RECORD OF SOCIETY OF ACTUARIES
1994 VOL. 20 NO. 3B

HEALTH ALLIANCES

Moderator: JAY C. RIPPS
Panelists: GREG D. KUZMA
DONALD T. WEBER
Recorder: JAY C. RIPPS

Health alliances are central to the President's proposal. Their structure, operations and effect on the market have numerous actuarial implications.

MR. JAY C. RIPPS: I will begin by introducing the panelists. I am with Arthur Andersen and am chairperson of the Academy's Work Group on Health Alliances. We have two other members of the Academy's Work Group on Health Alliances, Greg Kuzma from Prudential and Don Weber from Blue Cross/Blue Shield of Kansas City, MO.

Our discussion will be in four parts. I will speak briefly about the Academy's Work Group on Health Alliances and the status of our efforts so far. Then Greg will talk about alliance issues in general and about the approach that our work has taken to addressing some of those issues. You'll have me back again then to talk about issues relating to the size and membership of alliances and some of the issues relating to the structure of health alliances. Don Weber will conclude with issues related to administration of health alliances and also some alternatives to health alliances which may accomplish some of the same purposes.

We have purposely allowed ample time for discussion and participation from the audience. I encourage you to take advantage of the opportunity to comment or ask questions of the panelists. It will help us, and it will help you too.

First, where are we in terms of the Academy's work group? We were formed late last year, and we have produced a draft of an issue paper relating to health alliances which will be used to direct the Academy's interactions with federal policymakers and eventually state policymakers. The draft has gone through its first round of peer review, and we are currently redrafting it to reflect the peer reviewers' comments. Before we got to this point, we were invited back in March to appear before the House Committee on Small Business, and we had a choice to make: should the Academy reject the invitation to appear on a panel to discuss alliances or should we accept the invitation, given that we were faced with the work in progress and did not have our issue paper fully developed at that time. We decided collectively to accept the invitation and testified on the basis of our paper at that time. There was some account of our testimony in the *Actuarial Update*. Some of you may have seen it. If you have comments or questions about that testimony, this would be the appropriate forum to use.

It appears at this point that alliances, in terms of federal reform are very questionable and may be sort of moot. Nonetheless, it's also quite clear that alliances will be a factor in reform methods at the state level. They are already a factor in Florida, and they are already a factor in the legislation that's been enacted in the State of Washington. Regardless of what happens at the federal level, health alliances will be with us for some time to come.

As I say, we welcome your comments. The work group's paper, which we are developing on behalf of the Academy, and in a sense on your behalf, is very much a work in progress. This is a good opportunity to get input from people who have not had an opportunity to participate directly in our work group and to share our thinking with you. And with no further ado, I will turn the podium over to Greg to address alliance issues in general and our work-group approach.

MR. GREG D. KUZMA: I briefly want to touch upon our mission, some of the problems we faced, and how we dealt with them. Our mission was to provide policymakers with objective actuarial commentary in the world of health alliances as described in the President's health care reform proposal.

So what were some of the challenges? First, it's obvious that health alliance issues are complex; it's hard to reach a consensus on all issues, and I'm not even sure that we want to reach a consensus on all issues. I'd like to go over two brief examples. The first example pertains to the issue of whether health alliances will bring purchasing power to small businesses and individuals. Some contend that alliances are not necessary to bring the health insurance purchasing power of big business to small employers and individuals. They contend that insurance reform, guaranteed issue, adjusted community rating, and prevention of risk selection will go a long way toward bringing purchasing power to individuals and small businesses; therefore, there really is no need for health alliances and that health alliances will do little to further these goals.

Others have the opposite view. Health alliances are needed to assure a full range of choice of plan so that individual demand will be an effective market mechanism. The argument here is small employers tend to offer only one plan. They contend this provides a relatively inelastic price environment so prices tend to be higher. Their second point is that guaranteed issue does not mean guaranteed marketing and guaranteed availability, so they believe a health alliance is essential. In trying to come up with an issue paper on health alliances, we need to accommodate the views of one camp that believes you don't need them and another camp that believes you do.

The second example relates to the California Public Employees Retirement System (CALPERS). I'm by no means an expert on this topic. Jay questioned the assumption that the health care CALPERS held down health care cost, but let's just assume, for the moment, it did. One view holds that the low rate of premium increases over the last three years is evidence that global budgets and aggressive rate negotiations are effective ways to control costs.

A second view takes a much different slant—that offering multiple choices to individual subscribers delivers economies of scale and has led to control of costs. So again, relating back to alliances, we needed to address the issue of whether the alliance should be a price maker (that is negotiate) or a price taker (that is to be more passive and just let the price pass to the consumer). It's not that clear which is the better way to go, and there are definitely opposing views.

So how do we try to deal with these issues? Our main operating rule was to avoid advocacy of a policy position, limiting ourselves to comments on how various options relate to the intended purposes of health alliances. One benefit of this approach is

that it highlights how you can't have it all—it's impossible to achieve all six of the following intended purposes:

1. Promote or guarantee universal coverage
2. Stimulate competition
3. Control health insurance and health care costs
4. Spread risks for pricing purposes
5. Achieve economies of scale and promote efficiency in administration, marketing and distribution of health insurance
6. Extend economies of scale to small groups and individuals

Again, because there were so many variations and combinations out there, and it was hard to analyze all aspects, we tried to stick to four general topics. This is where Jay and Don are going to get into a little more detail. There's the size of membership. Who should be included, what groups? What should the structure be—mandatory versus voluntary, competing alliances versus exclusive? Should the alliance be a price taker or a price maker? Administrative issues are, can the alliance perform all the functions called for in the President's proposal? What would be best left to health plans? What would be best done by alliances?

MR. RIPPS: I'm going to cover the four major issues in our issue paper as it exists today. The employer size threshold, variation in rates by location, whether there should be one alliance in a given area or competing alliances in an area, and whether participation in alliances should be mandatory or voluntary.

The general theme of our thinking and of the paper which will eventually emerge, is that there's no one right way to structure health alliances. It depends on what you're trying to accomplish. In the case of alliances, there are multiple purposes, and the relative importance of each of those purposes is what's critical. Greg listed the possible purposes of an alliance. They form the basis for our analysis of each issue that comes up in terms of the structure, size, membership, and so on.

How do we apply them? Well, with respect to the employer size threshold, we posited a notion. If alliances are structured in such a way that federal and state employees are included, which is certainly something that is within the government's power to do, then health alliances would vary in size by state from 217,000 in a sparsely populated state like Wyoming, at an employer threshold of 25 employees or fewer, to 11.6 million in a state like California where, of course, there would likely be multiple alliances. The point is, if one includes state and federal employees, and if one includes individuals, then establishing an employer threshold at 25 employees or below produces alliances of substantial size. And, therefore, our conclusion is, as currently reflected in our paper, that the threshold that one sets depends upon the purpose that one has in mind. If what's most important is to stimulate competition, to spread risk for pricing purposes and to achieve economies of scale, a low employer threshold is sufficient, and one need not go beyond 25 employees or so. If, on the other hand, the primary purpose is to guarantee universal coverage and to spread the cost of high-risk groups (like people who receive Medicare benefits because they're disabled), or the cost of early retirees, or the cost of people who may be unemployed because of medical difficulties, then a higher threshold such as the 5,000-employee-threshold proposed in the Clinton proposal is more appropriate. This sweeps in more

people, provides a bigger base over which to spread costs and establishes a more convenient base to guarantee universal coverage and to control prices.

The next question that we looked at was that of variation of premium rates within an alliance by area. In our paper we show some examples of health care costs varying within a given state by 50% or so. The states we cite are California, Florida and New York. If one imposes the requirement that, in an alliance, premium rates do not vary by geography, high-cost areas are subsidized by residents in low-cost areas. In addition, plans that operate across an entire alliance area may have an unfair competitive advantage or disadvantage versus those that concentrate in either a high-cost or low-cost area.

Given that these are problems, what is an alliance to do, or what is an alliance designer to do? Well, there are several possible solutions. One could have multiple alliances within a given state, implying therefore less variation within an alliance. One could require all health plans to serve the entire alliance area, although this is probably impractical given the complexity of network formation and other operational impediments. One could allow rates to vary by area, or use risk adjusters, which I think are the preferred solutions that will be advocated, at least by implication, in the paper that emerges.

The next question is whether to allow more than one alliance in a given geographic area. Once again the answer is it depends. It depends upon what's most important in terms of the social policy, which the designers are trying to achieve in establishing alliances in the first place. If the primary purposes of the alliance are to guarantee universal coverage and control prices, that argues heavily for exclusive alliances, not multiple alliances per area. Having multiple competing alliances would make those two purposes more difficult to achieve. If, on the other hand, the primary purposes are to stimulate competition and provide affordable alternatives for a small business, then having multiple alliances compete increases the competitive pressures and the control achievable through free-market competition.

Now the most vexing question that the work group faced and that legislators are now facing is whether participation in that alliance should be mandatory or voluntary? And once again the answer is it depends on what you're trying to accomplish, and which of the various purposes are most important. It also depends on the context within which the alliance is being formed. For example, it makes a difference whether open enrollment and some form of community rating is required for plans operating outside the alliance, and whether the alliance is available on an optional basis to large groups. If the answer is yes, one is led to one set of conclusions; if the answer is no, it may be another. The paper examines a number of different scenarios relating to context. Our general conclusion on the issue of mandatory versus voluntary participation is, if the primary purposes are to guarantee universal coverage, to spread cost and to control prices, then mandatory participation in an alliance is preferable. If, on the other hand, the primary purposes are to stimulate competition and to provide portable options, then voluntary participation is probably a better idea. Those who favor mandatory alliances argue that they provide the basis for better control and better social engineering, for want of a better term. They support the enforcement of a universal coverage mandate and they provide a convenient basis for controlling prices and enforcing global budgets. Another argument in favor of mandatory participation

is a potential problem with voluntary participation. Unless carefully designed to prevent this, the alliance could become a dumping ground for bad risks, resulting in an assessment spiral, particularly if plans outside the alliance are subject to different operating rules and requirements from those inside the alliance.

Those who argue for voluntary alliances contend we don't need the government to tell people where and how to obtain health insurance coverage; it's more harmful than helpful to the small businesses that we are trying to help. More competition is better and will provide, over time, better control of cost and prices, and the performance record of voluntary alliances is strong. In places where voluntary alliances have been tried, they appear to work well.

Finally, and perhaps most importantly, it is certainly more palatable politically to have voluntary alliances. The constituency that is to be served here, the small business community, certainly is in favor of voluntary participation with as few mandates as possible, and they oppose a mandate to participate in alliances.

MR. DONALD T. WEBER: I will cover administrative issues and alternatives to the Clinton mandatory health alliances.

The major administrative duties include negotiating provider fee schedules that can be used by all the health plans; collecting cost and quality data from health plans and disseminating that information to consumers; processing enrollments, including initial enrollments, changes in enrollments, and annual re-enrollments; issuing the health security cards; billing, collecting and remitting premiums; administering subsidies and risk adjustments; and verifying that all residents have insurance coverage.

I'm going to address a few issues related to some of these items—first, negotiating the provider fees. There are many urban versus rural issues. Those of you involved in any Medicare replacement realize that the providers in metropolitan areas get much better compensation out of Medicare than the rural areas. There are also many issues related to the various physician specialties and nonphysician providers like psychologists and chiropractors. There are also difficulties related to specialty hospitals and teaching hospitals. All of these are going to involve political decisions, not just financial decisions.

Administrative systems and expertise issues. Substantial lead time will be required to develop the requisite administrative systems. The President's proposal includes an allowance of a 2.5% fee for administration, which sounds reasonable for ongoing cost. However, that amount may not be sufficient to fund initial development. Finally, the proposal prohibits conflicts of interest and industry involvement—it's the only place I think that you're going to get a great deal of the expertise for developing and operating the necessary systems.

Just maintaining the membership record will be difficult. Any of you involved in federal employee plans, or large employer plans know that just maintaining membership is often difficult. But those are little programs compared to mandatory alliances in which everyone will be participating. Premium accounting and the payment to the health plans will be very complex due to all the changes that occur every month.

Other issues relate to the calculations and other tasks to be performed by the alliances. Among other things, they need to determine average premiums, enforce global budgets, apply risk adjustments, and calculate consumer payments. They need to determine the low-income and small-employer subsidies.

And the last issue I'll address is assuring that everyone is enrolled. This is complicated by spouse and dependent employment situations and changes in marital status. It is complicated by the need to take into account employers in other alliance areas that have employees in your area and the need to coordinate with each of the corporate alliances. As Jay pointed out earlier, many corporate alliances would make this more difficult. Whenever people move, change jobs into a corporate alliance or move from one area to another, or just take a job across the state line, there may be difficult administrative problems.

All of these issues lead to some general questions: can the administrative systems really be developed timely enough; will they be financed; can they get the technical resources and hire the necessary staff when there's not to be any industry-related involvement? Can the politics and bureaucracy be controlled? Can health plan insolvencies be managed? Will individual choices reverse the current group savings? If you're down to an individual choice, are there going to be multiple agents calling on each of these people and trying to explain and sell those benefits. Do we get away from the group economies of scales that we've had in distribution? Can the alliance control costs without individual employer incentives? And will large government programs stimulate efficiency?

I'll conclude by mentioning some alternatives that could achieve the intended purposes of alliances in other ways. One of them is taking what's being done in the states in the area of small group reform and capitalizing on it—that is, using rating bands, guaranteed coverage, portability, limits on preexisting condition exclusions, and some risk adjustment.

The second alternative would be incremental reform, like limiting administrative charges; standard benefits, standard claim forms, electronic interfaces; promoting competition based on service and quality; uniform rating guidelines; regulating health plans through existing state agencies; and implementing malpractice reform.

The third is an individual mandate, which is part of some of the other bills, which would be supplemented through subsidies; encouragement of employer benefit plans; and development of alliances or pools for uninsureds.

And the fourth alternative is trying to capitalize on the Clinton Plan with modifications, relying more on health plans for administrative tasks and utilizing existing state agencies for more of the required regulation. This concludes my prepared remarks. We'll open the discussion up to questions at this time.

MR. RIPPS: We gave a summary of our thinking as currently reflected in the current draft of the issue paper. There's more in it than the high points that we have hit. But we very much appreciate your questions, your comments, and your ideas on this subject because we are very much involved in a work in progress.

FROM THE FLOOR: Is your paper available yet or is it still in progress?

MR. RIPPS: It's still in progress, and we are reluctant to share it with anyone until it has the official imprimatur of the Academy.

MR. HARLAN M. WELLER: I'm one of those people who are anxiously awaiting the paper and I want to encourage you to get it to Washington as soon as possible. I think there's some very valuable analyses that we can gather from what the actuaries said.

MR. RIPPS: Could you comment on why you're anxious and what the status is? Perhaps give both panelists and members of the audience some idea as to why a paper from the Academy at this time would be useful.

MR. WELLER: Well, as I'm sure all of you have been watching, there's a great deal of action going on in Congress right now. There's five different committees working on versions of health reform. They're going to end up with five different versions, and at some point, someone is going to have to meld those versions together into one, which, hopefully, will make some sort of sense. And looking at the trade-offs between the various versions, I think seeing the pluses and minuses from a dispassionate view would be most useful as you try to put together something that makes sense.

Now, as you noted, many of these issues are interrelated. The context of whether you have good insurance reform outside the system affects whether or not you want to have a different size threshold on the corporate versus the health alliances or the mandatory/voluntary issue. And I'll give you an example. I don't think you actually brought it up in today's conversation; hopefully, it's reflected somewhat in the paper, but I think in the Clinton Plan, one of the chief reasons that there was a concern about having a high threshold for corporate alliances which could voluntarily come in and out of the regional alliances is the existence of the 7.9% of pay compensation cap on the cost to the employer and the large risk of adverse selection with employers with a high underlying cost going into that alliance and the ones with lower underlying costs staying out of the alliance. That concern led to one, the high threshold and the mandatory inclusion in the alliance below. I think it also led to the 1% assessment on corporate alliance employers. Again, moving that threshold a little bit for corporate alliance does not adversely select against the group. So, as I say, that's an important background issue in deciding whether or not you're going to force people into a health alliance.

MR. RIPPS: Any comments?

FROM THE FLOOR: Let me just ask you a question. As a Washington insider, who undoubtedly follows this stuff with great attention, is it your judgment that alliances are going to live through the congressional process, what emerges out of Congress will include the notion of alliances?

MR. WELLER: My guesstimate is that there will be alliances in some form out of the final product. I don't think they will be as comprehensive as the ones in the Health Security Act. I think you might see something coming out of the process which

splits out things like the subsidies going to the Internal Revenue Service (IRS) or Department of Health and Human Services (HHS) or something like that, building on existing agencies for some of the functions that have been currently assigned to alliances under the Clinton Plan.

MR. GREGORY J. SAVORD: I've been one of the people involved in doing estimates on the Health Security Act and we have had to deal with different alliance sizes. One thing you didn't mention was, in listing advantages of a large employer threshold, did you consider an unlimited threshold? It seems to me that everyone must be in the alliance. It would solve some types of problems like families that have one person that would be in the alliance working, and another family member that would not be in the alliance. What plan covers people going in and out? Also, there is the concept of cross-subsidies for Medicaid and other high-risk people. Did you consider completely mandatory alliances?

MR. RIPPS: The short answer to your question is, no. At this point our paper does not take up the issue of having an alliance threshold of infinity. It's an interesting question to consider, but one that we did not address because we thought 5,000, as proposed in the Health Security Act, was a high threshold and didn't even think of a higher threshold. But that's something we ought to go back and consider.

MS. JUDITH A. DISCENZA: The alliances are tools, and you're talking about what characteristics they should have. It seems like you've answered all the questions about characteristics in terms of it depends on what you're going to use the tool for. It seems to me that the Society would owe those who are working on this thing a review of those purposes because that is crucial. It seems to me that's what's causing the confusion about what alliances should look like. It doesn't sound like you're dealing with an examination of the problems and purposes that led to the alliance idea in the first place, and maybe I misunderstood that. But if you're not dealing with those problems, is there some particular reason you chose to deal only with the back half?

MR. RIPPS: You're right on target and right in sync with our thinking, Judy. Our paper takes the view that each of these issues needs to be considered in terms of the purposes for which the alliances are intended. We purposely, however, take no position on the question of whether an alliance should be used to do this, that or the other thing. For example, we don't go into an analysis of why there is a problem with universal coverage, or is an alliance the appropriate way to address universal coverage, or is global budgeting at a federal or a state or alliance level a good idea or a bad idea, or should you or shouldn't you use an alliance for that purpose? Those are issues of social policy which need to be left to those who were elected to form that social policy. We, as you put it, deal with the back end. But we deal with the back end in the context of trade-offs; it depends on which purposes are viewed by the policymakers as being primary. Right or wrong, our paper does not take a position on questions like, should you use an alliance to accomplish certain social purposes? Rather, our approach has been to say, if you want to use an alliance to accomplish a particular social purpose here are some of the things you need to think about. So we duck the question of whether it is a good idea or not from a social policy or social engineering perspective, simply because that puts us into dangerous waters and waters where arguably the Society or the Academy has little to

contribute. You might think we actuaries have some awfully good ideas about those issues, but they are political judgments that others who were elected need to make.

MR. GEROLD W. FREY: Do I read you that the committee came to the conclusion that demand for administrative functions is so great that it is virtually impossible to build these organizations to function and carry out the tasks they would have to carry out?

MR. WEBER: I don't know that we came to the conclusion that it's impossible. We think it has not been given proper attention, and transitional rules probably haven't been given adequate attention in the Clinton proposal.

MR. FREY: Have you tried to estimate how many people would have to be employed by how many alliances?

MR. RIPPS: We have not. There is another work group that the Academy has established on administration and called curiously enough the Administration Work Group. They are dealing in more detail with problems of administration. I've seen a draft of their paper, and both our paper and their paper say there are really formidable problems in trying to create the administrative substructure for alliances. Both papers, however, do not reach the conclusion that it's impossible; they just say it's very difficult. What do you think?

MR. FREY: I don't know where all these people come from bringing all the expertise that will be needed to carry out the functions that apparently a full alliance would have to carry out, and I don't know how many alliances there would have to be.

MR. RIPPS: It's a formidable challenge. It's particularly formidable if there are restrictions on conflicts of interest and other restrictions that prevent anybody with practical experience from being involved. Hopefully, some of those restrictions will be relaxed, and the staffing of these alliances will come from the shrinkage of the health insurance industry, so there would be many knowledgeable people available.

MR. FREY: I was also surprised to notice that the alliance would negotiate with providers. I thought the plans of carriers would negotiate with the providers.

MR. WEBER: There's a provision in the proposed law that gives the alliance the responsibility to establish the fee schedules for services that are outside of health plan networks. For health maintenance organization (HMOs), the schedules pertain to out-of-network emergency services or nonemergency services provided out-of-network under a point-of-service feature. In addition, the schedule would apply to traditional indemnity-type plans.

MR. WELLER: I agree with you that insufficient study has been placed on the administrative burdens on the alliances, but I don't believe that they're insurmountable. Many of the functions that you're talking about are currently done by TPAs or brokers. It's not something completely unheard of. Certainly some of the functions that are involved are going to be new. But it's not as if you're looking for one individual who is going to be able to do every single function listed in the bill. I

think that eventually the health alliances will look like large TPAs or brokerages that are there today.

MR. RIPPS: One of the concepts in our paper is the notion that you suggest that, in order to get started, there be serious consideration of contracting out or delegating administrative functions to existing organizations, rather than creating new agencies to do them. Other comments?

MR. DEAN L. TAYLOR: I direct my question to Don Weber. You mentioned a funding limitation of 2.5%. Is that an assessment on the alliances after they get going? And, if it is, how do we pay for the start-up cost for those alliances? Are they coming out of taxes? And my third question is, did you arrive at the 2.5% number? Is that from the Clinton administration?

MR. WEBER: Right. The bill has within it a 2.5% provision for the administrative services that need to be performed by the alliance. But it seems to be totally silent about the funding of start-up costs, and that's why we raised it as an issue.

MR. STEVEN KESSLER: Have you addressed the role of brokers?

MR. KUZMA: The experience at the state level suggests that brokers and agents are probably going to work their way successfully into the alliance. In California, I am told, 75% of the business written through the Health Insurance Purchasing Cooperative (HIPC) is done through brokers and agents. And, in fact, the small employers feel there's value in doing so. They pay a separate distinct fee for the broker.

MR. RIPPS: In the draft of our paper as it exists today, there is relatively little about the role of brokers. There's some passing reference to the possibility of limiting commissions. But I'd be curious to know what prompts your question and whether you have a view. Would you share that with us?

MR. KESSLER: We're currently negotiating with a number of alliances that are up and coming or trying to get started I should say. While we have multiple distribution channels, we're trying to decide whether we should abandon the broker distribution system and go to the exclusive alliance distribution system, or do we do exactly what that gentleman is saying and allow the groups to pay if they feel there is a value for the brokers and eliminate our direct dealing with the brokers.

FROM THE FLOOR: There are a number of other reforms being considered in the nature of tax equity and particularly medical savings accounts for individuals. I was wondering if those aspects of anything like that being enacted would impact the need for or the structure of the alliances you're talking about.

MR. RIPPS: That is an interesting question. And I think it could be argued that, if some of those things were enacted there would be much less of a need for alliances. There are a number of alternative regulatory initiatives or legislative initiatives that could lessen the need for health alliances. Medical savings accounts certainly is an example.

The answer to your question is that we have not addressed those things directly in our paper as it currently stands, although we do have a section that relates to alternatives. We recognize that there are other ways to "skin this cat," there are other ways to achieve some of the intended purposes of alliances. I can't recall at this point whether tax initiatives or tax reform is in there or not. It's certainly worth our consideration because I think those kinds of changes could have an effect.