standard has a $500 deductible and our preferred has a $250 deductible. If you have questions about benefits later, I'll be happy to go over those.

Our plans gave us a price just on the benefits and their internal administrative costs. We didn't think that they would like it much if we then said, "Well, now you have to tack on $5 per month per person to cover our costs" or whatever it turned out to be. So we charge a program participation fee and we let our subscribers know right up front what it is. It's an add-on to the premiums that they see in our book; it's $20 per group plus $2.50 per person. That covers all the state expenses and the expenses of Employer's Health Insurance, which does the eligibility determination, the enrollment, disenrollments, and premium collection functions. We think that price is really pretty good, and we'll have to look back after we have a year's experience to kind of figure out what percentage it comes in at. We're thinking it's going to come in at about 2%.

A really hard policy issue was faced by Florida, by us, and will be faced on the Federal level which is payments to agents and brokers. Florida answered it very differently than we did. It has a very effective distribution system, but our board said, "Why, when medical care inflation is going at two to three times the general inflation rate, would these employees' reimbursements be inflating at that same level? What is the rationale for that?" We really didn't have a good answer for that, so our board decided to separate agent payments from the health care premiums. So in our pool, if the employers use an agent, they must pay our agent fees. By the term "use an agent," we mean an agent assists the small employer in completing the application, calculates or determines the cost of program participation, and assists the employer in enrolling eligibles. We define those as kind of the core agent services. If those three actions are present, then employers must pay the agent, and it's basically broken out by group size. Our smallest groups are 5-25. It's $50-a-month plus $4 per person. Our largest groups are over 51 people. It's $100 plus $4 per person. If an employer

gets our brochure and can figure out how to fill it out himself and no agent is present, then they need not add the agent fee to their application.

So what has this all resulted in? You'll have to know a little about California prices or your own book of business or the world in order to decide if these numbers impress you or don't impress you, but I'll read them for you. We'll take the San Francisco Bay area. Those who are 40-49 years old have a choice of up to 14 plans in the San Francisco Bay area through the pool. The premium for a single person buying our standard plan ranges from $111-170 per month, and that is the health premium. The program participation, and any agent fees would be in addition, if those are present. In the Los Angeles Basin, an area kind of known for high costs, but also known for a lot of large physician groups willing to cut deals, 40-49 year-olds range from $111-205. In this model, we didn't say all our plans have to be within 20% of each other. We really took choice to its fullest extreme this year and just said, "We deem these companies to be qualified to do business with us. They are willing and agreeable to do business on our terms, but we have these very large price ranges." Ranges like $111-205 are greater than most people envisioned would result from this kind of a model.

We opened the program on July 1 so this is all very new. In our first three months of operation, 868 employer groups with a total of 14,484 enrollees joined us. We're now well over 1,000 employer groups as we're moving through October, so we're basically enrolling 5,000 members a month. The average number of employees per group is 9.6, so it's at the low end of what our state's underwriting reform is.

A lot of people were worried, "Well, isn't the pool going to be the dumping group?" Looks like about 20% of our groups were previously uninsured. It's not the kind of information companies willingly share, but my buddies out there in the industry tell me that's what they're seeing in their nonpool business of plans that participate with us and those that don't as a result of our underwriting reform. Surprisingly to me, 72% of groups are using agents and brokers, which I think really validated the point that the agents and brokers made to us during our debate that they do provide a valuable service and employers appreciate their ability to explain things.

Eighty percent of our groups are selecting an HMO and 20% are selecting a PPO. One thing I didn't mention that distinguishes us from the outside market is the outside market has that plus or minus 20% rate band. In the pool, we chose not to have the plus or minus 20% underwriting. It would have been hard to do when you have employees choosing plans. If you have an employer group with eight members, if they can pick eight different plans, you've only got one person basically leading the group to be written up to the plus-20% level. Why would it be fair? Our law says groups rather than individuals have to be moved up for the rest of the companies that have the people in that group to get an additional 20%. Instead, we've just decided to go out and try to compete in a market where there is this plus or minus 20%; our difference and our uniqueness lies with our employee choice. Also, we have very good rates compared with the companies that are competing with the pool and this will keep our risks in balance.

One part of our contract explains to plans that we don't know what is really going to happen with risk so we need to do a risk assessment work group. That includes all

of our participating health plans, the staff of our board, and our consulting actuaries. We've had two meetings so far and we're trying to figure out the following things: How are we going to assess risk? Anybody who ends up with bad experience is going to feel that they are a bad risk, but we need to, at this point, decide upfront how we are going to decide when one company gets worse risk than another company.

In addition, we need to agree on what data to use. All the plans participating with us send us full -- to the extent they can -- utilization and cost data on their subscribers. The key in our thinking about risk assessment is we are only going to look at data that the plans provide to us, because that will alleviate the problem of all the plans coming to our risk assessment meeting with their own analyses. We'd like the state to be able to do the analysis. How much difference in risk is too much? At what point does it trouble you? And that's something else we'd like to decide before we get a lot of the claims information in, before anyone really has a vested interest in what the answer to that question is. Then we need to agree, if there is a problem, on how to equalize the risk between plans. One way you could do that is through program structure. Some of the plans have suggested that our six geographic areas aren't the right ones, that we could break up our geography differently. That would be a way to address it through program structure. The other way would be through risk adjustment of premiums. Then we would have to agree on how to do that.

We've had two meetings of our work group. Actuarial staff from our 18 plans attend, and these are the methods we're considering. Demographic data is obviously very appealing. It's easy to obtain, and it's generally available. Things like gender, which aren't factors in our rating, and occupation would be one way we could do risk adjustment in our pool. Clinical and morbidity-based data could be used by looking at specific diagnoses, not unlike New York State has proposed. We could either use those as a reinsurance model where we would cede some costs for those plans or we could just use them as a factor, kind of a risk-adjustment factor that would be part of some composite.

A problem with this is that we're contracting with the managed care industry. You've got a lot of HMOs in there and woefully inadequate data. If you can help this along, we, as purchasers, would really appreciate your help. Many HMOs don't really know how many office visits there were or lab tests or any of those important things that you'd really like to know when you're looking at health care. Another would be perceived and functional health status. There's another session at this meeting at which Dr. Bruce Bowen from Kaiser is going to be speaking. They're doing a project with the area Business Group on Health basically using a self-reported health questionnaire to assess risk. Prior use of health services is the fourth area our groups looked at, but it has discounted that one because of concerns about separating efficiency from the risk mix of the population when you look at prior use data.

MR. JOHN A. DWYER: Ms. Shewry, we understand there was some process where carriers provided rates and learned whether they were higher or lower than the pack. What was the motivation behind that and how did it work?

MS. SHEWRY: One of the questions we've been getting from Washington folks is, "Well, isn't this going to take a long time to implement? Isn't it really hard to start a

purchasing alliance and make all these decisions and do all this stuff and get plans to respond?" Well, California is a big market so people want to do business with you. We just don't think it's hard. So before I answer your question, I'm going to give you a little historical background on how long it took us to bring this project off.

In October and November 1992, we met with small employers and insurance industry representatives just to talk about the design of the pool. Basically we went from plan to plan. We'd ask anyone who'd meet with us for their ideas on how to structure it. From November through January our board set out the rules for the program. We had six public meetings. That's where those decisions about things like employee choice, what the benefit package would be, and agent compensation were all decided. The regulations implementing those were adopted at the end of January, and on February 9 we selected Employers' Health as our administrator. On February 11 we held an open meeting at which 70 people representing 40 health plans came and we basically walked through our contract and distributed it to anyone who wanted it. Then in February and March, we went around the state and, when we needed to, went out of the state to talk to those entities that were interested in negotiating with the board. In April we selected the plans. I just tell you that because I think when you hear the Clinton proposal and think about alliances, it sounds very cumbersome and slow and something that would take government years to do. I only offer this to say that it doesn't have to take a long time and if this kind of structure is passed, it could happen very quickly.

You're absolutely right that plans gave us an initial set of bids and their contractual amendments that they would need in order to sign a contract with us. They took our model contract and said, "These are the things we just can't do or won't do. Would you accept this? Here are the prices we're thinking of." Because it was an all-products guarantee-issue market, we knew this would be scary. Our impression of the people who would be doing the pricing is they are conservative and don't want to bankrupt the company. So we wanted to give the companies a chance to give us their first price and then think about it a little. So one day in March we asked for the prices. We promised we wouldn't tell anyone else what the prices were. So we got the prices, put them into spreadsheets and then we called each and every plan back that gave us a proposal and we talked to them about these factors. Some of the plans had 50-year-olds being cheaper than 40-year-olds and we said, "This seems like a mistake to us. Do want to think this one through?"

Then we did a little more analytic work. We said we have seven age groups. We set aside the highest age group which are those persons over 65. We looked at the six age groups below 65 and said, "If in four out of the six cells, you are 10% below the next highest plan, we'll give you feedback. We'll tell you whether you're getting out there into the great unknown where you might be putting your plan at some risk because we have no reason to want plans to lose money. It's absolutely not in our interest or in the plan's interest and we had no way to judge when someone's bid might be wild except to compare it to others. So we gave plans that feedback. Same analysis – we took the six age cells below 65 and said, "When you are consistently, in four out of six cells, 50% higher than the lowest cost plan, there may be a little bit too much caution in the actuarial analysis." We provided that feedback because there's some corporate face that goes into being in our book where everybody's prices are all listed together on one page and we want them to know how

they compared. These next two did not happen very often, but if the age slope between the persons less than 30 to that age group just before the 65-year-olds was over 350%, we let them know and when family-size slope was over 350% we also gave them that feedback.

There are some that think purchasing alliances should not give feedback. They should say, "We will not have an age slope in our lines of more than 200% or 250% or pick a number." We chose a model that wasn't dictating the pricing. We just called the plans and said, "This is where you're lining up in comparison with others." In response to that, of the 22 plans that had proposals into us, eight of them lowered their prices and no one raised their prices. People corrected errors. Finally, we don't have a Medicare supplemental rate, so if it looked like a plan was pricing for a Medicare supplemental policy we provided that feedback, and a third of the players came down in price.

An alternative way to approach that would almost be to have a bidding war. On the day when we pick the prices for the pool, come in with your chief executive officer, your actuary and your marketing person and we'll show you what 40-year-olds in L.A. are going for and you tell us if you can beat it. But frankly our worry about that approach is we thought instead of the ceiling coming down, the floor might be set. We used this other approach because then no one really knew what the floor was. As we were giving feedback, even the plans that had low rates had the fear that the sands would shift, and so we ended with some really good rates in our pool.

So who's been selected? Which of those 18 plans are getting the enrollment? Aetna's HMO has 30% of our enrollees. Aetna's HMO is usually the lowest-priced plan and it's has brand name recognition in our state. Our second largest enrollment goes to Kaiser North and Kaiser South combined. They operate two separate plans in our state. When you combine them, they have 16% of our enrollees. The third largest plan is TakeCare, an HMO in our state. It has 9% of the enrollees. With three months of enrollment, you can't predict what is going to be true a year from now, but it looks like it's the combination of low price and name brand recognition that is compelling our subscribers.

MR. RICHARD E. ULLMAN: How is this program being marketed? Who is publicizing it and who is bearing the expense of marketing it and making it known to the employers? The second question is, is there any fear among the plans that they're competing with themselves outside the pool in the same market?

MS. SHEWRY: First I'll address marketing. We use Employers' Health as our administrator which purchases marketing assistance for us. All funding for all pool operations come from small employers and it is all funded out of that $20 a group and $2.50 per person. Because we are a government-sponsored program, our governor has been really gracious in getting us a lot of free publicity for the pool. We also have asked every plan that is in the pool to include a notice of their participation in some portion of their plan's advertising. They try to piggyback on what they're already doing. An advertisement might say, "Kaiser Health Plan is a member of the Health Insurance Plan of California." We also were able to mail a little insert to each of the 600,000 employers in our state, as part of their tax filing notification.

Are plans afraid that we're taking their own members? The plans that are community-rated in our state are a couple of the plans that don't age-rate specifically and are very worried that they're going to get a transfer of their younger people into the pool. They've been watching that. It does not seem to be happening, but it is certainly a concern of theirs and they'll continue to monitor that. But the other plans have not expressed that concern. Basically, our plans have been delighted with the enrollment. Not being an insurance company person, I don't know if 5,000 enrollees a month is good or bad. We're very pleased with enrollment and our contracting health plans seem to think it's great.

MR. WILLIAM J. BUGG, JR.: I'm just curious. Can any group between five and 50 employees purchase through your plan?

MS. SHEWRY: Yes.

MR. BUGG: What's the process? How do you go about it?

MS. SHEWRY: There's an 800-number and there's the application. You can just fill it out at home. You can have one of our sales reps help you or, as 72% of the groups do, have your insurance agent get the form and help you fill it out.

MR. BUGG: This is an application for one of the employers?

MS. SHEWRY: That's the difference. It's an employer application with a one-page description of each of our health plans. So there's 18 plans marketed through this brochure. This brochure has all the prices in it, so by providing information on how old you are, where you live and what level of benefits you need, you can just flip through to see who has the doctors or hospital you want.

MR. BUGG: Now you're talking about it from an employer side – the employer decides that for its employees?

MS. SHEWRY: No. Each employee decides that on their own. Each employee gets one of these.

MR. BUGG: So as an employer with 30 employees, how do I go about it?

MS. SHEWRY: If you're an employer, you call the 800-number if you want to do it alone and you say, "I'm interested in the pool." We send you 30 packets. If you would like our assistance, give your employees our 800-number and we'll talk with them about it. If you'd like to use an insurance agent, we'll send your 30 packets to your agent, and the agent will just mail it back in.

MR. BUGG: And then each employee will decide what plan he or she wants?

MS. SHEWRY: Correct.

MR. JOHN A. TULLOCH: What basis do you have for evaluating the performance of the various carriers that you've selected and what are the procedures for rolling out the poor performers? What opportunities are there for new plans to get in? Also

with regard to rates, are they trended or are they fixed for a given period? Do you have any restrictions on how frequently they can raise rates or at what points in time they can raise rates?

MS. SHEWRY: In our contracts with the plans, we've asked for several accelerated customer service kinds of activities. I'm embarrassed that we had to ask for these, but we found as purchasers in our other program that we have to. We want people to have evidence of coverage and their card on the day that their coverage is effective. This is a big deal to plan sponsors. It's very hard for them to deliver that, but we insist on it.

We want them to answer their phones from 8:30 to 4:30 in Spanish and English. We want their provider directories to be flagged for non-English speaking providers. We require a data set that is really very much of a challenge for many plans to provide for us. These are the kinds of things for which we have liquidated damages included in our contract. In addition, because we're not a regulatory entity, we're trying to piggyback at this point, on the quality audits done by our Department of Corporations which regulates our HMO industry.

At this point we are only able to evaluate plans based on customer service. We have no history or no experience to make our own judgments about efficiency. For really the first six-to-nine months our only ability to critique plans is to determined if they are actually delivering what we thought they would. Persons that have access trouble getting into doctors or are charged the wrong co-pays should get a resolution quickly.

Over time this would beg the question of, should we allow there to be such a big range in premiums? This is going to be a crucial question in the Clinton thing. Should you let 1,000 flowers bloom if nobody's picking the 1,000 flowers or do you at some point just say, "We don't do business with you. Nobody picks you. It looks like your prices are bad and your service is crummy." This is a much more serious issue in the Clinton proposal with its mandatory nature. For us, if we choose not to do business with someone, they have all the rest of the market as an option.

Our rates are good for a year from July 1 through June 30, so the prices we opened the program with are the ones that plans will have to stay with until next July 1. We're going to stick with an annual rating period. Our plan sponsors, in their contracts, all committed to a trend that would stay below a certain level for Year 2. We were a little worried that we'd get some real bargain basement prices Year 1 and then all our members would get sticker shock in Year 2. So we do have a contractual provision. Our contracts have a 90-day cancellation clause so that we can get out of them.

MR. HARRY L. SUTTON, JR.: You mentioned the six or seven age factors. Do you use what we call list billing so that there's a set of age rates for each plan or do some have a community rate or an averaged rate and others have a separate rate for each age/sex cell? And if Employers' Health does all the billing, do they send a separate premium rate for each employee and his family along with the premium billing. Do they have to perhaps send a ten-life employer ten different premium notices together or list it on one billing run?

MS. SHEWRY: All our plans use all seven of our age categories.

MR. SUTTON: Even Kaiser which is currently community rated?

MS. SHEWRY: This is Kaiser's first foray into age rating. They're not happy. I don't blame them. I personally like the way they do their regular business a little better, but this is the market we're competing against and we have an age-rated product. So they all have an age-rated product. Our bill lists Sandra, Jim, and John, it shows what family size we're in, our health plan, and what the premium is.

MR. SUTTON: The federal government's never been able to understand that. Somehow they think every employer has an average rate and everybody's equal somehow. One other thing. The federal government's proposal (Clinton's proposal) would knock out any plan that's more than 20% higher than the weighted average of the plans in there. You mentioned notifying those that were 50% higher in four age categories. Just out of curiosity, how many would be in there if you used a 20% higher rate than the weighted average rate? Did you look at that?

MS. SHEWRY: That would be a wild guess on my part. It would be a significant number.

FROM THE FLOOR: You said you're not looking at quality very much right now, just consumer satisfaction. But have you checked in the HMOs that have signed up or the other restricted panels to determine whether in some specialty they have almost all new doctors just out of medical school or whether they actually have board certified specialists in each important area?

MS. SHEWRY: No. We didn't.

FROM THE FLOOR: Why should I buy it from you then?

MS. SHEWRY: As you can probably deduce from many of my comments, we're trying to walk a fine line of the government being involved in a process versus the government making the choice for the subscribers. We have a lot more plans in our pool than most would have expected. They're all licensed. They have no licensing violations against them.

FROM THE FLOOR: Have you checked all states for licensing?

MS. SHEWRY: No. We checked their California operations which is where our subscribers are.

FROM THE FLOOR: Did you check each of the doctors?

MS. SHEWRY: We have contractual provisions that require them to have licensed physicians and licensed facilities. It is certainly not outside the realm of where these pools will evolve for our agency to take a stronger role in quality assurance; many feel that's entirely appropriate. I tend to agree. At this phase though, given that we are entering into a market that basically competes with the market doing a voluntary program, we have not done much above and beyond what is present in the market

now except for demanding some of these accelerated customer service features and the fact that we are collecting utilization data. No large purchasers are very rigorous about making use of the data they collect. We have some experience in that we run the high-risk pool and another subsidized insurance program and asked plans that are ostensibly managed care plans to tell us how much babies born in their system weigh. To us this was a pretty good quality indicator of their prenatal systems. We also asked, "How do you identify those high-risk mothers?" and "What do the babies born to those mothers weigh?"

FROM THE FLOOR: Isn't that more a measure of the socioeconomic group of the people they're covering?

MS. SHEWRY: No. Not at all. No plan had ever thought to look at how much the babies weigh. You have preemie babies in every socioeconomic group. You have the bulk in Medicaid, but none of our subscribers are in the Medicaid program. So I guess the answer to your question is, it's an important area, we agree it's important, and as the right quality measures are developed, I can see us implementing them and instituting them, but right now we're basically relying on the market in California the way it is.

MR. DAVID A. SHEA, JR.: First, I'd like to commend you and the Board on your efforts. We'll be curious to see how the experience emerges. I wanted to get a little bit more clarification on how the rates are effective, on how long they will be effective, and I'll do it by way of an example. The program started July 1, and you have a book of premiums. A group signs up July 1 and pays those premiums. Now let's say a group signs up on December 1. Do they pay those premiums?

MS. SHEWRY: Correct.

MR. SHEA: If the group signs up on December 1, how long are those rates effective for that group?

MS. SHEWRY: Everyone pays these premiums until June 30, 1994. On July 1st, everyone pays new premiums.

MR. SHEA: So the entire pool, regardless of when they sign up, will be rerated and a group's rates could effectively change after a month.

MS. SHEWRY: Every spring there will be open enrollment when we will publish our rate book, send it to every employee in the pool, and say "Effective July 1 these will be the premiums. Would you like to stay with your health plan or would you like a different one?"

MR. SHEA: And you're going to go through the same rate review process that you went through previously, doing all the comparisons and things?

MS. SHEWRY: I don't know. When you're a pioneer, you make this stuff up as you go. Do you do it any differently in your business? We've never been faced with second-year rates before. We'll have to sit down and strategize the best method. I don't know if we'll just say, "Your first price is your best price" rather than go

through the feedback. They've all benefitted from seeing each other's prices now. The first time, nobody had a clue and we felt the feedback was appropriate. It could very well be that we'll just say, "They're due February, March, or whatever the deadline is, and whatever you give us is the rate that's going in the book, so make it good."

MS. NANCY F. NELSON: I have two other questions that are premium-related. Since all the groups are going to renew all at once on July 1, you could have a potential situation. What if somebody picked a plan because it was a low-cost plan but now that plan raises its rates and it's no longer the low-cost plan? Are they required to stay with that plan until their December anniversary date or are they allowed in July to pick a different plan?

MS. SHEWRY: Perhaps I wasn't clear. Every May they'll get a book. Anyone who's enrolled as of May 1, whether they joined in April or last July, will get a book showing all the prices for the next 12-month period beginning July 1. At that point every single member has the ability to choose the level of coverage they want, i.e., the preferred or the standard plan, and what company they want. They can change anything about their coverage.

MS. NELSON: I believe you said that the employer is required to contribute 50% of the cost. There appears to be some variation in the premium rates, especially if an employer going into it doesn't know what his outlay is going to be. Have the employers done anything to encourage people to go to the lower-cost plans?

MS. SHEWRY: Our participation standard is 50% of the lowest priced single plan available. That's what the employers have to agree to and our quoting system that Employers' Health provides to employers shows the employer what that dollar value would be based on their census. The Clinton plan has an 80% participation standard in it, and surprisingly, the average participation of our employers is 80% of premium.

MR. FRANK RUBINO: With regard to geographic ratings, I think you said that you did a study and determined you only needed maybe six or seven as opposed to the nine geographic regions. Could you elaborate a little on the study? Was it just provider fees or practice of medicine or anything else?

MS. SHEWRY: We went to our brethren state agencies and to some of the academic folks at the University of California and said, "Just how many different geographic areas are there in California in terms of price?" There wasn't anyone that we went to that could put forth a plausible argument for more than four. So our board, being a public body and needing to compromise and address the needs of those who wanted to do business with us, basically said, "Well, the law allows nine. We can't really see any justification for more than four, so six must be the right number." So it was really a consensus of people that we talked to but none of them had the same four areas in mind.

MR. GEORGE CALAT: You mentioned that you required all the plans to agree to a maximum increase in Year Two. Can you tell us what that is?

MS. SHEWRY: I can't.

MR. CALAT: Are you planning to expand the number of plans from 18?

MS. SHEWRY: Somebody did ask me that. I'm sorry I didn't answer that. We signed two-year contracts with our plans. We feel the plans that did sign on with us did so at some risk to themselves. Number one, they were in the pool when our guarantee issue law went into effect. The fact that the pool doesn't have the plus-or-minus-20% rate adjustment that the rest of our market did may have exposed them to more of the guarantee issue business than they otherwise would have been. So what we have decided is that we are not going to solicit any more participation. If a plan comes to us and has good geographic rural coverage -- we actually need more plans in the rural areas of our states -- and prices that look competitive, then we will consider adding them next July, but we are not actively soliciting any more participation.

MR. CALAT: I think I heard you say that you require an employer to have 70% of their employees participate. Or does this mean to apply and to be accepted.

MS. SHEWRY: To participate.

MR. CALAT: And, do you require that the employer contribute 50%? Do you have any kind of monitoring of that to assure that those two requirements are met?

MS. SHEWRY: We audit each small employer once a year using the state employment tax forms. You have to prove that you are a wage earner making enough wages to qualify as a full-time employee on a continuing basis. In terms of the employer participation standard in financing, we think probably the best enforcement of that will be employees. The information the employees get to enroll makes it clear that the employer must contribute 50% of the lowest cost plan for that employee.