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n also applies to other systems of cost weights developed specifically for HMOs. 1.0 beneficiary" could be selected from any demographic cell (for example, the ith the largest number of beneficiaries). Alternatively, it could represent the ıge" Medicare beneficiary. Bidding on the 1.0 beneficiary then would be identical ding on the whole Medicare population.

. Strict application of this principle would mean that beneficiaries in every eligi- category (aged, disabled, and ESRD) pay the same premium. To simplify matters, ll confine our attention to equal payments within each category. The strict case be viewed as an extension of our example with more demographic cells.

. The cutoff price could be determined by any of the systems described in the n "Setting the Government's Contribution to Premiums" (for example, cutoff equals the lowest bid).

. Alain C. Enthoven, *Theory and Practice of Managed Competition in Health Finance* (North Holland, 1988), p. 2. See also "Managed Competition: An Agenda tion," *Health Affairs*, vol. 7 (Summer 1988), pp. 25–47.

. Protection against risk redefinition generally is made possible by an agreement ısumers to remain in the pool for a certain period of time. Employees achieve that nent implicitly since it is unlikely that person would leave a job that offers nce just to change insurance products. Movement among sponsors, therefore, need to be relatively infrequent, but there is some anecdotal evidence that ear commitments to pools are sufficient to offer risk-redefinition protection.

. Health Care Financing Administration, Office of Prepaid Health Care Operations versight, January 16, 1992.

Restructuring Medicare: The Role of Public and Private Purchasing Alliances

James C. Robinson and Patricia E. Powers

MEDICARE HAS LED the field of indemnity health insurance ending benefit coverage, minimizing administrative costs, and rational- hospital and physician payment methods. Its progress in doing so has far outstripped, however, by organizational and financing innovations in ivate sector, where health maintenance organizations (HMOs) and other ged care plans have largely displaced indemnity coverage. Medicare has modest steps toward widening the range of choices available to its iciaries through the HMO risk-contracting program, which enrolls 13 nt of seniors nationwide and much more substantial percentages in states as California, Oregon, and Arizona. However, the program has been ned by an inefficient pricing system, inadequate compensation for risk ion, limits on the types of plans available, meager initiatives to improve

s paper was commissioned by the National Academy of Social Insurance.

quality, and inadequate consumer protection. More generally, Medicare's risk-contracting program has a regulatory orientation emphasizing uniformity and stability rather than a market orientation emphasizing diversity and innovation.

A consensus is growing among policy analysts that the Medicare program needs to be restructured in favor of managed competition in which the Health Care Financing Administration (HCFA) is a referee rather than a claims processor and micromanager.[1] The risk-contracting program is a first step in that direction. Medicare can be improved further by disconnecting the payment methodology from fee-for-service expenditures, improving risk adjustment, offering a wider range of plan types, and structuring the enrollment process to make beneficiaries' informed and cost-conscious choices easier. These changes can bring Medicare into line with the best current practices in the private sector, but will not ensure that the program continues to respond to new developments in the health care marketplace. In this era of managed care, the marketplace changes rapidly in ways that are difficult to anticipate. Medicare needs to adopt an administrative structure that permits it to evolve with the marketplace and to keep up with new payment methods and plan types while ensuring beneficiary access and quality of care.

The risk-contracting program has successfully incorporated HMOs, a major innovation from the private insurance and delivery system, into Medicare. The logical next step is to consider ways of incorporating the experience and innovations of the public and private purchasing alliances into the program. This paper examines the experience of purchasing alliances as sponsors of managed care programs, including public and private employers and large and small firms. In particular, we focus on experiences in California, which exhibits a diversified system with multiple sponsors and with the largest number of Medicare HMO enrollees of any state. The business coalition in Minneapolis and the Federal Employees Health Benefits Program (FEHBP) also provide a rich source of experience. We compare the potential advantages and disadvantages of allowing purchasing alliances to function as sponsors for Medicare beneficiaries, especially the retired members of the work forces they already sponsor. Three possibilities are considered. The Health Care Financing Administration could continue as the sole sponsor for Medicare beneficiaries, albeit with some functions delegated to the regional level. Alternatively, large firms and purchasing alliances could seek certification to sponsor their Medicare-eligible retirees, with the HCFA remaining the sponsor for beneficiaries who lack employment-based benefit programs. Finally, Medicare beneficiaries could choose among multiple certified sponsors, which could include retiree associations and labor unions as well as employers.

mitations of Medicare's Risk-Contracting Program

edicare's risk-contracting program has permitted a rapidly increasing
ıer of beneficiaries to leave the costly fee-for-service program in favor of
)s that offer more extensive benefits at lower cost in exchange for limita-
on choice of network.[2] Despite its undeniable accomplishments, the
am has been plagued by structural problems that threaten to undermine
ains from managed competition. The problems include the program's
ent method, the range of plan types, the paucity of attempts to improve
y, and the nature of the enrollment process.

ıe HCFA's administered pricing system provides perverse incentives to
s that frustrate the original intent of the program. The payment for each
enrollee is set at 95 percent of what the average Medicare beneficiary in
ıme county would spend in the fee-for-service system. This links HMO
ues to fee-for-service expenditures, perpetuating the tradition of shadow
ıg of indemnity premiums by HMOs in the commercial sector. Costs in
e-for-service system are driven by excess capacity in hospital beds and
ılist physicians, retrospective reimbursement that rewards unnecessary
ıent, and the medical arms race of spiraling technology and use. There are
ıtic geographic variations in Medicare expenditures per enrollee because
ional differences in system capacity and physician practice styles.[3] These
tifiable differences create major differences in Medicare HMO payment
encouraging health plans to avoid markets with efficient delivery sys-
and low costs. Public and private purchasers in the commercial health
ınce market have fought shadow pricing by using competitive bidding.
te their differences, many large private employers, public purchasing
ces, and small-firm cooperatives establish a contribution level that is
endent of (and typically lower than) the premiums charged by the fee-for-
e plans. Employees can choose among plans, but must pay all or part of
cremental premiums charged by the higher-cost options.

many areas of the nation, the HCFA's premium contributions exceed the
o the HMO of providing the standard Medicare benefit package. The
plans are not permitted to refund the excess payment to beneficiaries.
r, the plans must devote the surplus to enriching the benefit package
gh lower premiums and cost sharing, reduced limitations on hospital days,
ıe coverage of additional services such as outpatient drugs, vision care,
ental care. This restriction on premium rebates limits price competition
g health plans and stimulates nonprice competition through ever richer
ts. Nonprice competition harnesses market forces to increase expendi-
ather than to moderate them.[4] On a more philosophical level, the restric-

tion on premium rebates to enrollees in low-cost plans embodies a paternalistic judgment that consumers must spend their disposable income on more medical care benefits rather than on other goods and services. In the context of commercial managed care, sponsors often set their contribution no higher than the average premium of several plans, thereby stimulating price as well as nonprice competition among them.

Payments to HMOs are adjusted for the age, gender, disability, Medicaid eligibility, and institutional status of each Medicare enrollee. These demographic factors account for only a very small part of the variance in health status and use of medical services among beneficiaries. Health plans that through good fortune or targeted marketing enroll a mix of enrollees who are healthier than average earn undeserved profits; plans that enroll especially sick people suffer undeserved losses. This risk-selection problem is aggravated over time as plans with sicker enrollees drop their Medicare contracts, forcing the enrollees back into the fee-for-service plan. It is estimated that Medicare beneficiaries enrolled in HMOs are 10 percent healthier that those remaining in the indemnity plan, measured in terms of expenditures per person on medical care.[5] The problem of adverse selection in the indemnity plan further undermines the efficiency of the risk-contracting program because the higher average fee-for-service costs are used as the benchmark for establishing HMO payment rates in the subsequent year. In the private sector some purchasing alliances have developed risk-adjustment methods that go beyond demographic factors to capture the effects of high-cost illnesses. Others contract with only a limited number of plans to concentrate both the high- and low-cost employees in the same risk pools. This is currently a focus of widespread experimentation.

The risk-contracting program has limited the types of health plans that can compete for Medicare beneficiaries. Until very recently, only plain vanilla HMOs qualified. In some markets point-of-service (POS) options have been accepted. Preferred provider organizations (PPOs), managed indemnity plans, and other hybrid forms have been locked out. These limitations on type of plan are particularly a problem in areas of the nation where the commercial insurance industry has been slow to evolve and where local managed care options consist mostly of PPOs. It has also prevented the development of provider-sponsored networks that use local delivery systems without going through an HMO intermediary. In the commercial sector, sponsors typically offer a range of plans. In some communities such as Minneapolis, large sponsors are contracting directly with physician groups and hospital systems.

Medicare provides only weak incentives for HMOs to improve the clinical quality of the services they provide. It is difficult to monitor performance at the

gional and, especially, national levels. Egregious acts of omission or com-
ission can result in fines or contract termination, but the severity of contract
rmination ensures that this punishment will rarely be applied. More gener-
ly, the HCFA's quality protections have historically highlighted the small
umber of worst offenders while ignoring the large number of mediocrities.
edicare's peer review organizations have focused on assisting providers to
prove quality, rather than on assisting beneficiaries to understand and act on
ality differences. The HCFA does not tie health plan or provider payment
es to quality or other dimensions of performance. Most sponsors in the
vate sector are refocusing from the worst offenders to continuous quality
provement (CQI), which emphasizes the potential for quality improvement
ong all providers and all health plans. Some sponsors have initiated their
n quality studies while others evaluate those that the health plans and their
liated providers initiate. Many sponsors use performance information as
criterion for selecting health plans and disseminate quality data to consum-
to assist in their choice of plan.

The enrollment process used by the risk-contracting program offers both too
h protection and too little to Medicare beneficiaries who consider switch-
health plans. On the one hand, beneficiaries may switch plans every month.
offers the protection of easy exit but undermines the plans' incentive to
st in preventive services and allows beneficiaries to take unfair advantage
e benefit packages (for instance, switching plans after exhausting the
al limit on outpatient drug coverage). On the other hand, beneficiaries do
ave the protection of a sponsoring organization that can monitor undesir-
health plan activity at the local level. They receive very little information
the HCFA comparing the plans' quality, networks, benefits, and prices. In
rivate sector, individual companies and purchasing alliances typically
ture beneficiaries' choices through annual open enrollments. Employees
stay with their plan for an entire year, but their choices are abetted by
sive materials comparing plan options. Innovative sponsors are demand-
at plans provide performance guarantees for consumer service, grievance
sses, quality of care, and network access.

edicare's risk-contracting program is a major step forward from its exclu-
eliance on the unmanaged fee-for-service plan. Many of its features
are favorably with those developed by public employers, private corpora-
and small-firm alliances. But the cumulative lesson from the diverse
ms is that Medicare's risk program suffers from excess uniformity of
and insufficient innovation. It is cut off from many of the payment
ds, plan types, quality initiatives, and enrollment methods being pion-
y other sponsors. As a health plan, Medicare has much to offer but also

much to learn from managed care plans in the private sector. As a sponsor seeking to manage competition among health plans, the HCFA similarly has both much to offer and much to learn from purchasing alliances elsewhere in the economy.

Single or Multiple Sponsors?

The Medicare risk-contracting program to date has functioned as a single sponsor for beneficiaries who choose to enroll in HMOs. There is a single set of criteria for plan participation, single contracting strategy, single payment method, single enrollment system, and single oversight framework. Most policy analysts envision the retention of this uniform structure, albeit with an expansion in the number and type of health plans that are eligible for participation and with other reforms to improve performance. Some anticipate retention of the single-sponsor framework, but advocate the replacement of the HCFA by the FEHBP, which is less wedded to an indemnity insurance culture. President Clinton's proposed Health Security Act envisioned expanding the single sponsor to represent Medicare beneficiaries and all other citizens in each geographic region.

Reliance on a single administrative entity to manage competition has several important advantages. Experiences in the commercial HMO market suggest, however, that a single sponsor is not necessary to stimulate competition and innovation. California has many major sponsors, including the HCFA and FEHBP but also the California Public Employees Retirement System (CalPERS), the Pacific Business Group on Health (PBGH), and the Health Insurance Plan of California (HIPC). In addition, many large firms serve directly as sponsors for their employees and retirees. The presence of multiple sponsors contributes to plan performance in ways that offset many of the advantages of the single-sponsor framework. Sponsors may represent different constituencies, as is the case with major purchasing and negotiating alliances in California, or they may compete for the same enrollees. When considering structural reform of the Medicare system it is important to compare the relative strengths and weaknesses of the single-sponsor and multiple-sponsor approaches. If the multiple-sponsor structure is adopted, the advantages and disadvantages of competition among sponsors must be evaluated.

Advantages of the Single-Sponsor Framework

An administrative framework composed of a single sponsoring agency offers the advantages of uniformity and the potential for economies of scale.

gle payment

ned, single set of quality measurements, single set of financial and utiliza-ion reporting requirements, and single mechanism for consumer grievances. This uniformity facilitates comparisons of plans and simplifies the responsibil-ies of those that otherwise might face different demands from different ponsors. The size of the Medicare program implies that the single sponsor vould enjoy large economies of scale in developing ways of managing compe-tion. The most pressing need is for more quality measures that can be gathered a timely fashion, constitute valid indicators of the course and outcome of ire, and permit comparisons of plans. Better methods for evaluating the health atus of beneficiaries are also needed; these data can be used to risk-adjust the yments to particular health plans and to risk-adjust Medicare contributions to rticular regions if risk mix varies geographically.

The single sponsor also offers important, albeit more controversial, advan-ges for financing the Medicare program. Reliance on a single sponsor keeps Medicare beneficiaries in a single risk pool, which facilitates the cross-bsidy of the sick by the healthy. Health plans have to bid a single rate ljusted for risk mix) for the entire pool in the county, rather than bid different es for different sponsors' enrollee populations. This reduces the pressure on HCFA to develop a finely tuned risk-adjustment method that links premium tributions to health status for each beneficiary. As in the large group ket, health plans can set their revenue targets based on the group as a whole ier than ensure that revenues match expected costs for each enrollee. A gle sponsor possesses huge potential bargaining leverage with health plans, n that Medicare accounts for one-third of U.S. health care spending. It will ncreasingly difficult for large health plans to market their services solely in commercial market. As Medicare contracts become essential to health s, the plans' ability to extract high rates by threatening contract termination nishes. Bargaining leverage has not been prominent in Medicare risk racting because the HCFA has used an administered pricing method rather a competitive pricing method. If it disconnects its HMO payments from or-service expenditures, however, the agency would rely more on bargain-everage to achieve savings.

ie final and perhaps most obvious advantage of the single sponsor is that ICFA's risk-contracting program already exists in most metropolitan . The only program with a comparable scale and scope is the FEHBP. potential sponsors currently are concentrated in geographic areas with sive managed care penetration. For this reason, any movement toward ole sponsors would need to begin with regional demonstration projects.

Enumerating the potential advantages of a single sponsor immediately exposes the system's greatest weakness. For twenty years the Medicare program has had the technical expertise and market power to function as the preeminent sponsor of managed competition, yet has been hobbled by political resistance and conservative programming. Many of the innovations in methods of contracting, payment, quality measurement, and risk adjustment have come from much smaller sponsors in the commercial sector. Thus there is a fundamental trade-off between uniformity and size on the one hand and diversity and innovation on the other. A multiplicity of sponsors has augmented rather than diminished the vitality of managed competition in the commercial sector; comparable advantages may be achievable from encouraging multiple sponsors in the Medicare sector. Four potential benefits of such a framework deserve consideration.

First and most important, the presence of multiple sponsors permits diversity and encourages innovation in managing competition. Sponsors differ in the number and type of plans with which they choose to contract. Some contract with most, if not all, local HMOs to expand consumer choice. Others limit contracts to only a few plans, thereby encouraging mutual investments in the partnership and creating performance incentives for the plans. Some sponsors contract only with HMOs, some with both HMOs and PPOs, some with a full range of plan types. Some use only insured plans, while others are self-insured or combine insured with self-insured plans. Sponsors also differ in their payment mechanisms and in the ways they encourage price competition. Some accept whatever premiums the plans request but require individual enrollees to pay the difference above the sponsor's baseline contribution. Others prefer to use bargaining leverage to negotiate favorable rates with plans and place less emphasis on consumer switching to reward plans that offer low premiums. Sponsoring organizations have pioneered various methods for structuring enrollee choice, providing comparative data on health plans, monitoring for quality, and surveying consumer satisfaction. Some rely on consumer choice to motivate administrative efficiency among plans while others bargain explicitly for performance guarantees and impose financial penalties for noncompliance. Some sponsors impose a single-benefit design while others offer several options or leave wide latitude for health plans to establish their own benefit designs. Sponsors exhibit a wide variety of approaches to measuring risk differences among plans and compensating those that suffer from adverse selection.

Second, and more controversially, a framework with multiple sponsors
voids monopsonistic concentration on the buyer's side of the managed care
arketplace.[6] This deconcentration appears controversial in health policy cir-
es because so much has been made in recent years of the advantages of
ırchasing power in promoting market performance. This monopsonistic per-
ective, according to which purchasing alliances can never grow too large,
hoes the single-payer proposals that evolved in the context of indemnity
urance. Insights into the problems potentially afflicting a true government
onopsony in managed care can be derived from examining the military
ocurement industry, in which there is a dominant government buyer. The
ustry is characterized by the lobbying of government officials by the firms
ose viability rests on a single decision, up to the point where some observers
of agency "capture," in which the agency comes to depend on only a few
pliers. Were this framework to be extended to health care, where plans and
viders are well organized politically in every state and locality, it would
itably produce myriad legislative and judicial interventions that uphold
process and other protections for private entities against arbitrary govern-
t decisions. These rules and regulations would limit the flexibility of public
urement entities in deciding which entities should receive contracts and
r what terms.

hird, the multiple-sponsor framework is consistent with the nation's com-
ent to diversity and choice. Diversity permits a better matching between
ogeneous health care systems and heterogeneous citizen preferences. The
y of Medicare beneficiaries to elect sponsorship through their erstwhile
oyer or another entity would stimulate competition in better ways of
ging competition, counteracting the tendency toward bureaucratization
nevitably afflicts organizations with captive memberships. On a more
ophical level, government refusal to permit citizens to use the services of
endent sponsoring organizations limits initiative in a manner that requires
cation. Differing views on the relative importance of autonomy and
on the one hand and of community and uniformity on the other underlie
of the apparently technical debate on Medicare policy.
ally, and as a practical matter, many sponsoring organizations are well
shed and have strong records of performance in their regions. Some have
ped innovative programs for early retirees or Medicare-eligible retirees
. The HCFA would need to establish criteria according to which these
zations could become certified to sponsor Medicare beneficiaries and
need to establish a uniform contribution formula and other structural
s. The HCFA program would continue to function as the sole sponsor in

those geographic regions where no alternatives are available and would remain an option for Medicare beneficiaries even in areas with multiple sponsors.

Choice among Sponsors?

There are two variants of the multiple-sponsor framework. The first builds directly on the current retiree benefit programs of large firms, allowing them to evolve from a supplemental program for the Medicare fee-for-service plan to a sponsor for HMOs and other managed care plans, and will here be termed the employment-based sponsor system. The second permits a wider range of organizations to seek certification as Medicare sponsors and allows individual beneficiaries to choose among sponsors; it will here be termed the competing-sponsor approach.

Many large firms currently offer supplemental health insurance benefits for their Medicare-eligible retirees, using the same administrative framework developed for the health benefits programs for active employees and early retirees. As retirees move to HMO plans, these employer-based systems continue to offer various supplemental benefits. The scope and cost of the HMO supplemental benefits often are modest compared with those offered to retirees choosing Medicare fee for service because the HMOs already have lower cost sharing and offer richer benefits than does the indemnity Medicare plan, and there is less need for supplements. Some of these firms, or alliances of firms, could serve as sponsors for their Medicare-eligible retirees that choose an HMO plan. The firms thereby assume responsibility for the full range of premium negotiations, quality monitoring, open enrollment, and other sponsor functions. These would not be new tasks because the firms and alliances already perform such functions for their active employees and early retirees. Indeed, they are better set up than the Health Care Financing Administration to perform many of these functions. In this employment-based sponsor framework, individual Medicare beneficiaries could choose to be sponsored by the firm that provides retiree benefits or to be sponsored by the HCFA, in somewhat the same manner in which they currently choose to participate in the firm's retirement health program or go purely with Medicare. However, the employment-based sponsors would not cover Medicare beneficiaries other than their own retirees; individual beneficiaries would not have a choice among multiple sponsors (aside from the basic choice of employment-based sponsor or the HCFA).

In the competing-sponsor approach, a wider range of organizations could be certified as sponsors for Medicare beneficiaries. These could include senior

...Association of Retired Persons (AARP),
r unions, professional associations, and churches. Multiple sponsors could
ertified in each locality, and beneficiaries could choose among them. The
A would continue to operate as a backstop sponsor for beneficiaries who
ne to elect an independent sponsor. This framework approximates the
l-firm insurance market in California, where individual businesses can
nase coverage directly from a health plan, go through an insurance broker,
he public purchasing alliance (HIPC), or join a private purchasing alliance
ated by industry associations and brokerages). This option would be
ptible to greater problems of risk selection across sponsors than would the
n of employment-based sponsor and would require commensurably
er supporting regulation (open enrollment) and risk adjustment of Medi-
remium contributions. Its advantage over the employment-based system
i the greater potential for innovation and performance competition among
ors, and the greater number of choices available to beneficiaries. It would
choices to Medicare beneficiaries who do not have retiree benefit pro-
s.

amples of Sponsor Organizations

ıny organizations perform one or more of the functions of a sponsor.
corporations and government entities purchase coverage for their em-
es and sometimes join with other entities to increase leverage and gain
mies of scale. Purchasing cooperatives for small firms and individuals
run by public agencies, industry associations, labor unions, insurance
s, or professional associations. Some sponsors perform a wide range of
ons, including eligibility verification, plan enrollment, improvement of
enefit standardization, claims payment, information dissemination, and
ım negotiation, while others perform only one or two. Very few cur-
include Medicare beneficiaries. We focus our discussion on four large
es that operate successfully in markets with very high HMO penetration.
f these alliances represent Medicare-eligible retirees as well as active
ees and early retirees. We then consider the Federal Employees Health
Program, the largest nationwide sponsor of managed and unmanaged

fornia Public Employees Retirement System

blished in 1962, CalPERS manages health insurance benefits for the
California and for cities, counties, school districts, and other public

agencies that elect to participate. It covers ... dents, and retirees from almost 1,000 public agencies that vary in size from 600,000 employees (the state of California) to 2 (Antelope Valley Mosquito Abatement Program). CalPERS contracts with fourteen HMOs and four association plans (for example, the firefighters union) and manages two self-insured PPO plans. Covered enrollees can choose among plans at the annual open enrollment without regard to which public agency is their sponsor; more than 80 percent have selected HMOs. CalPERS is a quasi-public entity governed by a thirteen-member board appointed by the governor, the state legislature, nonstate public agencies, public employee labor unions, and others.

CalPERS was the first purchasing alliance to develop a standard benefit package, which all contracting plans must offer. The package was standardized to improve consumers' abilities to compare plans and to limit risk selection created by subtle differences in benefits. The state and other public sponsors set their premium contribution at a level lower than PPO premiums but similar to many of the HMO premiums. Enrollees pay the difference themselves if they choose a high-cost PPO but typically have no out-of-pocket contribution if they choose an HMO. CalPERS does not rely primarily on price-conscious consumer demand to discipline HMOs. Rather, it negotiates premiums each year and is willing to freeze enrollment in particular plans or drop plans altogether if it believes that unreasonable rates are being charged.

The transition of CalPERS from a passive payer of insurance premiums to an active sponsor with a defined benefit package, limited employer contributions, and aggressive premium bargaining, a change that has occurred only in the past five years, has achieved significant cost savings for program beneficiaries.[7] After a decade of double-digit premium inflation, CalPERS achieved actual reductions in HMO premiums of 0.4 percent in 1994, 0.7 percent in 1995, 5.3 percent in 1996, and has negotiated a decrease of 2.5 percent for 1997.[8] CalPERS uses consumer satisfaction surveys covering preventive services, satisfaction with care, and satisfaction with administrative aspects to facilitate enrollee comparisons among plans. Recently, it has developed health plan performance scores based on beneficiaries that are high users of services (those who, for example, have been hospitalized during the previous year) in addition to scores based on all beneficiaries.

Pacific Business Group on Health

The Pacific Business Group on Health is a coalition of thirty-three large public and private purchasers that together have 3 million covered employees, dependents, and retirees. A subgroup of eighteen PBGH firms in California

gotiates with HMOs over premiums, quality improvements, and other per-
rmance features. In 1996 this Negotiating Alliance represented 380,000
ive employees, dependents, and early retirees. The alliance also negotiates
40,000 Medicare-eligible retirees, 30 percent of whom are enrolled in
dicare HMO plans. Participation in the Negotiating Alliance is limited to
se firms that are willing to use the PBGH standard benefit package, which
embles the CalPERS package. Prices for modifiers to the package, such as
varying copayment levels and for mental health or prescription drug carve-
s, also are negotiated by the alliance on behalf of firms with individual
ds. Companies agree to use the rates negotiated by the alliance without
king firm-specific rates based on firm-level differences in risk mix; demo-
phic risk differences among firms are small. The University of California
some other entities with different benefit packages (typically the result of
n negotiations) choose not to participate in the Negotiating Alliance, but
icipate in the coalition's quality-improvement and data-sharing activities.
PERS and the state's small-firm purchasing alliance are members of the
GH but conduct their HMO negotiations separately.

irms participating in the PBGH Negotiating Alliance include Pacific Tele-
Bank of America, Stanford University, Bechtel, Mervyns, Wells Fargo
k, Varian, and Chevron. The PBGH entities also maintain self-insured
s outside the Negotiating Alliance; approximately two-thirds of all benefi-
es have chosen HMO coverage, with a range among employers of 50
ent to 97 percent. All member employers are committed to basing their
ium contributions on the rates charged by the lower-cost plans, but they
hasing in this defined contribution over several years. The PBGH realized
ge HMO premium decreases of 9.4 percent in 1995 and 4.3 percent in
and negotiated level premiums (no increase or decrease) for 1997.[9] Many
H members have employees in other states who are offered regional
s and the employer's national self-insured plans. The Negotiating Alli-
is beginning to expand to other states where member firms have sizable
ers of employees.

e PBGH is a negotiating alliance rather than a purchasing alliance such as
HBP or CalPERS. It negotiates premium rates and performance require-
with all HMOs. Each member entity, however, contracts with only a few
using PBGH-negotiated premiums. This preserves their autonomy but at
st of narrowing choices for individual employees. Gradually the Negoti-
Alliance is coming to resemble a purchasing alliance as employers
ct with larger numbers of HMOs and as the HMOs themselves consoli-
Participation in the alliance has permitted member employers to achieve
ning leverage, lower administrative costs, reduced concern for adverse

selection, and other advantages of scale that previously were available only if they severely restricted the number of plans with which they contracted. Employers are also expanding their offerings to encourage market entry and growth of additional HMOs.

The PBGH has steadily increased the range of issues over which it bargains with health plans. In addition to premiums, it has negotiated performance levels for customer service, quality, enrollee satisfaction, and data reporting that HMOs must achieve or risk losing 2 percent of the premiums.[10] Until recently, the PBGH focused on employees, dependents, and early retirees, but now it is actively increasing its attention to Medicare-eligible retirees. It is negotiating with Medicare HMOs over network scope and composition, administrative issues, and supplemental benefits. Employers are very interested in having the plan design for Medicare-eligible retirees mirror the design for active employees and early retirees as a means of ensuring continuity of care and cost-conscious choice. Negotiated performance criteria for Medicare HMOs include flu shots, health risk assessments, and maintenance of good communications and relations with medical groups and hospital systems.

Health Insurance Plan of California

The Health Insurance Plan of California is a purchasing alliance for small firms with 3 to 50 employees that is managed by the state of California. It currently includes 6,185 employers with 115,000 employees and dependents and is growing at the rate of 5,000 enrollees a month. The HIPC contracts with twenty HMOs and nine other managed care plan types (PPOs, POSs), all of which are fully insured. More than 95 percent of enrollees have chosen HMOs. The HIPC offers two HMO and two PPO plan designs. As a state entity it seeks to include a very large number of plans. It does bargain over premiums, but prefers to discipline plans by exposing them to price-conscious consumer choices instead of terminating their contracts. The HIPC is a purchasing alliance rather than merely a negotiating alliance and assumes marketing, eligibility, and enrollment functions. A distinguishing feature of the alliance within the small-group insurance market, where most businesses offer only one health plan choice to employees, is that employees can choose from the full set of health plans regardless of employer. Employers are required to contribute a minimum of 50 percent of the premium for their employees. Many pay the full premium, which reduces the element of cost-consciousness in enrollees' choices.

The HIPC has had a significant effect on the small-firm insurance market in California. HMO premiums declined by 3.6 percent in 1995, 2.8 percent in

, and 0.2 percent in 1997.[11] It has pioneered a risk-adjustment method that fers premium dollars from health plans enrolling especially healthy popu- ıs to plans enrolling sicker populations. Employers pay premiums based ge, gender, and region but not on diagnoses. The alliance then monitors -cost hospitalizations and retrospectively transfers funds from plans with such admissions to plans with many. In practice this has implied shifting ium dollars (less than 1 percent) from several HMOs to several PPOs, the majority of HMOs attracting enrollees with average risk profiles.[12]

ıe HIPC continues to enroll only a small minority of its target constitu- , in part because of resistance from health insurance brokers and agents, are reimbursed less generously under the alliance than in the outside :et. The principal reason for the modest rate of growth in enrollment, ever, is that premiums outside the HIPC have declined due to spillover of petitive incentives. Two HMOs with large enrollments in the small-group :et, Blue Cross and Foundation Health, have declined to contract with the C but work closely with brokers and offer rates similar to those available ıgh the alliance. The HIPC does no underwriting and charges a community adjusted for age, family size, and region to all enrollees. Health plans ıg outside the HIPC structure are prohibited by California law from deny- overage or charging especially high rates to high-risk employers. There is iderable controversy over whether plans and brokers are engaged in subtle s of risk selection outside the HIPC. Currently the organization does not esent Medicare-eligible retirees from its member entities.

uyers Health Care Action Group

he Buyers Health Care Action Group is an alliance of twenty-two large ıte firms with 250,000 employees and dependents in the Minneapolis area. ıdditional 150,000 state employees are affiliated. All twenty-two firms cipate in a self-insured POS plan operated by the alliance that contracts :tly with medical groups and physician-hospital organizations (called care ems) in the Twin Cities. A few member firms also contract with HMOs de the BHCAG structure. Unlike their California counterparts, there is use of capitation payment methods. Approximately 100,000 of the total)00 employees and dependents currently participate in the BHCAG plan, his number is rising rapidly as member firms terminate contracts with de HMOs.

he BHCAG has pioneered a strategy of contracting with care systems er than primarily with health plans. It uses the services of the thPartners HMO to provide claims processing and other administrative backup services to the care systems and to member firms. Each care system establishes its own target payment rate per enrollee, which is then used to establish a fee schedule for that system based on utilization patterns and the care system's target rate. Because the BHCAG plan is self-insured, it is prohibited from capitating care systems but must reimburse on a fee-for-service basis. The use of budget targets to set fee schedules mimics the incentives of capitation (creating a budget within which the care system must operate), while allowing the alliance to remain exempt from state insurance regulation. The payment system combines the virtues of prepayment incentives (virtual capitation) with the data advantages of retrospective fee-for-service payment. Each member firm sets its contribution below the level of the lowest care system premium, thereby forcing employees to make price-conscious choices using their own money. At present, the care systems are grouped into three categories for determining premium contributions by employees. The BHCAG does not negotiate premiums (claims targets) with the care systems; systems with high rates are expected to lose market share because of consumer choices.

The BHCAG assesses risk differences among provider organizations based on fee-for-service claims data processed through the Ambulatory Care Group's (ACG) software.[13] The fee schedules for each provider organization are adjusted up or down from their budget-based target depending on whether their risk mix is above or below the average for all organizations. This transfers monies among providers but not among employers (each employer pays all the claims for its own employees). A major advantage of this system is that it adjusts payments for medical groups and hospitals, not payments for health plans. Differences among health plans in risk mix may be fairly small, while differences among provider organizations may be large. For example, there is a 35 percent difference in ACG risk among the fifteen care systems with BHCAG contracts in Minneapolis.[14]

The BHCAG system has had major effects on the Minneapolis health care market. Medical groups and hospital systems have coalesced into fifteen care systems, each providing or contracting for the full range of medical services. This offers the benefits of system coordination while avoiding the extremes of oligopolistic concentration; in the non-BHCAG insurance market, three HMOs account for 80 percent of insurance enrollment. The BHCAG system can be thought of as a mechanism for dispensing with health plans as intermediaries in favor of direct provider contracting. The costs of components of the system, such as service delivery and administration, are made transparent. The BHCAG system reduced member firm costs by an average of 9 percent for 1997, its first year of direct contracting with providers. In collaboration with the care systems and with the HealthPartners HMO, the BHCAG has devel-

xtensive information on each care system—its medical groups, primary oviders, specialty referral panels, and hospitals—that is made accessible ɜumers choosing among systems. The BHCAG cooperates with major ɜr organizations, such as the Mayo Clinic and Park Nicollet, on clinical ɩys and protocols that will improve health care. It works closely with the ɜota Health Data Institute, a public-private partnership created by the ɜota legislature, to obtain community data for comparison of clinical and quality at the care center level.

Federal Employees Health Benefits Program

Federal Employees Health Benefits Program has a distinguished record ɪaging competition among health plans while maintaining a national ɔf operations.[15] It oversees the health insurance benefits for 9 million employees, dependents, and retirees, contracting with more than 400 , PPOs, and indemnity plans. Approximately 40 percent of active em- s and 20 percent of retirees have chosen HMOs. All health plans con- ɡ with the FEHBP must cover a core set of benefits, but they are allowed ion in adding others, which increases the range of choices for benefici- ut makes comparisons among plans difficult. The Office of Personnel ement (OPM), which manages the FEHBP, does not bargain with health ɔver premiums. Instead, plans are required to assure OPM that their ? rates do not exceed the rates offered to any other purchasers in the . Plans also submit rates with the understanding that the FEHBP sets its ıution at 60 percent of the average premiums of six large plans, which ɜ that beneficiaries must contribute toward premiums for all plans and e full difference when choosing a high-cost plan.[16] Low-cost plans the lowest FEHBP premium contribution because the government contribute more than 75 percent of any premium. The most expensive eceive the highest dollar contributions, although these cover only half mium. The result is a wide range in employee contributions, with most ɪg plans with mid-range premiums. Although this contribution strategy price-conscious consumer choice, it mitigates the effects of adverse ɔn that have afflicted indemnity plans in the FEHBP.

eficiaries choose among health plans in an annual open enrollment . Detailed information on the benefits, premiums, and other features of an is prepared in different forms by the OPM, the National Association red Public Employees, and independent publications such as *Consumer ɔook's Guide*. The FEHBP has encountered adverse selection among ealth plans because of its community rating payment method, according

to which plans receive the same premium for each enrollee regardless of age or health status. A risk-adjustment method is needed to protect health plans with large numbers of older enrollees. Aside from this technical problem, the FEHBP has proved its ability to sponsor choice and competition in all fifty states and among all forms of health plans. During the 1980s it enjoyed lower premiums than those found in the outside market despite improving benefits and covering an increasing number of retirees. Premium inflation has declined sharply in recent years, with an average increase of only 3 percent in 1994 and an average decrease of 3 percent in 1995.[17] In California the program experienced HMO premium increases of 6.2 percent in 1993 and 2.9 percent in 1994, then decreases of 5.8 percent in 1995 and 4.5 percent in 1996.[18]

Criteria for Sponsors in a Multiple-Sponsor Model

The Medicare risk-contracting program could benefit greatly from closer links with public and private sponsors. In the employment-based version of the multiple-sponsor model, large firms and purchasing alliances that sponsor HMO coverage for their active employees would be allowed to extend their sponsorship to cover their Medicare-eligible retirees. Many large firms already offer retiree benefits that supplement Medicare's benefit package under the fee-for-service plan, but play no commensurate role in supporting retirees that choose HMO plans. (The HMO benefit packages already cover at no extra cost many of the cost-sharing, prescription drug, and ancillary benefits that the employer-paid supplementary packages cover for Medicare fee-for-service enrollees.) In the competing-sponsor version, consumer cooperatives, retiree groups, and other independent organizations, as well as employers, could be authorized to sponsor the coverage of Medicare beneficiaries with whom they had no previous employment relationship. In either case the HCFA would need to establish criteria against which to evaluate applications by public and private organizations to become sponsors for Medicare beneficiaries.

Employment-Based Sponsors

In principle, large employers that sponsor active employees' and early retirees' choices among competing health plans could extend their programs to cover Medicare-eligible retirees. Many offer health insurance to retirees older than age 65. In the past this almost exclusively took the form of supplemental benefits such as outpatient prescription drugs that fill in the holes in the Medicare package. Even where the majority of active employees have chosen HMO coverage, most retirees have stayed with fee-for-service Medicare and

nployer's supplemental benefits. There has been no financial incentive ese retirees to choose the HMOs because the employers already offer the ded benefits through which the HMOs compete for enrollment in the idual Medicare market. HMOs are not permitted to compete for enrollees ffering rebates of premiums. An additional factor influencing retiree e has been the limited geographic scope of most HMO networks and cted benefits for out-of-area use. This is unattractive to retirees who spend inter months in a warm state and the summer months in their state of 1.

any large employers are moving toward a defined contribution payment gy for retiree benefits. In the new format the full cost of retiree coverage id by the employer if the retiree chooses an employer-sponsored HMO but only a fraction of the cost is paid if he chooses an indemnity igap) supplement. (The actual dollar contribution by the employer is the in either case; the medigap premium is much higher than the HMO ium for similar benefits.) A defined contribution encourages retiree mi- on to the more efficient plans. Migration is also facilitated by the growing lment in and familiarity with HMOs among the active employees, who choose to stay with their HMOs after becoming eligible for Medicare. e employers are limiting employer-paid health benefits to retirees who t HMO coverage. In more extreme circumstances, some large employers ropping retiree health insurance coverage altogether as a means of con- ng spiraling premium costs.

riteria for certifying individual employers as sponsors for Medicare bene- ies will differ from criteria for purchasing alliances or other noncorporate sors. Most obviously, it would be impossible to demand that corporate sors be nonprofit organizations or that they be governed by a consumer 1. Private sector sponsors are structured as taxable nonprofit membership orations or for-profit organizations owned by participating employers and agement. It is unlikely that a purchasing organization in the commercial et would qualify for tax-exempt status because of the private benefits that ie to participating businesses.

ompeting Sponsors

he Institute for Health Policy Solutions, a Washington, D.C., association monitors and assists small-employer purchasing pools, has developed ria for sponsoring organizations. They should be publicly operated or rned by a board of employers and consumers with no financial conflicts of est. They should offer standardized benefits and a choice among competing health plans (several plan products within one carrier would not qualify). Interested sponsors for Medicare beneficiaries might include:

—a public or quasi-public agency (CalPERS, FEHBP, HIPC);

—a private sector business group (BHCAG, PBGH, The Alliance in Madison);

—a private sector industry or union purchasing pool (the meat packers Taft-Hartley trust);

—a senior citizen or consumer organization (the American Association of Retired Persons, the California Group Insurance Trust of United Way); and

—a private brokerage or benefits organization (California Choice, developed by brokers; National HMO Group, developed by the William M. Mercer consulting firm).

An important consideration is whether a qualified sponsor would be required to offer its plans to all Medicare beneficiaries or only those who meet its own criteria. For example, a sponsor that represents entities with at least 1,000 employees, or one that serves only nonprofit organizations, may be very interested in becoming a qualified sponsor for its own members retirees but less interested in opening up its pool to all Medicare beneficiaries.

Corporate Status and Ownership

In health care debates nonprofit organizations once seemed to wear halos. Nonprofits often are perceived as providing a social good and placing the organization's constituents first. In contrast, for-profit organizations often are perceived as placing shareholders' interests above those of customers. However, many nonprofit health care organizations have come under criticism for their failure to provide evidence of social contributions that justify their tax exemption and by behavior patterns that mirror those of their for-profit counterparts. In recent years many nonprofit health care organizations, such as Blue Cross/Blue Shield associations and community hospitals, have become for-profit entities. To remain competitive in a fast-moving health care marketplace, access to capital is essential and is most readily obtained through such conversions.

Nonprofit or for-profit status may be less important than ownership. Public ownership by state or local government is a possibility, although public entities are subject to lobbying and capture by plans and organized provider groups. Texas and Florida have created unique models by chartering alliances that are managed by private not-for-profit organizations. Given the recent debate surrounding physician self-referrals, it is unlikely that owners with any financial conflict of interest would qualify. For example, a sponsor owned by providers

or others directly involved in the delivery of health care would present a conflict of interest. One solution would be to set forth ownership principles and hen evaluate individually those candidates that pass a preliminary screening. Alternatively, the HCFA could specify the kinds of representatives (for examole, consumers or employers) to serve on a sponsor board. This was the ipproach taken by President Clinton's Health Security Act.

Sponsors would assume many activities currently performed by the HCFA, nd thus the federal government would have an interest in overseeing their iability and integrity. Financial oversight may include reserve, capital, and eposit requirements. Examples may be found in states that have formed urchasing pools in recent years, as well as in federal and state regulations overning health plans. At a minimum, the HCFA should require an annual udit and public report of each sponsor's financial condition and retain the right conduct an audit or inspection at any time.

Scale and Geographic Scope

The geographic scope of an organization may be a criterion for whether it ould be designated as a sponsor for Medicare beneficiaries. Nationwide, ate, regional, and city-specific organizations and alliances could apply to onsor Medicare beneficiaries in their market areas. Allowing sponsors to fine their own geographic boundaries would increase flexibility and build on eir experience with the commercial market. It would also avoid creation by HCFA of what might be arbitrary geographic boundaries. The major awback is that some areas could be highly competitive, while others could k any sponsor.

An alternative would be for the HCFA to create geographic areas paralleling current regions or to examine each market on a local basis. For example, hough the California HIPC itself is statewide, health plans compete within geographic areas. Theoretically, each of these six could be covered by one more sponsors. Several brokerage alliances are attempting to compete with HIPC in narrow geographic areas.

Should the HCFA control the number of sponsors in a given area, perhaps specifying a minimum or maximum number of enrollees? A pure market roach would resolve this issue through the sponsors' own evolution. To ain viable by offering sufficient volume to payers and to cover the nsor's own costs, a minimum number of pooled beneficiaries would rge. The HCFA may wish to establish a minimum threshold for other ons. Fewer sponsors could create economies of scale, limit the opportunity biased selection by sponsors, ensure that undesirable areas would be covered, and keep the HCFA's oversight responsibilities manageable. These considerations must be balanced with the goals of stimulating and maintaining competition. Size does not pose a problem for government sponsors with respect to antitrust laws; however, a public monopoly would raise questions of efficiency. The PBGH requested a formal review and letter of approval from the Department of Justice, demonstrating that its membership comprised less than a quarter of any health plan's or geographic area's commercial market. In general, the department tends to view organized purchasing favorably.

Sponsor Administrative Fees

On average, purchasing pools use 1 to 3 percent of their enrollees' premiums to cover administrative costs. Sponsors with a very large pool of enrollees could keep this fee very low. The Health Security Act capped administrative fees at 2.5 percent. It would be difficult, however, to develop a reliable working definition of what is included in administration. For example, although one large public sector sponsor asserts that it adds a mere 0.5 percent onto its premium, the full costs of the state's staffing are not considered in this figure. This dilemma is similar to that faced by sponsors that have attempted to evaluate the administrative fees of health plans. There is sufficient wiggle room in the definition that the spread in HMO administrative fees and profit presently ranges from 30 to 3 cents on the dollar (a medical loss ratio of 70 to 97 percent). This spread is likely attributable to differences in product, market, and geographic mix rather than substantive differences in the value-added activities of the HMOs.[19]

Selecting and Managing Health Plans

Medicare sponsors could assume two responsibilities in selecting and managing health plans: managing all plans and provider systems that meet specified criteria set by the HCFA or contracting selectively with a more limited number of plans. The first option assumes that consumers rather than sponsors are best suited to motivate competition, efficiency, and quality among health plans. A wide array of health plan choices permits a closer match between the heterogeneous preferences of Medicare beneficiaries and the characteristics of the health plans. Contracting with numerous plans limits the potential for incumbent plans to offer low premiums in the early years of the relationship and then boost premiums in later years when the membership is locked in. In this approach the sponsor is relatively passive, focusing on the collection and dissemination of information on plan structure, price, and quality. It is import-

;, however, for the sponsor to enforce a defined contribution toward the
:mium because consumer choice on the basis of price is what drives cost
nsciousness and efficiency among health plans.

Most firms and purchasing alliances contract with a subset of available
alth plans in each region. Limiting the number of contracting plans reduces
ninistrative costs, makes measurement and adjustment for risk selection
ier, and creates an initial stage of competition in which health plans vie for
ntracts on the basis of premiums and performance.[20] This approach is partic-
rly attractive when sponsors are unwilling to impose a defined contribution
ause it relies more on sponsor bargaining power than on cost-conscious
sumer choice to motivate health plan performance. An extreme example of
:ctive contracting is the Department of Defense's award of a five-year
AMPUS contract to one plan in each region. Plans bid to provide supple-
ntary services to the department's own health care system within one or
e of its twelve regions. DOD represents 8 million enlistees, dependents,
retirees nationally. Sole-source contracts require beneficiaries to switch
sicians when the sponsor switches health plan contracts unless the physi-
s and medical groups contract with the new health plan.

f selective contracting were applied to Medicare, sponsors could compete
beneficiaries based in part on their strategies for selecting and managing
s and providers. Not all health plans in a given market would be offered by
sponsors. Differences in plan choices among sponsors would create a
eived clash with the philosophy of equal treatment for all beneficiaries in
federal entitlement program. The reality of Medicare, in contrast to its
oric, is that beneficiaries face very different health care options depending
vhether they have an employer's retiree program to fill in the gaps of the
fit package, whether they are eligible for Medicaid as well as Medicare, or
her they are personally responsible for paying an individual medigap
ance premium or directly paying for noncovered benefits. A significant
culty with selective contracting is that it magnifies the information require-
s for individual Medicare beneficiaries, who now would need to under-
l the differences among sponsors and the health plans they offered.

ne private sector offers several examples of diverse strategies for creating
competition. The Mercer National HMO group, which negotiates in
ty-seven cities nationwide for half a million people, typically selects four
Os in each market. Participating businesses are required to offer all these
to their employees. If a participating company had an HMO in place that
not selected by the group, it must freeze its enrollment in that plan. The
P takes a similar tack, offering a select few medigap carriers to its
bers nationwide. The association is deploying this strategy for selecting
Medicare HMOs as well. Several coalitions with large employers, including
the PBGH and the St. Louis Gateway Purchasing Association, allow any
licensed HMO to participate in negotiations. Each participating employer then
chooses plans to offer its employees.

Some employer-driven purchasing arrangements were formed because of a
lack of health care competition in their marketplace. In Memphis and Houston,
where there have been few managed care plans and little provider competition,
employers decided to contract directly with hospitals and physician groups. In
the Twin Cities, the earlier BHCAG exclusive contract with one plan produced
a consolidation of the market as HMOs merged to bid for the sole-source
contract. To undo this oligopoly as well as to create informed consumer choice
of physicians, the BHCAG created a self-insured plan owned by the employer
alliance rather than by a health plan. Business coalitions in rural states such as
Iowa that do not have managed care and in states threatened by HMO oligop-
oly, such as California, are closely monitoring this approach.

Ground Rules for Competition

Ground rules need to cover criteria for contracting health plans, premium
negotiations and enrollment, adjustment of payments to reflect differences in
risk, and customer service and quality of care.

Criteria for Contracting Health Plans

Most sponsors that contract with HMOs use competitive bidding. Some use
state licensure as a criterion for bidding. For Medicare beneficiaries federal
qualification may be appropriate. The HCFA could take the best state licensure
requirements and expand them to all states. This would ensure that consumer
protections are upheld through financial, administrative, and quality assurance
requirements without duplicating or creating new regulations.

In addition to establishing criteria for HMO participation in sponsored-
choice programs, the HCFA could set ground rules to ensure that every benefi-
ciary retained access to a fee-for-service plan. This would maintain the current
extent of choice while subjecting the fee-for-service plan to a competitive
market where costs and quality can be compared to those available through
HMOs. The agency could require that all sponsors offer the standard Medicare
fee-for-service plan as one option along with the HMO, PPO, and POS plans.
Most purchasing pools in the public and private sectors today offer a range of
plan types. In markets with high managed care penetration, PPOs have re-
placed indemnity carriers as the option that combines higher premiums with

ɔader provider networks compared with HMO coverage. There is, however, compelling reason to offer more than one indemnity plan or other broad cess plan. National insurance carriers experienced in offering indemnity verage typically contract with large employers to serve as third-party adminrators for the self-insured broad access plans. By working with one national rrier, the firms' administrative burdens are reduced and the standardization benefits and contributions across state lines is simplified.

For Medicare beneficiaries, sponsors could be allowed to select a private surer or other third-party administrator for the indemnity plan or contract th the HCFA and its fiscal intermediaries. Alternatively, the HCFA could ersee the Medicare fee-for-service plan outside of the sponsored-choice mework, while determining contributions toward the fee-for-service and MO plans in an unbiased manner. Maintenance of an indemnity option may especially important for public and private sponsors with Medicare-eligible irees who reside part of the year outside their home state. Reciprocity reements among HMOs and other managed care plans is another potential lution to this snow bird phenomenon.

Premium Negotiations and Enrollment

Nearly every sponsor conducts an annual evaluation of the bidding health ıns and then determines rates. Because of the long time horizon that sponsors ed to develop open enrollment materials, health plans typically bid eighteen onths before enrollment opens. Some sponsors conduct more frequent inpth reviews of health plan financial records or audit the quality of care ınnually. Many large employers offer Medicare risk plans to their retirees tside the calendar year cycle. This allows them to concentrate on communiions to retirees apart from the busy season with active employees and early irees. Medicare sponsors could consider conducting their negotiations offcle as well to avoid the health plans' busiest times of year.

Although employers prefer an annual lock-in enrollment cycle to ease ministration, many health plans are not opposed to allowing Medicare beneiaries to enroll and disenroll on a monthly basis. In the commercial health urance market, people can disenroll when they expect not to use medical vices and then reenroll when they anticipate use, but Medicare beneficiaries nain continuously insured. This mitigates the adverse selection problems tentially posed by monthly enrollment and disenrollment. Annual open ollment and lock-in facilitates informed consumer choice because the spons can gather and publish comparative information on premiums, networks, quality, and patient satisfaction. This should be weighed against the [illegible] of beneficiaries' being able to respond quickly to dissatisfaction by switching plans. The ability to switch monthly is likely to be viewed by the elderly as a significant safeguard against the possibility of a mistake in health plan choice. The annual lock-in may discourage seniors from experimenting with managed care.

Many of the states that created small-group purchasing pools simultaneously enacted insurance underwriting practices for this market. Insurance carriers who participate in these pools, as well as competitors who do not, must guarantee issue and renewal for small businesses and limit clauses for not covering preexisting conditions. Most insurers still medically underwrite individuals; it would be important for the HCFA to disallow this for Medicare beneficiaries to avoid competition based on risk selection.

Most sponsors ask health plans to price a core benefit for HMO and non-HMO products. Some request prices for options to the core design, such as higher or lower copayments, carve-outs for mental health, or such extra services as alternative healing. The prices of these additional benefits are also negotiated by the sponsor. The greater the clarity in the definition of the product, the less room for creating competition based on biased selection and the easier it is for consumers to compare options.

Adjusting Payments to Reflect Differences in Risk

Much has been written about selection bias with respect to Medicare beneficiaries. This has also been an important issue for the small-group market, in which health plans avoided businesses perceived as high risk. Most of the sponsors that pool small firms use traditional rating practices to address differences in risk. These sponsors tend to operate in markets that have created uniform rules with respect to issuing and renewing insurance and medical underwriting. Adjusting enrollee premiums by age and family size, and in some instances allowing health plans to bid competitively in defined geographic areas, ensures that most of the differences in plans risk are taken into account. Large sponsors such as the FEHBP, CalPERS, and PBGH have successfully managed competition among health plans with little or no adjustment of payments for risk. One advantage of a multiple-sponsor framework, however, is that it permits experimentation in risk-measurement and risk-adjustment methods. The HIPC and BHCAG have developed the most innovative risk-adjustment methods for active employees; these could potentially be adapted for Medicare-eligible retirees.

Customer Service and Quality of Care

A key feature of a sponsored-choice structure is that consumers must be able compare health plans on the basis of both price and nonprice criteria. Many nsors currently demand extensive information from health plans concerning tomer service, satisfaction, utilization rates for preventive services, network adth, and techniques for managing use. This information helps sponsors ect plans for contracting, improve consumer understanding of their options, develop incentives for rewarding plans'performance improvement. The FA has begun to form partnerships with private sector organizations to elop new information on the quality of care in HMOs. In collaboration with National Committee on Quality Assurance, the agency is developing Medi-e-specific measurements for the HEDIS database. It is requiring health plans dminister the Consumer Assessment of Health Plans Survey, developed by Agency for Health Care Policy and Research.

Conclusion

he Medicare risk-contracting program relies on three oversight mecha-ns to protect beneficiaries and ensure quality of care. The HCFA uses latory powers to control benefit design, network breadth, grievance proce-s, and related structural facets of HMO performance. Beneficiaries may the tort liability system under traditional malpractice law and new legal rines to gain compensation in cases of negligent performance.[21] Most rtant, perhaps, beneficiaries may switch plans every month if dissatisfied. of these mechanisms for oversight and beneficiary protection has gths, but each has significant limitations. Command and control regulation mpose severe penalties, up to and including contract termination, but is slow moving, bureaucratic, and subject to political influence. Litigation xact high damages and attract unfavorable publicity, but is unpredictable neven in its treatment of patients with similar problems. Plan switching is ck and low-cost means of expressing dissatisfaction, but consumers may nderstand the technical aspects of care and may quit only in response to r problems in amenities or service. Moreover, health plans can profit from isenrollment of particularly sick or demanding patients.

e private sector lacks the regulatory powers of government and relies d on purchasing power to elicit improvements in price and performance health plans. Medicare has taught private purchasers of health insurance valuable lessons and developed many important methods to improve care in traditional fee-for-service coverage. As it moves further into

managed care, new problems present themselves and new responses are needed. Here Medicare has much to learn from public and private purchasing alliances. Through its risk-contracting program, Medicare has evolved from a public insurance company to a system of multiple competing health plans for senior citizens. The logical next step is to consider moving the risk-contracting program from a purchasing monopsony to a system of multiple purchasing sponsors.

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Carve-outs for Medicare: Possible Benefits and Risks

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IN RECENT YEARS, pressure has mounted on the Health Care :ing Administration to incorporate successful private sector health insur- ;trategies into the Medicare program. *Carve-outs,* which are generally ıtely administered specialized health care programs, are one of the strate- ıat experts have urged the HCFA to consider. Gail Wilensky, former istrator of the HCFA and current member of the Medicare Payment ory Commission, has advocated allowing risk-based carve-outs among Medicare reforms that would increase the availability of managed care, e barriers to managed care growth, and provide incentives for beneficiar- :hoose cost-effective health plans.[1] Others have advocated using disease ;ement programs for conditions such as diabetes that cause significant ity and mortality in the Medicare population. Specialists see carve-outs 'ay to maintain their professional autonomy and their patient volume. ·outs appear promising because unlike some comprehensive risk-based

contracts that give health plans incentives to avoid or undertreat the chronically ill, these programs can combine incentives to provide cost-effective care with the delegation of responsibility for care to companies that specialize in treating serious or chronic diseases.

Descriptions of selected carve-outs are placed throughout the text to elucidate important points. These examples were chosen because they are particularly relevant to the discussion of using carve-outs in the Medicare program. The first example, the ESRD Managed Care Demonstration, will be a carve-out run and financed by Medicare. The second, SalickNet, is the only capitated cancer care company now operating. It is also the only capitated carve-out company not associated with mental health care. The third example, the Community Medical Alliance, is a highly regarded health plan for the severely disabled and chronically ill. Its success is an example of how carve-outs can deliver high-quality, patient-centered care. Our last example, Control Diabetes Inc., was profiled because improving diabetes care in the Medicare program is a subject of particular interest to legislators and advocates.

What Is a Carve-out?

There is no standard definition of a carve-out. All definitions, however, assume that carved-out care will be separated administratively or legally from other care a patient receives. This means, at a minimum, that carve-outs rely on separate entities employing different providers to deliver care for carved-out conditions, procedures, benefits, or patient groups. Carve-outs also commonly use payment systems (including methods of sharing financial risk) and benefit designs different from those governing the rest of the care received by patients with carved-out conditions, services, or procedures.

One source of confusion in discussions of carve-outs is the terms *disease management* and *carve-in,* which are sometimes used interchangeably with carve-out. By our definition, disease management refers to a systematic effort to improve the management of a condition by applying appropriate guidelines, protocols, and information systems that are specifically designed for a given disease. As efforts to apply such techniques, disease management programs can be used by any provider with the capacity to employ them, including both carve-out companies and patients' usual or routine source of care. Nothing about disease management programs requires that they be used by administratively or legally separate providers.

The term *carve-in* is best used to connote a program of care for a particular disease, condition, or procedure that is organized within a single health plan to improve the quality or reduce the costs of care for the problem in question. A