Small Group Market Health Insurance Purchasing Cooperatives Revisited

Thursday, July 28, 1994
8:00 to 8:30 am - Continental Breakfast
8:30 to noon - Discussion
Quality Hotel Capitol Hill
415 New Jersey Avenue, NW
Congressional Room

A workshop featuring

Cary Badger
Vice President and Health Plan Manager
Kaiser Permanente of Northern California

Robert Karp
Assistant Vice President, Underwriting
Employers Health Insurance Company

Paul Pietzsch
President
Health Policy Corporation of Iowa

John (Jack) Burke
Vice President/Actuary
Aetna Health Plans

Richard Curtis
President
Institute for Health Policy Solutions

John Ramey
Executive Director
California Managed Risk Medical Insurance Board

Emery (Soap) Dowell
Director
California Managed Risk Medical Insurance Board

Ernesto Scorsone
Kentucky State Representative

John Erb
Executive Vice President
Community Health Purchasing Alliance, District 10
Broward County, Florida

Daniel Winegarden
First Deputy Insurance Commissioner
Iowa Division of Insurance

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North Carolina Department of Insurance

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Small Group Market Health Insurance Purchasing Cooperatives Revisited

With the federal government embroiled in a debate over the scope and nature of health care reform, the ultimate role of health purchasing alliances or cooperatives\(^1\) remains uncertain. Notwithstanding the unresolved political turmoil over whether to require universal coverage and how to slow the growth of health costs, an increasing number of states are developing cooperative purchasing entities designed to give employees of small businesses a choice of health plans at prices comparable to those that large employers can negotiate.

While the alliances envisioned in the Clinton health reform bill would be mandatory for employees of firms with fewer than 5,000 employees, would help subsidize premiums for lower-income people, and would help enforce government-determined premium caps, states are moving in far more modest ways. Virtually each state cooperative or alliance is a unique experiment with differing policy goals and design features. So far, none of the alliances is mandatory for private employers or employees. Some are open to all employers of a certain size; others are not. Some states allow competing alliances; others do not. Some have the power to negotiate and exclude health plans, but some do not. Some provide a virtually unrestricted set of choices and some information but are otherwise passive. Moreover, each state has a different set of small-group insurance reforms and its own regulatory environment, key factors in the potential success or failure of purchasing cooperatives.

How these varying design attributes might combine to realize the goals of increasing access to health insurance and containing costs is the central question to be addressed at this Forum session. California’s purchasing cooperative, which enrolled more than 54,000 people during its first year in operation, will provide a major focus for discussion. Also on the table will be Florida’s purchasing alliances and those planned for Iowa and Kentucky. Issues for discussion will include how active purchasing alliances should be in negotiating with health plans and what kind of insurance reforms might allow health plans offered through alliances to operate "on a level playing field" with those offered outside of them.

**STATE ACTIVITIES**

So far, 13 states have passed legislation to create or encourage the development of some form of purchasing alliance or cooperative designed to help small employers and their employees purchase health insurance, according to the Institute for Health Policy Solutions, an organization that has worked with some states setting up purchasing alliances and that monitors and analyzes related issues. At one end of the spectrum are laws that authorize a single state-sponsored purchasing cooperative open to all businesses of a certain size, such as the Health Insurance Plan of California (The HIP). In contrast, under Ohio law, a wide range of entities can become alliances, so long as member firms have 150 or fewer employees. Such organizations may look very much like multiple-employer groups that have inhabited the health insurance landscape for quite some time.

**POLICY OBJECTIVES AND DESIGN FEATURES**

Evaluating the features of a purchasing alliance depends on the public policy objectives that the alliance is supposed to realize. Alliances in the Clinton health bill would have several functions, including mandatory pooling, subsidizing lower-income groups, regulating prices, managing competition among health plans, and

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\(^1\)In this paper, *alliances* and *cooperatives* are used interchangeably as generic terms.

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adjusting for risk differentials. Most of the multiple-employer purchasing entities created by the states are not compulsory and are designed to give the employees of small firms more choices of health plans and better prices than otherwise might be available. Depending on the alliance's design, employers may enjoy savings through lower administrative costs achieved through economies of scale and by aggregating purchasing power in order to negotiate better prices with health plans. In their current form, alliances or cooperatives are not designed to have a major impact on the total number of uninsured workers. However, as part of a universal health insurance reform package, such organizations might represent vehicles for providing businesses and their employees with affordable coverage.

How effective purchasing alliances might be in containing costs and increasing access depends on a series of interlocking issues, including the following:

- which employers must participate, can or cannot participate, and can opt out;
- how many alliances are allowed to operate in a given region;
- whether alliances may negotiate with plans;
- whether alliances must offer all willing health plans and under what terms;
- who governs and operates the cooperatives and to what degree they pursue purchasers' interests;
- the degree to which increased levels of choice and competition increase the opportunities for risk segmentation and risk-related price differentials among competing health plans; and
- whether insurance reforms that apply to the entire small-group market favor, or at least do not undermine, a purchasing alliance.

Florida: A Passive Model

A key issue is how an alliance should attempt to contain costs. Some analysts advocate that the alliance should be a "passive" vehicle used to offer consumers a selection of health plans and information to help them choose. Florida's 11 community health purchasing alliances (CHPAs) are not allowed to negotiate rates with health plans and must accept all willing plans that meet data specifications. Open to employers of 1 to 50 employees, the CHPAs are just beginning to enroll members.

Employers pay $25 a year for "selection and information," according to John Erb, executive vice president of Community Health Purchasing Alliance, Broward County, District 10 (which contains Fort Lauderdale). The Broward County CHPA also receives $3.95 a month per insured employee for premium billing and collection. Broward County CHPA staff members have trained 1,000 insurance agents in the county and have signed up 35 insurers offering a total of 50 plans. Enrolling employers must offer their employees the choice of at least two of the plans. Prices vary widely. With so many plans on the menu and only a handful of employers on board, it is difficult to determine how the CHPA might affect prices. "If this thing depends on purchasing power, we have to enroll a significant portion of eligible businesses in the county," Erb said in an interview. Asked if he thought the CHPA might be more effective if the state allowed it to negotiate with plans, he said: "I don't know if I really want it [negotiating ability]. I like the supermarket approach. Here are 50 prices for 50 products." Next year, he said, the CHPA will begin publishing a "report card" grading each health plan on member satisfaction, percentage of physicians that are board-certified, and network size and adequacy.

Bidding in California

Unlike the more passive approach in Florida, California's statewide purchasing alliance goes through a negotiation process with health plans and may exclude them. During its first year of operation, The HIPC offered small firms competitive rates. The state-appointed California Managed Risk Medical Insurance Board (MRMIB), which manages the cooperative, negotiated contracts for a standard benefit package with 18 plans and in many cases won more favorable rates than the California Public Employees Retirement System (CALPERS), according to MRMIB managers. For its second year, which began July 1, the rates of plans offered through The HIPC have been reduced by an average of 6.30 percent overall and 3.25 percent for current customers. As of July 1, 1994, the cooperative had signed up 3,022 employers with an average of 10 employees. Including dependents, 54,060 people had chosen one of 20 plans contracting with MRMIB.

As of June 1, almost 39 percent of the cooperative's population chose either an HMO or a PPO offered by Aetna Health Plans. About 21 percent signed up with either Kaiser Permanente-North or Kaiser Permanente-South. Employers Health Insurance Company (headquartered in Green Bay, Wisconsin) plays a dual role, both administering The HIPC and offering a health plan that enrolls more than 4 percent
of its population (while offering insurance outside The HIPC, as do all the other insurers competing in the alliance). Blue Cross of California Companies, a major player in the small-group market, originally tried to block the state from creating The HIPC and chose not to offer a plan through the alliance; Blue Shield of California also does not offer a plan through The HIPC. One reason that Blue Shield decided to stay out of The HIPC is that the company depends heavily on agents and brokers to bring in business. Because of this dependency and the fact that Blue Shield is a regional carrier confined to California, the company stood to run greater risks by alienating the state's agents and brokers than did competitors that offer products in many states, according to John Saari, Blue Shield senior vice president for finance and information. "They [agents and brokers] were very unhappy about The HIPC" because of the diminished role that they play within its operation, he added. Because it is important for new alliances or cooperatives to offer carriers with significant shares of the small-group market, the participation of Kaiser—which has a 26 percent penetration of the small-group market in Northern California—gave The HIPC a needed boost, according to Kaiser executive Cary Badger. Once Kaiser signed on with The HIPC, several other insurers followed suit, he added.

Growing at a rate of about 5,000 people per month, the California HIPC is still a very small player in the market and has had a minor impact on the number of uninsured. About eight million people in the state, roughly half of whom are uninsured, work for employers eligible to purchase through the alliance. About 24 percent of employers using The HIPC previously did not provide health insurance for their employees.

Despite its modest growth, the alliance has had a significant impact on pricing in the small-group insurance market, not only within the menu of plans that it offers but also among outside plans. In the June 11, 1994, issue of the New York Times, senior California Blue Cross executive Mark Weinberg was quoted as saying: "There is no question in my mind that it has had a huge effect on the pricing. We have lowered rates twice since the alliance began." In an interview, Emery (Soap) Dowell, a MRMIB board member said: "It's not accurate to say that something that started 11 months ago has come to dominate the small-group market. It has come to dominate the pricing. Everybody is chasing our prices." The California alliance has had "a collateral, beneficial impact on the outside [small-group] market," both in driving down prices and raising plan quality, according to Robert Karp, of Employers Health Insurance. MRMIB managers act as "consumer advocates" negotiating with health plans, he said.

More than one theory is afloat about how MRMIB's negotiation process has helped to drive down health plan prices; much of the impact seems to be related to a greater flow of information about prices both among competing plans and purchasers. In February 1993, MRMIB first solicited bids from insurers for every possible age, benefit, and family group combination offered to employees. As recounted by John Burke, vice president/actuary, small business market, Aetna Health Plans, MRMIB executives told participating insurers if their rates for any combination were "outliers." Insurers were then given the opportunity to resubmit bids and prices tended to come down and converge. "The hidden message is: 'I don't have to accept you if I don't want to,'" said Karp, of Employers Health Insurance. "They [MRMIB negotiators] have the advantage of being able to play their prospective companies against each other. . . . There's no third party to initiate this kind of dynamic in the outside market." A major reason that insurers participating in The HIPC could offer competitive rates during the first year was the way MRMIB designed its benefit package, Karp said. There was no fee-for-service option and, in instances where an individual received care outside a plan's network, the plan was required to pay a percentage of its negotiated fee and not of a provider's charges, added Karp.

This year, during the second year's bidding process, MRMIB unexpectedly gave insurers more feedback, said Burke. Insurers were told that bids on average were 6 percent lower than the previous year's rates and that bids by weighted average were 2.5 percent lower. This information tended to reveal Aetna's bids (which were very competitive) more than other carriers' because Aetna has the largest share of business within the cooperative, Burke said. After learning of the overall rate reduction, many plans lowered their rates, he added. John Ramey, MRMIB's executive director, said that the alliance is important in pegging prices in the small-group market because it attracts about one-quarter of firms in the "new market," which he defined as firms looking to switch carriers or seeking insurance for the first time. While the new market is very small compared to the renewal market, firms in the renewal market are likely to stay with their current carriers without shopping around. According to Aetna's Burke and others, one reason
that the cooperative may have had an impact on the small-group market as a whole is simply that MRMIB publishes its carriers' rates. This information may act as a benchmark for insurers and the operators of small firms negotiating outside The HIPIC. "The HIPIC provides price information that folks can get to, so it has a lot of impact both about where customers feel that rates should be and about how insurers set rates," said Saari, of Blue Shield. "[The HIPIC has] received a lot of publicity. It gets rate reductions. I think it builds off of CALPERS."

While MRMIB is working to negotiate on behalf of small firms, other organizations are doing likewise in other segments of the California market, apparently with some success. CALPERS recently negotiated a 1.1 percent premium reduction for the 920,000 people it covers, according to a report in the June 21, 1994, issue of the Wall Street Journal. Also, San Francisco's Bay Area Business Group on Health, which represents large employers, has just negotiated premium reductions averaging 5 percent to 10 percent from 18 HMOs, according to the Journal.

In a multiple-payer system, when one buyer announces that it has cut a great deal, the question arises: To what extent were costs shifted to purchasers with less ability or skill in negotiating and to what degree did health plans increase efficiency?

Market Fragmentation and Risk Selection

Advocates of a passive model of managed competition would forbid alliances from negotiating with health plans. Cost containment under this model would be achieved because "rational consumers," given a choice of health plans and comparative information, are supposed to move toward the most efficient plans. Risk segmentation tends to pose problems for competitive health insurance systems; because the health status of an insured group can have much more impact on a health plan's price than the efficiency of its providers or administrators, most analysts advocating a market-driven approach say that inter-plan transfer payments are needed to neutralize the variation in risk levels facing competing insurers. Yet, risk adjustment remains an infant technology with as yet limited effectiveness. Some state laws establishing purchasing alliances or cooperatives mention the need to develop risk-adjustment methods, but often do not specify exactly how this might be accomplished. Some offer limited "reinsurance" programs, designed to partially mitigate the risk segmentation problem, and many have no provision for either risk adjustment or reinsurance.

If the risk-adjustment methods that eventually may be applied to competing health plans are not strong enough to overcome risk differentials, then the prices that consumers see may not necessarily attract them to the most efficient plans. Many argue that the employees of small firms need to aggregate their purchasing power by joining alliances, whose managers may act as bargaining agents for the employees in dealing with health plans.

Insurance agents and brokers, groups that often exercise considerable political clout in state legislatures, often see purchasing alliances or cooperatives as competing with or displacing them. Agents and brokers (as well as some insurers that see alliances as threats) may try to block the development of state-sponsored alliances, become part of a cooperative's marketing system, or attempt to steer legislators toward softening the impact of alliances (for example, by sanctioning many cooperatives or creating passive ones).

The increased level of choice that purchasing alliances may offer employees of small firms actually may increase the opportunity for risk segmentation. With more choices, employees would have more options to sort themselves into non-random groups (with the help of insurers competing with varying levels of success to attract low-risk people and repel high-risk people). The more fragmented the market, the harder it would be to make transfer payments among plans to account for differing risk levels.

Legal Standing in the Market

A critical ingredient in the potential success of purchasing alliances is just how federal and state laws might combine to define their status, responsibilities, and powers relative to other entities in the marketplace. Such entities include benefit plans and commercial insurers, as well as multiple-employer welfare arrangements (MEWAs), which, under the Erlenborn amendment to the Employee Retirement Income Security Act of 1974 (ERISA), are defined as employee welfare benefit plans or any other arrangement providing any of the benefits of an employee welfare benefit to the employees of two or more employers.

Under current federal law, many, if not all, of the purchasing alliances now being created by the states are defined as MEWAs. In the past, regulation of MEWAs has been either nonexistent or fraught with

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2See Issue Brief No. 641, "The Role of Risk Adjustment in National Health Reform."
problems. While some MEWAs have helped small employers gain access to insurance, many have become insolvent, leaving thousands of employees without health coverage. (See Issue Brief No. 604, "Multiple Employer Purchasing Groups [METs, MEWAs, HINs, HIPCs]: The Challenge of Meshing ERISA Standards with Health Insurance Reform.") Self-insured MEWAs operating without reserves pose the most pressing problems and many have become insolvent, according to labor department regulators. So far, most of the state-sanctioned purchasing alliances or cooperatives would be required to offer fully insured health plans.

The Erlenborn amendment, which took effect in 1983, makes a special exception to ERISA's broad preemption of state regulation of employee benefit plans so that states can regulate MEWAs, in varying degrees, depending on the status of a MEWA. The full extent of state insurance regulation can be applied to MEWAs that do not meet ERISA's definition of an employee welfare benefit plan. For fully insured MEWAs that meet the ERISA definition, states may apply insurance laws pertaining to reserve and contribution levels. For MEWAs that meet the definition but are not fully insured, states may apply insurance laws not inconsistent with ERISA (that is, they may apply regulations that do not weaken ERISA's requirements, including disclosure and fiduciary requirements).

Despite the clarity that the Erlenborn amendment was supposed to provide, regulatory problems surrounding MEWAs have grown. Among the wide variety of multiple-employer groups that may be defined as MEWAs are organizations used by insurers or third-party administrators as marketing vehicles to attract small groups and plans offered by associations to their members.

If state and federal laws allow for the creation of multiple-employer organizations such as alliances or cooperatives, what would distinguish them from MEWAs? Should alliances, for example, be required to be open to all employers of a certain size? What public policy goals should alliances or cooperatives be expected to achieve and what advantages should they be given to reach those goals? Should MEWAs be allowed to continue to operate and under what terms? How (if at all) should risk segmentation be neutralized among competing alliances, MEWAs, and health insurers, which might have the option to offer plans in all possible venues, including cooperatives and MEWAs, but might choose to offer plans only in those where favorable risk selection might be expected? What additional risk selection and adjustment issues arise if the Federal Employee Health Benefit Plan, Medicare Part C, or Medicaid were also made available to small employers?

Regulating the Playing Field

Most advocates of today's nascent alliances say that the regulatory habitat surrounding these organizations should not put them at a disadvantage. If, for example, outside insurers are able to deny access to high-risk people, thereby steering them into plans in an alliance, or can simply use rating differentials to push high-risk people into alliances, then rates in alliance plans might soon become uncompetitive, even assuming skillful negotiations and lower administrative costs. Among market-wide reforms that might foster the development of alliances are:

- guaranteed issue (products must be equally available to all in the small-group market);
- guaranteed renewal;
- standardized plans (comparable to consumers);
- no medical underwriting; and
- tight rating rules (modified or pure community rating).

The less rates are allowed to vary in the small-group market, the harder it is to discriminate against plans in The HIPC, according to Ramey, of MRMIB. California bars insurers from using industry, occupation, or gender in setting rates. The state does, however, allow variation based on family structure and geography, and, to a limited degree (plus or minus 20 percent), health status. Plans competing inside The HIPC submit bids based on combinations of three factors: seven age groups, four family composition possibilities, and nine regions. (Thus, each insurer must submit bids on a matrix of 28 age/family composition combinations in each region.) However, plans inside the alliance are not allowed to make a health status adjustment, a rule that over time might put them at a disadvantage to plans outside the alliance competing to attract a low-risk population. Although there is considerable speculation among competing plans about the impact of risk selection, no plan has had enough experience in The HIPC to assess its claim experience, according to Aetna's Burke. So far, there is little evidence that the cooperative as a whole is experiencing adverse selection. It has tended to attract more young people and males than average. "I think it's sustainable. We thought we might get
adverse selection and we didn't," according to MRMIB board member Dowell.

Designing a risk-adjustment process in a market with plans operating both inside and outside a purchasing alliance presents major challenges, which might be multiplied by the presence of competing alliances and other multiple-employer groups. Some analysts argue that risk adjustment should be done between insurers, based on their state-wide books of business in different market segments. However, risk adjustment might become much more difficult in a market including voluntary cooperatives or several competing ones. For example, even if insurer A and insurer B attracted the same population statewide, most of A's sicker insureds might be enrolled inside an alliance while B's population happened to be uniform throughout the market, thereby putting A's offering inside the alliance at a competitive disadvantage. How regulators then might adjust between insurer A's alliance-enrolled population and the rest of the market without throwing the original statewide risk neutrality between the two insurers out of balance (all the time using very proximate risk-adjustment methods) is open for question.

POLITICAL PRESSURES

In August 1992, the California legislature created The HIPC in a bill that also contained a series of small-group insurance reforms, many of which have been mentioned above. Although the cooperative was vehemently opposed by some insurers, agents, and brokers, for a time it may have escaped the full brunt of interest group opposition because voters and legislators were considering several proposals that were more far-reaching. These proposals, none of which eventually became law, included state insurance commissioner John Garamendi's single-payer, managed competition plan; a proposal involving an employer mandate; and a Canadian-style, tax-financed plan. (See "Interest Groups and Reform," by Thomas R. Oliver and Emery B. Dowell, Health Affairs, Spring III, 1994.) The insurance reforms that passed "did little to extend insurance" to people other than those in high-risk small groups, according to the article by Oliver and Dowell, who noted that "a legislative analysis projected that [the reform bill] would make employer-based insurance available to 100,000 more persons—less than 2 percent of Californians without insurance."

The California purchasing alliance has accommodated insurance agents and brokers by allowing them to be paid flat fees for bringing in customers. The flat fees amount to about 5 percent of premium, instead of the roughly 10 percent that the agents and brokers are used to in the small-group market, Dowell said in an interview. Under the arrangement, employers can join The HIPC without paying an agent or broker; however, so far about 73 percent of enrolling employers have used their services.

As the California cooperative gains a foothold in the marketplace, it remains a political target. So far, it appears to have avoided the pitfalls that have undermined some state agencies—domination by industry groups and/or inadequate staffing. In fact, according to one observer of California health care politics, "somebody deserves a lot of credit" for staffing The HIPC with top-notch, seasoned state officials rather than the "political has-beens" that have sometimes ended up running similar state-sponsored organizations.

STATE VARIATIONS

In Iowa, reforms enacted in 1993 would allow the creation of several privately operated health insurance purchasing cooperatives (HIPCs) licensed by the state insurance department. After the first HIPC is licensed to operate in a given geographic area, the onus is on any additional HIPC to show that it will not grow at the expense of the existing one(s). Because part of the purpose of cooperatives is to aggregate purchasing power, state regulators do not anticipate licensing more than two or three HIPCs in any region, according to a state insurance official. The first purchasing cooperative to gain a license is sponsored by the Independent Insurance Agents of Iowa (IIAI). (Both insurance agents and carriers exert considerable political influence in Iowa, according to many sources.) The IIAI has hired Employers Health Insurance to administer the HIPC, which will operate statewide, and has negotiated with five insurers to provide eight standard health plans. In Central Iowa, a second cooperative, the nonprofit Community Health Purchasing Corporation, is being organized by the Health Policy Corporation of Iowa to help both large and small-sized employers buy coverage. At some point, a purchasing coalition serving large employers in Cedar Rapids may extend services to insured small employers and individuals, as well.

The Kentucky General Assembly in April enacted insurance reforms and created the Kentucky Health

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3 One proponent has referred to the cooperative as a "stealth HIPC." Some wonder whether similar cooperatives might be allowed to take root in other states if the California experiment ends up putting downward pressure on prices while displacing some players in the insurance industry.
Purchasing Alliance, which is directed to be operational by July 15, 1995. The law stipulates that the organization will be the only entity permitted to operate as a statewide purchasing alliance. Membership is voluntary for individuals, for employers of 100 or fewer employees, and affiliated groups or associations of 100 individuals or less. By January 1996, 300,000 public employees will be required to purchase health insurance through the alliance and, at some point, up to 500,000 Medicaid recipients may be enrolled as well, according to Ernesto Scorsone, a Kentucky state representative who helped engineer the reforms. The law grants the alliance the power to negotiate with health plans.

THE FORUM SESSION

Richard Curtis, president of the Institute of Health Policy Solutions, will begin the meeting with an overview of the key issues in developing purchasing alliances. John Ramey, MRMIB’s executive director, will discuss the California cooperative’s first year of experience, including the impact of the bidding process and effects of state insurance regulations. A discussion will follow involving a MRMIB board member and executives from insurers competing both inside and outside the alliance, including the company hired to administer it. After a break, the discussion will turn to purchasing alliances being developed in Florida, Iowa, and Kentucky and will include comments from state insurance regulators.

Issue Questions

Among the questions to be addressed during the session are the following:

- What are the capacities and limits of various models of purchasing alliances?
- Given the evidence available so far, to what degree will the ability to negotiate with insurers enable purchasing cooperatives to gain more favorable prices for employees of small firms?
- What package of small-group insurance reforms is needed for purchasing alliances to succeed?
- How should federal and state laws be coordinated and rationalized to define and regulate various types of multiple-employer arrangements, including alliances or cooperatives?
- In what ways can cooperatives or alliances help to aggregate purchasers in the small-group market and empower them? How might alliances or cooperatives cause opportunities to fragment the market?

- What are the advantages and disadvantages of having more than one alliance operating in the same region?
- How might risk adjustment be accomplished in a market populated by competing cooperatives and other multiple-employer arrangements, with insurers free to offer products both within any number of such arrangements and outside of them?
- In what ways are those opposed to empowering purchasers attempting to weaken the impact of purchasing alliances?
- Who should govern and operate purchasing alliances or cooperatives? What role, if any, should insurance agents, brokers, general agencies, and insurance carriers play in an alliance’s governance and operation?

Speakers and Panelists

Cary Badger, vice president and health plan manager for Kaiser Permanente of Northern California, is responsible for development and coordination of the plan’s overall strategy for marketing, benefits, products, and customer services to members and purchasers. Mr. Badger joined Kaiser in June 1992 as director of marketing and assistant health plan manager for the Northern California region. Previously, he was with AV-MED Santa Fe in Gainesville, Florida.

John (Jack) Burke is vice president/actuary, Aetna Health Plans, and heads the Business Management Unit within its Small Business Market strategic unit. He is responsible for pricing, underwriting policy, and product development for group health and life insurance and managed care products marketed to customers with 300 or fewer employees. Before assuming his current position in 1991, he held four other positions at Aetna, the latest of which was director of the Benefit Payment Unit, Pension and Financial Services.

Richard Curtis is president of the Institute for Health Policy Solutions, a nonpartisan, nonprofit organization that he founded in 1992 to identify, analyze, and develop policies to solve health system problems. He and his colleagues have developed alternative strategies for federal, state, and private coalition health purchasing cooperatives for small employers.

A long-time observer of California health care and insurance politics, Emery (Soap) Dowell is a director of the California Managed Risk Medical Insurance Board. He previously ran a public affairs consulting
firm and worked for Blue Cross of California, where he was responsible for all corporate concerns with the U.S. Congress and the California legislature, as well as with all state and federal agencies.

John Erb is executive vice president of the Community Health Purchasing Alliance, District 10, which serves Broward Country, Florida. From 1988 to 1994, he was a principal with A. Foster Higgins & Co., in New York, serving as a consultant to large corporations and government agencies on health care cost management.

Allen Feezor has served as chief deputy commissioner of the North Carolina Department of Insurance since 1985. From 1985 to 1988, he also served as the executive administrator of a 500,000-member health plan. Mr. Feezor has chaired several lay committees for the National Association of Insurance Commissioners (NAIC). The most noted of these was the NAIC task force that developed model small-group-market reform legislation, which has now been adopted in 38 states and is a part of most proposals for national health care reform.

Robert Karp, assistant vice president for underwriting, Employers Health Insurance Company, led his organization’s efforts to contract as a participating health plan with The HIPC in California and was integrally involved in renewal negotiations. Before joining Employers Health in 1990, Mr. Karp held various positions with Central Life, Kemper, Washington National, and CNA, building up more than 15 years of underwriting expertise encompassing association, individual, large-group, self-funded, and small-group health insurance.

Paul Pietzsch is president of the Health Policy Corporation of Iowa (HPCI), a private, nonprofit, independent organization formed in 1982 by Iowa leaders in the private and public sectors to develop and support initiatives relating to cost containment, quality, and access to health services. Among HPCI’s activities are developing health care purchasing initiatives; conducting research, data collection, analysis, and education; and providing leadership in setting community health goals.

John Ramey is executive director of California’s Managed Risk Medical Insurance Board, which oversees the state’s health insurance purchasing cooperative for small employers. Before assuming his current position in 1991, Mr. Ramey was deputy secretary at the California Health and Welfare Agency for five years. Previously, he served as chief of staff of the California Department of Health Services.

Ernesto Scorsone was first elected to the Kentucky House of Representatives in 1984, and voters have returned him to office four times. During the legislature’s special session in 1993 and general session of 1994, he was one of the leading advocates for health care reform and was one of the primary architects of the state’s Health Care Reform Act of 1994.

Daniel Winegarden is Iowa’s first deputy commissioner of insurance and chief of the insurance division’s Policy, Rates and Forms Bureau, with responsibility for the division’s public policy initiatives, including health care reform. Also serving as the governor’s project director for health care reform, Mr. Winegarden was the chief architect of the Iowa government’s policy to enable voluntary, market-based reforms. These included insurance reforms and the establishment of voluntary, privately based, publicly regulated health insurance purchasing cooperatives.