

## The Evolution of Voluntary Choice Cooperatives

**A** LONG WITH AN AMAZING EXPLOSION OF HEALTH CARE INFORMATION on the Internet, new technologies and therapies not only sustain life but significantly improve its quality. Yet millions of Americans are unable to make even the simplest health care choices because they have no control over their health care resources. Rather than directing the manner in which their health care (or benefit) dollars are spent, most Americans must accept the choices offered by their employers or the government. It is a health care system driven by insurance companies and employers, not consumers.

This situation is an unfortunate by-product of the nation's employment-based health care system, but it doesn't have to be this way. With access to the right information and the freedom to make choices about their coverage, services, and providers, patients can be reconnected with their providers in a truly consumer-driven health care system.

According to a 1997 survey by the Kaiser Family Foundation and the Commonwealth Fund, only 40 percent of workers in America have a choice of health plans. Another 40 percent have only one health plan offered to them and 17 percent have no health plan through their employer. In addition, those without a choice were far more likely to be employed in small groups than in large companies and were twice as likely to have annual incomes below \$20,000. It's this population of workers and family members who would benefit most from the creation of voluntary choice cooperatives.

There seems to be growing sentiment among members of Congress, policy analysts, and the public that the consumer choice model should, and indeed must, characterize health care delivery in the next century. One sign of this is the growing interest in tax equity for people who lack employer-based health care insurance. Another sign is the steady increase in employers offering defined contribution health benefit plans that enable employees to pick from a menu of available health plan options.

Legislation introduced by Congressman Tom Bliley

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(R-Va.), chairman of the House Commerce Committee, would create the conditions needed to foster the formation of voluntary choice cooperatives (VCCs), which the Bliley legislation calls "HealthMarts." The goal of this reform effort is to strengthen the patient/provider relationship to achieve substantial improvements in the quality, accessibility, and affordability of health care.

While Congressman Bliley's "HealthMarts" exist only in the form of legislation and a white paper, the HealthCare Village (HCV) is a real, financially feasible model, ready to be implemented.

### It Takes a Village

In essence, the HCVs are voluntary choice "supermarkets" that allow employers and the self-employed to join together so that employees and their families can enjoy the expanded choices and reduced costs attributable to large pools. In this manner, employees—not their employers or health benefits administrators—will be able to get the coverage and services they need from the providers they want at a price they can afford. In other words, the HCV serves as an unfettered pooling mechanism that enables employees to make the fullest use of the freedom that

defined contribution makes possible. As a result, employees will finally be able to act as consumers, empowered to establish and satisfy their own definition of quality, responsiveness, and value.

HCVs are different from purchasing cooperatives. The latter term typically refers to employers who join together to select, contract for, and purchase health plans at lower prices than would be available to them independently. Where these structures differ significantly from VCCs is in the additional functions they perform, since purchasing cooperatives retain for the member-employers such additional roles as selection, negotiation, and rate establishment.

VCCs, by contrast, vest full power of choice in the individual employees who are their members. VCCs offer employers the closest parallel in the health care system to their outsourcing of payroll administration to companies such as Pay-Chex and EDS. These distinctions are of

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critical importance because they determine whether individuals—as opposed to their employers or health benefit administrators—will be permitted to select the coverage and care they need.

The HealthMarts legislation passed the House of Representatives in July 1998 as part of the Patient Protection Act, and again in November 1999 as part of the Quality Care for the Uninsured Act.

### The Next Generation

On its face, the prognosis for America's health care system doesn't look rosy. The

ranks of the uninsured continue to grow each year, despite the nation's tremendous economic growth and low unemployment. This phenomenon impacts the employed and unemployed alike. It increasingly reaches those who are witnessing the erosion of their employer-provided coverage, a reduction in health plan options, and an increase in employee cost-sharing. Just as important, the health care system causes providers to feel disenfranchised and patients to feel powerless, since both communities lack the information, resources, and freedom of choice they need to take control of their own health care.

Despite this grim picture, recent headlines indicate that incremental but fundamental changes are occurring in health care today without the direct aid (but perhaps because of the threat) of government intervention. A new generation in health care is unfolding that appears far more capable than its predecessor of recognizing consumer needs and achieving consumer satisfaction.

The Xerox Corp., for example, is looking into giving its 50,000 employees vouchers to purchase health coverage in the open market rather than manage and administer their health benefits in house. At about the same time, United Healthcare, one of the largest managed care plans in the United States, announced that its affiliated physicians would have the final say in patient treatment decisions. Finally, the employee benefit-consulting firm of KPMG released the findings of its survey of employee attitudes in *Fortune* 1,000 firms. According to the KPMG survey, almost three out of four employees said they would prefer to shop for their own health coverage rather than take the

coverage chosen by their employers.

Both the scope of the health care system's problems and the promise of its next generation raise an important question: Can the health care system correct itself (as functioning free markets do) or does Congress need to intervene? As is often the case, the answer to both questions is "yes."

As the above examples indicate, the health care system can correct its excesses, albeit after much delay. Growing support in Congress to impose liability on health plans and health benefit fiduciaries will energize the search for alternatives, since the risk of liability will cause employers to shy away from providing health coverage directly to their employees.

#### **A Model for the Masses**

Chairman Bliley modeled HealthMarts after a program he and every other member of Congress, their spouses, dependents, staffs, and colleagues in the federal government know well—the Federal Em-

ployee Health Benefits Plan (FEHBP). FEHBP is a working example of the power a consumer-driven health care marketplace can unleash.

Each year, federal employees choose their health coverage from a menu of at least 10 health plans. This variety of coverage options, which includes plans of differing costs and benefits packages, enables federal workers to select the plan that best meets their health care and financial needs.

Just as important, employees are able to make this choice *without regard* to the choices made by their co-workers or employer because FEHBP treats federal employees as individual consumers, not as captive members of the office or agency in which they're employed. Recognizing that this process of selection depends on the availability of information about the coverage options, FEHBP also provides federal employees with all the informational tools they might need, including

data on each plan, paper-based and Internet-accessible resources, and even periodic "health fairs."

Empowered with virtually unmatched freedom of choice, as well as with the information they need to make their choice, federal workers can select coverage that enables them to establish close and lasting connections with their providers. For example, many FEHBP participants choose their health plan because it includes a medical specialist they want and need to see. It's this freedom to choose one's own physician that's at the heart of a consumer-driven health system.

#### **If It's Good Enough for Congress**

The HealthMarts legislation builds upon FEHBP's model of consumerism by fostering the creation of private, competitive, and patient-empowering voluntary choice cooperatives. The HealthCare Villages achieve this objective by allowing the major stakeholders in the health care system—including consumers, providers, employers, and insurers—to cooperatively establish clearinghouses that offer a wide variety of health coverage options.

Under this legislative proposal, employers are permitted to contract with an HCV, outsourcing the *selection* of coverage even as they continue to finance it. This alternative to the current system is often characterized as the transition from a defined benefit to a defined contribution environment. Employers would realize the benefits of pooled risk and minimal administrative duties, and their employees would enjoy the freedom to annually choose the plan that best meets their needs *as they define them*.

The role of the HCV is limited primarily to the administrative functions associated with serving as a clearinghouse of health coverage options. The HCV can make available a wide variety of coverage options, including health maintenance organizations, preferred provider organizations, point of service organizations, and indemnity plans, as well as high-deductible catastrophic coverage and medical savings accounts.

State laws and regulations governing

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health plans—such as rating laws, solvency standards, premium taxes, and consumer protections—apply to plans participating in an HCV. In order to remove an additional barrier to consumer choice, the HealthMart legislation also deems plans and providers that are accredited by a nationally recognized accrediting body to meet all state and federal consumer protections standards relating to such accreditation.

Because HCVs are envisioned as both physical entities and “cyber-marketplaces,” they could be an Internet-based insurance clearinghouse that reaches consumers where they work rather than restricting their ability to exercise choice to a specific location to access their health care. For example, by allowing consumers to compare health plans on the basis of their benefits and price, ChannelPoint Inc. serves as an information resource and streamlines the application and enrollment processes.

Where the HCV model takes a step beyond the current market, however, is in its removal of the legislative and regulatory barriers that today impede the establishment of a truly consumer-driven health care marketplace. According to the Progressive Policy Institute, the think-tank arm of the Democratic Leadership Council, the Bliley proposal arrives at “the longstanding Progressive Policy Institute vision of an Information Age system—a health ‘network’—in which purchasing groups, health plans, and providers all compete to give people better health.”

### **The Role for Congress**

HealthMarts legislation would pre-empt insurance mandates that have had the unintended effect of increasing the cost and decreasing the array of health insurance plans. Indeed, according to Blue Cross/Blue Shield, there were more than 1,000 state laws mandating that specific benefits and providers be covered by health insurers in 1998. This doesn't include laws regulating managed care plans or coverage for specific patient populations. The impact these mandates have

had on the cost of coverage is significant, with General Accounting Office estimates ranging as high as 22 percent.

These mandates are doubtless well intentioned. The problem with mandates, though, is that while they may meet one person's individual health needs, they waste the premium dollars of those with different needs. Just as troubling, health insurance mandates have been passed precisely because a consumer-driven health care system doesn't yet exist. Voluntary choice cooperatives would make benefits mandates unnecessary, dramatically reducing the cost and increasing the variety of health insurance options.

In 1999, Congress heard testimony that amplified the need for mandate relief. Robert Morehead of Gallagher Byerly, Inc., testified before the Commerce Committee of the U.S. House of Representatives that eliminating mandated benefit laws could save 15 percent to 20 percent of health premium costs. The committee also heard from other Americans who work full time but are either not offered coverage or are unable to afford the coverage available to them.

In addition to its provisions on mandate relief, the HealthMart legislation eliminates the so-called fictitious group laws in some states that prevent the fraudulent aggregation of small groups into large pools. While such practices were an appropriate target of legislation, the laws themselves have also prevented small groups and the self-insured from creating voluntary choice cooperatives, even when no intent or hint of fraud exists. As a result of this measure, small groups and the self-insured will be able to enjoy the benefits of large-group underwriting, lower rates, and aggregated administrative functions.

### **Evolutionary, Not Revolutionary**

The evolution toward consumer-based health care choices doesn't take place by upending the employer-based health insurance system but by taking advantage of a little-known and underused section of the tax code. That section, which has been on the books for more than 50 years,

allows employers to outsource their employees' health benefits without losing the tax exclusion on employer contributions to health plans.

Section 106 of the Internal Revenue Code governs the tax treatment of employer-provided health benefits. Specifically, Section 106 allows employers to make contributions to an employee's health benefit plan and excludes those contributions from the employee's gross income. The tax exclusion applies if the employer purchases the coverage directly or if he contributes to “a separate trust or fund which provides accident or health benefits directly or through insurance to one or more of his employees.” This language gives employers the ability to allow their employees to choose their own health coverage while maintaining the tax preference on the contributions that finance it.

In virtually every sector of the American economy, consumers are king. Control lies within their hands, innovation flourishes to meet their demand, and competition ensures that only those most fit to satisfy their needs survive.

Standing in stark contrast, however, is the current “market” for health care coverage.

Employers choose the health plan their employees receive, mandates inflate prices and restrict variety, and nearly 45 million Americans either choose or are compelled to go without coverage.

America's health care industry is the largest business in the world (\$1.1 trillion in 1999) with growth projections that dwarf the auto, energy, and technology industries. It's estimated that in 2015, there will be 70 million people over the age of 65 in the United States with a health care cost of \$3.5 trillion per year, or 35 percent of the GDP.

Under the current payment structure and system, we as a country will have difficulty surviving these projections. The time is now to move the country's health care system to a market and consumer driven model. The HealthCare Village can be a vehicle to help start this process. It stands poised and ready. ●