Voluntary Purchasing Pools

A Market Model for Improving Access, Quality, and Cost in Health Care
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American College of Physicians*

Voluntary purchasing pools—groups of businesses, governments, and sometimes individual persons formed to purchase health coverage—hold many potential advantages for the practice of medicine in the emerging marketplace. Purchasing pools can decrease costs, provide access for some otherwise uncovered populations, increase choice and continuity of care, and provide competitive opportunities for a wider variety of health plan types, including community-based, physician-run networks.

Of special concern to both physicians and their patients is the potential of purchasing pools to protect continuity of care. In a purchasing group, employers and individual persons continue to finance care, but buying is done through a central pool that offers an array of plans from which individual employees can choose. Consolidation of buyers creates a mechanism—the pool—for aggregating and expanding health plan choices beyond those offered by individual employers. One survey of employers (1), done by the Kaiser Family Foundation and KPMG Peat Marwick, found that 84% of firms that offered health insurance made only one plan available. Another Kaiser survey (2) found that 45% of nonfederal workers had only one health plan available to them. (The percentage of employees without choice is lower than the percentage of firms offering choice because more employees work for larger firms, which are more likely than small firms to offer choice.)

By breaking the employment-insurance link and offering a wider choice of health plans, pools increase the likelihood that patients who change jobs can keep their personal physicians. Although we are not aware of any data that measure job-related disruptions in patient care, many physicians and their patients are acutely aware of the problems such disruptions cause. Without a mechanism to break the link between employment and health coverage as more persons move into network managed care plans, these disruptions will only worsen.

In addition to providing continuity, the expanded consumer choice enabled by purchasing pools increases the competitiveness of types of health plans other than those offered by the large proprietary managed care companies. In the current environment, in which employers rather than individual persons do most of the choosing of health plans, large employers control huge segments of the consumer market and tend to deliver them to large corporate plans. However, if individual employees choose from a menu available to an entire region, then smaller health plans, such as physician-directed networks or physician-hospital organizations, might enjoy greater access to patients. Both continuity and a broader diversity of available health plans can play an important role in the overall quality of care in a community.

Purchasing cooperatives are attractive to the general public because they can decrease costs through administrative savings and group leverage, making health coverage more affordable and therefore more accessible to cooperative members. More broadly, purchasing cooperatives consolidate what has become an extremely fragmented marketplace structured on risk-selection practices. Combined with insurance reforms, consolidation of the buyers' side of the health insurance marketplace can reduce risk-selection opportunities, forcing health plans to compete by delivering high-quality, cost-effective health care. The American College of Physicians has supported all three of these principles—expanded ac-

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cess and market-induced quality improvement and cost containment (3).

In the 3 years since the "managed competition" brand of health care reform catapulted the concept of purchasing cooperatives to national prominence, more than 20 states have adopted legislation to help establish some variant of that idea. The results of this have primarily been voluntary groups—either private or state-operated—available to small businesses and sometimes to individual persons and public employees (4). Even before states became involved, firms in the private sector were busy forming health care purchasing coalitions on their own when state law allowed, and some of these date back two decades. The National Business Coalition Forum on Health represents 90 such coalitions, about 8000 employers, and more than 10 million persons. Additionally, the Federal Employees Health Benefits Program operates as a purchasing pool, and many states operate similar pools that are open to state, university, and local government employees.

Legislative support for voluntary purchasing groups is also seen at the federal level. The first important health care reform bill reported out of committee in the 104th Congress—the Health Insurance Reform Act of 1995, sponsored by Senators Nancy Kassebaum (R-KN), chair of the Labor and Human Resources Committee, and Ted Kennedy (D-MA), ranking minority member—preempts state laws that inhibit the formation of voluntary health care purchasing cooperatives, gives such cooperatives legal definition under state law, and sets standards that make such cooperatives broadly available (5). Other bills in the 104th Congress also address the issue (6, 7). In a departure from his 1994 health care legislation, which calls for mandatory pools with complex regulatory responsibilities, President Clinton has given his support to voluntary pools (8, 9).

Not all of the recent movement toward collective health care purchasing has been positive, however; only a handful of states have designed purchasing cooperatives according to criteria likely to protect the pools' viability against risk-selection practices; enhance choice; and achieve lasting, overall improvements in cost, access, and quality as outlined above (10). With some exceptions (coalitions of larger employers that are beginning to focus on quality and value along with price), traditional purchasing pools in the private sector generally restrict membership, restrict choice among health plans, and focus largely on price cutting for low-risk persons (11). Moreover, the proliferation of selective private-sector pools, along with increasing numbers of self-insured employers, has contributed to market fragmentation, and some proposed legislation would encourage this destructive trend by allowing small businesses to form self-insured pools that escape state requirements for open enrollment and ratings (12). In the current environment of purchasing pool proliferation, legislation at both the state and federal levels should facilitate purchasing pools with broad membership that minimize risk selection and maximize choice. Pools with these standards will advance the College's goals of access, cost containment, and quality improvement.

As their increasing numbers suggest, voluntary purchasing pools are particularly well suited to the current political environment. From a more distant perspective, an infrastructure of voluntary pools through which much of the health care in the United States is purchased could bring a measure of consistency and universality to the nation's fragmented health care system. In so doing, pools might open the door an inch wider to universality of health care coverage. For example, because they have lower administrative overhead costs than private and small group policies, purchasing groups would make efficient vehicles for the distribution of subsidies to low-income patients (13). Ultimately, a system of voluntary purchasing pools could increase the reach of health services.

**Balance Needed in the Marketplace:**

**Shoring Up the Demand Side**

The private health care financing system was largely designed by the insurance industry. Since the inception of commercial health insurance, the industry has controlled the buyer's side of the marketplace through ever more ingenious methods of risk selection as a way to gain market share. Through risk-segmentation practices, insurers control who can buy insurance and the cost of the insurance. Now, with the entry of huge insurers into managed care and into the delivery as well as the financing of health care, the insurance industry expands its control to the supply side of the marketplace as well.

Because the proprietary managed care industry is so large and its reach so vast, efforts to counteract its power in the marketplace are vital to the integrity of the health care economy, the health care system, and health care as a profession. Practitioners and their patients are both deeply affected by the power of this single industry. To the degree that they can compete effectively, community-based physician-directed health plans could help to balance power on the supply side of the marketplace. Purchasing cooperatives, combined with insurance reforms, offer a way to reorganize the demand side. These mechanisms would transfer power and discretion from insurers to individual patients and curb...
the propensity of insurers to compete through risk selection rather than through the delivery of cost-effective, high-quality health care. In turn, purchasing pools that allow individual choice are likely to enhance the competitiveness of local physician-run health plans.

Conventional wisdom points to insurance reforms such as modified community rating and guaranteed issue and renewal to solve problems of risk segmentation and excessive insurance industry influence over purchasing decisions, and most states have enacted some version of insurance reform. However, many of these state regulatory efforts still allow for wide variations in health plan rates, and even relatively tight reforms still leave insurers and health plans many opportunities to organize their own low-risk communities. The College supports insurance reforms, but additional steps are necessary.

Even under stricter market rules, insurers find it easy and profitable to continue risk-selection practices (14-16). Although they ostensibly serve the broader community, insurers can focus serious marketing efforts only on low-risk persons. They can discourage enrollment or induce disenrollment of high-risk patients by processing applications and claims more slowly or by not returning telephone calls. Integrated health plans can discourage high-risk patients through physician panel design, by maintaining a very few inaccessible specialists, or by turning away providers in high-risk geographic areas. Employers exacerbate the problem by choosing health plans that offer initial low rates that result from risk-selection techniques. Whole industries of young, healthy, low-risk employees seek out industry and trade-based plans that reflect their low risks. They form exclusive purchasing pools (multiple employer welfare plans [MEWAs]) or association-based health plans. Indeed, insurers themselves help bring groups like these together. Insurers also encourage the creation of self-insured groups for whom the insurer can act as a third-party administrator. Even if a plan is community rated and available outside a given group, insurers need not market the plan outside. With tens of thousands of contracts and hundreds of insurers in a given market, attempts to regulate this sort of subtle risk selection become impossible.

When employers and individual persons consolidate into a pool, however, it becomes more difficult to skirt market rules, because risk-selection efforts through marketing and service are more apparent to a pool than to individual purchasers. In addition, pools (such as large employers) have the market leverage to negotiate terms that protect quality health care and patients.

Large and mid-sized employers have already begun to wrestle some control away from insurers by self-insuring, selectively pooling their purchasing power, and negotiating with hospitals and health plans on price and quality. These coalitions have developed in most major cities; Cincinnati and Rochester, New York, are two examples (17, 18, A Model for Health Care Reform: The Cincinnati Experience. Washington, DC: The Jefferson Group; 6 January 1993. Presentation for Congressional Staff). These employers, however, still restrict the choices available to employees—putting local physician-directed health networks at a competitive disadvantage—and indirectly support questionable utilization review practices. Employers in Minneapolis plan to break the formula of employer-restricted choice by giving vouchers to employees and thus enabling them to choose any provider network. This approach is essentially a purchasing coalition that provides total individual choice and continuity. Interestingly, the approach was developed to counteract domination of the market by four large managed care organizations and to increase competition. The approach gives individual provider groups direct access to patients and makes them directly accountable for price, quality, and value.

The current health care marketplace is fraught with change and uncertainty. Physicians are challenged to preserve the practice of quality medicine and the integrity of the medical profession, an endeavor that is also of mutual concern to patients. Coalitions and innovative approaches are needed to meet the challenge. Given a choice of allies—insurers, employers as large restrictive buyers, or individual patients and employers represented by purchasing pools—the mutual desire of physicians and patients for the maintenance of high-quality, accessible, affordable health care is clearly best served by the empowerment of individual persons in the marketplace. The College believes that this empowerment can be achieved through purchasing pools.

Choice and Continuity

To physicians, the most important role of a purchasing pool is to broaden individual choice and expand medical continuity. From this feature flows much of the construct's ability to counteract the excessive influence of corporate managed care and employer-negotiated health plan restrictions.

Nearly all federal health reform bills in 1994 and three bills that were cited as legislative vehicles in 1995 claim a portability provision by limiting preexisting condition clauses (5-7). However, true portability exists only when persons can carry the same health coverage and the same physicians from one job to another. By itself, a prohibition on preexisting conditions offers not true portability but only
maintenance of coverage, often in a different health plan and with a different physician (19). True portability enhances quality of care and health maintenance; the lack of true portability (caused by linking health coverage decisions to employment and to carriers’ ability to use risk selection) discourages health plans from investing in health maintenance because their patients may be forced to switch plans at any time.

Voluntary purchasing pools can be designed to greatly enhance choice and continuity, or they can recreate the continuity problems of the current system. Pools that provide the broadest possible choice of health plans provide the greatest opportunity for individual persons to maintain the same plan despite changes in employment or payer status. Yet only a handful of states, including California, Minnesota, and Kentucky, have designed pools to provide broad choice (10). Most states allow pools to greatly restrict choice; this is a concession to insurers who benefit by reserving better prices for employers and pools that can deliver a greater share of the market. Many states also permit the development of many competing purchasing pools, which further restricts choice and continuity through market fragmentation.

Recommendation 1: Choice of health plans offered through a purchasing pool must be made by individual persons.

The most important question about this choice is who makes it. Continuity of care and the competitiveness of physician-run health plans depend on the fact that individual persons, not their employers, choose health plans from an array offered by the cooperative. It is disturbing that many states give selection rights to employers, who argue to state legislatures that they can control health costs only if they can control choices and benefits. This approach is grounded in the very insurer-controlled marketplace dynamics that the purchasing pool is designed to change. (Insurers seek market share, which requires employers to restrict choice.) Also, individual choice is central to competition based on price and quality rather than risk selection, because individual choice is a more accurate measure than employer choice of a health plan’s performance with regard to these two criteria (20).

Recommendation 2: To provide the broadest possible choice of health plans, purchasing pools should offer all qualified health plans. If that is not done, the authority of purchasing groups to negotiate price should be limited. As an alternative, states should set a minimum threshold for the number of competing plans that must be offered, in the aggregate and by type of plan.

Another crucial design factor that affects the degree of choice available to consumers is a purchasing cooperative’s authority to selectivity contract with health plans. Whether cooperatives should aggressively negotiate or accept all qualified health plans that meet general state regulatory requirements, such as a Blue Cross indemnity plan, is arguable, and pros and cons exist on each side. As stated above, cooperatives that have the authority to negotiate like employers can weaken the market position of smaller, community-based plans that can provide a benchmark for quality. In the Enthovian model of purchasing pools, if competition is effectively restricted to price and quality, the marketplace will work on its own to drive quality up and costs down (21, 22). Too often, the quality component of the twin forces of cost and quality is forgotten. It is not quality that should be factored out of the competitive equation, but risk selection.

Nonetheless, purchasing groups have been credited with cutting premium costs through negotiations, and their negotiating authority is looked on favorably by many observers and states, especially in the context of voluntary, competing pools, which are nonmonopsonist by design. The California Public Employees Retirement System (CALPERS) has been credited with decreasing the rate of premium growth from about 22% in 1989 to 1.4% in 1993. Premiums declined slightly in 1994; health maintenance organization premiums declined an average of 5.2% in 1996. (The extent to which the decline in rate can be attributed to CALPERS’ negotiating authority is unclear; CALPERS has had the same authority since 1963, but rates did not begin to decline seriously until a state budget crisis forced cuts in all state spending. Simultaneously, the premium rate increases of other buyers also began to slow [23].) The California Health Insurance Purchasing Cooperative for small employers, which also has negotiating authority, achieved about 15% savings in its first year of operation and 6% in its second, and it has achieved 5% savings since 1 July 1995 (24). Some degree of negotiating authority for voluntary, nonmonopsonist purchasing pools is probably constructive, if not inevitable, but this authority should be limited.

One way to limit this authority would be to prohibit pools from using premium price as a reason to refuse to contract with health plans if those plans offer premiums within a certain percentage of the average premium in the pool (say, 110% to 120%). This approach would balance the goals of cost savings, choice, and quality. Within a range, consumers should be able to weigh quality of service (as defined by factors such as convenience, service, and outcomes) against price. A narrow price spread among plans will maintain the dynamic toward
lower premiums while allowing plans to incur marginal costs for important service components, such as extended office visits, greater choice of physicians, or preventive health or nutrition counseling. Both health care providers and their patients can benefit from a price margin that allows the market to determine the value of some important components of care without stimulating cost growth through the overutilization of services and the misuse of expensive technology.

Another way to broaden the selection of available plans offered by a pool is to create a regulatory requirement stating that cooperatives must offer a minimum number of competing plans, including at least one health maintenance organization, one preferred provider organization, and one point-of-service plan. Additionally, any plan that includes most of the region's primary care providers must be offered. State actuaries would have to estimate the number of plans a given market could bear, and the cooperative would have to offer that minimum number, assuming that qualified plans submit bids.

The inclusion of a point-of-service provider should broaden the selection of individual physicians available to patients beyond that which is available in the current employer-constrained system.

**Recommendation 3: Purchasing pools should be as large as possible and as few in number as possible in a given area.**

Size and exclusivity of purchasing groups are also important determinants of choice and continuity in the physician-patient relationship. The larger the alliance and the fewer alliances serving a given region, the greater the choice of health plans and the more continuity that exists.

Theoretically, the ideal purchasing pool would be exclusive (no other competing pools would exist) and would include everyone (membership would be mandatory, at least for anyone who has a source of financing for health insurance) in a given geographic area. This would totally break the link between health plan choice and source of payment. Under these circumstances, anyone with health insurance would also have complete choice and continuity. One could choose any health plan or any physician and continue with them regardless of changes in employment or other changes in payer.

Size and exclusivity are also crucial in preventing adverse risk selection within a purchasing pool. Greater size and fewer pools decrease the ability of insurers to risk select, because any one pool will be too large for a competitive insurer to ignore. Pools with a disproportionate number of high-risk members will fall into a death spiral and will eventually collapse under the weight of the premiums they will have to charge.

However, size and exclusivity also have disadvantages. One, applicable to state-operated purchasing pools, is the potential for bureaucratic expansion and intrusion into health care decision making (a potential perhaps not unlike that now exercised by insurance companies). Another argument against larger and fewer pools is that the pools, like health plans, will perform better given competition.

In a marketplace of voluntary purchasing groups in which large employers self-insure, these arguments do not prevail. First, voluntary pools, state-operated or private, must compete against the outside market. Second, the administration of state-operated purchasing cooperatives can be legislatively constricted if most tasks are contracted to the private sector, as in California. Third, the basis of competition among purchasing pools is weak. Choices are likely to relate more to the health plan and physicians than to the pool itself.

For these reasons, the College recommends that pools be as large as politically practicable and that the number of competing pools be limited. Before licensing additional pools in an area, states might require competing pools to prove that they will not destabilize existing pools (this is a requirement in Iowa). Federal legislation could authorize development grants for states that establish just one purchasing pool per geographic area or that develop innovative risk-adjustment programs to compensate for unequal risks between competing pools.

Several ideas on how to enhance choice and continuity in the imperfect but improved world of competing voluntary purchasing pools have been suggested. Hoy and Curtis (19) propose a clearinghouse mechanism that would allow new employees to retain coverage in their former plans, at least for a 2- to 3-year period, during which treatment courses could be completed. For all employees who retain past coverage, health plans would bill the clearinghouse rather than the current employers. The clearinghouse would do the sorting and send one bill for past-coverage recipients to each current employer, which would send one payment to the clearinghouse. This would be administratively simple for employers, and the work of the clearinghouse could be contracted by the state to a third-party administrator. Hoy and Curtis also propose a voucher system. Essentially, these approaches isolate and centralize the billing component of numerous purchasing pools into a single billing pool.

Use of the mechanisms described above to achieve the broadest possible choice of health plans for a given individual person should make the health care marketplace friendlier to physician-directed, community-based health plans and should provide a welcome check on the hegemony of corporate managed care.
Although managed care can help to improve coordination of care and possibly outcomes, profit-driven managed care makes concern for quality and access suppliant to the concerns of stockholders. With professional leadership, community-based, physician-directed integrated health networks have the potential to set a standard of quality for all managed care organizations in a geographic area, compelling larger for-profit conglomerates to meet similar standards. However, small local health plans may find it difficult to compete effectively against larger managed care corporations in a market in which purchasing dynamics are dominated by insurers (through risk-segmentation practices) and employers (who restrict health plan choices). If physician-directed local plans are to gain a serious foothold in the managed care marketplace, individual consumers must be able to make their own purchasing decisions from among a broad array of health plans.

The concept is best explained with a hypothetical example. If Main Street Medical Plan of Manassas attracts just one fifth of the employees (most of them from Manassas) of each of five companies that employ 1000 workers each, this community-based plan gains 1000 patients. If, however, each of these large companies chooses just one or two health plans for its employees, Main Street of Manassas has little chance of winning any single contract. It is more likely that a larger firm, such as Aetna, U.S. Healthcare, Humana, or Columbia-HCA, will win the contract. These companies have more capital, greater marketing ability, more established corporate relationships, more locations, and more leverage with which to enlist physicians to participate. Providing individual choice from among many health plans through purchasing cooperatives gives the smaller plan a fighting chance.

In addition, broad choice enhances the value of pools vis-à-vis association-based health plans, MEWAs, and other private-sector pools that restrict choice and fragment the market. Association-based health plans and MEWAs are designed specifically for defined groups, such as professional groups, trade groups, or employer groups. Further exploration of restrictions on these types of plans is warranted but is beyond the scope of this paper.

**Market Rules for Voluntary Purchasing Cooperatives**

In a voluntary, nonexclusive system of purchasing groups, there must be safeguards against risk selection practices that entice healthy persons to purchase coverage for a lower cost outside of the pool. The viability of purchasing groups rests on market-wide rules and safeguards that help to confine competition to price and quality and minimize competition based on risk selection.

**Recommendation 4**: Standardize one or two benefit packages across the entire small group market—in public state-chartered purchasing pools, in private pools such as MEWAs and employer purchasing coalitions, and outside of all pools.

Insurers in the small group market should make the standardized package or packages available to all pools and individual small employers. Insurers who wish to sell only within the public purchasing pool may do so. Insurers may also sell other products outside of a public pool. A product may be sold as a whole, or states may require that additional benefits be sold separately from standardized packages. All products available to small employers, inside or outside of a pool, must be disclosed to all purchasers inside or outside of a pool. The objective of these requirements is to guard against adverse risk selection in public purchasing pools through benefit design. Standardization of benefits is also needed to foster choice based on price and quality; a multitude of various benefit packages only confuses consumers.

**Recommendation 5**: Standardize community rating rules and regions, as well as other market rules, across the entire small group market. Rating factors must exclude health status and claims experience.

States should also enact other basic insurance reforms, including guaranteed issue and renewal and annual open season for all of the small group market, inside and outside of purchasing pools. It is critical that health plans operate under the same market and rating rules inside and outside of purchasing pools; otherwise, insurers will seek out the healthiest people for nonpool plans. Purchasing groups, in turn, will have adverse risk selection and unsustainable premiums. These reforms should not prohibit a pool from passing on lower premium prices achieved through administrative efficiencies and economies of scale.

**Recommendation 6**: Allow participants in public purchasing pools to use an agent’s or broker’s services for enrollment and employee education but require commissions to be line-itemed separately from the pool premium so that consumers know the cost of the extra administrative service and the cost of the plan.

The commission must be a flat fee per enrollee or group and may not be based on the health status of any small group employer or individual person—an industry incentive for brokers to seek out low-risk enrollees. California maintains such a requirement for plans in its state-operated pool, the Health Insurance Plan of California (HIPC). Still,
many employers in the HIPCs enroll through brokers. Applied across the entire small group market, the commission itemization requirement might serve as an incentive for employers to enroll in the purchasing pool directly—a sort of reverse adverse risk selection. By enrolling directly, small employers avoid administrative costs and gain the same advantage enjoyed by large employers. Moreover, this scenario is perhaps the path of least resistance to a much-needed shakeout of small carriers and agents, a prerequisite for substantial system-wide administrative savings.

Recommendation 7: In a system of competing public pools, require state certification and monitoring of the pools' adherence to the same market rules to deter competition among pools based on risk selection.

Apply prospective and retrospective risk adjustment mechanisms, as they exist now and as they become more refined, to compensate for unequal risk in competing purchasing pools. A thorough review of risk adjustment techniques is beyond the scope of this paper (26-29).

Recommendation 8: Eventually, make public purchasing pools available to low-income and underserved persons. Adopt federal legislation prohibiting states from pooling Medicaid population premium costs with public purchasing pools.

Medicaid populations should have the purchasing pool benefits of choice and continuity and should be granted access to pools as they gain stability and credibility. To retain the viability of pools, states must allow pools to maintain separate funding streams for Medicaid and non-Medicaid populations. This will force states to adequately finance the higher premium costs of the Medicaid population, while allowing Medicaid recipients access to all plans in the pool. Separate, overt state financing of Medicaid populations is necessary to ensure that their disproportionate costs are not borne by the lower-wage employees of small firms who make up the pools (20). The average wage of firms with fewer than 10 employees is half that of firms with 1000 or more employees (13).

Many low-wage earners served by purchasing pools, as well as many Medicaid clients, reside in underserved areas, both urban and rural. Purchasing pools can take several steps to induce health plans to serve these areas. First, with market leverage, pools can negotiate service requirements and standards into contracts with health plans. Standards could cover office locations, hours of service, marketing requirements, and other issues. Second, pools could award exclusive franchises, including distribution of state funds for underserved areas, to health plans that agree to invest in capital development in underserved areas. Third, pools can use risk adjustment mechanisms, such as a geographic variable, to create incentives for health plan expansion into underserved areas (20).

By making purchasing pools as large as possible, the risks of less healthy persons are diluted and at some point become negligible. Limiting the number of competing pools contributes to size, as does raising the firm size threshold for participation in the pool.

Most states with purchasing pool legislation set the maximum threshold at 50 to 100 employees. A maximum is needed to prevent larger firms with older, sicker populations from opting for the purchasing pool. This adverse risk selection would threaten the pool's viability. The problem could be partly solved by allowing larger firms to opt into the alliance at a risk-adjusted rate. If the risk adjustment is accurate, some of these firms would realize marginal savings at most. Many others would find it cheaper to buy their own insurance or to self-insure.

The Employee Retirement Income Security Act (ERISA) of 1974, which shields self-insured health plans from state regulation (including mandated benefits and employer financing), is another disincentive for larger firms to join purchasing pools. Limiting the ERISA preemption through legislation should increase the number of employers opting to join purchasing pools, thus making the pools more capable of including sicker populations.

Governance of Purchasing Pools

Recommendation 9: Make purchasing groups accountable to the purchasers they serve—employers and consumers. Minimize political appointments to the boards of state-operated purchasing pools. Create incentives for pools to minimize in-house staff and use performance-based contracting for labor-intensive tasks.

The College calls for state governments to set up public purchasing cooperatives, but state governments need not operate them. Public purchasing groups should be either 1) state-chartered cooperatives or not-for-profit entities following state and federal guidelines for the operation of purchasing groups, with a board of directors, or 2) operated by a state health agency, with an advisory council (30). Both board and advisory council members should be employers and consumers elected by or representative of individual members of the purchasing groups. Board and council members should have no vested interest in a health plan, insurance plan, or related group while on the board and for a period before and after service on the board (say, 3 years). Each board or council should have at least one
pools negotiate premiums with health plans and can exclude plans, both allow individual persons (not employers) to choose their plans. In HIPC, participation is limited to firms with 3 to 50 employees; MEIP does not limit participation by firm size. Each purchasing group requires generally standardized benefits. Twenty-four plans—a mix of health maintenance organizations and preferred provider organizations, each with two different levels of cost-sharing—are offered by HIPC. Four health maintenance organizations and four preferred provider organizations are offered by MEIP; employers choose which of the two types of coverage to offer, and then employees choose a plan of that type. Both HIPC and MEIP enforce similar insurance reforms in the small group market—guaranteed issue and renewal, annual open enrollment, and limited community rating.

About 4500 insured members are covered by MEIP through 375 employers; about 10 to 20 new groups are added each month. Compared with MEIP’s steady growth, the growth of HIPC has been explosive. In its first year, HIPC enrolled 44,000 employees of 2500 firms. By September 1995, 94,000 persons were enrolled through 5000 firms. The influx of enrollees is attributed to lower premiums and broader choice than most firms can find in the outside market.

**Conclusion**

While maintaining its commitment to universal coverage, the American College of Physicians supports the concept of voluntary purchasing pools as an incremental mechanism for 1) expanding access to small groups and individual persons, 2) reducing administrative costs, and 3) maintaining quality in a marketplace increasingly dominated by corporate managed care. The College supports federal and state initiatives that stimulate the creation of voluntary purchasing pools in every state.

Allowing for flexibility so that different states can meet different local needs, the federal legislative initiative should lay out basic design requirements essential to viable cooperatives that maximize choice and continuity of care. By building on the work of states that have already established purchasing pools, minimal federal legislation can facilitate the availability of a voluntary public purchasing pool in every geographic area.

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