
**Wisconsin Family Impact Seminars
and the
Wisconsin Health Policy Forums**

**Rising Health Care Costs:
Employer Purchasing Pools and
Other Policy Options**



**University of Wisconsin-Extension
Center for Excellence in Family Studies
School of Human Ecology
University of Wisconsin-Madison**

Rising Health Care Costs: Employer Purchasing Pools and Other Policy Options

First Edition

Wisconsin Family Impact Seminars and the Wisconsin Health Policy Forums Briefing Report

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Purpose and Presenters

In 1993, Wisconsin became one of the first states to sponsor Family Impact Seminars modeled after the seminar series for federal policymakers. Because of the success of the Wisconsin Family Impact Seminars, Wisconsin is now helping other states establish their own seminars through the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension.

Family Impact Seminars are a series of seminars, briefing reports, newsletters, and discussion sessions that provide up-to-date, solution-oriented research on current issues for state legislators and their aides, Governor's Office staff, legislative support bureau personnel, and state agency representatives. The seminars provide objective, nonpartisan research on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Rising Health Care Costs: Employer Purchasing Pools and Other Policy Options" is the 18th Family Impact Seminar in a series designed to bring a family focus to policymaking. Family Impact Seminars analyze the consequences an issue, policy, or program may have for families.

This seminar is being co-sponsored by the Wisconsin Health Policy Forums. The Wisconsin Health Policy Forums is part of a national network of nonpartisan health policy organizations and is housed at the Wisconsin Public Health and Health Policy Institute, part of the Department of Population Health in the UW Medical School. The Forums' core principals are: the honest broker, the safe harbor, and balanced nonpartisan information. Each Forum provides an in-depth written summary of a relevant state health issue. In addition, public and private policymakers and other stakeholders have candid, off-the-record discussions based on unbiased information of relevant state issues.

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Wisconsin Family Impact Seminar Briefing Reports

Each seminar is accompanied by an indepth briefing report that summarizes the latest research on a topic and identifies policy options from across the political spectrum. Copies are available at:

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Executive Summary

Health care spending grew 10% per person in 2001 with anticipated growth rates of 7% to 9% in the years ahead. In Wisconsin, health benefit costs for employers rose 14.8% in 2002, while general inflation rose by only 2%. Wisconsin citizens' employee health care costs are \$6,940 per employee, 20% higher than the national average for workers in businesses with 500 or more employees. Across the country, states are struggling to understand what is behind escalating health care costs and how best to contain them, while continuing to maintain quality and choice.

The good news about the increasing amount spent on health care is that it reflects great advances in health technologies that allow people to live longer, healthier lives. On the other hand, rising costs mean our society is sacrificing a greater share of other goods and services to pay for health care. What's more, many small employers and their employees are deciding they must opt out of coverage because of cost. This briefing report addresses the driving forces behind rising health care costs, why Wisconsin's employer purchasing pool law has not been implemented, and how the nation's largest employer purchasing pool in California has worked.

In the first chapter, Len Nichols discusses the reasons for the dramatic increases in health care cost growth. Hospital services are by far the largest segment of U.S. health care spending, but expenditures on other services (i.e. physicians' services and prescription drugs) have increased at a faster rate. Three major factors affecting cost growth are: medical price inflation; the growth in volume of services; and the growth in intensity of services. Most expenditures are driven, not by inflating medical prices, but rather by the increasing volume and intensity of services. For example, while the number of bed days in hospitals has fallen by more than half since 1980, the total hospital costs per person has risen by 60% because patients are receiving more intensive services each day they are in the hospital. Managed care (i.e., HMO's) seemed to offer some promise in containing costs, but appear to have had only a short-term effect. In the next decade, the rate of cost growth is expected to accelerate.

Wisconsin has one of the highest rates of employer-sponsored coverage in the country. The next chapter, prepared by Rick Curtis and his colleagues of the Institute for Health Policy Solutions for the Wisconsin Department of Employee Trust Funds, focuses on why the private employer purchasing pool program passed in Wisconsin in 1999 has not yet been implemented. In order to alleviate the burden of escalating health care premiums on small employers, purchasing pools are often seen as a possible solution. Employer purchasing pools are a potential means to increase administrative economies of scale and purchasing clout. What's more, purchasing pools can offer employees something not normally available in the small employer market—specifically, choice of competing health plans. But to date, voluntary, unsubsidized consumer-choice pools have not gained enough market share to lower health care costs for small employers.

Small-employer purchasing pools have demonstrated problems, such as administrative inefficiencies, wide variation in premium cost, wildly fluctuating premium increases, and adverse selection (i.e., disproportionate enrollment of high-cost individuals).

Several options developed specifically for Wisconsin policymakers are explored in this paper: (a) reducing adverse selection by adopting rate rules that do not vary based on health status or claims experience; (b) making subsidies available to uninsured, low-income employees of small firms and providing premium assistance for populations otherwise eligible for public programs like BadgerCare could reduce state outlays; and (c) designing the small employer pool as the exclusive small employer coverage venue in Wisconsin to achieve large scale purchasing, more stable coverage, and reduced administrative costs. The authors recommend that for any of these options to work, state policy changes are required.

In the third chapter, John Grgurina describes California's PacAdvantage, the country's largest non-profit, small-employer health insurance purchasing pool. PacAdvantage now includes over 11,000 small California businesses, covering about 130,000 employees and dependents. PacAdvantage combines the purchasing power of thousands of small businesses (two to 50 employees) by sharing risks and negotiating competitive prices that offer a wide choice of quality plans, full-service products, and affordable co-pays.

Purchasing pools try to balance the competing demands of quality, cost, and availability. Additionally, purchasing pools can encourage smaller employers to offer health insurance coverage to their uninsured employees. For example, studies show that before joining PacAdvantage, 30% of small-business employees in California were uninsured.

One lesson learned from the PacAdvantage experience is that employee choice of health plan, product, and co-pay are highly valued by employers and employees. PacAdvantage also learned that the purchasing pool must be similar in operation to the market place to avoid adverse selection. For example, if general health plans are not required to cover self-employed individuals, but the small group pool was, the adverse selection of the enrollment from higher-risk, self-employed individuals could cause all of the pool's rates to rise. Finally, a voluntary purchasing pool by itself will not dramatically reduce prices and solve the problem of the uninsured.

The next chapter by the Wisconsin Health Policy Forums describes some commonly-used cost containment policies. Cost containment approaches such as insurance regulation, purchasing pools, and prescription drug purchasing have shown little evidence of limiting cost increases for any length of time. Direct price regulation and managed care did hold down costs in the 1990s, but some analysts argue that these were one-time savings. The same is true for purchasing pools which can hold down the price per individual by spreading risk and cost across more people, but do not directly address the problem of rising health care costs.

Even the apparently successful single payer public purchasing pool (Medicare) may actually attain its savings by shifting some costs onto the private sector and the administrative burden onto the provider. Approaches tried in other countries, such as single-payer universal health care systems, have contained costs but resulted in unpopular practices such as waiting lists and inadequate access to the latest technology.

To contain costs, policymakers must ultimately focus on purchasing value by measuring quality and outcomes. Until systems for collecting outcome and quality data are in place, the cost containment focus should be on setting policy cost goals and working on short-term containment of the biggest factors affecting prices.

The last chapter of this report is written by Laura Rose from the Wisconsin Legislative Council describes the Private Employer Health Care Coverage Program (PEHCCP). PEHCCP, created in 1999 in the Department of Employee Trust Funds (ETF) and amended in 2001, seeks to provide a voluntary health insurance purchasing pool for small businesses (i.e., two or more eligible employees). Employers who participate must offer health care coverage under one or more plans to all eligible employees and pay at least 50% of the lowest premium rate for each eligible employee. The program would be funded through \$205,100 in general revenues and \$850,000 in the form of loans by the Office of the Commissioner of Insurance (OCI) to the general fund. The general fund must repay the loan with interest at the end of the 2001-2003 biennium.

Although it was designed with an initial implementation date of January 1, 2001, the program has not yet begun; vendors say no bids were submitted to administer the program due to flaws in the program design. Legislative changes were enacted in the program model in 2001. Insurance rate banding—which limits the amount any one purchaser can be charged for insurance—was passed by the Legislature, but vetoed by the Governor.



A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or proposed program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles that serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.

This checklist can be used to conduct a family impact analysis of policies and programs.

✓ *For the questions that apply to your policy or program, record the impact on family well-being.*

1

Principle 1. Family support and responsibilities.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

2

Principle 2. Family membership and stability.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

3**Principle 3. Family involvement and interdependence.**

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

4**Principle 4. Family partnership and empowerment.**

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services required? Does it integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?

5**Principle 5. Family diversity.**

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- acknowledge intergenerational relationships and responsibilities among family members?
- provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

6**Principle 6. Support of vulnerable families.**

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

The Policy Institute for Family Impact Seminars aims to connect research and policymaking and to promote a family perspective in research, policy, and practice. The institute has resources for researchers, policymakers, practitioners, and those who work to connect research and policymaking.

- To assist researchers and policy scholars, the institute is building a network to facilitate cross-state dialogue and resource exchange on strategies for bringing research to bear on policymaking.
- To assist policymakers, the institute disseminates research and policy reports that provide a family impact perspective on a wide variety of topics.
- To assist those who implement policies and programs, the institute has available a number of family impact assessment tools for examining how responsive policies, programs, and institutions are to family well-being.
- To assist states who wish to create better dialogue between researchers and policymakers, the institute provides technical assistance on how to establish your own state's Family Impact Seminars.

This checklist was adapted by the institute from Ooms, T. (1995). *Taking families seriously as an essential policy tool*. Paper prepared for an expert meeting on Family Impact in Leuven, Belgium. The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988). *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington DC: Family Impact Seminar.

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Health Care Cost Growth: Trends, Sources, Strategies, and Feedback Loops

By Len Nichols

This chapter discusses reasons for the rapid increases in health care costs. Even though hospital services are by far the largest segment of U.S. health care spending, expenditures on other services, such as physicians' services and prescription drugs have increased at a faster rate. The cost growth is attributed to medical price inflation, the growth in volume of services, and the growth in intensity of services. Most expenditures are driven, not by inflating medical prices, but rather by the increasing volume and intensity of services. In the next decade, the rate of cost growth is expected to accelerate.

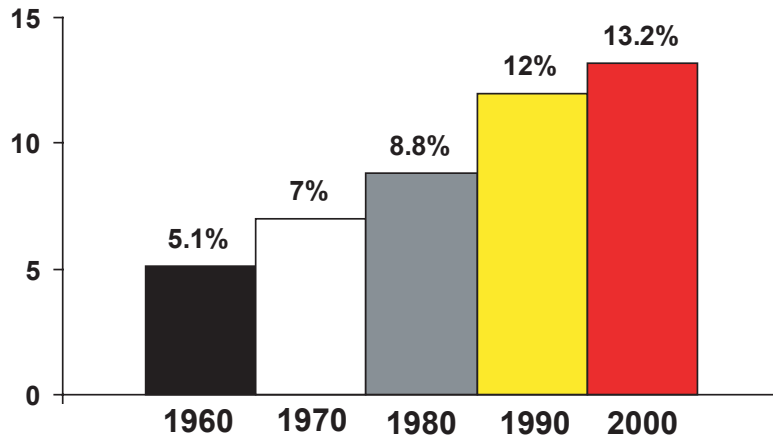
In 2001, health care spending grew by 10% per person, the first double-digit increase in more than a decade.¹ Experts on national health care costs are forecasting 7% to 9% annual growth in health insurance premiums for the next decade. Across the nation, states are struggling to understand what is behind escalating health care costs and how best to contain them. This chapter examines the major cost drivers in the health care system, how they are changing.

What Are the Impacts of the Growth in Health Care Costs?

Health care spending comprises 14% of U.S. Gross Domestic Product (GDP). For the past forty years, health care spending has become a larger and larger proportion of the U.S. Gross Domestic Product (GDP; see Figure 1). In 1960, the U.S. spent 5% of its GDP on health care. As of 2000, that proportion had grown to 14%, or nearly three times what it was forty years ago.

This growth rate marks a profound change in the role health care plays in Americans' lives. The good news about this shift is that it reflects the marked advances in health technologies that allow more people to live longer, healthier lives. On the other hand, rising costs for health services mean that our society must sacrifice an increasingly greater share of other goods and services in order to pay for health care.

Figure 1. Health Care Costs Are an Increasing Percentage of Gross Domestic Product



Source: CMS, National Health Accounts Data

The costs of health care for the uninsured. Access to insurance and addressing the needs of the uninsured are also strongly affected by overall health care cost growth. Historically, the health care costs of people without insurance have been absorbed by consumers who have health insurance—who are charged more than their care actually costs—and by taxpayers as governments subsidize these safety-net providers directly. With continued cost growth, however, it is becoming more difficult to hide these costs and more challenging to pay for them.

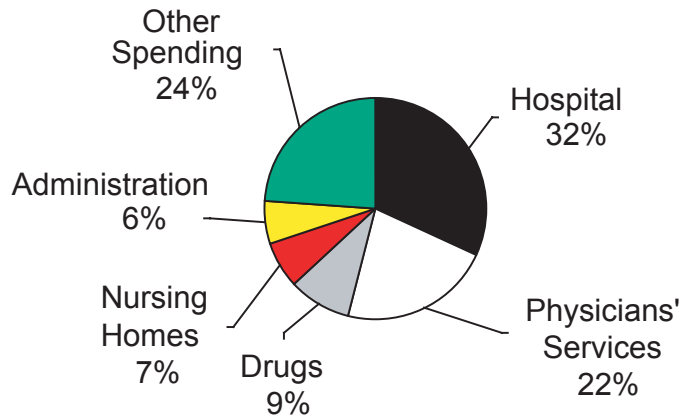
Health care costs have grown faster than the U.S. economy. Because health care costs have risen faster than overall U.S. economic growth, a growing fraction of the workforce is unable to pay for health care without some kind of subsidy. When premiums rise faster than wages, this translates into a *relative* price increase for health insurance compared with other consumer goods. Even if this relative price change is small in any single year, it can still cause a larger proportion of workers to decline health insurance—a trend that has emerged over the past 15 years.

Hospital services are by far the largest segment of health care spending.

What Is Happening to Health Care Costs Over Time?

Hospitals get the largest share of health care spending. To understand how costs are changing over time, it is useful to examine what our health care dollars buy (see Figure 2). Hospital services are by far the largest segment of U.S. health care spending. Yet, while hospitals are still the largest recipient of health care dollars, expenditures on other services have increased at a faster rate. Therefore, hospital costs are now a smaller piece of the total health care spending pie than in the past. At the same time, physicians' services and prescription drugs are becoming increasingly larger proportions of total health care costs. Despite the attention paid in recent years to accelerating prescription drug costs, they still account for only 10% of total health care expenditures.

**Figure 2. What Do Our Health Care Dollars Buy?
How Are U.S. Health Care Dollars Spent?**



Source: CMS, 2002. Calendar year 2000 data

If we were to break down patterns of cost growth, three major categories emerge:

- 1) Medical price inflation;
- 2) Growth in volume of services; and
- 3) Growth in intensity of services.

Medical prices rise in relative terms when the price per unit of the service—say of an office visit or a particular surgical procedure—rises faster than other prices. While this is important, most expenditure growth is actually driven by increasing volume and intensity of services (i.e., more services or more complex services are being delivered during an office visit or during surgery).

Technology leads to increases in volume and intensity of services. One of the complex aspects of cost growth is that the lines between these categories are often blurred. For example, in the research community, there is widespread agreement that the most important source of cost growth, accounting for more than 50% of the increase, is related to technological advances.

The reason technology has played such a major role in cost growth is that it impacts both the volume and intensity of services. Complex and resource-intensive procedures require providers to charge higher prices. Meanwhile, other less-invasive technological advances that could lower prices can be used with a higher number of patients, thus still increasing overall costs. For example, 11% of Medicare patients with a heart attack in 1984 received surgical treatment. Ten years later, this number had increased to 47%. While there is no question that this intervention helped many heart attack patients, that 10-year span saw a spending increase of almost 60% for each heart attack case.

Most expenditure growth is actually driven by increasing volume and intensity of services.

Fewer in-patients, more services. To further illustrate the overlapping of volume and intensity in services, consider, for example, that the number of days people spend as hospital in-patients has fallen by more than half since 1980. Yet, over this same time period, the total hospital costs per person have risen by almost 60%, because patients are receiving more intensive services each day they are in the hospital. Of course, breaking cost growth down this way may be oversimplified because it does not take into account potential increases in productivity.

Technological developments result in other costs as well. In addition to higher costs for services, many treatments require other complementary services. For example, before a patient has bypass surgery, he or she must receive cardiac catheterization. Post-surgical rehabilitation treatment also creates added costs.

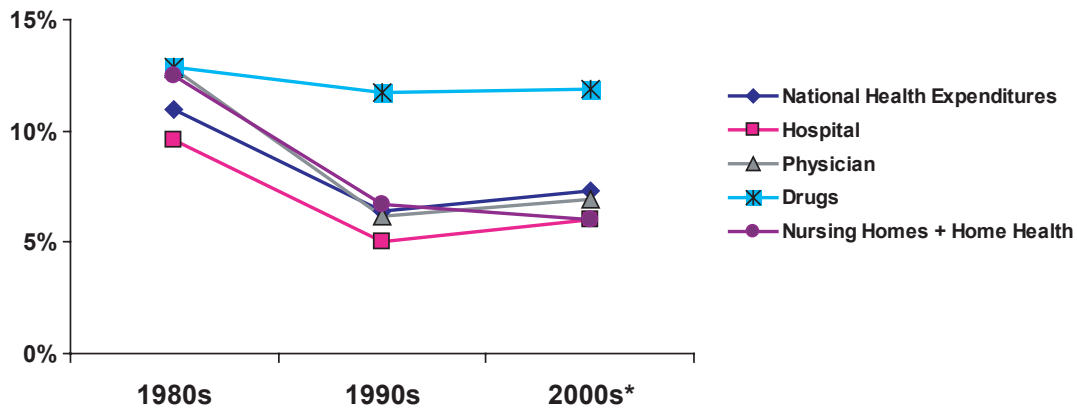
Other, more specific sources of health care cost growth currently being discussed include:

- ❖ **An aging population.** Our population is aging, and health care costs increase with age, so many people assume that aging per se is a major driver of health care cost growth. Recent research suggests that is not the case: in 2001, population aging contributed an estimated 0.7 percentage points, or less than 10% of the total increase in per capita health care spending for people under 65.²
- ❖ **The spread of more comprehensive insurance.** More comprehensive insurance provides pooled purchasing power so that more people can afford new technology and more complex services. This, in subtle ways, makes for continued cost growth, as well as expanded access to these services over time.
- ❖ **The rise of defensive medicine.** Providers, especially physicians, fear malpractice claims and may provide more diagnostic and in some cases therapeutic services just to reduce the risk of being held liable for negligence in a medical injury lawsuit. This has proven hard to document, but is a real phenomenon in many providers' minds.

Where Are Increasing Health Care Costs Coming From Over Time?

Growth in the cost of all health care components declined in the 1990s, although prescription drug costs showed the least decline (see Figure 3). Yet, there is evidence that these apparent declines may be a “one-time shot” caused by the transition to managed care. The management of health care use and new price discounts resulting from managed care are real efficiencies in the health care system. Yet in the next decade, each component of health care cost is expected to grow.

Figure 3. Growth in Costs Declined in the 1990s, with the Smallest Declines in Prescription Drugs



Source: Author's calculations, annual compound growth rate by decade, using CMS National Health Account data, 2002

*Projected

Hospital spending is the key driver of cost growth. Increased hospital spending continues to stand out as the recent key driver of growth in overall spending. The cost of hospital in-patient services grew 7.1% in 2001, which is nearly three times the 2000 increase (2.5%). At the same time, hospital out-patient services also grew at a dramatic rate, climbing 16.3% in 2001. Together, in-patient and out-patient hospital services accounted for more than half of total spending increases in 2001.³

Prescription drug costs are high, but comprise a small share of spending. Increases in prescription drug spending continue to be high, but studies show that the growth rate for 2001 slowed slightly for the second year in a row. In 2001, prescription drug spending grew by 13.8%, down from 14.5% in 2000.⁴ In real terms, prescription drugs continue to rise faster than any other segment. Relatively speaking, however, their role in overall health spending has less of an impact than rising hospital costs.

Prescription drug costs continue to rise faster than any other segment of health care costs.

What Is Driving Health Care Costs Now?

The causes of current rising health care costs can be broken down into four major factors:

- ❖ **Managed care loosening.** Fearful of consumer backlash, managed care plans have reduced restrictions on access to specialists and other services. Formerly, managed care plans tightly controlled access to health care.
- ❖ **Provider capacity constraints.** Mounting evidence indicates that there are capacity constraints on the current health care system. Patients are reporting more frequent delays in receiving care and more time when their needs are not met. Physicians are working longer hours and are less likely to take new patients. Hospitals are reporting nursing shortages

which impact both emergency rooms and regular beds. All of this lets providers know they can raise prices.

- ❖ **Provider consolidation and ‘pushback’ for higher payment rates.** Providers have increased their market leverage vis-à-vis health plans. In addition to recent hospital capacity shortages, consumers’ demands for broad networks in the health care system and consolidation in the hospital industry have resulted in a shift of power between hospitals and health plans. Hospital providers are now in a position to be able to demand higher payment rates to remain in existing health plans. This “push back” by hospitals is, in part, a backlash effort to reverse the effect of agreeing to discounted payments during the mid-1990s.
- ❖ **Direct-to-consumer advertisements for prescription drugs.** The proliferation of direct-to consumer advertisements from drug companies also plays a role in driving up the costs of overall health care. These advertisements include magazine, newspaper, radio, and TV promotions targeted at consumers. Between 1995 and 1998 alone, promotional spending of this type more than tripled, from \$400 million to \$1.3 billion.⁵ These ad costs are passed on to consumers in the form of higher prices for advertised medications. Along with other information that is more readily available in ‘unfiltered’ forms, advertising has also led to an increase in the number of patients who make specific requests of their providers. Physicians worried about patient satisfaction are increasingly reluctant to send patients away “empty handed.”

It is likely that states will need to address health care cost issues without substantial assistance from the federal government.

How Are Stakeholders Responding to Rising Costs?

Employers

Employers are responding to rising health care costs in two ways. Many are attempting to increase employee cost-sharing by raising employee premiums and out-of-pocket payments at the time of service, and less frequently, are reducing benefits. However, employers also are trying to increase employee choice.

States

States’ responses to rising costs are complex. In a time of budget shortfalls, states are trying to make the most effective cuts possible without hurting their citizens. As a part of this effort, many states are reducing benefits, raising eligibility requirements, and reducing payments to providers. Given current fiscal conditions, it is likely that states will need to address health care cost issues in the future without substantial assistance from the federal government.

Federal Government

Efforts to control costs at the federal level include granting Medicaid waivers to states and discussions of long-term reform to control health care costs. Many policy options are currently on the table. In the future, the federal government could take measures to insulate states from the effects of recessions. Similar to unemployment compensation, the U.S. also could have cyclical federal matching payments to offset the effects of economic downturn on states.

Conclusion

Despite efforts by stakeholders at all levels of the health care system, no single or simple solution exists. Policymakers, health care providers, and citizens alike wrestle with how best to contain health care costs while continuing existing levels of health care coverage for those Americans who are covered today, along with the 41 million Americans who are uninsured.

This paper is based on the following talks given by Dr. Nichols:

“Health Care Cost Growth: Sources and Prospects.” National Conference of State Legislatures. July 26, 2002.

“Health Care Cost Growth: Trends, Sources, Strategies and Feedback Loops.” October 24, 2002. National Institute for Health Policy.

Some material in this paper is also drawn from the following published articles:

Nichols, Len M. (June 2002). *Can defined contribution health insurance reduce cost growth?* Employee Benefit Research Institute Issue Brief 246. Washington, DC: Author.

Pauly, Mark V., & Nichols, Len M. (October 23, 2002). The nongroup health insurance market: Short on facts, long on opinions and policy disputes. *Health Affairs* Web Exclusive downloaded from: http://www.healthaffairs.org/WebExclusives/Nongrp_TOC.htm

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The Potential for a Small-Employer Purchasing Pool in Wisconsin:

Issues and Options for Overcoming Barriers to the Development of the Private Employer Health Care Coverage Program (PEHCCP)

Prepared for the Wisconsin Department of Employee Trust Funds

By Rick Curtis, Rafe Forland, and Ed Neuschler

Institute for Health Policy Solutions

This chapter focuses on why the private employer purchasing pool program passed in Wisconsin in 1999 has not yet been implemented. This paper explores several options developed specifically for Wisconsin policymakers: (a) reducing adverse selection by adopting rate rules that do not vary based on health status or claims experience; (b) making subsidies available to uninsured, low-income employees of small firms and providing premium assistance for populations otherwise eligible for programs like BadgerCare could reduce state outlays; and (c) designing the small employer pool as the exclusive small employer coverage venue in Wisconsin to achieve large scale purchasing, more stable coverage, and reduced administrative costs.

Overview

The Attraction of Purchasing Pools

Although Wisconsin has one of the highest rates of employer-sponsored coverage in the country, small employers have been increasingly concerned about often unprecedented escalation in their health care premiums. Given these escalating costs and the inherent fragmentation among small employers, the small group market in Wisconsin and other states is increasingly characterized by administrative inefficiencies, wide variation in premium costs, and wildly-fluctuating premium increases.

Policymakers often are drawn to purchasing pools as a potential means to stabilize small employer premiums through increased administrative economies of scale and purchasing clout with health plans. In addition, by aggregating a large number of small firm employees, purchasing pools can offer those employees something not normally available in the small employer market—specifically, choice of competing health plans. Such choice is typically available only to the employees of very large employers, and to state and federal employees.

But to date, voluntary, unsubsidized consumer-choice pools have not gained enough market share to realize lower costs for small employers. And, health plans would generally not be serving their own interests if they were to offer lower rates that

would allow a start-up or small pool to become a larger purchaser. However, the potential for large pools could likely be realized if subsidies or other policies are structured so that health plans could reach an attractive group of enrollees only through such a pool, or if reforms less attractive to health plans are the likely alternative.

To pursue their goals, such purchasing pools have several common characteristics. Particularly to maximize administrative efficiency, pools centralize the administrative functions of enrollment, premium collection, and customer service. Also, to minimize adverse selection (i.e., disproportionate enrollment of high-cost individuals for the pool overall or for individual plans participating in a pool), pools create participation rules, benefit plans, and premium rating methodologies that are relatively uniform across all participating plans. In addition, pools often consolidate and perform communication activities on behalf of the participating health plans.

The passage of 1999 Wisconsin Act 9 charged the Department of Employee Trust Funds to develop the Private Employer Health Care Coverage Program (PEHCCP) and to have this program operational by January 1, 2001. Unfortunately, several aspects of this authorizing legislation inhibited the development of the program. Many of these issues were addressed in subsequent legislation (2001 Wisconsin Act 16), but health plans are highly unlikely to participate in the program unless it is significantly restructured.

Some have suggested that health plans would participate and offer preferable rates if such participation were a condition of state employee plan participation and/or its pool premium rates were tied to those offered to state employees. But this approach alone is of dubious merit. As with most such “painless” ideas, a free lunch is unlikely here. It is likely that, with Wisconsin’s existing market, the pool’s rates for small employers would be made more affordable only if heavily cross-subsidized.

However, as we discuss later, there are other approaches which have substantial potential to achieve the cost and choice goals stated above.

What Is the Critical Difference Between a Large Employer and a Small Employer Pool with Respect to Adverse Risk Selection Issues?

A large employer group constitutes an attractive pool of people to insure because it is what carriers often refer to as a “natural group”—a group that is constituted for purposes other than health insurance. Such groups reliably include a healthy share of relatively low-risk persons. However, because individual small employers by definition do not have large populations, they are more likely to have a disproportionate concentration of low or high risk employees. Therefore, in this critical sense, an aggregation of small employers that each have unconstrained choices about where, how, and whether they obtain health insurance is not a “natural group.”

Broader risk spreading is important because a large share of health care costs are generated by a relatively small number of persons. As shown in Table 1, only 5% of the population consistently accounts for over half of total health care costs.

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And the 50% of the population that is most healthy in a given year accounts for a tiny portion of total costs. This pattern holds for the total population and also for HMO enrollees, the privately insured under 65 years of age, and those uninsured under 65.

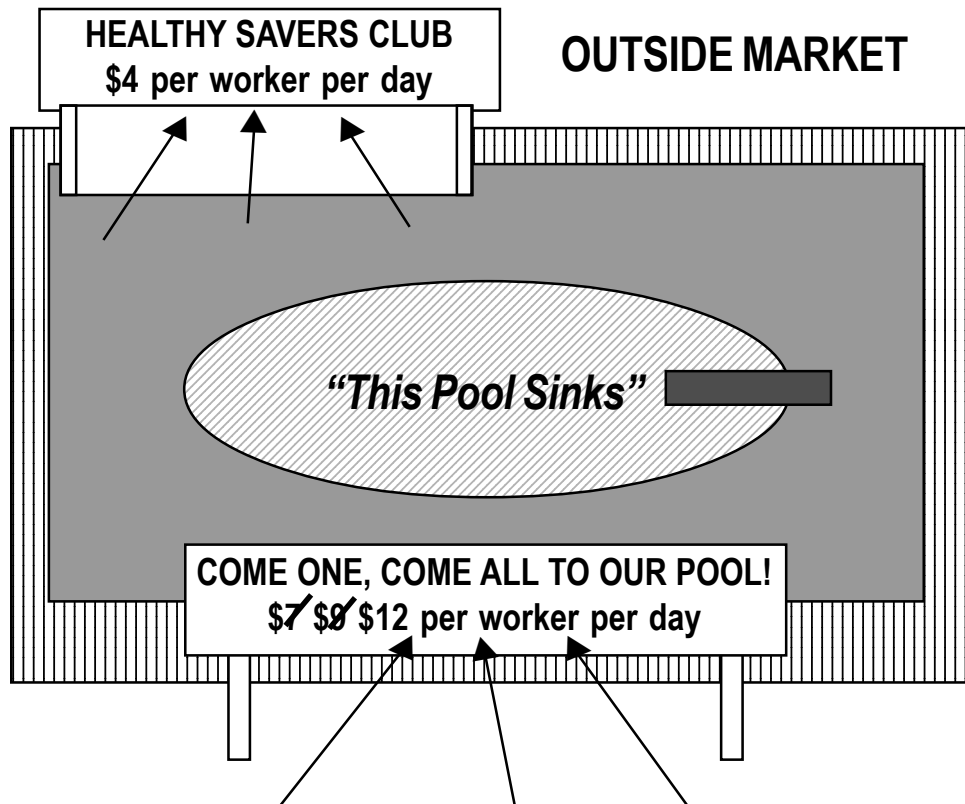
Table 1. The Most Expensive 5% of the Population Accounts for Over Half of Total Health Care Costs (Percent of Total Expenditures Incurred by Top x% of Population, Ranked by Total Payments for Health Services)¹

Percentile	Total Population, 1987	Total Population, 1996	HMO Enrollees 1996*	Privately Insured All Year <65	Uninsured All Year <65
Top 5%	56%	55%	51%	51%	60%
Top 10%	70%	69%	64%	65%	75%
Top 50%	97%	97%	95%	95%	99%

**Includes only HMO enrollees under age 65 with employment-based coverage.*

To assure at least some spreading of risks across the small employers a given carrier insures, states have established small employer market rating rules (i.e., constraints on how much insurers can vary premiums for the same health plan across individual small employers). However, those rules in Wisconsin (and a number of other states) allow substantial variation in rates based on the risk profile of a given small employer. Whereas such policies can attract many carriers to participate in the market, they also mean that relatively low premium prices will be available to a small employer pool participant when its members are healthy. So if the pool has rating policies that spread costs more broadly within the pool than health plans spread risks in the outside market, it is likely to attract only firms with a disproportionate share of high-cost individuals which will increase the daily cost per worker. Consequently, the pool is likely to suffer an adverse selection “death spiral” and, as illustrated in Figure 1, “sink.”

Figure 1. Avoid “Poolish” Pricing Policies: Pooled Rates Won’t Work If Healthy People Can Get Preferred Rates Elsewhere.



Similarly, the pool would be put at an inherent disadvantage if it is required to accept some applicants on more preferential terms than carriers in the rest of the market. For example, if the pool and only the pool is required either to accept self-employed individuals on the same terms as employer groups, or to give the same rates to all participating employers, it will inevitably be what is sometimes referred to as a “risk magnet.” Those who are healthy and can obtain a lower price elsewhere will do so. Those who present higher risks and would be charged more elsewhere would come to (and often be aggressively referred to) the pool. As a result, the pool’s costs will be higher, not lower, than those in the open market. This dynamic has played out due to such well-intentioned, but unrealistic, policy constructs in a number of states.

In the Eyes of Health Plans, What Would It Take to Make a Small Employer Pool More Like a Very Large Employer’s Health Plan Choice Program?

Some observers like to cite the Federal Employees Health Benefits Program (FEHBP) experience or the Wisconsin State Employee Group Health Insurance Program experience as proof that voluntary small employer or individual pools offering a broad choice of competing health plans and benefit designs would be

viable. In fact, many health plans are very concerned about the risk selection problems experienced in FEHBP, which does not have standardized benefit plans to temper such selection problems. But federal employees represent a huge source of enrollment and premium revenue that plans cannot reach through any other means; if health plans want access to that population, they must participate in FEHBP—so many do. Similarly, if changes can be structured so that health plans would view the Private Employer Health Care Coverage Program (or similar purchasing pools) as the sponsors of a significant “natural group” that can only be reached through the pool, then that pool should be relatively attractive.

More generally, employer groups are attractive to health plans for the simple reason that workers receive substantial “subsidies” (employer contributions) that they cannot use to buy insurance elsewhere. If premium assistance, tax-credit, or other public-subsidy amounts were sufficiently large, and if a sizable small-firm worker population could only use those subsidies towards coverage purchased through the pool, then plans would be motivated to participate.

If health plans view purchasing pools as the only way to reach a “natural group,” then the pool should be relatively attractive.

Why Do Health Plans Prefer Direct Employer Contracts Over Pools? Why Can't Pools Underwrite As Effectively As a Single Plan?

Most health plans would far prefer exclusive direct contracts with employers over small employer pools which allow workers choice of competing plans. Also, the higher the proportion of a “natural group” covered, the more certain a health plan is of its ability to spread high-cost claims over lower cost members of a group.

- ❖ It should be noted that, while less controllable by a given health plan, a pool can achieve this risk-spreading objective through risk adjustment (i.e., techniques that adjust the net payment rates based on the risk profiles of enrollees in each plan). One example has evolved in California’s PacAdvantage.
- ❖ Another rationale health plans often give for direct, exclusive contracts with employers is that the higher the proportion of a given employer group that a health plan enrolls, the lower its administrative and marketing costs due to economies of scale. But a choice pool can also achieve scale economies by behaving more like one, large employer.

Concerns can be greatly exacerbated where small employer pools have fewer limitations on access, or less aggressive health rating than carriers in the open market. Again, experience in a number of states underscores the legitimacy of these concerns.

Further, most health plans understandably have little interest in helping to create larger purchasers with more bargaining clout out of smaller, weaker groups. Moreover, they do not want to cede control over marketing or administrative functions to a pool. By doing so, health plans lose control over which employers and employees enroll, the accuracy—and potential associated liability—of premium collection and enrollment activities, and a key component of their resource base and administrative role.

In addition, health plans are extremely reluctant to give up control over the medical underwriting process that is an (economic) necessity in the current Wisconsin small employer market where carriers can and do vary rates based on the health status or claims experience of a given small employer. A pool could allow each plan to underwrite and rate each enrollee from the pool. But this would in effect emulate the individual market, and thus involve high administrative costs and individual selection-based competition among the participating plans.

However, the prospect of the pool performing underwriting functions is fraught with difficulties as well. In particular, health plans would have difficulty cooperating with each other, let alone agreeing on a common system, given differences in their provider contracts, networks, base experience, and business philosophy. Moreover, health plans are wary of training or transferring such critical trade secrets to their competitors through a collaborative design process.

The end result for such a small employer pool under Wisconsin's current market rules is two undesirable options. One option would be to adopt the high road and utilize less stringent underwriting practices (which some former, and no longer operational, pools have done). But a pool doing so would be unlikely to attract health plan participation and, even if it did, the ultimate, and potentially quick, result would be significant adverse selection from the market. The other option would be to adopt the most comprehensive medical underwriting process possible that is acceptable across participating carriers. But because such a process would very likely represent a "least common denominator" combination of the participating health plans' approaches, it would be less effective than most individual carriers' underwriting practices. The end result—adverse selection—might take longer to occur but undoubtedly would be the same. Choice pools that have attempted either approach have generally failed.

Are There Alternative Policy Approaches That Might Work in Wisconsin? Three Alternative Scenarios

A. Small Group Market Rating Reforms

If the state were to adopt rating rules that did not allow rates to vary based on the health status or claims experience of a given employer group (but still allowed some adjustment for "case characteristics" such as age and geography), then the pool would be much less likely to experience adverse selection at the hands of the open market. This change would also substantially reduce the maximum premium costs or the volatility in rates a given small employer might experience in the open market. It would also increase rates for those employers who currently present the lowest risks.

Some advocates claim such market rules greatly reduce coverage rates, while others claim they increase coverage rates. Well-documented and peer-reviewed research studies, however, generally find no or very little effect. The reader may wish to refer to one thorough, recently-published study that finds no effect on overall coverage rates or costs and that includes a careful review of other previ

ous research on this issue.² It should be noted, however, that most of the research covered periods when average premiums were more stable than the current environment.

Such rating reforms could greatly diminish the degree of exposure to adverse selection for a pool. But it is still unlikely that more than a few (if any) Wisconsin health plans would be willing to participate on a voluntary basis in a pool that largely competes against the plan's own direct contracting with small employers. Some plans with small market shares or with limited numbers of participating physicians or hospitals (who might be more attractive as an individual employee choice) might be willing to participate. But even with such state market rules, if federal legislation is enacted allowing "Association Plans" to operate outside of state market rules, the pool as well as traditional health plans would be at a disadvantage.

B. Subsidies for Low Income Employees of Small Firms Exclusively Through the Pool

If significant subsidies for uninsured small firm workers were made available exclusively through the pool, a sizable and attractive pool of people could be uniquely reached through the pool. In effect, the subsidies would play the role that large employer contributions play for their employee plans. They would create cohesion similar to that which a "natural" group enjoys and presents to a health plan. (If health plans nevertheless refused to participate, in an effort to avoid "building" a sizable pool, the state could establish linkages to participation in other state programs without significant risk of expensive cross-subsidies.)

Such "premium assistance" subsidies for populations otherwise eligible for public programs like BadgerCare could reduce rather than increase state outlays. Employer coverage with premium assistance for the employee share, combined with employer contributions and federal tax subsidies, would cost the state less than enrolling those families in the public BadgerCare program. But such savings would likely be realized only if those eligible for such employer coverage were required to take it as a condition of receiving subsidies (i.e., in lieu of direct BadgerCare enrollment).

It should be noted that when BadgerCare was designed, the state's intent was that low-income working families should rely on employer coverage whenever possible. This advances two goals: to encourage career development and increase low-income workers' attachment to work (rather than welfare), and to strengthen, rather than undermine, employment-based coverage generally. But this intent has not been realized due to other BadgerCare policies. Information about employer coverage is not obtained for almost half of employed BadgerCare applicants. For applicants for whom the necessary information is obtained, about half are found to have employer coverage available; however, only a tiny fraction ever become enrolled in that coverage and receive premium assistance. (This is because several program policies, some reflecting previous federal constraints under which the state had to operate in designing and implementing the program, have the effect of significantly reducing the number of BadgerCare eligibles who can qualify for premium assistance.)

"Premium assistance" subsidies for populations eligible for public programs like BadgerCare could reduce state outlays.

Making premium assistance available to low-income, small-firm workers through the pool could also encourage more uninsured small employers to offer coverage.

Under a revised policy context, premium assistance could do a much better job of accessing employer coverage that is available, or could be available to people who are otherwise eligible for BadgerCare. One way to simplify and encourage this would be to make the pool the sole venue through which low-income small-firm workers and their families can receive premium assistance.

Using the pool to manage the flow of subsidy dollars on behalf of small-firm workers and their families would be administratively efficient. And working with such a pool rather than with a myriad of individual small employers and associated health benefit plans could make it much easier to meet federal and state requirements regarding premium assistance (e.g., verification of enrollment and use of funds, reviewing and approving benefit structures, etc.).

Making premium assistance available to low-income, small-firm workers through the pool could also encourage more uninsured small employers to begin offering coverage—by allowing them to make a smaller employer contribution than would usually be required. This could be a very cost-effective way of expanding coverage to the low-income working population. But, since most small firms have childless workers as well as parents in their employ, arranging subsidies for low-wage childless workers would need to be addressed.

The potential new enrollment represented by people receiving public subsidies should help to overcome the chief obstacle to the growth of consumer-choice pools in the current marketplace—the reluctance of health plans to participate in them (discussed above).

We would note one significant design issue here. If a substantial number of employers participate because of premium assistance available to eligible low-income employees and their dependents, would this create a “critical mass” that could extend benefits to other small employers and employees? This potential would be limited by small employer market rules. To the extent existing rules continue to allow rates to vary substantially by health status in the outside market, the pool would, at minimum, still need to underwrite unsubsidized applicants for purposes of health rating.

C. The Pool IS the Small Employer Health Insurance Market

Some have suggested a more sweeping option: that the “pool” be constituted as the exclusive small employer coverage venue in Wisconsin. While quite controversial, some have observed that this approach would be more effective than rating reforms in protecting the pool, its health plans, and its enrollees from a systemic adverse selection spiral. And this approach could almost certainly achieve economies associated with large scale purchasing, with more stable coverage, and with substantial administrative economies of scale. (While turnover in small businesses, their workers, and their coverage status is higher than for local governments, administrative costs might be more like the Wisconsin Public Employers’ Group Health Insurance Program than to the existing small employer market.)

But unless such an approach were tied to broader health insurance financing and coverage policies, it should be recognized that a number of lower risk small employers might choose the option to “self-insure” under either existing federal law (i.e., Employee Retirement Income Security Act preemption of state regulation of employee benefit plans) or pending federal proposals (i.e., Association Plan proposals).

There are a range of challenging policy design options associated with this general approach, including the appropriate organizational and governance structure for such a pool. One key issue would be the purchasing role of such a pool. In general terms the pool might be:

1. Given authority to aggressively negotiate rates—in which case it would effectively be a price regulator for the small-employer market, or
2. Expected to dictate a highly structured marketplace—e.g., have plans bid on several specified benefit packages, limit and/or have approval authority over marketing materials and approaches, or
3. Given more of a “clearinghouse” function which achieves administrative economies (e.g., through centralized electronic enrollment and premium collection) and establishes guidelines to preclude abuse (e.g., minimum benefit and direct marketing guidelines).

Conclusion

While a small employer purchasing pool might improve health insurance cost, coverage rates, and choice for small firms and their workers, it would require state policy changes. Options include market rating rules, premium assistance, and exclusive venue approaches. A carefully crafted combination of some of these concepts would have substantial potential to meet these goals.

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Employer Purchasing Pools: California's Experience Making Health Insurance Available to Small Employers

By John Grgurina, Jr.

This chapter describes PacAdvantage, the country's largest non-profit small-employer, health insurance purchasing pool. PacAdvantage now includes over 11,000 small California businesses, covering about 130,000 employees and dependents. PacAdvantage combines the purchasing power of small businesses (two to 50 employees) by sharing risks and negotiating competitive prices that offer a wide choice of quality plans, full-service products, and affordable co-pays. PacAdvantage has been able to expand coverage; before joining PacAdvantage, 30% of small-business employees were uninsured.

Health care costs have risen sharply in the past several years, with premiums potentially doubling in the next four to five years. This trend stems from many factors, including new and expensive drug therapies, increased negotiation power of consolidated hospital and provider groups, and administrative inefficiencies. At the same time, research on customer satisfaction and clinical quality indicates that overall health care quality has not kept pace with escalating costs.

One response that California has tried is the creation of small-employer purchasing pools, which spread the potential risks among a greater number of consumers. These pools attempt to balance the competing demands of quality, availability, and cost.

Small businesses have found it particularly challenging to offer and maintain a choice of affordable health, dental, vision, and chiropractic coverage options to employees during a time of escalating costs. Small firms that do offer coverage typically can provide only one plan to their work force. In many cases, small employers do not offer any insurance coverage to employees or their families because of cost, lack of options, and administrative complexity. The high rate of uninsured workers in small businesses adds costs to the health care system when the price of their unpaid care must be shifted to the public sector, and to customers who pay through insurance or out of pocket.

California's Response: Insurance Purchasing Pools for Small Businesses

California is a pioneer in helping small employers provide insurance through employer purchasing pools. The Pacific Business Group on Health (PBGH), founded in 1989, is a nationally recognized, nonprofit coalition of major California employers that aims to improve the quality and availability of health care while moderating costs. Referred to as value-based purchasing, employer purchasing pools balance the competing demands of quality, availability, *and* cost.

PacAdvantage is the country's largest nonprofit small-employer health insurance purchasing pool for employers with two to 50 eligible employees. Taken over by PBGH from the State of California in 1999, PacAdvantage combines the purchasing power of thousands of small businesses by sharing the risks and negotiating competitive prices for small business owners. It allows participating businesses to offer their employees a wide choice of quality health insurance plans, full-service products, and affordable co-payments. Among PacAdvantage's features are:

- ❖ **Choice.** Seven health plans are available [offering three Health Maintenance organization (HMO) co-pay products; two Preferred Provider Organization (PPO) products and one Point of Service (POS) product]; seven dental plans [offering Dental Maintenance Organization (DMO); Dental Provider Organization (DPO) and fee for service products]; two vision plans (offering two co-pay products); and a complementary care plan (offering two co-pay products).
- ❖ **Affordability.** Rate stability through pooling employers, offering a maximum employer contribution level, and employee choice of health plan, product (HMO, PPO, POS), and co-pay level;
- ❖ **Simplicity.** One convenient bill includes all the options that employees choose; and
- ❖ **Quality.** Similar benefits offered to large employers associated with PBGH are available to small employers through PacAdvantage.

How Did PacAdvantage Get Started?

PacAdvantage originated in 1992 as part of small-business health insurance reforms enacted in California under Assembly Bill 1672. No state funding was provided. However, a loan was authorized from the state's high risk pool (The Major Risk Medical Insurance Program), which was to be repaid over time. The loan from the high-risk pool was \$5.5 million over a two-year period. Revenues to repay the loan and for the operation of the purchasing pool were generated from administration charges paid to participating employers in the program. Formerly known as The Health Insurance Plan of California (HIPAC), PacAdvantage now includes over 11,000 small California businesses, covering about 130,000 employees and dependents.

How Does California's PacAdvantage Work?

PacAdvantage pools small businesses to leverage purchasing clout to make health insurance more affordable. PacAdvantage strives to increase consumer choice and improve quality. The program also works to reduce the administrative burden for small employers.

PBGH's goal of containing cost increases while encouraging higher quality may seem like "Mission Impossible," especially now—when health care costs are escalating and the quality of products and services are stagnating. Yet, PBGH's promotion of value in health care is taking hold at many levels.

PacAdvantage now includes over 11,000 small California businesses, covering about 130,000 employees and dependents.

A variety of PBGH initiatives seek to:

- ❖ Reward quality;
- ❖ Contain costs;
- ❖ Develop innovative benefit packages;
- ❖ Problem-solve in areas such as provider disruption;
- ❖ Push health plans and providers to improve performance; and
- ❖ Provide tools to members to be better purchasers.

PBGH identifies methods to improve performance through effective value purchasing and engaging consumers in making informed health care choices. For example, through the Negotiating Alliance and other purchasing strategies, PBGH supports employers in identifying ways to compare value across health plans. The coalition identifies health care and business trends, assesses the impact of those trends, and recommends practical steps to advance a common agenda. Activities include:

- ❖ Restructuring performance measures.
- ❖ Coordinating with all PBGH members to better reflect purchaser priorities as a guide to selecting health plans.
- ❖ Helping employers to develop and assess near- and long-term purchasing strategies.

PBGH seeks to provide incentives to employees of both large and small employers to be “smart shoppers” in meeting their own health care needs. PBGH increases the availability and usefulness of information about the quality and economic efficiency of all levels of care: health plans, hospitals, medical groups, and individual physicians.

What Advantage Does California’s Model Offer Small Employers?

By pooling purchasing power and offering employees’ choice of health plans, small businesses and their employees can buy more affordable health care. Together, small businesses can receive insurance options formerly reserved for large corporations. PacAdvantage makes available multiple choices for health and optional benefits coverage to small employers joining the purchasing pool. These plans all offer the same set of benefits—the only variations are price and providers. PacAdvantage is based on consumer choice and offers a variety of health and optional benefits plans.

What Advantages Does California’s Model Offer Families?

The PacAdvantage model provides each employee the opportunity to select the health plan, product, and co-pay level that best meets their family needs. It also allows the employee to change plans, products, and co-pay levels each year

Together, small businesses can receive insurance options formerly reserved for large corporations.

during their employer's annual open enrollment period. With this opportunity employees may select a lower cost plan, change health plans to maintain their physician (if their physician is no longer available in the plan in which they are enrolled – which is happening in California on a more frequent basis), and change products that meet their changing family needs.

What Are the Effects of PacAdvantage?

PacAdvantage seeks to expand the number of insured employees in this sector and to offer a choice of health plans to each employee. Studies show that before joining PacAdvantage, more than 30% of small-business employees were uninsured and very few employees had the power of choice about their preferred health plan and product.

PacAdvantage has recently updated the HMO benefit offerings to more closely reflect packages being bought and sold in the California small-business market. For instance, previous HMO co-pays of \$5, \$10, and \$15 products changed to \$10, \$20, and \$30.

Additionally, in an effort to assist employees in making the best decisions about health plan, product type, and co-pay level, PacAdvantage now offers members an online health plan chooser tool. The PacPlan Chooser Tool (available at www.pacadvantage.org) gives consumers a way to bring cost, quality, and outside references into their health care decision-making.

This tool integrates member premium contributions, out-of-pocket costs, network providers, benefits, quality information, and plan rules into a single selection device. Its interactive capabilities give users the ability to rate and choose health plans according to their preferences. It is the first decision-making tool for members that has been used in the small-group market, and it provides a way for PacAdvantage members—and virtually all insured Californians—to better understand their health care coverage.

Other measures of PBGH efficacy include pioneering employee health plan satisfaction surveys in the early 1990s, and working closely with providers, payers, researchers, and others to achieve the highest quality and most cost-effective health care.

How Does PacAdvantage Meet Three Major Needs: Choice, Simplicity, and Affordability?

Choice

- ❖ Employers have a choice of affordable benefit packages for seven medical plans, seven dental plans, two vision plans, and one chiropractic/acupuncture plan, as well as a choice of employer contribution options.
- ❖ Employees have a choice of health insurance providers including Blue Shield, Health Net, and Kaiser. Employees have an annual open enrollment period in which they can change health plans and/or product types and/or co-pay levels.

Before joining PacAdvantage more than 30% of small-business employees were uninsured.

- ❖ Employees can choose from a comprehensive array of plan types, including HMOs, PPOs, and POS plans.
- ❖ Brokers have a larger selection of health, dental, and chiropractic/acupuncture plans than any other multi-choice program in California.

Simplicity

- ❖ Employers benefit from reduced paperwork through a simplified qualification and enrollment process and one monthly billing statement.
- ❖ Employees cannot be turned down for coverage because of health, age, occupation, or residence as is the rule in the rest of the small group marketplace.
- ❖ Brokers benefit from simplified benefits administration, as well as online quoting and sales tools.

Affordability

- ❖ Employers are guaranteed rates that are locked in for one full year.
- ❖ Employers can set a defined contribution and yet allow their employees to have a full array of choices from which to select.

What Advice Can PacAdvantage Offer States Interested in Setting Up Employer Purchasing Pools?

The most important building block in creating a small-employer purchasing pool is that the market rules for the pool must be the same as for health plans offering products outside the pool. It is critical not to set up the pool with rules and or regulations that would provide an incentive for adverse selection to occur within the pool. For example, if most health plans were not required to cover self-employed individuals, but the small-group pool was, the adverse selection of the enrollment from high-risk, self-employed individuals would cause all of the pool's rates to rise. Over time, the pool's rates for small employers would be much higher than from the direct health plans. This could create a "death spiral" of rates and risk inside the pool, ultimately leading to its demise.

The most important building block is that the market rules for a small-employer purchasing pool must be the same as for health plans outside the pool.

Conclusion:

What are the Lessons Learned From the PacAdvantage Experience?

The four major lessons learned from the small group purchasing pool are:

1. Employee choice of health plan, product, and co-pay are critical features highly valued by small employers and their employees. Employers and employees both strongly desire to have the choice between HMO and PPO products and want to have large brand name plans available to them.
2. The purchasing pool must be similar in operation to the market place to avoid adverse selection as well as to be a viable product in the small group market. These include:
 - ❖ Underwriting and eligibility rules

- ❖ Structure and payment of commissions to insurance agents and brokers
 - ❖ Benefit design and offerings
3. A voluntary purchasing pool (voluntary for employers to join and voluntary for health plans to participate) *by itself* will not dramatically reduce prices and solve the problem of the uninsured.
 4. Purchasing pools offer a great opportunity to be used as the vehicle for subsidy programs to encourage small employers to provide health coverage to their employees, particularly their uninsured employees.

This chapter was adapted with permission from information available at the following websites:

<http://www.pbgh.org/>

<http://www.pacadvantage.org/default.asp>

For more information

PacAdvantage website: <http://www.pacadvantage.org/default.asp>

John F. Grgurina, Jr. is the Executive Director of Pacific Health Advantage (also known as the Health Insurance Plan of California), a small-group purchasing pool providing health insurance to more than 11,000 small employers in California since 1993. Prior to joining PacAdvantage, Mr. Grgurina was the State of California's Chief Deputy Director/Lead Negotiator of the Managed Risk Medical Insurance Board. Mr. Grgurina is a frequent speaker and presenter at health care industry conferences, both in California and throughout the nation.

Grgurina, J. (2003). Employer purchasing pools: California's experience making health insurance available to small employers. In B. Friese, E. Gross, K. Bogenschneider, & C. Johnson (Eds.). *Rising health care costs: Employer purchasing pools and other policy options*. (Wisconsin Family Impact Seminar Briefing Report No. 18, 50 pages). Madison, WI: University of Wisconsin Center for Excellence in Family Studies.

State Policy Options: Health Costs and Financing

By Wisconsin Public Health - Health Policy Institute

T *This paper begins by summarizing the major issues driving the increasing costs and price of health care, including the patchwork of cost containment policy remedies that are commonly used. It then reviews the cost-impact of various insurance models, including the potential of purchasing pools, universal coverage, and single payer systems, to leverage lower prices and reduce cost shifting. This paper concludes with a discussion of the relationship between prices and quality, and the long-term potential of value purchasing to control health care costs.*

The major challenges in health care policy reflected in this paper are *costs, quality, and coverage (i.e., the uninsured)*. These three are so fundamentally linked that any long-term effective solution must address all three. Historically, when one element of rising costs is targeted, it inevitably creates unintended consequences elsewhere. For example, efforts to contain prices paid to providers may reduce the amount of outpatient charity care available for uninsured persons and therefore increase the use of and costs associated with emergency-room care. The system is like a balloon that, when squeezed in one area, bulges elsewhere.

The U.S. has faced a problem with runaway health care costs, with only temporary relief, since the Nixon Administration. Many market-based and regulatory solutions have been tested. Some remain, while others have fallen away. None yet have sustained their promise in the long term; we continue to face the fundamental and reoccurring challenge of rising costs.

Many observers now seek to reframe the questions, focusing on the relationship between costs and outcome. Often referred to as value-purchasing, this concept links cost containment to the measuring and purchasing of “quality” in order to achieve a healthier population. Fundamentally, value-purchasing requires explicit decisions on the relative costs and benefits involved in purchasing health services.

What Factors Are Behind Rising Health Care Costs?

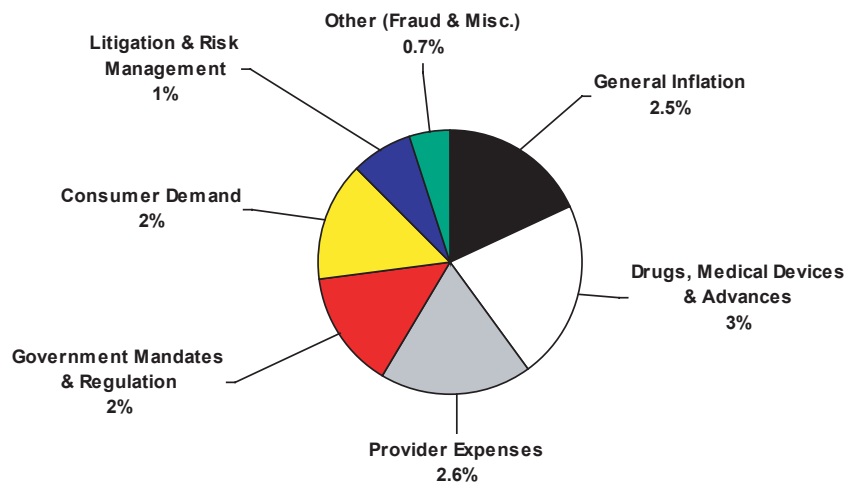
The shift to outcome- or quality-based purchasing will take time. More immediately, options are available to address the underlying factors (“drivers”) behind these costs. Analysts generally agree that these cost drivers include the following:

- ❖ Consumer demand.
- ❖ Costs of training, hiring and retention of a health care labor force.
- ❖ Drugs—both disease- and lifestyle-oriented.
- ❖ Emergency medical response (mobile & within hospitals).

- ❖ End of life and chronic care.
- ❖ General inflation.
- ❖ Government mandates and regulations.
- ❖ Hospital care.
- ❖ Medical research.
- ❖ Medical supplies.
- ❖ Outpatient care.
- ❖ Defensive actions (litigation & risk management).
- ❖ Public education/advertising.
- ❖ Technology.

Medical costs in the U.S. increased 13.7% in 2001. The rates contributing to the medical inflation rate vary from year to year and among analysts. Nevertheless, PriceWaterhouseCooper, a widely cited source, estimates the 2001 contributions to the total medical inflation as illustrated in Figure 1:

Figure 1. Factors Contributing to Health Care Inflation Rates in 2001



What Policies Have State and Federal Governments Used to Contain Costs?

In response to these drivers, federal and state governments have initiated a range of cost containment policies, some of which focus on the market and others on regulation (see Chart 1). Most have worked for a limited time and could be implemented, or re-implemented, in Wisconsin at least on a temporary basis.

Chart 1: Several Policy Options Exist for Containing Care

Market Force Examples	Regulation Examples
Co-payments	Rate Setting
Deductibles	Insurance Rate Banding
Defined Contributions	Medicare Physician Fees
Managed Care	Generic Drugs
Risk Pooling	Certificate Needed
Capitation	Medicare DRGs, RBRVS
	Oregon-type "Rationing"
	Preventive Policies (e.g., tobacco taxes)

**These as well as other terms are fully defined in the accompanying paper and glossary produced by the Wisconsin Public Health and Health Policy Institute, through the Health Policy Forums project.*

Policy Options

The following policy and regulatory tools have been implemented by other states. Some have already been tested in Wisconsin.

- ❖ **Insurance purchasing pools.** Large insurance purchasing pools for low-wage workers and small employers. The larger the pool, the more leverage the pool has in negotiating insurance prices.
- ❖ **Certificate of need and hospital rate-setting.** Strategies that have been tried in Wisconsin and largely discredited, but may still merit consideration in a more targeted form.
- ❖ **Safety net services.** Programs, often government supported, that provide health care to those without insurance or the ability to pay, thereby directing the uninsured towards primary and preventive care, and away from more costly, emergency care.
- ❖ **Cost sharing, limited benefits, and defined contribution.** Private-sector tools that may be available to Wisconsin in its role as an employer and purchaser of coverage.
- ❖ **Disease management.** The use of evidence-based guidelines, structured patient education, and case management to reduce the costs and improve the health status of patients with chronic conditions
- ❖ **Prescription drug purchasing.** Joint purchasing, formularies, alternative therapies, pharmacy benefit management, manufacturer reimbursement strategies, or limiting number of prescriptions or days of supply (see Family Impact Seminar Briefing Report, "Designing a State Prescription Drug Benefit: Strategies to Control Costs.")
- ❖ **Insurance regulation.** Policies such as rate banding; expansion of who is eligible for insurance pools; damage caps; tort reforms and limits to malpractice awards and contingency fees; and no-fault systems.

- ❖ **Managed care.** HMO and PPO plans for state employees and expanded enrollment for those populations for which the State now provides Medicaid and BadgerCare coverage.
- ❖ **Patient safety initiatives.** Reducing medical errors and their associated costs.
- ❖ **Limiting the range of Medicaid-covered services.** Limiting coverage for optional Medicaid services, or adopt a more overt priority-setting process like that used by the State of Oregon.

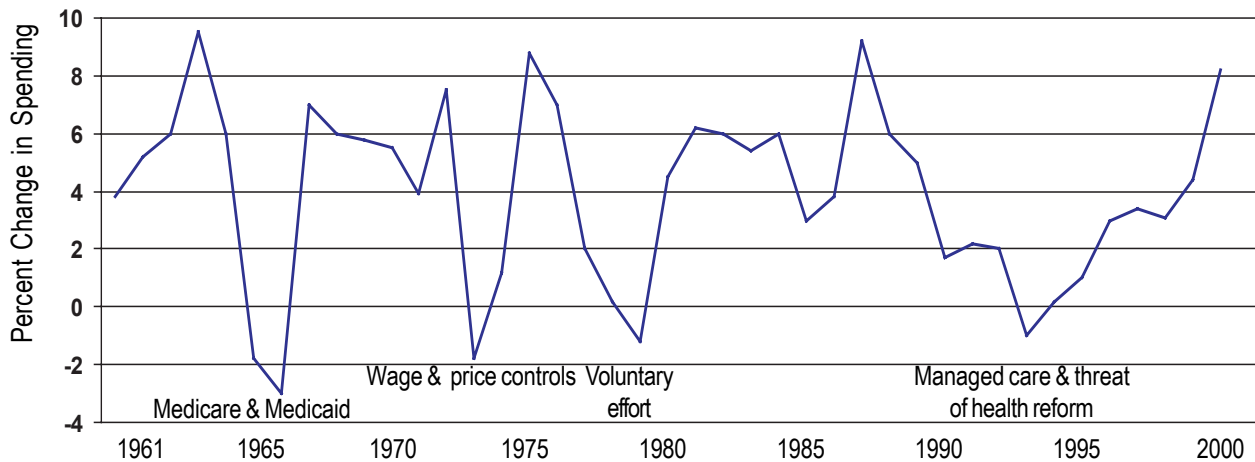
Other approaches include leveraging additional federal Medicaid dollars to reduce the burden on the state budget:

- ❖ Explore opportunities to expand Medicaid coverage to additional eligibility groups, and thereby leverage federal financial participation.
- ❖ Work with Congress to change the low reimbursement rates in Medicare and Medicaid payment formulas, which result in cost-shifting to the private sector.

Will These Policies Work?

Research shows little evidence that most “fixes” will limit cost increases for any length of time. Nearly all would require increased administrative resources. Historical experience, reflected in Figure 2, suggests that cost containment attempts have failed to provide long-term relief (see Figure 2).

Figure 2: Annual Private Health Spending Per Capita 1961-2001 Has Ebbed and Flowed (Adjusted for Inflation)



for-service” may have encouraged excess service, managed care eliminated the financial incentive for such “over-utilization.” Yet more powerful drivers of cost—technology, consumer demand, mandates and regulations, and pharmacy costs—remain.

The National Academy for State Health Policy, in its exhaustive review of the options, concludes:

“The key lesson we can take from the past is that a haphazard approach to cost containment will not achieve or sustain its objectives. Policymakers need methods to integrate supply, price, and demand.... Such a comprehensive approach to health care cost containment may well require a re-thinking of the entire health care delivery system to assure that clear goals are set and that incentives are properly aligned to reach them.”

Purchasing Pools: Better Prices and Lower Costs?

Common responses to rising prices include (a) regulating payments to doctors and hospitals and (b) creating larger insurance purchasing pools by expanding opportunity for various sectors and populations to participate. Both public and private employers use these large purchasing pools to combat prices, either through negotiating lower commercial insurance rates or by directly contracting with physician organizations for lower prices based on larger pools of insured.

Pooling does hold down the price per individual. This has been shown in strategies such as the creation of large purchasing pools for employees, low-income consumers (i.e., Medicaid), or those over 65 (i.e., Medicare). But pooling does not directly address health care costs. Instead, pooling spreads risk and financing across more people, while most of the underlying factors affecting cost remain firmly in place.

Single- and Multi-Payer Systems and Universal Insurance Coverage: How Do These Relate to Cost?

Pooling does hold down the price per individual, as has been shown by contemporary solutions such as single-payer, universal insurance, and aggregated pools whether of employees, the poor (Medicaid), or those over 65 (Medicare). But pooling does not directly address health care costs. Rather pooling spreads risk and the financing across more people while most of the cost drivers remain firmly in place.

Single-payer and multi-payer universal health care systems are logical extensions of pooling. Each model has intrinsic benefits, but also several drawbacks. Single-payer, in particular, would require major changes in the American market system. Many powerful sectors of the economy would resist such change.

Some observers argue that the multi-payer commercial insurance system diverts resources to profits, excess employees and administration, and inappropriate medical interventions. A single-payer system could potentially reduce these costs and use the savings to expand coverage to currently uninsured persons. Such cost savings, however, would only occur through central, possibly, government

Pooling does not directly address health care costs.

administration and regulation. Even then, many argue that despite the private sector's perceived excesses, potential advantages of public administration would be offset by the oft-presumed inefficiency of government.

Those who favor universal single-payer programs cite the success of Medicare—in essence a single payer system—in containing cost increases and maintaining relatively low administrative expenses. However, Medicare providers argue that those savings occur only because Medicare shifts the administrative burden to the provider. Moreover, Medicare payment may not cover the true costs of care nor expected profits, which is then shifted to the private sector. In other words, the private sector may actually subsidize the apparent Medicare savings. And Medicare, which does not cover outpatient prescription drugs, has avoided these significantly increasing costs.

Universal coverage could be pursued through either a single-payer or a multi-payer model. Research suggests that providers incur significant costs associated with caring for the uninsured. Providers currently cover the costs of providing charity care by shifting costs to private insurance, thereby increasing the costs to the commercial insurance sector. Universal coverage, some argue, would itself reduce health care costs by promoting timely and effective primary and preventive care, and reducing the costs associated with delayed interventions and use of emergency rooms.

Nonetheless, some analysts argue that consumer demand (a powerful factor affecting health costs) would soar and that physician capacity could not accommodate such demand. Higher quality providers, it is argued, may opt out of the system and limit their practices to those able to pay for care out-of-pocket or through alternative mechanisms. In some countries, single payer or national health systems result in long waits for care, inadequate access to the latest technology, and questions about overall quality. And Americans appear uncomfortable with systems that rely on overt “rationing.” At times, however, such systems have demonstrated an ability to contain some costs and reduce inequities in health care. From purely a cost-containment perspective, single payer systems, along with universal coverage, remain options to consider and are being studied in a number of states.

The private sector continues to look for ways to encourage employees to take personal and financial responsibility for their health.

Private Sector Experiments: Shouldn't Consumers Bear More Responsibility?

The private sector continues to look for ways to encourage employees to take financial responsibility for their health and promote better employee health as a cost saving measure. Most recently, private employers, under the banner of consumer-driven purchasing, have used the concepts of defined contributions, high deductibles and after-tax savings and pre-tax spending accounts as a means to share the increasing burden of payment with employees. Employers and insurers are now experimenting with varying levels of cost-sharing, each with a different employee price tag based on the employee's willingness and ability to pay.

These tools could be more widely adopted by the public sector. However, substantial changes might be required in existing union-negotiated contracts.

However, there are significant concerns that “consumer-driven purchasing” may further segment the market and erode the broad risk-sharing advantages of pooling. That is, younger, healthier, lower-risk purchasers would opt for minimal coverage plans, while older, sicker or higher-risk patients would still need to purchase broad-based coverage. These people would then find themselves further priced out of the insurance market.

The trend toward consumer-driven plans reflects a broader intent: to make consumers more responsible for their health status and more aware of the relative costs and benefits of various services. All of the reforms mentioned above, nevertheless, focus almost exclusively on price as the mediator of value. They are limited in their ability to promote value based on quality, which many observers argue is essential to the cost-benefit analysis.

Doesn't Price Relate to Quality and Value?

The literature defines value as quality divided by price. As currently practiced, consumer-driven purchasing does not promote the underlying goal of value-purchasing:

1. There is little opportunity for purchasers to acquire the information needed to judge providers' quality or outcomes.
2. Currently, the dollar amount employees actually spend or have at risk on their insurance may be too small to motivate consumers to shop around for the best value. In 2001, consumers paid, on average, less than 15% of the premium for a single person, 27% for family coverage, and single-digit percentages for employees in the public sector.
3. Even where data are available, some analysts question the ability of consumers or the willingness of purchasers to sort through the data to make informed decisions.

There is little opportunity for purchasers to acquire the information needed to judge providers' quality or outcomes.

Both the private and public sectors promote the use of data [Health Plan Employer Data and Information Set (HEDIS), for example] as a step towards measuring quality. Large corporate payers are spearheading national efforts, most notably through the “Leapfrog Initiative,” which examines the relationship between price, quality, and value.

Many public and private organizations, both in and outside of medicine, have become increasingly skilled at using data to analyze the quality of health care practices and outcomes. Such efforts have provided some definite conclusions, as noted in the Dartmouth Atlas and recently published Institute of Medicine studies:

- ❖ Medical practice varies greatly, both among physicians and between and within hospitals.
- ❖ Errors and poor practices are widespread and not limited by reputation, credentials, or geography.

- ❖ There are significant regional variations in prices for identical services, as has been noted in the recent studies of comparing Milwaukee to other metropolitan areas.

A decade ago, Wisconsin led the nation in initial efforts to acquire critical health care data.

What Role Can Government Play In Increasing Quality and Value?

A decade ago, Wisconsin led the nation in initial efforts to acquire critical health care data. Since then, politics, stakeholder resistance, administrative barriers, and falling state revenues have diminished this promising effort.

Various options are available to invigorate and expand state and private initiatives to acquire, analyze, and publicly disseminate health and outcomes data. These could allow statewide comparisons across provider and payer systems. Effective and tested methods for evaluating and reporting medical outcomes are available, relatively easy to understand and, through Internet-based technologies, relatively inexpensive.

Such a data infrastructure requires that government and the private sector collaborate, such that all purchasers of health care might understand and make comparative judgments about the available health care “products.” Success in this undertaking requires health data collection and analysis to work in a flexible and neutral environment.

Where Do We Start?

Policymakers can work on more immediate containment of the health care cost drivers, while also working to build systems for collecting outcome and quality data. The available strategies to contain cost may buy some financial breathing room. Ultimately, cost and prices remain rooted in quality, outcomes measurement, and value purchasing. To make it all work, public and private purchasers will find themselves in unprecedented economic, programmatic, and political collaborations.

This chapter is excerpted from a more complete issue brief with full references by the same title that will also be distributed to participants of the January, 2003 Seminar/Forum. The full text is available from David Austin, Coordinator, Wisconsin Health Policy Forums, 760 WARF, 610 Walnut Street, Madison, WI 53726 (608.263.8298) and on our website: www.medsch.wisc.edu/pophealth/StateForums

These issue briefs are a product of the Wisconsin Public Health and Health Policy Institute and are written especially for the Wisconsin Health Policy Forums. The authors for this brief were: Robert Stone-Newsom, PhD, Institute Senior Scientist and Forums Director, Donna Friedsam, MPH, Institute Senior Policy Analyst, and David Austin, JD, Forums Coordinator. Patrick Remington, MD, MPH, Institute Director and David Kindig, MD PhD, Institute Co-Director also provided editorial and content review.



Wisconsin Legislative Council

Terry C. Anderson, Director
Laura D. Rose, Deputy Director

TO: PARTICIPANTS, FAMILY IMPACT SEMINARS

FROM: Laura Rose, Deputy Director

RE: Private Employer Health Care Coverage Program

DATE: December 11, 2002

Program Background

This memorandum describes the Private Employer Health Care Coverage Program (PEHCCP) created in the Department of Employee Trust Funds (ETF). The PEHCCP was created by 1999 Wisconsin Act 9 (the 1999-2001 Biennial Budget Act) and was amended by 2001 Wisconsin Act 16 (the 2001-03 Biennial Budget Act) and 2001 Wisconsin Act 109 (the 2001-03 Budget Adjustment Bill). The purpose of the PEHCCP is to provide a voluntary health insurance purchasing pool for small businesses.

Although the statutes require the PEHCCP to be implemented by January 1, 2001, the program has not been implemented as of the date of this memorandum. Because the ETF was unable to enter into a contract for administering the PEHCCP so the program could begin by January 1, 2001, the ETF submitted a report, as required by statute, to the co-chairs of the Joint Committee on Finance (JCF) on December 28, 2000, specifying the reasons for not entering into the contract. In the letter to JCF, the ETF cited problems with the program design that were cited by potential contract vendors as the reason that no bids were submitted to administer the program in the response to the ETF's Request for Proposal. This led ETF to request statutory changes in the program in order to improve the chances of obtaining bids from potential administrators of the program. Most of the statutory changes requested by ETF were enacted into law in 2001 Wisconsin Acts 16 and 109. The insurance rate banding recommended by ETF as being an important component of the program's success was passed by the Legislature but was vetoed by the Governor.

The program must include more than one group health insurance plan.

ETF, Administrator, and Board Responsibilities

The ETF is responsible for designing the PEHCCP. The program must be an actuarially sound health care coverage program for private employers and may not be combined with the health care coverage plan operated by ETF for public employees. The PEHCCP must also include more than one group health coverage plan. In designing the program, the ETF must consult with the Office of the Commissioner of Insurance (OCI) and the Departments of Commerce and Health and Family Services.

Under the statute, the ETF is also required to solicit and accept bids and make every reasonable effort to enter into a contract for the administration of the PEHCCP. The ETF is required to provide all administrative services necessary for providing the health care coverage plans for the PEHCCP if a private administrator is not obtained. During the period that the ETF is providing these administrative services, it must continue to make every reasonable effort to contract for the administration of the health care coverage plans. The ETF is also required to enter into contracts with insurers who are to provide health care coverage under the PEHCCP.

The ETF or the administrator, if one is selected, must solicit and accept bids and enter into a contract to market the PEHCCP. In addition, the ETF or the administrator must maintain a toll-free telephone number to provide information on the PEHCCP. Further, if an administrator is selected, the administrator must charge employers who participate in the PEHCCP a fee to cover the cost of administrative services for the PEHCCP. The administrator is required to reimburse the ETF for expenses incurred by the ETF in designing, marketing, and contracting for administrative services for the program. If no administrator is selected to administer the program, the ETF must charge the employers the fee to cover the administrative costs. The ETF may not sell any health care coverage under the PEHCCP to an employer, or enroll any employee in the PEHCCP, but the ETF must make information about the PEHCCP available to employers on a statewide basis.

The Private Employer Health Care Coverage Board oversees the PEHCCP. The board, located in ETF, consists of the Secretary of Employee Trust Funds or his or her designee, the Secretary of Health and Family Services or his or her designee, both who are nonvoting members, and the following members appointed for staggered three-year terms:

1. One member who represents health maintenance organizations.
2. One member who represents hospitals.
3. One member who represents insurance agents.
4. Two members who are employees eligible to receive health care coverage under the PEHCCP and whose employer employs not more than 50 employees.
5. One member who represents insurers.
6. Two members who are, or who represent, employers that employ not more than 50 employees and who are eligible to offer health care coverage under the PEHCCP.

7. One member who is a physician.
8. Two members who represent the public interest.

The board is responsible for approving the PEHCCP prior to its implementation. Other board responsibilities are described under the appropriate headings in this memorandum.

Plan Design

Every health care coverage plan under the PEHCCP is subject to the provisions of the Insurance Code (chs. 600 to 646, Stats.) that apply to group health benefit plans.

No health care coverage plan under the PEHCCP may provide coverage for a nontherapeutic abortion (defined as an abortion not directly and medically necessary to prevent the death of the woman) except by an optional rider or supplemental coverage provision that is offered and provided on an individual basis and for which an additional, separate premium or charge is paid by the covered individual. Claims and related administrative expenses for these abortions may only be paid for with the funds from the premiums or charges paid for coverage under the rider or supplemental coverage. Also, funds from the premiums or charges under the rider or supplemental coverage may not be used to pay any claim or administrative expenses related to any other type of coverage under the plan.

All plans under the PEHCCP must have an enrollment period that is established by the board.

All insurance rates for health care coverage under the PEHCCP must be made available to employers and employees in a manner determined by the board. Rates that apply to coverage for small employers must be published at least annually. The rates may be listed by county or by any other regional factor that the board considers appropriate.

Employer Responsibilities; Eligible Employees

An employer for the purposes of the PEHCCP means any person doing business or operating an organization in Wisconsin and employing at least two eligible employees. However, a person operating a farm business must employ at least one eligible employee. (An “eligible employee” is an employee who works on a permanent basis and has a normal work week of 30 or more hours. The term includes a sole proprietor, a business owner, a partner of a partnership, and a member of a limited liability company if the sole proprietor, business owner, partner, or member is included as an employee under a health benefit plan of an employer.) An employer participating in the PEHCCP must do all of the following:

1. Offer health care coverage under one or more plans to all of its eligible employees and, if permitted by any plan offered by an insurer under the PEHCCP, may offer health care coverage under such a plan to any of its other employees.

An employer means any person doing business or operating an organization employing at least two eligible employees.

2. Provide health care coverage under one or more plans to at least 50% of its eligible employees who do not otherwise receive health care coverage as a dependent under any other plan that is not offered by the employer, or to a percentage of such employees specified by the board, whichever percentage is greater.
3. Pay for each eligible employee at least 50% of the lowest premium rate for single coverage that is available to the employer for that employee's coverage under the PEHCCP.
4. Make premium payments for the health care coverage of its employees in the manner specified by the board.

Insurer shall cover any employer that applies for coverage and all that employer's employees who elect coverage.

An employer that provides health care coverage for its employees under the program and who voluntarily terminates coverage under the program is not eligible to participate in the program for at least three years from the date that the coverage is terminated.

Insurer Responsibilities

Any insurer that offers a health care coverage plan under the PEHCCP shall provide coverage under the plan to any employer that applies for coverage, and to all of that employer's employees who elect coverage under the health care coverage plan, without regard to the health condition or claims experience of any individual who would be covered under the plan if all of the following apply:

1. The employer agrees to pay the premium required for coverage under the plan.
2. The employer agrees to comply with all provisions of the plan that apply generally to a policyholder or an insured without regard to health condition or claims experience. Notwithstanding this provision, the ETF, in consultation with the board, may limit this requirement to compliance with s. 635.19, Stats., relating to issuance of coverage in a small group market.

Health care coverage under the PEHCCP may only be sold by licensed insurance agents. An insurance agent may not sell any health care coverage under the PEHCCP on behalf of an insurer unless he or she is listed by the insurer in required reports to OCI. The board may establish training requirements that an insurance agent must satisfy to sell coverage under the PEHCCP.

Commission rates on the sale of a policy under the PEHCCP must be set by the board and may be adjusted as often as semi-annually. The commission rate must be based on the average commission rate that insurance agents are paid in Wisconsin for the sale of a comparable health insurance policy at the time that the rate is set or adjusted.

Reporting Requirements

The board must submit a report to the appropriate legislative standing committees and the Governor on the operation of the PEHCCP each year by December 31. The report must specify the number of employers and employees participating in

the PEHCCP, calculate the costs of the PEHCCP to employers and their employees, and include recommendations for improving the PEHCCP.

The board must also submit a report to the appropriate legislative standing committees on an annual basis specifying the average insurance rate for the health care coverage under the PEHCCP by county or by any other regional factor the board considers appropriate.

The board must also report, no later than January 1, 2008, to the appropriate legislative standing committees and the Governor on recommendations as to whether the ETF should continue to be involved in the design, marketing, and contracting for administrative services for the PEHCCP. If the board recommends that the ETF not be involved in the performance of these functions, the board shall submit proposed legislation eliminating the ETF's involvement in these functions to the appropriate legislative standing committees at the time that the board submits its report.

The Legislative Audit Bureau must prepare a program evaluation audit of the PEHCCP by January 1, 2008.

Funding and Positions

2001 Wisconsin Act 16 appropriated \$211,100 general purpose revenue (GPR) in 2001-02 for the PEHCCP. 2001 Wisconsin Act 109 reduced this appropriation by \$6,000. Act 109 also provided \$850,000 GPR in 2001-02 to fund the operating costs for the PEHCCP. The funds are provided in the form of a loan by OCI to the general fund, created by a lapse of \$850,000 from OCI's general program operations to repay the loan. The general fund must repay the OCI loan, with interest, at the end of the 2001-03 biennium. Funds that could be used to repay the loan are lapsed funds from ETF from PEHCCP appropriations, or, if these funds are insufficient, funds from the general fund.

Sunset

The plan sunsets on January 1, 2010.

LR:jal:wu:rv;

Laura D. Rose is Deputy Director of the Wisconsin Legislative Council.

Rose, L. (2003). Wisconsin's private employer health care coverage program. In B. Friese, E. Gross, K. Bogenschneider, & C. Johnson (Eds.). *Rising health care costs: Employer purchasing pools and other policy options*. (Wisconsin Family Impact Seminar Briefing Report No. 18, 50 pages). Madison, WI: University of Wisconsin Center for Excellence in Family Studies.

Glossary

Adverse Selection

Disproportionate enrollment of high-cost individuals for the pool overall or for individual plans participating in the pool.

Aggregated Insurance Pools

See Purchasing Pools

Benefit Package

A defined set of specific services or benefits that an insurer is required to provide to subscriber groups or individuals.

Capitation

Refers to managed care organizations' practice of setting a specific amount to be paid per member per month. Health care providers know in advance how much money they can collect from the capitated population, regardless of what services are actually performed. Capitation is the opposite of fee-for-service.

Certificate of Need

A tool used by state governments to control expenditures, usually for hospitals but also for other providers. Before an expenditure can be made (for buildings, equipment, technological advances), a hospital must provide documentation that shows that there is a need for the new service or facility.

Complementary Care Plan

A complementary care plan may be added to a member's health plan; such plans may include coverage for chiropractic and acupuncture services.

Consumer-Driven Plans

Health plans that provide employees with funds that the employee, rather than the employer, uses to purchase health care services or insurance. The idea is to allow employees to make their own cost-benefit decisions, selecting those providers, services, and insurers that provide the most value to them as consumers.

Co-Payments

Health care related costs that a consumer pays out of pocket. These are in addition to what is paid by other parties. Co-payments are very common with drugs, and in many plans also apply to office visits and other services.

Cost-Sharing¹

A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, co-insurance, and co-payments are all examples of cost-sharing.

Cyclical Federal Matching Payments

If (not the current system) the federal share of Medicaid and State Children's Health Insurance Programs (SCHIP) increased during recessions and decreased back to normal during boom times to alleviate state fiscal stress when most severe.

Damage Cap

A statutory limit on the amount of compensation for damages that can be awarded to plaintiffs in legal cases.

Deductibles

As in the case of car insurance, deductibles are health care related costs (either annually, over a lifetime, or case-specific) that the individual must pay out of pocket before any additional costs will be picked up by the insurance policy. For example, one might be required to pay any hospitalization costs up to \$1,000—usually, the higher the deductible, the lower one’s annual premium.

Defensive Medicine

Describes physicians’ practice of providing more diagnostic and therapeutic services as a means of reducing the risk of being held liable for negligence in medical injury malpractice suits.

Defined Contribution

A pre-set dollar amount representing the maximum employer contribution to health care benefits for a given period of time.

Dental Maintenance Organization (DMO)²

A managed care business that organizes dental care services for its members, either on a for-profit or a not-for-profit basis. DMOs have the following specific and distinct characteristics: the use of primary care dentists to coordinate patient care; the regulation of specific providers and facilities members must use; and the existence of a fixed fee structure as opposed to having providers pay for specific services rendered. DMO’s are the dental equivalent of a HMO.

Dental Provider Organization (DPO)²

A managed care plan that contracts with networks or panels of providers to furnish dental care services and to be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on a preferred list, but may use non-network providers as well. A DPO is the dental equivalent of a Preferred Provider Organization (PPO).

Employer contribution

The money that an employer pays for its employees’ health plan. Employer contributions vary widely and can be based on percentage of cost, length of employment, family circumstances, or a flat fee.

Generic Drugs

Drugs that are no longer under patent to a particular drug company and thus can be identically duplicated by other manufacturers. Nearly always the generic version of a drug is much less expensive than the brand name version.

Health Maintenance Organization (HMO)³

A managed care business that organizes health care services for its members, either on a for-profit or a not-for-profit basis. HMOs have the following specific and distinct characteristics: the use of primary care providers to coordinate patient care; the regulation of specific providers and facilities members must use; and the existence of a fixed fee structure as opposed to having providers pay for specific services rendered.

Indemnity Insurance²

A system of health insurance in which the insurer pays for the costs of covered services after care has been rendered. An indemnity insurance contract usually defines the maximum amounts which will be paid for covered services. While this is the most common type of insurance in the United States, there is little enrollment in indemnity insurance in California.

Insurance Rate Banding

Rate banding is an insurance regulation that limits the amount any one purchaser can be charged for insurance premiums. The purpose of rate banding is to extend the price advantages of large purchasing pools to smaller purchasers.

Insurance Regulation

All states have insurance commissioners who regulate private insurance companies operating within their states. States also sometimes regulate pricing, advertising, payment turnaround, and the type and ages of individuals who are offered coverage. Insurance regulation seeks to protect citizens from loss of capital, failure to pay, discrimination, and other harm that might occur in the absence of regulation.

Managed Care

Managed care is a term that describes any system of health service payment or delivery arrangements where the health plan attempts to coordinate how services are delivered and used by its members. The purpose of these arrangements can be to save costs, improve quality, or both. Managed care plans often involve a set system of health care providers who have a contractual agreement with the plan.

Managed Care Loosening

As a response to consumer criticism about the constraints of managed care, some plans have reduced restrictions on access to specialists and other services which had formerly been tightly controlled.

Market Rating Rules

Constraints on how much insurers can vary premiums for the same health plan across individual small employers.

Medicaid Waivers⁴

The Department of Health and Human Services (DHHS) can waive certain requirements of federal law and regulation in order to encourage innovation and provide states with greater flexibility in their Medicaid and the State Children's Health Insurance Programs (SCHIP). These waivers can enable states to better tailor their programs to meet local needs, and they allow states to experiment with new approaches to providing health care services to Medicaid and SCHIP recipients.

Medicare DRGS (Diagnostic Related Groups)

A system originally developed for the government to control hospital payments and now used in both the public and private sectors. This system allows groups of patients to be classified together (standardized in terms of payment) based upon diagnosis, procedures performed, age, and length of time in the hospital.

Negotiating Alliance

The purchasing pool for large employer members in the Pacific Business Group on Health.

Point of Service (POS)³

A program of health insurance in which members are given the option to choose a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or fee-for-service delivery system when they are in need of health care services, rather than during the open enrollment period. Usually members are required to pay more to see PPO or non-participating providers than to see HMO providers.

Preferred Provider Organization (PPO)³

A managed care plan that contracts with networks or panels of providers to furnish services and to be paid on a negotiated fee schedule. Enrollees are offered a financial incentive to use providers on a preferred list, but may use non-network providers as well.

Prescription Drug Purchasing

Refers to situations where a group purchases prescription drugs directly from a manufacturer at a discount. The purchasing agent may be a government entity (Medicaid), a group of employers, health care provider entities, or even an organization (e.g., the American Association of Retired Persons).

Provider Capacity Constraints

A collection of conditions that constrain health care providers in delivering services. These conditions include: patients' reports of frequent delays, physicians who are less likely to take new patients, and hospitals with nursing shortages that impact both emergency rooms and regular beds.

Provider Disruption

Provider disruption occurs when medical groups and/or hospitals cannot agree to contract terms with health plans that they currently serve, thereby forcing subscribers in those plans to select alternative providers or change health plans to retain their provider.

Provider Pushback

Because of provider capacity constraints (see above), providers have increased their market leverage vis-à-vis health plans and are demanding higher payment rates to remain in existing health plans.

Purchasing Pool

Grouping together many small business employers, their employees, and dependents into a larger pool to offer choice of benefits and stability of rates similar to large employers.

Rationing: Oregon-Type

A program designed by the State of Oregon which attempts to determine the relative cost-effectiveness and ethics of restricting coverage by the Medicaid program for some medical services that are otherwise normally covered.

Risk Pooling/Sharing

The idea that the greater the number of people who are insured, the more stable are predictions of claims against the pool. That is, larger groups of people allow insurers to use anticipated savings from healthier persons to balance the risks of losses in covering unhealthier persons.

Safety-Net Services

Services and programs, often government-sponsored, that provide health care regardless of insurance status or ability to pay. This generally includes Medicaid, community health centers, public hospitals, and hospital emergency rooms.

Single Payer Systems/Programs

Systems where medical providers bills are paid by a single entity, rather than the current U.S. system that involves many insurance providers and movement by individuals across insurance plans. Medicare is often referred to as an example of a single payer within the U.S.: many consumers, many providers, and a single entity (the federal government) paying for all covered services.

State Rate Setting & Hospital Rate Setting

Used by state governments as a means to control, or balance, prices charged by hospitals and other providers of care.

Universal Coverage

Basic health insurance coverage for an entire population which is financed through taxes—on either individuals, employers, or both.

Value/Quality/Outcome Purchasing

Attempts by purchasers to control costs by focusing not only on the price they pay, but what they get in return. The rationale is that unless purchasers have the means to determine quality or outcomes, they are left purchasing health care based on price alone, without any certainty about the quality of care received for the money spent.

We would like to acknowledge the following people for their contribution to this glossary: Robert Stone-Newsom, John Grgurina, Len Nichols, and Rick Curtis.

¹Adapted from the National Coalition on Health Care. *Glossary of Health Care Terms* <http://www.nchc.org/know/glossary.html> by Len Nichols.

²Adapted from the National Coalition on Health Care. *Glossary of Health Care Terms* <http://www.nchc.org/know/glossary.html> by John Grgurina.

³National Coalition on Health Care. *Glossary of Health Care Terms* <http://www.nchc.org/know/glossary.html>.

⁴Adapted from: United States Department of Health and Human Services. (2001) *Medicaid and SCHIP Waivers: Promoting state flexibility and innovation*. Downloaded from: <http://www.hhs.gov/news/press/2001pres/01fsmedicaid.html>.

Selected Resources in Health Care Costs and Employer Purchasing Pools

By Carol Johnson

Legislative Council

Richard Sweet, Senior Staff Attorney

Wisconsin Legislative Council Staff
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Madison WI 53701-2536
(608) 266-1304
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Interests: Health administrative rules and health-related legislation

Laura Rose, Deputy Director

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P.O. Box 2536
Madison WI 53701-2536
(608) 266-1304
laura.rose@legis.state.wi.us
<http://www.legis.state.wi.us/lc>

Interests: Health, family and medical leave, and insurance

State Agencies

Peggy Handrich, Administrator

Division of Health Care Financing
Wisconsin Department of Health and Family Services
1 West Wilson Street
Madison WI 53702
(608) 266-1865
HandrPL@dhfs.state.wi.us
www.dhfs.state.wi.us

Health Care Information available online at
www.dhfs.state.wi.us/healthcarecosts/index.htm

Reports:

Wisconsin Family Health Survey 2002 (February 2002)

A Report on the Health and Well-Being of Wisconsin Citizens 2002 (October 2002)

Thomas Korpady, Administrator

Division of Insurance Services
Wisconsin Department of Employee Trust Funds
P.O. Box 7931
Madison WI 53707
(608) 266-0207
tom.korpady@etf.state.wi.us
<http://etf.wi.gov>

Interests: Private Employer Health Care Coverage Program

Office of the Commissioner of Insurance

121 East Wilson Street
PO Box 7850
Madison WI 53702
(608) 266-3585 or (800) 236-8517
Fax: (608) 266-9935
<http://oci.wi.gov>

University of Wisconsin-Madison/Extension

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610 Walnut Street
Madison WI 53705
(608) 263-0764
Fax: (608) 262-6404
dakindig@facstaff.wisc.edu
plreming@facstaff.wisc.edu
www.medsch.wisc.edu/pophealth/wphi/index.html

Interests: Preventive health practices and behavioral risk factors for poor health

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University of Wisconsin-Madison
School of Human Ecology, Room 370B
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Madison WI 53706
(608) 263-7088
Fax: (608) 265-6048
rriorte@facstaff.wisc.edu
<http://www.uwex.edu/ces/flp/specialists/riortel.html>

Interests: Barriers to accessing care for under-served populations and Medicare.

Robert Stone-Newsom, Program Director

David Austin, Outreach Coordinator

Wisconsin State Forums Partnership Program

Department of Population Health Sciences

7th Floor WARF Building

610 Walnut Street

Madison WI 53705

(608) 263-8298 or

(608) 263-6294

Robert Stone-Newsom Email: rnewsom@facstaff.wisc.edu

David Austin Email: daaustin@wisc.edu

www.medsch.wisc.edu/pophealth/StateForums/

National Organizations and Associations

Center for Studying Health System Change

600 Maryland Avenue, SW #550

Washington DC 20024

(202) 484-5261

Fax: (202) 484-9258

www.hschange.com

Reports:

Cutting Back But Not Cutting Out: Small Employers Respond to Premium Increases (October 2002)

The Role of Health Insurance Brokers: Providing Small Employers with a Helping Hand (October 2002)

Tracking Health Care Costs: Growth Accelerates Again in 2001 (September 2002)

The Insurance Gap and Minority Health Care (June 2002)

Kaiser Family Foundation

2400 Sand Hill Road

Menlo Park CA 94025

(650) 854-9400 or (800) 656-4533

Fax: (650) 854-4800

www.kff.org

State Health Facts Online

Reports:

Wisconsin Family Health Survey 2002 (February 2002)

A Report on the Health and Well-Being of Wisconsin Citizens 2002 (October 2002)

Institute for Health Policy Solutions

Rick Curtis, President
1444 I St., NW Suite 900
Washington DC 20005
(202) 789-1491
Fax: (202) 789-1879
www.ihps.org

Report:

Tax Credits for Individual Health Insurance: Effects on Employer Coverage and Refinements to Improve Overall Coverage Rates (August 2002)

Institute of Medicine

The National Academies
500 Fifth Street NW
Washington DC 20001
(202) 334-2352 or (800) 424-2460
Fax: (202) 334-1412
www.iom.edu

Reports:

Leadership by Example: Coordinating Government Roles in Improving Health Care Quality (October 2002)

Health Insurance is a Family Matter (September 2002)

Care Without Coverage: Too Little, Too Late (May 2002)

Coverage Matters: Insurance and Health Care (September 2001)

National Academy for State Health Policy

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50 Monument Square, Suite 502
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riley@nashp.org
www.nashp.org

Reports:

State Health Policy Responses to Recessions (1970-2000): What Have We Learned? Where Are We Headed? (May 2002).

Rising Health Care Costs: State Health Cost Containment Approaches (June 2002).

State Purchasing and Regulation of Health Care Services: A Snapshot of Strategies to Reduce Racial and Ethnic Health Disparities (May 2002)

National Conference of State Legislatures

Dick Cauchi
7700 East First Place
Denver CO 80230
(303) 364-7700
Fax: (303) 364-7800
www.ncsl.org

Reports:

2002 State Health Priorities Survey (available online)

State Purchasing for Health Care Quality (October 2000) includes Wisconsin data

United Health Foundation

Mail Route: MN008-W109
9900 Bren Road East
Minnetonka MN 55343
(650) none
<http://www.unitedhealthfoundation.org/>

Reports:

Annual State Health Rankings Online 2002 (available at
<http://www.unitedhealthfoundation.org/shr/index.html>)

The Urban Institute

John Holahan or Linda Blumberg
2100 M Street, N.W.
Washington DC 20037
(202) 261-5709
www.urban.org

Reports: Assessing the New Federalism

Expanding Health Insurance Coverage (July 2002)

Variations Among States in Health Insurance Coverage and Medical Expenditures: How Much is Too Much? (June 2002)

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