REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-99)
Employer Purchasing Alliances: An Evolutionary Step Toward "Voluntary Choice Cooperatives" Under Individually Selected and Owned Health Insurance
(Reference Committee A)

EXECUTIVE SUMMARY

At the 1998 Annual Meeting, the House of Delegates adopted the recommendations in Council on Medical Service Report 9, "Empowering Our Patients: Individually Selected, Purchased, and Owned Health Expense Coverage." The report described the AMA's long-range plan for reform of the health insurance system, which involves a preference for individually selected and owned health insurance. A key component of the AMA's proposal involves changing the tax treatment of health insurance expenditures so that individually selected and owned health insurance is a viable alternative to employer selected insurance. A system that encourages individual ownership of health insurance through tax incentives, however, does not necessarily obviate the need for mechanisms to group risks. Hence, another key component of the AMA's proposal is fostering the development of individual voluntary choice cooperatives to facilitate and expand patient choice. Recent press reports indicate that there is a misconception that the AMA proposal advocates nothing more than existing products from the individual insurance market, which are expensive and often unavailable for patients with pre-existing conditions. In order to dispel such misconceptions that might otherwise prevent serious consideration of the AMA's proposal, the Council has developed a report on existing institutions that are similar to individual voluntary choice cooperatives.

This report presents available information on existing employer health insurance purchasing alliances that have already implemented various aspects of individual voluntary choice cooperatives. The report compares the experiences of employer purchasing alliances in terms of legislative and market environments, membership structure, standardization of benefit packages, contracting approaches, degree of consumer choice, and other design elements. Evidence suggests that the group size and bargaining power of employer purchasing alliances can achieve cost-savings and expand consumer choice. To date, employer purchasing alliances appear to have had variable but limited success in expanding access to the otherwise uninsured.

Although different in certain respects from individual voluntary choice cooperatives envisioned by the AMA, employer purchasing alliances represent market-based responses to the problems of high premium costs, the growth of the uninsured population, and limited choice of plans. The Council believes that existing employer purchasing alliances demonstrate the feasibility of individual voluntary choice cooperatives to address these problems. The Council also believes that more research is warranted on the characteristics of successful and unsuccessful employer alliances in order to offer further guidance in the design of voluntary choice cooperatives.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - A-99

Subject: Employer Purchasing Alliances: An Evolutionary Step Toward "Voluntary Choice Cooperatives" Under Individually Selected and Owned Health Insurance

Presented by: Kay K. Hanley, MD, Chair

Referred to: Reference Committee A
(Marilyn K. Laughead, MD, Chair)

The AMA's long-range plan for reforming the health insurance system was presented in Council on Medical Service Report 9 (A-98). The report proposed a number of measures to transform the health care system from a system based primarily on employment-based health insurance to one of individually selected, purchased, and owned health expense coverage (Policy H-165.920, AMA Policy Compendium). The core of the AMA's proposal involves revamping the tax treatment of health insurance expenditures, thereby creating an enabling environment for alternative sources of coverage and increased competition among health plans. A system that encourages individual ownership of health insurance through tax incentives does not necessarily obviate the need for mechanisms to group risks. Hence, another key component of the AMA's proposal is fostering the development of individual voluntary choice cooperatives to facilitate and expand patient choice.

Several recent press reports indicate that there is a misperception that the AMA proposal advocates nothing more than existing products from the individual insurance market, which are expensive and often unavailable for patients with pre-existing conditions. In order to dispel such misconceptions that might otherwise prevent serious consideration of the AMA's proposal, the Council decided to develop a report on existing institutions that are similar to individual voluntary choice cooperatives. The following report reviews available literature on existing employer alliances that have already implemented various aspects of individual voluntary choice cooperatives.

KEY COMPONENTS OF THE AMA'S PROPOSAL FOR INDIVIDUALLY SELECTED AND OWNED HEALTH INSURANCE

Changing the Tax Treatment of Health Insurance Expenditures

The current tax code subsidizes health insurance only if it is obtained through an employer. Compared to group insurance, individual policies are generally much more expensive because they are not subsidized, and because they lack the substantial cost-savings of pooling risk and reducing administrative overhead. For these reasons, employment-based coverage is effectively the only choice most Americans have. Changing the tax code so that individuals receive tax benefits regardless of whether they obtain health insurance through their employers or elsewhere is an important first step in expanding individuals' options for obtaining affordable coverage.

As described in Council on Medical Service Report 9 (A-98), the AMA proposes replacing the existing tax exclusion for employer expenditures on health insurance with a refundable tax credit Policy H-165.920[12]. Under the current system, individuals obtain tax benefits because their employers' expenditure on health insurance is not reported as income. Under the proposed new system, employer contributions to health insurance would be reported as taxable income, and an individual or family would receive a tax credit equal to a portion of spending on health insurance, up to some cap. The tax credit would be directly subtracted from the individual or family's tax bill. Tax credits would be available only to those individuals with health insurance or other health expense coverage, providing a strong incentive to purchase health insurance. The AMA proposal also includes several features to ensure equitable access to health insurance. First, the percentage of insurance expenditures credited towards an individual's tax liability would be inversely related to income so as to increase access by lower-income persons and reduce the extent of uncompensated care. Second, the tax credit would be a "refundable" tax credit. Persons whose incomes are low enough that their tax liability is less than the credit to which they are entitled would receive a refund for the difference. Council on Medical Service Report 2 (A-99) provides an update on efforts to increase access to the uninsured.

Individual Voluntary Choice Cooperatives

The proposed tax change is expected to create new opportunities for individuals to pool risks and obtain group insurance. The second major element of the AMA's vision for expanding access to health insurance coverage is voluntary choice cooperatives through which individuals could purchase insurance. As described in Council on Medical Service Report 9 (A-98), the AMA supports federal legislation enabling the formation of voluntary choice cooperatives (Policy H-165.882 [14]). Such groups could include coalitions of small employers, unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, and ethnic coalitions (Policy H-165.882 [15]). Such groups would be encouraged to serve as voluntary choice cooperatives by exempting the insurance plans they offer from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws (Policy H-165.882 [14]). It should be noted that grouping individuals into voluntary choice cooperatives to purchase health insurance does not preclude employment-based groups. The AMA proposal permits the continuation of employment-based insurance to the extent that the market demands it, while opening up new sources of health insurance for employees, children, and the general uninsured population.

OVERVIEW OF EXISTING EMPLOYER PURCHASING ALLIANCES

Under the existing health insurance system, employers have banded together in a variety of arrangements to purchase health insurance. Although different in certain respects from individual voluntary choice cooperatives envisioned by the AMA, employer purchasing alliances represent market-based responses to the problems of high premium costs, the growth of the uninsured, and limited choice of plans. Existing employer alliances demonstrate the feasibility of individual voluntary choice cooperatives to address these problems, and offer lessons for designing voluntary choice cooperatives.

State governments and employers have responded to the problem of purchasing affordable health insurance by legislating a range of insurance reforms and creating a variety of employer health insurance purchasing alliances. Employer alliances resemble benefits departments of large firms,

performing functions such as negotiating with health plans (or providers), screening plans for inclusion in alliance offerings, marketing plans to members, providing comparative information about plan benefits and performance, conducting patient satisfaction surveys, administering enrollment and premium collection, and processing claims. Administration of policies is almost always centralized with the alliance so that employers do not have to deal with multiple insurance companies. For these reasons, employer alliances may threaten benefits administrators of firms already offering health insurance. In addition to streamlined benefits administration, member employers are attracted to alliances by the prospect of decreased health benefits costs, improved access to insurance, and greater choice of plans and providers. The actual experience of employer purchasing alliances has varied from state to state depending on factors such as the legislative environment, membership structure, approaches to contracting with insurers or providers, other design elements, and health insurance and health care market conditions.

Names

Various names are used to describe employer health insurance purchasing alliances. Different names sometimes signify distinct types of employer alliances, although in some cases, there are no clear differences between entities with different names. The most common names for employer purchasing alliances are Multiple Employer Welfare Associations (MEWAs), Consumer-Choice Health Purchasing Groups (CHPGs), and Health Insurance Purchasing Cooperatives (HIPCs). Unlike most other arrangements, MEWAs are set up to bear risk and have other distinct characteristics described below. CHPGs, sometimes called Consumer-Choice Health Purchasing Cooperatives (CHPCs) or Community Health Purchasing Alliances (CHPAs), represent small employer groups, offer individuals a choice of competing health plans, and have standardized benefits. Other names include Cooperatives for Health Insurance Purchasing (CHIPs), Voluntary Health Care Purchasing Cooperatives, Voluntary Purchasing Pools, Health Purchasing Alliances, and Health Purchasing Coalitions. Employer groups that purchase health insurance will herein be called employer purchasing alliances or employer alliances. Other entities, such as the Vermont Employers Health Alliance, are coalitions of employers who band together for activities other than purchasing health insurance, for example, gathering and disseminating comparative information on health care quality, lobbying state legislatures, and holding seminars on how to negotiate with insurers.

Legislative Environment

More than 20 states have enacted legislation creating or authorizing the creation of employer health purchasing alliances for private businesses, state or local government agencies, or both. Specific laws vary considerably by state. A few states, such as Texas, have simply removed legislative barriers such as restrictions on private groups joining together to seek insurance coverage. In other states, such as California, Florida, and North Carolina, an alliance or series of non-competing alliances with fixed geographic areas is chartered, funded, and run by the state government. State-sponsored alliances typically gather and disseminate comparative information on plan or provider quality, offer consumer support, and in some cases, negotiate with insurance plans. Many states limit participation to groups of fewer than 50 or 100 employees. Employer alliances are usually prohibited from excluding groups or individual employees on the basis of health status or risk.

Laws governing employer alliances are often accompanied by market-wide insurance reforms such as community rating bands, guaranteed issue, guaranteed renewability, and limits on exclusions for preexisting conditions. Community rating promotes the viability of alliances by checking adverse

selection against alliances. If community rating is used within an alliance but premium rating and underwriting are used outside the alliance, high-risk groups will be penalized more outside than within the alliance. Such a lack of uniformity in rating practices could cause the alliance to become a high-risk pool, making it ultimately unviable. A 1996 article by the American College of Physicians in The Annals of Internal Medicine states, "It is critical that health plans operate under the same market and rating rules inside and outside of purchasing pools; otherwise, insurers will seek out the healthiest people for nonpool plans." Other reforms that make alliances more attractive to prospective members are guaranteed issue, guaranteed renewability, and limits on exclusions for preexisting conditions – either within insurance purchasing alliances or more generally. Employer alliances in states with such reforms, such as California, Florida, and Minnesota, appear to have been more successful than alliances in states without such reforms. A 1997 Urban Institute analysis by Blumberg and Nichols concludes that "[i]nsurance reforms define the range of feasible options for HIPC design.… Guaranteed issue and similar premium rating restrictions outside the HIPC are essential for long run HIPC survival."

Membership

Only a few alliances offer insurance to individuals outside of employment groups, which is not surprising given the existing tax subsidy for employer-based insurance. Federal employees make up the largest health insurance purchasing pool, the Federal Employees Health Benefits Program (FEHBP). Many states provide insurance to state and local government employees through similar pools, for example the California Public Employees Retirement System (CalPERS) and the Massachusetts Group Insurance Commission (GIC). At least one state, Minnesota, joined an established private-sector alliance of large employers, the Buyers Health Care Action Group (BHCAG). In the private sector, alliances were traditionally made up of large, private employers that already offered health insurance prior to joining the alliance, e.g., in Cincinnati, OH and Rochester, NY. Following the national health reform debate of the early 1990s, alliances of small employers started forming, often with the help of state legislation. Compared to alliances of large employers, those of small employers are more likely to extend insurance coverage to individuals who were previously uninsured. Some employer alliances specify conditions of membership such as minimum levels of employee participation and that all group coverage must be obtained through the alliance. In a few cases, such as Ohio's Council of Small Enterprises (COSE), employer groups can be denied membership on the basis of the medical conditions of their employees. Also under COSE, individual employees are subject to medical underwriting and may be denied coverage if they do not enroll in a COSE plan within 90 days of being hired and did not have other coverage.

Standard Benefit Packages

Virtually all of the private employer alliances studied state that they have standard benefit packages. Some public sector pools, including the FEHBP, do not specify a benefit package, although there have been recurrent debates about whether the FEHBP should do so. Although the FEHBP does not standardize benefits, it does limit variation in benefits across plans. The rationales for standard benefit packages are to facilitate comparison on the basis of price and quality, promote price and quality competition, limit risk segmentation within the alliance, and prevent insurers from stripping down plans in order to attract only low risks. Standardization of benefits means that the set of covered medical services is the same from plan to plan. However, there is usually considerable variation and consumer choice along other dimensions such as type of plan, level of cost sharing, and provider networks. Optional dental and vision plans are often

offered as well. North Carolina's network of employer alliances, Caroliance, offers a standardized benefit package through Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point of Service (POS) plans, and indemnity plans. Ohio's COSE offers these forms of insurance plus a Medical Savings Account (MSA) option. Most alliances offer at least two levels of cost-sharing for each type of plan, with different cost-sharing structures across plans types.

Approaches to Contracting and Choice

Some employer alliances seek to negotiate a restricted number of policies at the lowest price, whereas others offer individuals a wide range of choice in plans and carriers. In some cases, member employers can restrict the number of options available to employees. More commonly, individuals can choose from the full range of plans contracting with the alliance. Among state-operated employer alliances, individual rather than employer choice is mandatory in only a few states, including California and Kentucky. A similarly small number of states, including Florida, require employer alliances to contract with all qualified health plans, which increases consumer choice but weakens the alliance's bargaining power. At its inception, the Twin Cities' BHCAG adopted a "winner takes all" approach. BHCAG specified price and quality goals in requests for proposals from plans and then signed a multiple year contract (1993-95) with the plan most closely meeting its specifications. BHCAG has since moved to an approach in which individuals choose among multiple provider networks. In California, the Pacific Business Group on Health (PBGH), another privately operated alliance of large employers, permits employers to select which plans to offer their employees. In contrast, the California Health Insurance Purchasing Cooperative (HIPC) and CalPERS both emphasize individual choice. In the Colorado's Cooperative for Health Insurance Purchasing (CHIP), employers choose one of three benefit levels, while employees choose a plan from four insurers. Employers belonging to Florida's Community Health Purchasing Alliances (CHPAs) may restrict the number of plans offered to employees but are required to offer a minimum of two or three plans depending on the firm's size.

Direct Contracting

Recently, a few employer alliances have contracted directly with networks of health care providers. Direct contracting is usually done by alliances of large, self-insured employers (e.g., the Minnesota BHCAG). In order not to jeopardize their Employee Retirement Income Security Act (ERISA) exemptions from state regulations, they generally refrain from transferring risk to providers, paying on a discounted fee-for-service basis. The networks of both the Madison, WI, Alliance and the Colorado Health Care Purchasing Alliance include any hospital or physician willing to accept the negotiated rates and credentialing requirements. Such inclusiveness maximizes individual choice and curtails potential opposition from providers, but restricts the alliance's purchasing power by reducing the volume of patients going to any one provider.

Quality Initiatives

Some of the larger employer alliances have devoted resources to "value-based" purchasing strategies. Such strategies entail measurement of quality and satisfaction indicators, efforts to improve quality of care, and disseminating comparative cost and quality information to individuals when individuals rather than employers play a large role in plan choice. The PBGH in California

requires participating plans to report Health Plan Employer Data Information Set (HEDIS) data, but it also requires that plans' HEDIS records be audited independently. Minnesota's BHCAG collaborated with the Institute for Clinical Systems Integration (ICSI) to develop more than 40 medical practice guidelines and to integrate the protocols into medical practices. Employer alliances occasionally provide financial incentives to participating plans based on performance indicators, or contract on the basis of quality. The PBGH places a proportion of premiums at risk, making them available to plans that meet established quality goals. Alliances also may contract selectively with plans or providers based on quality and price, or simply screen out those plans that do not meet minimum standards. Providers may be reluctant to participate in quality measurement if results are to be made public, especially if results are not adjusted for severity mix or are considered unreliable for other reasons. In some cases, employer alliances have worked with providers to monitor and improve quality without disseminating results. As mentioned earlier, some employer coalitions have formed to undertake quality initiatives without purchasing as a pool.

Employee Premiums

Most small-group alliances specify a minimum employer contribution to premiums, such as 50% of each employee's premium or at 50% of the lowest premium. Many employer alliances including Minnesota's BHCAG have defined contribution systems, whereby employees are responsible for paying any difference in cost between the employer's fixed contribution and the premium of the chosen plan. Defined contributions foster cost-consciousness by individual consumers and price competition among plans. Although the California PBGH does not require defined contribution systems, most member employers use them. Occasionally, the portion of premiums paid by employees are adjusted for individual characteristics such as age and gender. In North Carolina's network of alliances, Caroliance, employer groups demonstrating exceptional health status receive preferred rates.

Risk Adjustment

Although insurance market reforms such as community rating can limit risk segmentation between an alliance and the general market, risk segmentation among plans within an alliance can still be a problem. In rare instances, large, well-funded employer alliances such as the California HIPC have started risk adjusting payments to participating health plans in order to reduce or mitigate risk segmentation within the alliance.

Market Conditions

Employer health insurance purchasing alliances appear to be most likely to succeed in densely populated areas with high managed-care penetration. Alliances may also face challenges in very large metropolitan areas. The small number of potential enrollees in sparsely populated areas fails to attract numerous competing providers or plans. Experience from the California HIPC's six regions confirms that there is less competition in rural areas. On the other hand, organizing small employers is difficult in areas such as New York City, Los Angeles, and Chicago. Because of geographic dispersion and ethnic and socio-economic diversity, employees and unions want to maintain access to the broadest network of providers. In large metropolitan areas with no employers dominating the market, employer alliances may have difficulty generating purchasing leverage.

SELECTED CASE STUDIES

Multiple Employer Welfare Arrangements

First formed in the late 1970s, Multiple Employer Welfare Arrangements (MEWAs) are risk-bearing entities created to offer one or more insurance plans to a group of small employers. In the late 1990s, a proliferation of fraudulent MEWAs gained media attention by closing down in the wake of mounting unpaid health claims. Some MEWAs are operated by sham unions that attract small businesses with underpriced premiums that cannot cover claims costs. When an unscrupulous MEWA goes out of business in one state, it may simply repeat the process in another state, operating under a different name. Thirteen states, including West Virginia, are currently investigating the activities of defunct MEWAs run by the same sham union. It is important to note, however, that not all MEWAs are operated unscrupulously, and that some have successfully secured health insurance coverage for members.

Because MEWAs are set up as risk-bearing entities composed of employer groups, they claim to be exempt from state regulations under ERISA. State regulations from which MEWAs claim to be exempt include solvency requirements, coverage mandates, rating requirements, premium taxes, and high risk pool assessments. There has been ambiguity and lack of agreement about whether MEWAs are actually entitled to ERISA exemptions. In 1983, Congress amended ERISA so that states could regulate MEWAs with certain exceptions, including plans established under collective bargaining agreements. Until recently, the Labor Department has resisted issuing a determination on whether ERISA applies to MEWAs generally. In late 1998, the Labor Department undertook a negotiated rulemaking process to develop rules enabling state regulators to regulate all MEWAs. At the time that this report was prepared, the negotiated rulemaking process was ongoing.

California Health Insurance Purchasing Cooperative

The California Health Insurance Purchasing Cooperative (HIPC) operates in a state with legislation conducive to employer health insurance purchasing alliances and some of the country's most prominent alliances. The California Public Employees Retirement System (CalPERS) is the purchasing pool for state and municipal employers. The Pacific Business Group on Health (PBGH) is an alliance of large employers. Both CalPERS and PBGH conduct enrollee satisfaction surveys and have extensive programs of quality measurement, reporting, and improvement. One of the first alliances for small businesses in the U.S., the HIPC started offering insurance in 1993. The HIPC competes with a newer, smaller alliance of small employers, California Choice. Although the HIPC and California Choice are very similar, California Choice is privately operated and offers different plan options than the HIPC.

The HIPC was established by state legislation that also introduced reforms of the small group market: guaranteed issue and renewal, limits on exclusions for preexisting conditions, annual open enrollment, and community rating bands of plus-or-minus 10% of average premiums. A state agency with a staff of 13 manages the HIPC, subcontracting basic administration to a private firm chosen through competitive bidding (currently the PBGH). Employers interact directly with the HIPC rather than with multiple insurers, and there is a standardized application form for all plans. Participating insurers are prohibited from offering plans with similar or richer benefits at lower premiums outside the HIPC.

The HIPC is open to private firms of 2 to 50 employees and to larger firms that join through qualifying trade associations. Only full-time employees are eligible, and at least 70% of a firm's eligible employees must elect coverage. Benefits are standardized, and employees have a choice of 18 HMOs and two POS plans, each with a high and low cost-sharing option. There is also optional dental coverage offered by seven different insurers. Employers must pay at least 50% of the lowest single-coverage premium. Premiums paid by employees vary by age (seven categories), family size (four categories), and geographic region (six categories). Although the HIPC emphasizes consumer choice, plan participation is not automatic. The HIPC negotiates with plans, and participating plans are required to report HEDIS and cost data. Plans are not required to offer coverage in all six regions but must be available throughout their licensed service areas.

In its first year, 2,500 firms with a total of 44,000 employees joined the HIPC. Membership is now 7,500 firms with 140,000 employees, representing 2% to 3% of all eligible firms. The mean number of full-time employees of firms in the HIPC is 10, and nearly 95% have fewer than 25 employees. Eighty percent of member firms offered insurance before joining the HIPC. However, few offered employees a choice of health plans.

The rapid growth in the HIPC's enrollment has been attributed to lower premiums and greater choice than in the outside market. In its first four years, the HIPC achieved 5% to 15% savings in premium costs. Administrative costs were about 3% of premiums, compared to 25% to 40% for small groups and individuals. Further, between 1993 and 1996, competing plans aggressively reduced premiums, and plans with the lowest premiums gained market share accordingly. In contrast to other areas, rural regions attracted fewer participating plans, experienced less price competition, and faced higher premiums. Observers believe that the HIPC might have had spillover effects in the outside small-group market, lowering prices and increasing coverage by 2%. However, it is difficult to separate the effects of competition within the HIPC, insurance market reforms, and fierce price competition in the California managed care market during the mid-1990s.

It does not appear that the HIPC has attracted an adverse selection of enrollees compared to the general small-group market. However, despite a standardized benefit package and age-adjusted premiums, substantial risk segmentation occurred within the HIPC. PPOs attract a disproportionate share of higher-risk enrollees. During the first two years of the HIPC, the ratio of PPO to HMO premiums rose sharply, and two PPOs withdrew. The state spent approximately a half a million dollars to develop a rudimentary risk adjustment mechanism, introduced in 1996-97. Plans with a disproportionately high number of enrollees with certain high-cost conditions receive payments from plans with disproportionately few such enrollees. In the first year of risk adjustment, the seven plans with the most favorable selection (all HMOs) paid into a fund compensating the two plans with the most adverse selection (PPOs). The transfer was equal to slightly more than 1% of total HIPC premiums.

Texas Insurance Purchasing Alliance

The Texas Insurance Purchasing Alliance (TIPA) is a private, non-profit employer alliance. TIPA started offering insurance to employer groups of two to 50 in 1995. Although TIPA was created through state legislation, it operates in a relatively unregulated insurance market. Texas has guaranteed issue but is essentially a risk-rated market because of wide community rating bands.

Employees choose a standardized benefit package with two levels of cost-sharing. The lower cost-sharing option is available only if at least 40% of an employer group chooses it. Premiums paid by employees vary by age, gender, and type of coverage (individual or family). After starting with 20 insurance carriers, TIPA has experienced severe carrier attrition. Currently, only Blue Cross/Blue Shield offers insurance through TIPA, defeating the intent of consumer choice and carrier competition. At its peak, TIPA insured 13,000 individuals compared to 8,000 currently. In contrast to the California HIPC, 50% of employers belonging to TIPA did not previously offer health insurance. TIPA currently faces the prospect of closing down in the year 2000. In an effort to avert this possibility, TIPA is trying to attract new insurers and is lobbying the state to develop incentives for insurers to participate.

TIPA's difficulties can be attributed to a variety of factors, including unfavorable legislative and market environments. Limited community rating led to the perception, and possibly the reality that TIPA had become a high-risk pool, driving away participating insurers. Compared to the HIPC, TIPA has a much smaller membership base and a lack of resources for activities such as quality reporting, risk adjustment, and outreach to prospective members. According to a TIPA official, the alliance also experienced resistance from insurers who were not operationally equipped to handle a group of smaller groups. Rather than treating all TIPA enrollees in a plan as one large group, insurers reportedly insisted on maintaining records for each small member group as well as for individuals, thereby preventing cost savings. Insurers' claims and information systems were also not designed to process information from multiple age/sex/type-of-coverage cells. Additionally, in 1998, HMOs in Texas experienced losses equal to approximately 5% of revenue.

CONCLUSION

The AMA's long-range proposal for health care reform is to transform the current health system from one relying primarily on employment-based coverage to a system of individually selected, purchased, and owned health insurance. Policy H-165.920 [12] recommends replacing the existing tax exclusion for employer expenditures on health insurance with a refundable tax credit equal to a portion of individual or family expenditures on health insurance. Under this proposal, individuals would not be restricted to obtaining insurance through their employers in order to obtain a subsidy. Further, since tax credits would be inversely related to income, subsidies would be targeted to those most likely to be uninsured, creating a greater impact on access than untargeted subsidies. Changing the tax treatment of health insurance expenditures in this manner would have a profound effect on the economic environment regarding the financing, provision, and organization of health insurance. The tax change would create new opportunities for entrepreneurship, and individual voluntary choice cooperatives would be likely to emerge as a natural market response to the changed environment. Policy H-165.882 [14] supports federal legislation enabling the formation of voluntary choice cooperatives through which individuals could purchase insurance.

This report examined existing employer health insurance purchasing alliances as potential prototypes of individual voluntary choice cooperatives. Evidence suggests that the group size and bargaining power of employer purchasing alliances can achieve cost-savings and expand consumer choice. Often, a key element in success is support from the state, particularly for alliances of small employers. State support includes small-group insurance market reforms and funding for administration, risk adjustment, quality initiatives, and marketing to small employers. However, alliances of small, private-sector employers have succeeded without active state intervention (e.g., the Ohio Council of Small Enterprises).

To date, employer alliances appear to have had limited success in expanding access to the otherwise uninsured, although this varies by state. For instance, only 18% of Colorado's Health Care Purchasing Alliance member groups did not previously offer health insurance, whereas 55% of individuals covered through Florida's CHPAs were previously uninsured. According to Blumberg and Nichols (1997), "Without substantial subsidies,… HIPCs and insurance reforms alone will not reduce the rate of uninsurance very much." The Administration's budget proposal for FY 2000 includes a $44 million tax credit for businesses with fewer than 50 employees purchasing insurance through nonprofit alliances. Tax credits would equal 10% of the employer's contribution to health insurance with a cap of $200 for an individual policy and $500 for a family policy. In contrast to the AMA's more comprehensive proposed tax changes, the Administration's proposal would benefit only employees of small firms and would not facilitate purchase of insurance outside the context of employment.

Existing employer health insurance purchasing alliances have contained premium costs, expanded individual choice of plans, and extended insurance coverage in some cases. In these respects, employer alliances serve as models for individual voluntary choice cooperatives. However, individual voluntary choice cooperatives envisioned by the AMA may have certain characteristics not shared by all employer alliances. For example, under the AMA proposal, individuals would not be limited to insurance options offered by their employers, and individuals, not employers, would purchase and own their insurance policies. Individuals would be able to choose from multiple plans, and perhaps multiple voluntary choice cooperatives, thus spurring greater competition among plans. The formation of voluntary choice cooperatives, in conjunction with the proposed tax changes, is likely to have a greater impact on access to health insurance than previous employer purchasing alliances. Finally, in contrast with most existing employer alliances, voluntary choice cooperatives could be designed along the lines of the Federal Employees Health Benefit Program (FEHBP), which does not restrict plans to a single standard benefit package, and which includes plans from any insurer that is willing to conform to established standards such as solvency requirements.

The Council on Medical Service believes that existing employer alliances demonstrate the viability of individual voluntary choice cooperatives. The Council also believes that more research is warranted on the characteristics of successful and unsuccessful employer alliances in order to offer further guidance in the design of voluntary choice cooperatives. The Council will continue to study issues related to institutions resembling voluntary choice cooperatives, and will work toward further refinements, as needed, in the AMA's long-range plan for reform.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted and that the remainder of this report be filed:

> That the AMA continue to study existing employer health insurance purchasing alliances that resemble individual "voluntary choice cooperatives" envisioned in the AMA's proposal for individually selected and owned health insurance.