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REVIEW OF THE STATUS OF COMMUNITY HEALTH PURCHASING ALLIANCES IN FLORIDA

REPORT ABSTRACT

- Community Health Purchasing Alliances (CHPAs) have helped increase access to affordable health care. However, approximately 2.7 million Floridians continue to go without health insurance, and additional policy options will be needed to significantly reduce this number.
- The design of Florida's managed competition model limits the ability of CHPAs to compete effectively and provide affordable insurance to small businesses.
- The current configuration of the CHPAs limits their ability to become self-supporting.

PURPOSE AND SCOPE

This review is designed to provide the Legislature with information on the status of Florida's efforts to promote managed competition by establishing CHPAs. Since managed competition is relatively new in Florida, the review focuses on the following:

- Whether CHPAs are likely to significantly affect the number of uninsured Floridians;
- Whether design changes could help the CHPAs compete more effectively and provide more affordable insurance; and
- Whether any changes in CHPA configuration are needed to help the CHPAs become self-supporting.

We also assessed whether the Agency for Health Care Administration should do more to implement Florida's managed care model and whether it has a method for evaluating the success of CHPAs in obtaining desired outcomes.

BACKGROUND

The large number of Floridians without health insurance is a continuing public concern. Approximately 2.7 million Florida citizens do not have health insurance. Three-fourths of these uninsured citizens are workers or the dependents of workers. Although most people obtain health insurance benefits through the work place, nearly 16% of Florida's workers do not have coverage. As illustrated in Exhibit 1, large businesses (those employing 50 or more workers) are much more likely to offer health insurance benefits than small businesses.

Exhibit 1
Florida's Large Businesses Are More Likely
To Offer Health Insurance Benefits

Size of Business	Percent That Offer Health Benefits
1 - 4 Workers	28%
5 - 9 Workers	49%
10 - 24 Workers	62%
25 - 49 Workers	79%
50 or More Workers	93%
All Establishments	55%

Source: 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey; reprinted in State Initiatives, September/October 1995.

Historically, small businesses have encountered problems finding insurers willing to provide them health insurance coverage. Due to the high risks insurance companies face when extending health care coverage to a small number of individuals, they traditionally either denied coverage to small businesses or based rates on the health of the businesses' workers and their dependents. Thus, one worker or dependent with a serious illness could dramatically increase a small business' insurance premiums.

In 1992 and 1993, the Florida Legislature enacted laws to reform Florida's insurance market and make health insurance more accessible and affordable to small businesses. The 1992 law requires small group insurers to offer a basic health benefit plan and a standard health benefit plan to all small businesses and their employees regardless of their health status, preexisting conditions, or claims history.¹ In addition, the law requires insurers to determine premiums by using a modified community rating method.²

The 1993 law provides for statewide implementation of a structured health care competition model, known as managed competition. The managed competition model is expected to reform the state's health care system by pooling purchasers together in organizations that broker the best health care available for the lowest price and enable consumers to make informed, cost-conscious selections of health plans. Although the law provides that these organizations can serve several groups including small businesses, Medicaid recipients, and state employees, they currently serve only small businesses.

The Legislature established Community Health Purchasing Alliances (CHPAs) to implement the managed competition model. CHPAs are state-chartered, nonprofit private organizations, located in the 11 health service planning districts. Each CHPA is governed by a volunteer Board of Directors representing consumers, business and industry, and state and local government. The Board appoints an Executive Director who serves as the CHPA's chief operating officer. In addition to the director, each CHPA employs from one to three full-time staff and contracts with a third-party administrator.

The CHPAs are financed through membership fees in addition to start-up funds provided by state general revenue. Since fiscal year 1993-94, the state has provided approximately \$8.1 million in general revenue funds to the CHPAs.³

Under Florida's managed competition model, self-employed persons and businesses that employ no more than 50 workers can join the local CHPA and purchase CHPA-sponsored insurance. The CHPAs act as clearing houses for health insurance plans that qualify as Accountable Health Partnerships (AHPs). AHPs are organizations that assume risk and integrate health care providers and facilities. AHPs have a variety of forms. Some are insurance carriers; others are health maintenance organizations.

The Agency for Health Care Administration is responsible for helping develop a statewide system of CHPAs and for establishing a data system to provide members with comparative information on provider prices, utilization, patient outcomes, quality, and patient satisfaction. The Agency provides technical assistance to the CHPAs, annually certifies that each CHPA complies with applicable statutes and rules, conducts annual reviews of the performance of each alliance, and reviews appeals from CHPA members whose grievances were not resolved by the alliance.

OBSERVATIONS AND RECOMMENDATIONS

The CHPAs' ability to significantly affect the overall number of uninsured Floridians is limited.

CHPAs were intended to reduce the number of uninsured Floridians by sponsoring affordable health insurance. CHPAs have made some progress toward enabling some previously uninsured Floridians to obtain health insurance coverage, but they have not significantly reduced Florida's uninsurance rate. As of April 1996, about 74,000 individuals were covered by CHPA-sponsored health insurance. A little more than 38,000 of these

¹ The law provides that all basic and standard health plans offered to small employers include coverage for inpatient hospital and outpatient services; newborn children up to the age of 18 months as described in s. 627.6575, F.S.; child health supervision from birth to age 16 as described in s. 627.6579, F.S.; adopted children upon placement in the residence; handicapped children beyond a policy's limiting age under conditions described in s. 627.6615, F.S.; mammograms; hospice services; and emergency treatment outside of the geographic area. Standard plans may offer additional benefits.

² Modified community rating refers to spreading risks across a large population, allowing for adjustments for specified characteristics. In Florida, small business insurers are to establish premiums based solely on county of residence, age, gender, family composition, and tobacco usage.

³ In fiscal years 1993-94 and 1994-95, each CHPA received \$275,000; for fiscal year 1995-96, each CHPA has been allotted approximately \$138,000; and in fiscal year 1996-97, each CHPA will be allotted around \$48,000.

individuals did not previously have health insurance coverage. However, this represents about only 1.5% of the 2.7 million Floridians who do not have health insurance.

The CHPAs' ability to have a large impact on the overall number of Floridians without health care insurance is limited by their focus on the small business market. However, decreases in the cost of health insurance for the small business market may not make insurance premiums affordable for many Florida workers. For example, in 1993, it would have cost a worker earning an average annual income of \$28,700 (200% of the federal poverty level for a family of four) nearly 16% of his or her gross income to purchase family health insurance coverage. Nearly two-thirds of Florida's uninsured are workers or the dependents of workers earning less than \$25,000 a year. Even if their businesses offered health insurance coverage, these workers might not be able to pay the insurance premiums without assistance.

If the Legislature wishes to improve access to affordable health care coverage, it may need to consider two policy alternatives:

- First, it could implement existing laws that give CHPAs the authority to provide subsidized health insurance coverage to low-income uninsured individuals.
- Second, it could encourage local initiatives that increase low-income individual's access to affordable health care.

Authorizing CHPAs to Offer Subsidized Insurance

CHPAs were originally intended to serve more than the small business market. To obtain a large number of members and thereby attract insurers willing to offer affordable health insurance policies, the law allows CHPAs to serve Medicaid recipients, state employees, and small businesses. In addition, CHPAs were to participate in two programs (Medicaid buy-in and MedAccess) that subsidize health insurance premiums for individuals whose incomes were at or below 250% of the federal poverty level.⁴ These programs would

have given many low-income individuals access to affordable health insurance. In Tennessee, a similar program reduced the number of low-income, uninsured individuals by a little more than 75%.

Due to concerns over many issues, including anticipated changes in the federal Medicaid program and uncertainty concerning the potential cost to provide these subsidies, the Legislature has not yet taken the steps needed to fully implement the law that authorizes CHPAs to serve Medicaid recipients and state employees and participate in the Medicaid buy-in and MedAccess programs. However, Florida received the federal approval needed to implement the Medicaid buy-in program. Therefore, the program continues to be an option the state could use to improve access to affordable health care and reduce the number of uninsured Floridians.

Encouraging Local Initiatives

Another option would be for the Legislature to encourage local communities to develop initiatives for increasing access to affordable health care and health insurance. A number of Florida communities have already developed such initiatives in response to rising health care costs. Two of these local initiatives are described below:

- Hillsborough County Health Care Plan -- This countywide plan was implemented in February 1993 to provide comprehensive health care to uninsured residents whose incomes are at or below 100% of the federal poverty level. The plan is funded through a county optional sales tax and matching state general revenue.⁵ The plan provides services through competitively-bid contracts with local health care providers in four networks. Case managers help clients access health care as well as other needed services such as public assistance and housing.
- Marion County's Indigent Care System -- This countywide integrated health care system was established in 1991 to provide health care services to uninsured county residents with incomes below 125% of the federal poverty level. The System is

⁴ Both the Medicaid buy-in program and the MedAccess would have subsidized health insurance premiums for individuals with incomes at or below 250% of the federal poverty level. The Medicaid buy-in subsidies would have been funded by savings the state expected to obtain by enrolling all Medicaid recipients into managed care programs. The MedAccess subsidies would have required legislative appropriations.

⁵ Hillsborough County imposed a 0.5% discretionary sales tax on its residents as authorized by s. 212.055, F.S. The tax expires in September 1998, and Hillsborough County needs legislative approval to continue it.

funded with user fees, third-party reimbursements, and approximately \$3 million in county revenues. The System comprises five components: an episodic care center, the county public health unit, both community hospitals, county government, and local providers who donate services. County personnel determine eligibility and help clients obtain needed health care services.

Each of these programs appears to be meeting most of its objectives. Both the Hillsborough County Health Care Plan and Marion County's Indigent Care System have been formally evaluated with favorable results. The Marion County System received an award from the U.S. Department of Health and Human Services' Bureau of Primary Health Care for its innovative approach to providing health care to low-income residents. The Hillsborough Plan received two national awards, one from the Ford Foundation for Innovation in Government and one from Rutgers University for Excellence in State and Local Government. In addition, the Robert Wood Johnson Foundation has reviewed the Hillsborough Plan and is considering providing funds to help other communities replicate the plan.

The Legislature could encourage local initiatives in two ways. First, it could direct the Agency for Health Care Administration to gather information about the strategies local communities have used to develop these initiatives and disseminate this information to other communities. Second, it could provide start-up grants to help communities develop similar initiatives. The advantage of this option is that local communities would help fund programs to increase access to affordable health insurance. The disadvantage is that smaller, rural counties may not have the resources to implement these programs, even with state assistance.

Recommendation

If the Legislature wishes to improve access to affordable health insurance, it may need to consider

- Appropriating funds to implement existing laws that authorize CHPAs to sponsor health insurance in other markets and create a program to allow low-income individuals to obtain insurance by buying into the state Medicaid program, or
- Encouraging local communities to develop their own initiatives for improving access to affordable health care by providing them technical assistance or seed grants.

Of these two options, encouraging local communities to develop their own initiatives appears to be the most viable. Uncertainty over the future of the federal Medicaid program and the potential costs of the Medicaid buy-in program is likely to continue to dampen support for this program. In contrast, local communities, many of which support public hospitals, have demonstrated an interest in finding ways to reduce the costs of uncompensated care, and some have developed publicly- and privately-supported initiatives to provide affordable health care to low-income individuals.

If the Legislature considers improving access to affordable health care to be a priority, we recommend that it consider ways to encourage local communities to develop similar initiatives. For example, the Legislature could require the Agency for Health Care Administration to study the means local communities have used to develop initiatives to extend health care coverage to low income people and disseminate this information to other communities. It also could offer competitive grants to help selected communities implement similar initiatives. These grants could be limited in number and in the amount of start-up funds the Legislature would provide. They also could require local communities that wish to receive start-up funding to delineate the goals of their initiatives and the mechanisms by which they would evaluate their success.

Several factors inhibit the ability of CHPAs to compete effectively and provide affordable health insurance.

The design and implementation of Florida's managed competition model limits the CHPAs' ability to compete effectively in the small business market. Most small businesses that purchase health insurance do not buy CHPA-sponsored plans. Furthermore, small businesses that purchase CHPA-sponsored plans tend to have fewer employees than those that purchase insurance from other sources. Because these very small businesses pose greater risks to insurers, adverse selection could occur within the CHPAs, driving up costs and thereby limiting the CHPAs' ability to continue sponsoring competitively-priced products. However, changes in the design and implementation of Florida's managed competition model could enable CHPAs to compete more effectively.

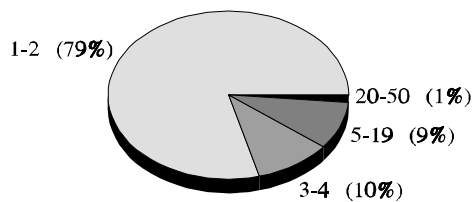
CHPAs May Not Be Competing Effectively

Small businesses that purchase health insurance generally do not purchase CHPA-sponsored plans. As of December 31, 1995, after the CHPAs' first year and a half of operation, nearly 15,000 small businesses were enrolled in CHPA-sponsored health insurance plans. These businesses represented about 10% of the small businesses with health insurance coverage as of that date.

Furthermore, businesses that purchase CHPA-sponsored plans are generally smaller than those that purchase non-CHPA products. At the end of December 1995, about 80% of the groups purchasing CHPA-sponsored insurance were businesses with only one to two employees (see Exhibit 2), and the average number of employees covered per CHPA group was 2.3. In contrast, the average number of employees covered per small business group by non-CHPA plans was 3.8. When asked to identify reasons businesses may not be purchasing CHPA products, 7 of the 11 CHPA Executive Directors indicated that either the CHPA products were too expensive or that the non-CHPA market was more competitive.

Exhibit 2

**Nearly 80% of Small Businesses
Purchasing CHPA-Sponsored Insurance
Have Only 1 to 2 Employees**



*Number of Employees Per Group as of December 31, 1995,
Includes 14,889 Groups*

Source: Office of Program Policy Analysis and Government Accountability analysis of Agency for Health Care Administration data.

Very small businesses pose higher risks to insurers than larger businesses. In businesses that employ only a few people, decisions to purchase health insurance coverage are more directly influenced by one or two individual's health status and anticipated need for

medical services. Because CHPA-sponsored plans tend to attract businesses with only one or two employees, the CHPAs are at risk of adverse selection and CHPA-sponsored plans could experience premium increases. This would diminish the CHPAs' ability to operate competitively and to sponsor affordable health insurance products.

Factors Limiting CHPA Competitiveness

Several characteristics of Florida's managed competition model limit the CHPAs' ability to operate more competitively and increase small businesses' access to affordable health insurance. These include the CHPAs' inability to negotiate with and select from competing health plans, the large number of geographic areas used to define rating regions, and the reluctance of some agents to sell CHPA-sponsored plans.

Inability to Negotiate. Under Florida's passive model of managed competition, the CHPAs must accept all health plans that meet state specifications and are not allowed to negotiate. Although the CHPAs tend to sponsor insurance plans with lower premiums than similar plans offered outside of the CHPAs, the differences are small. According to a study commissioned by the Agency, premiums for CHPA-sponsored insurance plans are about 6% less than premiums for the same plans offered outside of the CHPAs.⁶

Alliances that negotiate and select plans are able to compete more effectively. For example, the Health Insurance Plan of California (HIPC) is authorized to negotiate with and select from competing health insurance plans. A recent report noted that in the first year of HIPC's implementation, premiums for HIPC insurance products were 10% to 15% lower than those charged for similar products offered outside of the alliance.⁷ Although the report noted that other factors could have contributed to these price differences, it concluded that HIPC's ability to negotiate was a major contributor. In addition, representatives of two non-CHPA, Florida-based alliances believe that their ability to negotiate enabled them to obtain premium savings ranging from 15% to 40%.

⁶ Florida Small Group Reform: A Preliminary Impact Analysis, Lazarus Associates (August 1995).

⁷ Debra J. Lipson and Jeanne De Sa, The Health Insurance Plan of California: First Year Results of a Purchasing Cooperative, Washington, D.C., Alpha Center (1995).

These lower premiums may result, in part, from the alliances' ability to limit the number of plans they sponsor. When an alliance sponsors a large number of health plans, insurers may be reluctant to offer lower premiums because they may not be able to obtain sufficient market share to warrant a price reduction. For example, at the end of April 1996, the CHPAs sponsored from 9 to 24 plans in each region. However, only from 3 to 8 of the plans in any region were able to garner 5% or more of the enrolled members. If the CHPAs negotiated with the AHPs and selected plans offering the most competitive benefits and prices, the AHPs might be more inclined to reduce premiums as they could expect to enroll a higher proportion of the CHPA market.

Large Number of Rating Regions. The large number of areas health insurers use to set small business premium rates can also limit CHPAs' ability to sponsor affordable insurance plans. Historically, insurers based premiums for small businesses on the specific risks posed by the individual health status of the businesses' employees and dependents. Florida law now requires insurers to use a modified community rating system to determine premiums. Under this system, small business health insurers base rates on the risks associated with certain factors for all small business employees and dependents within a defined geographical area. In Florida, these geographical areas are defined as counties.

Thus, Florida has 67 rating regions, some of which may not have small business populations large enough to encourage more competitive rate-setting by insurers. Other states with similar rating systems establish fewer rating regions and larger population bases over which insurers spread risks. For example, California, which is larger in both size and population than Florida, requires insurers to use six regions when setting small business insurance rates.

Agent Reluctance. Insurance agents who do not wish to sell CHPA-sponsored health insurance products can also affect the competitiveness and affordability of CHPA-sponsored plans by effectively limiting the number or size of the businesses buying these products. The CHPAs do not control the number of agents selling CHPA-sponsored products or set the commissions agents obtain by selling these products.

Under Florida law, only insurance companies can appoint agents to sell their products. Consequently, the CHPAs rely on agents designated by the AHPs that offer insurance through the CHPAs. Some agents may encourage businesses to obtain non-CHPA health insurance because the agents earn higher commissions on non-CHPA plans. A study commissioned by the agency noted that agents receive less for selling CHPA-sponsored products than they do for selling other health plans.⁸

According to Agency for Health Care Administration staff, CHPAs have worked to develop good relationships with agents who are willing to promote CHPA-sponsored products. This effort has been somewhat successful, but more work is needed.

Recommendations

To enable CHPAs to more effectively compete and provide affordable health insurance to small businesses, we recommend that the Legislature consider making the following changes to the design of Florida's managed competition model:

- Amend s. 408.702, F.S., to allow CHPAs to negotiate with AHPs and select health plans that offer the most competitive products and prices.
- Amend s. 627.6699, F.S., to increase the size of the geographic areas insurance companies use to set rates for small businesses.

We also recommend that the Agency monitor the CHPAs' ability to find agents who are willing to market CHPA-sponsored products and, if needed, pursue other means of encouraging agents to sell these products. For example the Agency could look for ways to increase the commissions agents receive for selling CHPA-sponsored products. Or it could ask the Legislature to amend s. 626.331(2), F.S., to allow CHPAs to appoint these agents.

⁸ Florida Small Group Reform: A Preliminary Impact Analysis, Lazarus Associates (August 1995).

The current configuration of the CHPA regions limits their ability to become self-supporting.

The configuration of the CHPAs may inhibit their ability to become self-sufficient. State law establishes a CHPA in each of the state's 11 health service planning districts. (See Exhibit 3.) The Legislature has provided funds to help the CHPAs in their first few years of operation but has decreased the funds provided and expects the CHPAs to become self-supporting. Because the number of small businesses varies among the CHPA regions, some CHPAs could find it difficult to attract enough members to become self-supporting without raising fees or decreasing expenses.

CHPAs Depend on State Funding

All of the CHPAs depend on state revenue to cover their operating costs. In fiscal year 1994-95, the \$275,000 each CHPA received from the state comprised from 58% to 94% of the CHPA's total

revenue. Without state funds, CHPAs' expenses in that fiscal year would have exceeded their revenue by \$85,000 to \$293,000. Although each CHPA has established a reserve from start-up funds, these reserves could be depleted over the next few years if the CHPAs do not bring in additional revenues or reduce their expenses.

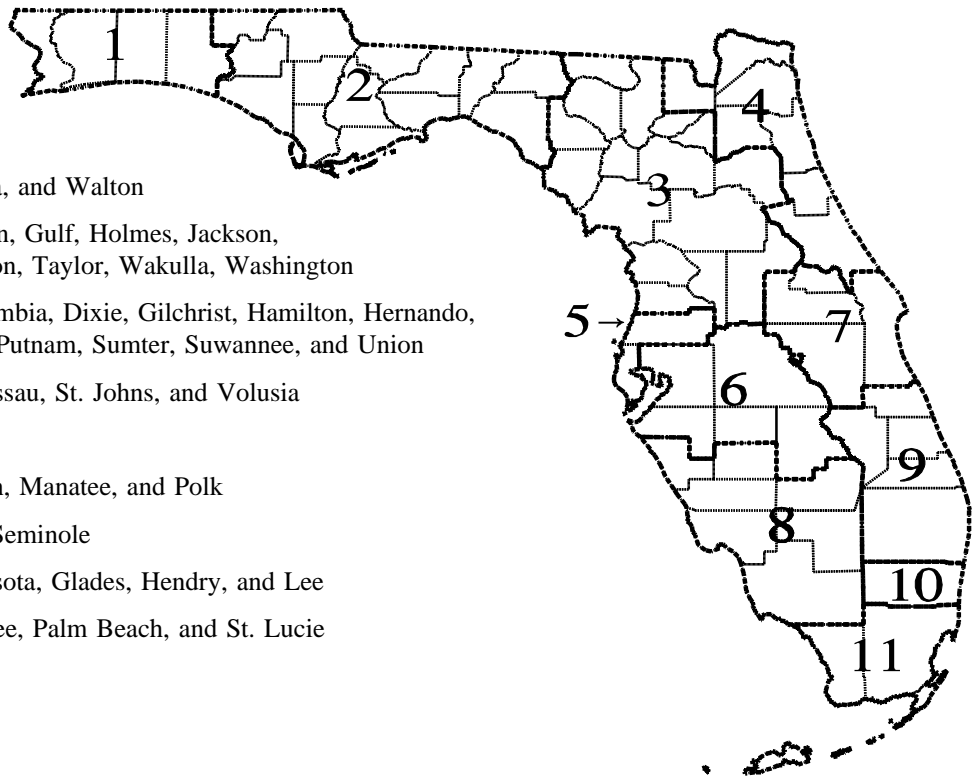
Number of Potential CHPA Members Is Limited

Even though the CHPAs could increase their income by increasing the number of members they serve, their ability to do so is limited by the number of small businesses located in their regions. Florida's small businesses are not evenly distributed among the 11 CHPAs. As illustrated in Exhibit 4, at the time the CHPAs were established, the number of small businesses located within the CHPA regions ranged from 11,000 to nearly 60,500.

Exhibit 3
Florida Contains 11 Community Health Purchasing Alliance Regions

Counties in Each CHPA Region

- 1*- Escambia, Okaloosa, Santa Rosa, and Walton
- 2*- Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
- 3 - Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
- 4*- Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
- 5 - Pasco and Pinellas
- 6 - Hardee, Highlands, Hillsborough, Manatee, and Polk
- 7*- Brevard, Orange, Osceola, and Seminole
- 8 - Charlotte, Collier, DeSoto, Sarasota, Glades, Hendry, and Lee
- 9 - Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
- 10 - Broward
- 11 - Dade and Monroe



* To date, CHPA Regions 1 and 2 and Regions 4 and 7 have consolidated.

Source: Section 408.702(1), F.S.

Exhibit 4
The Percent of Small Businesses
In CHPA Regions Varies

Small Businesses Located in Each Region as of June 30, 1995		
CHPA Region	Number	Percentage
1	11,005	3.31%
2	12,306	3.71%
3	19,635	5.91%
4	30,287	9.12%
5	25,584	7.70%
6	34,706	10.45%
7	36,468	10.98%
8	27,226	8.20%
9	37,290	11.23%
10	37,122	11.18%
11	60,469	18.21%
Statewide	<u>332,098</u>	<u>100.00%</u>

Source: Office of Program Policy Analysis and Government Accountability analysis of Agency for Health Care Administration data.

Studies show that only a small percentage of small businesses will purchase alliance-sponsored health insurance. Some small businesses already provide health insurance benefits to their employees and may not wish to change their coverage. Others may not be profitable enough to provide health insurance benefits or may employ workers who are not eligible for small group health insurance, such as part-time workers, or workers who are covered under a spouse's or parent's policy. A recent study of the Health Insurance Plan of California included information on the extent to which small businesses purchased health care insurance through four purchasing alliances similar to the CHPAs.⁹ This study reported that although one alliance, in its early stages, served around 17% of the small businesses in its regions, the others served from 4% to 5% of their respective markets.

Consequently, most CHPAs cannot reasonably expect to become self-supporting simply by increasing their membership. As shown in Exhibit 5, CHPAs enrolled between 2% and 14% of the small businesses within their regions by the end of April 1996. To become self-supporting without changing their fees or

expenses, however, CHPAs would need to enroll between 8% and 23% of the small businesses in their regions. Given the experience of other health insurance purchasing alliances, some CHPAs may not achieve this enrollment level.

Exhibit 5
To Become Self-Sufficient
CHPAs Would Need to Enroll A Larger Percentage
Of Small Businesses in Their Regions

Percent of Small Businesses		
CHPA Region	Enrolled April 26, 1996	To Be Self-Supporting ¹
1	14%	20%
2	3%	14%
3	2%	16%
4	5%	8%
5	7%	11%
6	7%	16%
7	5%	14%
8	5%	8%
9	5%	17%
10	6%	23%
11	2%	9%

¹ These estimates are based on the CHPA fee structures that were in effect in October 1995 and on the assumption that the average size of the businesses that obtain CHPA-sponsored insurance will not increase.

Source: Office of Program Policy Analysis and Government Accountability analysis of Agency for Health Care Administration data.

Other Actions Could Limit Enrollment Growth

CHPAs that do not enroll enough members to become self-supporting may have to increase their fees or reduce their operating costs. Each CHPA has established annual membership fees for its members and a monthly administrative fee for each employee covered by health insurance. According to CHPA Executive Directors, 3 of the 11 CHPAs have already increased fees in an effort to improve their ability to become self-supporting. In addition, seven Executive Directors reported that marketing is the area most likely to be affected by the reduced state grants. As one Executive Director noted, the rest of their operating expenses are fixed and cannot easily be reduced.

⁹ Debra J. Lipson and Jeanne De Sa, The Health Insurance Plan of California: First Year Results of a Purchasing Cooperative, Washington, D.C., Alpha Center (1995).

CHPAs that increase fees or decrease marketing expenses are likely to affect membership growth and movement towards self-sufficiency. Since fees are added to the premiums members must pay for insurance coverage, they effectively increase the cost of CHPA-sponsored insurance. By increasing fees, CHPAs may adversely affect their ability to provide affordable health insurance to small businesses. Reducing their marketing efforts can also impede CHPAs' efforts to attract new members by limiting their ability to inform small businesses about the availability of CHPA-sponsored health care coverage.

Mergers Could Help Self-Sufficiency

Reducing the number of CHPAs by merging those serving adjacent regions could increase the CHPAs ability to become self-supporting without raising fees or reducing expenses. According to CHPA Executive Directors, the primary benefit of 11 separate CHPAs is greater local representation and support, particularly in the marketing of CHPA-sponsored insurance. However, a majority of the Directors believe that consolidating the CHPAs would reduce operating costs by streamlining staffing and making better use of marketing funds. Fixed costs would also be spread over a larger, combined membership. According to two of the Executive Directors, consolidation would result in reduced membership fees or insurance premiums.

State law allows for the merger of two or three CHPAs that serve contiguous, predominately rural regions. To date, CHPA Regions 1 and 2 and Regions 4 and 7 have consolidated. However, limiting CHPA consolidation to primarily rural regions may not result in small business markets large enough for the CHPAs to become self-supporting.

The boundaries of the regions served by consolidated CHPAs could be configured in several ways. Some CHPA Executive Directors as well as individuals associated with other health insurance purchasing alliances in Florida believe that CHPAs should be aligned according to natural health or medical markets. This would result in 5 or 6 CHPAs. Others believe there should be one statewide CHPA with satellite offices serving the regions defined by the state's medical markets.

Although the boundaries of the state's medical markets are not well-defined, the distribution of Florida's small businesses and health care providers suggests that the 11 CHPAs could be reasonably consolidated into five alliances comprising CHPAs 1, 2, 3, and 5; CHPAs 4 and 7 (recently combined); CHPAs 6 and 8; and CHPAs 9 and 10. CHPA 11 contains a sufficient number of small business and health care providers to remain a separate entity.

Recommendations

To enable CHPAs to become self-supporting, we recommend that the Legislature amend s. 408.702, F.S., by removing language that restricts CHPAs from merging unless they meet the conditions currently specified.

In addition, the Legislature could consider one of the following alternatives:

- Use information about the location of small businesses and the state's medical markets to establish geographic boundaries that reduce the number of CHPAs to, for example, five or six regions.
- Establish a single purchasing alliance to serve all of the state's small businesses and give this alliance authority to have regional offices configured according to Florida's medical markets.

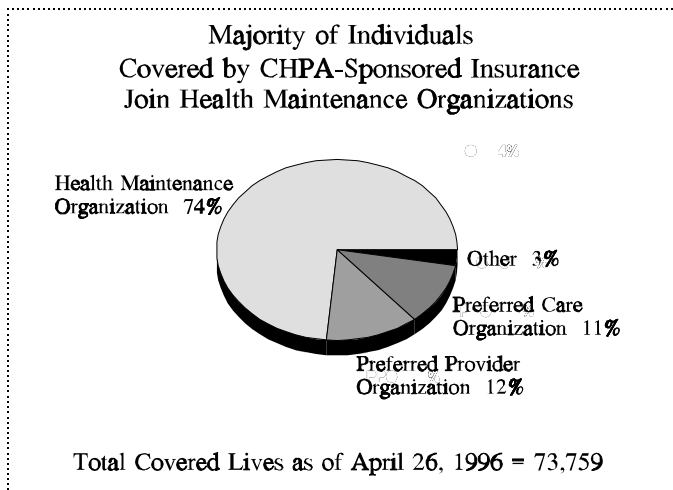
The Agency for Health Care Administration should increase its efforts to fully implement and evaluate Florida's managed competition model.

Pursuant to state law, the Agency has actively assisted with developing the statewide system of CHPAs. Since the CHPAs first organized in the fall of 1993, the Agency has focused its efforts on providing ongoing technical support to the CHPAs. As a result, at the time of this review, the Agency had not yet developed a data system capable of providing CHPA members information about the quality of services provided by AHPs. Nor had the Agency established performance measures or benchmarks for evaluating the effectiveness of the statewide system of CHPAs.

Cost and Quality of Health Services

Managed competition is predicated on the assumption that the health care market will become more competitive as consumers make choices based on information that compares both the cost and quality of health care services. Quality of care information becomes particularly important when individuals purchase health insurance plans that manage their care by limiting their access to certain health care providers. As shown in Exhibit 6, nearly three-fourths of the individuals covered through CHPA-sponsored insurance obtain managed-care plans offered by health maintenance organizations.

Exhibit 6



Source: Office of Program Policy Analysis and Government Accountability analysis of Agency for Health Care Administration data.

State law directs the Agency to establish a data system to aid the CHPAs in providing members with comparative information about CHPA-sponsored health plans. A data advisory committee report, dated December 1993, recommended that the Agency collect qualitative information in 1994 and provide comparative information on quality indicators to CHPA members by April 1995. While the Agency has not yet implemented the required data system, staff are working to develop procedures for comparing AHP performance. According to staff, the Agency plans to make consumer guides and satisfaction reports available to CHPA members by the end of 1996. At a later date, the Agency plans to report on other indicators, such as mortality rates and average length of hospital stays.

Performance Measures and Benchmarks

Now that the statewide system of CHPAs is maturing, the Agency should take steps to systematically evaluate the impact of the CHPAs. For example, the Agency could establish annual performance objectives and measurable targets for assessing the extent to which the CHPAs meet expectations. The Agency could also replicate a survey of Florida businesses sponsored by the Robert Wood Johnson Foundation in 1993 that profiled the provision of health insurance coverage by private employers. By comparing changes in health insurance coverage, the Agency could assess the overall effect of Florida's small business health insurance reforms. In addition, the Agency could use insurance enrollment trend data to predict how much growth in small business insurance sales would be expected to occur as a result of factors not related to CHPA implementation, such as growth in the number of small businesses.

Recommendations

To ensure that the Agency establishes the AHP data system in a timely manner, we recommend that the Legislature require the Agency to develop a plan for implementing the data system that includes specific actions and target dates, to submit this plan to the Legislature, and to periodically report on the status of its implementation. The Agency's plan should include a discussion of any barriers to developing the system and offer alternative ways to collect comparative information on the quality of CHPA-sponsored plans.

We also recommend that the Agency develop a plan for evaluating the effectiveness of the statewide system of CHPAs. As part of its plan, the Agency should identify annual performance objectives and benchmarks that could be used to measure the extent to which the CHPAs meet expectations. To the extent possible, the plan should include methods that isolate the effect of the CHPAs from other insurance reform efforts.

AGENCY RESPONSE

August 29, 1996

Mr. John W. Turcotte, Director
Office of Program Policy Analysis
and Government Accountability
The Florida Legislature
P.O. Box 1735, Section 912
Tallahassee, FL 32302

Dear Mr. Turcotte:

Representatives of the Community Health Purchasing Alliances (CHPA) and the Agency have had an opportunity to review the status report on the CHPAs. I appreciate your providing an opportunity for comment. This comment is summarized below, identified by the report section to which it applies.

CHPA ability to affect number of uninsured

The CHPAs believe OPPAGA should take into consideration the broader indirect impact the CHPAs have had. The CHPAs monitor market conduct throughout the small group market, serving as sort of consumer advocates. In addition CHPA rates have been a kind of benchmark for the broader small group market. It is interesting to note that based on Florida Hospital Association data, the CHPAs have had a significant impact in reducing the burden of uncompensated hospital care. Because more than half of CHPA enrollees were previously uninsured, CHPA coverage represents a \$21.9 million reduction in uncompensated hospital care, based on June 1996 enrollment.

CHPAs offering subsidized insurance

The CHPAs agree that most small business employees who are low wage earners cannot afford health care without some kind of subsidy. Therefore, they feel that the report's conclusion that the CHPAs have not made as large an impact on the uninsured population as anticipated ignores the fact that large numbers of these low wage earners in small business cannot afford health coverage even if their employers make coverage available and contribute 50% of the cost of the premium.

Local initiatives

The CHPAs agree that it is always a good idea to explore local initiatives as solutions to health care issues. However, they believe such programs, both those mentioned in the report and others, need to be studied carefully to ensure that they indeed are cost effective and can attain their goals. Without careful review, the CHPAs believe, funding of such organizations could further dilute the effectiveness of funds available for health care reform initiatives. They believe it wise to consider investing in systems already in place.

The CHPAs see a positive role for themselves in helping to implement programs that transition people from Medicaid. Further, they believe few communities will be willing to tax themselves as Hillsborough County has to support such programs, making CHPA involvement an attractive choice.

The CHPAs expressed concern that delegating responsibility for the uninsured to the local level, even with grant money, would result in unequal service levels and unequal burden. They believe considerable advantage could be gained through use of existing networks serving Medicaid recipients to make it possible for CHPAs and their health plans to offer coverage for other groups of uninsured people.

If specific local initiatives are to be cited, however, CHPA 9 would like to see mention made of the Palm Beach County Health Care District, a tax supported program providing health care coverage to county residents who meet financial criteria. Services are provided through the public health unit and private sector providers. The district also operates a trauma program.

Factors inhibiting CHPAs

The CHPAs do not agree that smaller groups are, by nature, higher in risk. They agree they are most costly per capita to administer but believe that, taken as a whole, they are not any more or less healthy than the business population in general. Even if small employers enter and exit the insurance market based on health needs, pre-existing condition limitations make this strategy less than viable, since each employee would have exclusions ranging from 12 to 24 months. In reality, small employers with anticipated need for medical services would actually be better off seeking coverage outside CHPA, through a federally-qualified HMO, since the enrollee would not be subject to any pre-existing waiting periods. The CHPAs suggest looking at ways to pool the smallest businesses into larger master groups with CHPA maintaining custody of the master policy.

Agent issues

On page 6 the report mentions that CHPAs do not control the number of agents selling CHPA-sponsored products or set the commissions agents obtain by selling these products. The CHPAs note that it is common practice among companies serving the CHPAs to pay lower commissions to agents writing coverage for 1 to 3 employees. They feel this practice is widespread and has a chilling effect on agents' willingness to work with these very small businesses. Typically, commissions are 2% to 3% on 1- to 3-lives but 5% to 8% on larger numbers. This acts as a strong disincentive and does much to defeat the intent of small group reform efforts. The lower commissions apply not only to 1- to 3-life businesses but also to larger businesses in which three or fewer employees select the same plan. This lowering of commissions gives the appearance of steering the market away from small group coverage. The CHPAs seek a level playing field in the competitive market for both premiums and commissions.

Configuration of CHPA regions

The CHPAs agree that the structure of their regions will and should change. However, they support allowing those changes to evolve on their own through merger decisions made by the CHPAs themselves based on good business, efficiency and medical market reasons rather than through legislative action.

State funding

The CHPAs believe they are closer to self sufficiency than the report would indicate. They have focused on achieving financial independence by keeping costs low and working to improve market share. For example, District 6 believes it will be self-sufficient by the end of calendar year 1996. District 7 shows a fiscal 1997 break-even budget based on operational revenue. All believe their reserves are sufficient to carry them through to self-sufficiency. They note that OPPAGA figures pre-date recent changes in CHPA administrative fees and also do not include revenues from associate members or interest drawn from premium and reserve accounts. New fee structures materially change the number of businesses each CHPA needs to enroll to break even.

Mergers

The CHPAs support action by the Legislature to remove current limitations on merging of districts and suggest allowing natural business forces to dictate the consolidation of districts for administrative purposes. Further, the CHPAs disagree with the creation of a single statewide alliance. They believe such an approach negates the intent of community-based health care reform and removes the CHPAs from their small-group connection and the vital agent base.

Agency implementation of managed competition

The CHPAs urge legislative caution in providing government with control over goals and practices of the CHPAs. They point out that the CHPAs were originally established by the Legislature as private non-profit corporations, that their start-up funding from the state is coming to an end, and that they should be operating with fewer, not more, government restrictions.

Performance measures/benchmarks

The CHPAs note that a number of focus group studies have been done, both in Florida and in other states, to determine what information consumers consider to be most important about their health plans. Uniformly, the focus group studies reveal that people are less concerned with so-called outcome measures, e.g., number of cesarean births, levels of childhood immunization, etc., than with consumer satisfaction reports. The Agency is pursuing satisfaction measurement in surveys developed this summer and now being administered. We expect a preliminary report in November and a final report after the first of the year.

The Agency supports the comments from the CHPAs. Agency staff and the CHPAs work well together and have a number of aggressive efforts under way to increase CHPA enrollment. Thank you for the time and care you and your staff have devoted to this study and for this opportunity to respond to the report.

Sincerely,

/s/ Douglas M. Cook
Director

cc: CHPA Executive Directors

This project was conducted in accordance with applicable evaluation standards. Copies of this report may be obtained by telephone (904/488-1023), by FAX (904/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302). Web site: <http://www.state.fl.us/oppaga/>

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