office of
Rural Health & Primary Care
MINNESOTA DEPARTMENT OF HEALTH

Health Care Purchasing Alliances: A Small Employer Alternative for Minnesota

July 2003

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Executive Summary

In 1997, the Minnesota legislature passed the Community Purchasing Arrangements Act, authorizing the formation of alliances among small Minnesota employers, including businesses of one, to pool the purchasing of health care services. This innovative piece of legislation was in response to a concern among policymakers about the ever-increasing number of uninsured and underinsured people, most notably in rural areas of Minnesota, where small businesses and farms predominate. In mid-2003, these alliances have achieved varying degrees of progress in their efforts. The first health purchasing alliance product was introduced into the market on January 1, 2003, and several more regional products are expected within a year.

The Driver: Increasing Uninsurance Rates

Between 1990 and 1995 the number of persons in the United States under age 65 without health insurance increased from 34.7 to 44.3 million, a rise from 13.9% to 16.3%. The issue of an increasing number of uninsured Americans is common to both urban and rural areas. Because the rural economy is generally supported more by small businesses and farm businesses, disproportionately more rural residents rely on individual plans or coverage purchased through small employers than do their urban counterparts. Rural employment is more likely to be in firms employing fewer than 10, self-employment, or agriculture.

Rural residents are thus:

- likely to have a lower average income,
- be disproportionately cut off from opportunities to participate in large-pool health, insurance purchasing, with its economies of scale and risk management capacity,
- likely pay more for their health insurance than urban residents, or
- may not be offered (or able to obtain) any insurance at all.

In 2001-2, about 68% of all Minnesotans had health insurance coverage through an employer, but only half of employers offered health insurance coverage. Counties with the highest uninsurance rates tend to be in the north central, west central and headwaters areas of the state.

Small Employer Purchasing Alliances: A History

Referred to by a variety of names – small employer purchasing pools or health insurance purchasing coops or coalitions – health care purchasing alliances are one way to support the small employer trying to provide insurance for its employees. Employers who participate in purchasing coalitions hope to spread financial risk, achieve economies of scale, manage relationships with insurers, and increase purchasing power.

Other states

A review of other states' efforts to build health insurance purchasing alliances reveals that programs have generally met with mixed success. Four states have attempted small employer purchasing alliances and have had follow-up studies done: California, Connecticut, Florida, and Texas. While these programs had some benefits, they did not reduce small-group market health insurance premiums, and they did not increase the number of small

employers offering health insurance to their employees. It was concluded that success rates of health care purchasing alliances would improve by:

- allowing individual alliances to negotiate directly with carriers to encourage competition and obtain lower prices,
- attracting greater market share by establishing and maintaining full agent cooperation,
- changing regulatory mechanisms to allow more flexibility,
- providing substantial public subsidy support, and
- placing limits on both the number of plans and the number of carriers. Larger enrollment is crucial to attracting health plans, achieving economies of scale, mitigating adverse selection, and increasing negotiating power.

Minnesota

Minnesota's previous experience with the Minnesota Employees Insurance Program (MEIP), established in 1993 and abolished in 1998 mirrors the experiences of other states. The resulting design of Minnesota's regional health care purchasing alliance program appears to have taken these lessons into account and may, in the end, make it a win for Minnesota's small employers and their employees.

Minnesota's Regional Health Care Purchasing Alliances

The health care purchasing alliance movement in Minnesota began in the mid-1990s, following other widespread health reform efforts that took place earlier in the decade. Advocates for Marketplace Options for Mainstreet (AMOM), a coalition of health providers and business representatives, began working with communities to develop the program in Minnesota. The Community Purchasing Arrangements Act, signed into law in 1997, allows small businesses to join together to negotiate benefits packages from health care insurers. Minnesota's law, unlike those of other states, allows purchasing alliances to include employers of one; as of this writing, no other state has adopted this provision. The legislation also introduced the Accountable Provider Network (APN) option, which allows groups of community physicians and other health care providers to directly contract with health care purchasing alliances to provide services and benefits packages.

Purchasing alliance stop-loss fund

In 1999 and again in 2001, the Minnesota legislature appropriated funds to support the development of the first regional health care purchasing alliances in Minnesota – in the southwest, northwest, northeast, and north central regions. By 2001, the regional alliances in the southwest and the northwest had identified a problem with the issue of risk when recruiting enrollees who had previously been uninsured and had pent-up medical needs.

In response, the 2001 legislature authorized the Purchasing Alliance Stop-Loss Pilot Project appropriating $1.7 million to fund the stop-loss fund. This fund allowed health plans contracting with a rural health care purchasing alliance to receive reimbursement from the fund for 90% of the portion of any enrollee's claims between $30,000 and $100,000 per year, thus mitigating an insurer's high medical claims that fall under the $100,000 minimum for commercial reinsurance benefits. With this fund, the social and economic benefit to rural communities and their working families is considered to outweigh the costs of providing this public reinsurance program, and could be a critical factor in its long-term success.

A regional progress report

Minnesota's regional progress at health care purchasing alliances is as widely varied as the regions represented. The northwestern alliance launched their *RuralCare Partners* product in January 2003. The southwest alliance is expected to launch their *Prairie Health Care* product in July 2003. The northeast and north central alliance are expected to follow with products in later 2003. Other organizational efforts are underway in west central and south central Minnesota.

It is clear that later efforts were able to benefit from earlier work accomplished by the northwest and southwest alliances. The stop-loss fund was initiated in 2001. In 2002, due to provider issues identified by the northwest group, an HMO demonstration project law was passed allowing health maintenance organizations to extend coverage to a rural health purchasing coalition. The southwest alliance experienced delays due to provider network conflicts. The north central alliance has worked with an accountable provider network and has met with some resistance due to high start-up costs and risk concerns. Each region has identified issues unique to its participants.

And yet, each region has also identified creative solutions to bring affordable, quality health care to its small employers and their families:

- the northwest and northeast regions are employing percentage co-pays as a way to engage the consumer in health care decisions
- the northeast region is considering wellness incentives to help the consumer hold down their costs, thus benefiting the whole program
- the southwest's and northwest's insistence upon including employers of one reaped the unique stop-loss fund

Summary

Small employer purchasing alliances have obviously met with mixed success in other states and in Minnesota's own earlier attempt with MEIP. There are reasons, however, that the idea continues to surface. Small employers are gradually being priced out of the health insurance market. Uninsurance rates are rising. Past and current options have proven inadequate for the unique needs of small employers and self-employed individuals; creative, bold options must be considered. While small employer allowances have had their share of problems, the idea of working to strengthen this model is well placed. Minnesota's health care purchasing alliances appear to be off to a solid start, showing an intent to take the lessons learned from other states and from MEIP, and develop unique and sustainable programs, for example:

Issue	*Strategy*
Statewide or state-administered program	Regionally-based programs respond to unique needs of region.
Inability of purchasing alliances to negotiate directly with health plans.	Regional alliances negotiate directly with health plans.
Agents left out of relationships between programs and employers.	Requirement for employer to purchase product through designated brokers.
No employers of one.	Employers of one are included.
Insufficient planning funds.	State-funded planning grants to regional alliances has helped alliances meet actuarial and legal expenses of planning products.

Minnesota's regional alliances have benefited greatly from start-up funding from the legislature and technical assistance and guidance provided by AMOM, but, more importantly, from community leaders committed to delivering health care products that meet the needs of their regions. This final ingredient, unique to a regionally-delivered system that has its roots among the people it serves, may bode well for the success of the program in Minnesota.

There are some cautions, however. One big factor that may impact the success of any good plan is the fluctuating economic picture. As attractive as the regional health care purchasing alliance concept may be to local employers, they still must have the resources to provide a health insurance benefit to employees. The program simply won't work if small employers can't afford any program at all.

Recommendations

1) Based upon the repeated problems with agent relationships in previous efforts in Minnesota and elsewhere, it is important that the alliances continue to build upon the model of **strong agent involvement and ongoing training**.

2) A decision to devote adequate resources to **marketing and advertising** is paramount. Marketing should not be seen as an extra, but as a vital piece of a successful program. If possible, professional marketing should be considered in order to reach as many potential small employers as possible, since program strength will depend upon volume.

3) Programs that are in still in the beginning stages of planning must have access to **development funds** (i.e., state grants) similar to those made available to the earlier alliances. Even though many legal issues have been addressed by other alliances, each alliance is unique and must develop its own legal and actuarial structures in order to deliver a plan to market.

4) A final issue that will require scrutiny, energy, and financial resources is maintaining a **strong stop-loss fund**. With a current value of $1.7 million, it could quickly become swamped or expended. Passage of the 2003 law allowing private contributions may address this concern.

As Minnesota's efforts at developing regional purchasing alliances unfold, other states will likely be watching. Regional health care purchasing alliances may or may not ultimately be the model that succeeds. But Minnesota's health care purchasing alliances are making a serious attempt at crafting the kind of innovations that will lead to long-term success.

Introduction

In 1997, the Minnesota legislature passed the Community Purchasing Arrangements Act (Minnesota Statutes, Section 62T), authorizing the formation of alliances among small Minnesota employers, including businesses of one, to pool the purchasing of health care services. This innovative piece of legislation was in response to a concern among policymakers about the ever-increasing number of uninsured and underinsured people, most notably in rural areas of Minnesota, where small businesses and farms predominate.

In 1999, and again in 2001, funds were appropriated to assist in the development of these regionally-based health care purchasing alliances. In mid-2003, these alliances have achieved varying degrees of progress in their efforts. The first health purchasing alliance product was introduced into the market on January 1, 2003, and several more regional products are expected within a year.

This report will discuss and analyze: 1) the issue of uninsurance and underinsurance, and its particular significance for rural America and rural Minnesota, 2) efforts to develop health care purchasing alliances in other states, 3) the history and development of each of Minnesota's regional health care purchasing alliances, and 4) the current status of each regional program. Finally, it will attempt to glean lessons learned from Minnesota's regional efforts thus far, and consider recommendations or modifications to programs in Minnesota as appropriate.

Background

The issue of affordable, accessible health insurance coverage has become an important component of recent health care debates. The statistics regarding ever-increasing health care costs and health care premiums are known not only by researchers, but by employees, who have watched their take-home pay dwindle as their salary increases are

eliminated and exceeded by rising deductions for health insurance coverage. And they are the lucky ones. In a system of employer-provided health insurance coverage, those in low-paying jobs, and those who are unemployed, underemployed, or self-employed, are increasingly unable to obtain or afford any type of health insurance. Meanwhile, small employers are increasingly unable to afford skyrocketing premium costs, further causing the numbers of uninsured to rise. All of this places a burden not only upon individuals and families, but upon the entire health care system in the form of uncompensated care, which providers must absorb. Public programs, which are in peril due to budget shortages, have also proven inadequate in addressing the issue.

Health Insurance in Rural America

Data from the national Current Population Survey (CDC, 1995) showed that between 1990 and 1995 the number of persons in the United States under age 65 without health insurance increased from 34.7 to 44.3 million, a rise from 13.9% to 16.3% (Pol, 2000). The issue of an increasing number of uninsured Americans is common to both urban and rural areas. However, in the debates and discussions that have taken place by policymakers who have begun to attempt to understand the problem, inadequate attention has often been paid to the uninsured in rural America, and to how their needs may differ from those of the uninsured in urban areas.

Because the rural economy is generally supported more by small businesses and farm businesses, disproportionately more rural residents rely on individual plans or coverage purchased through small employers than do their urban counterparts. Rural employment is more likely to be in firms employing fewer than 10 persons (40% vs. 31% in urban areas), self-employment (16% vs. 9%), or agriculture (7.6% vs. 4%)(Pol, 2000).

Table 1. Sources of Employment, Urban v. Rural

Type of Employment	*Rural*	*Urban*
Firms employing fewer than 10	40%	31%
Firms employing 1,000 or more	21%	25%
Self-employed	16%	9%

The implications of these statistics are: 1) average income is likely to be lower for rural residents; 2) because of the predominance of small employers and self-employed in rural America, rural residents are disproportionately cut off from opportunities to participate in large-pool health insurance purchasing, with its economies of scale and risk management capacity; 3) these residents are likely to pay more for their health insurance than urban residents, and to have to settle for high deductibles and/or less coverage; or 4) they may not be offered (or able to obtain) any insurance at all. The Kaiser Family Foundation 2002 Employer Health Benefits Survey reported that only 55% of the smallest companies (3-9 workers) reporting offered health insurance to employees, compared with 88% for businesses with 25+ employees and 99% of firms with 200+ employees (see Table 2).

Table 2. Percentage of Firms Offering Health Benefits

Number of employees in firm	*Percentage offering health benefits*
3-9	55%
10-24	74%
25-49	88%
50-199	96%
200+	99%

Kaiser Family Foundation, 2002

The report points to the drop in the number of very small employers offering coverage (down from 60% in 2000) as an indicator that, as health insurance benefits continue to increase, they may be becoming more costly than small employers can afford.

Health Insurance in Minnesota

Nearly 75% of Minnesotans receive coverage in the private market through employer-based health insurance, while almost one-fourth of the population participates in a public program, such as Medicare (13%), Medicaid (5.9%), MinnesotaCare[1] (2.4%), and General Assistance Medical Care (GAMC) (0.5%). Minnesota's uninsured rate in 2000 was 5.3%, down slightly from 6.0% in 1993 (Health Economics Program, 2002b).

In 2001, about 68% of all Minnesotans had health insurance coverage through an employer. However, according to a 2002 survey of private businesses, only 49% offered health insurance coverage. When that number is split between urban and rural, it is clear that rural Minnesota is at a disadvantage. Fifty-six percent of private businesses in Twin Cities offered coverage in 2002, compared with 39% in rural Minnesota – a nearly 20% difference (Health Economics Program, 2003).

Confirming the findings of the national Kaiser survey, this study found that smaller firms in Minnesota were less likely to offer coverage than larger firms. Only 36% of firms that had fewer than 10 employees reported offering insurance to employees, while 92% of firms of 200 or more provided health insurance benefits.

The uninsured. Based upon data from the 2001 Minnesota Health Access Survey, almost one fifth (23%) of Minnesota's uninsured had access to coverage through their employers in 2000 but were not enrolled. More than half (56%) of that number reported that

[1] MinnesotaCare was founded in 1992 as a state-subsidized health care program for people whose employers do not offer health insurance, or offer insurance but pay less than 50% of the monthly premium (DHS, 2003)(Minnesota Statutes Chapter 256L, 2002).

they declined enrollment because they could not afford their share of the premiums (Health Economics Program, 2002a). Moreover, Minnesotans are ineligible for MinnesotaCare if their employers offer to pay for 50% or more of the total premium cost for employer-provided health insurance (Health Economics Program, 2002a). The result is that, while they may be unable to afford private employer-based coverage, they are also locked out of eligibility for MinnesotaCare.

Geographic differences. While Minnesota has one of the lowest uninsurance rates in the nation (5.4%) (Health Economics Program, 2002b), certain rural counties in the state experience much higher uninsurance rates than the state average (Mahnomen County, 13.5%; Cass County, 12.5%, Clearwater County, 12.2%). The counties with the highest uninsurance rates tend to be in the north central, west central and headwaters areas of the state. As expected, counties with poor economic conditions, higher percentages of people of color, and few large employers have higher uninsurance rates. Interestingly, those counties with large elderly populations seem to have low uninsurance rates; high Medicare coverage is the likely explanation (Health Economics Program, 2002c).

The predominance of small employers and self-employed individuals (and correspondingly higher rates of uninsurance and underinsurance) in rural areas suggests that strategies for increasing rates of health care coverage in rural areas must be targeted toward these groups.

Small Employer Purchasing Alliances

Referred to by a variety of names – small employer purchasing pools or health insurance purchasing coops or coalitions – health care purchasing alliances are one way to support the small employer trying to provide insurance for its employees. These alliances attempt to address problems unique to small employers, such as high premiums (due to the

inability to spread risk or take advantage of economies of scale), limited choices of health plans, and an inability to negotiate benefits packages with insurers. Employers who participate in purchasing coalitions hope to spread financial risk, achieve economies of scale, manage relationships with insurers, and increase purchasing power.

A review of other states' efforts to build health insurance purchasing alliances reveals that programs have generally met with mixed success. Four states have attempted small employer purchasing alliances and have had follow-up studies done: California, Connecticut, Florida, and Texas. A study of the California, Connecticut, and Florida programs done by Kahn and Pollack through Project HOPE in 2001 concluded that, while there were some benefits, these programs did not reduce small-group market health insurance premiums, and they did not increase the number of small employers offering health insurance to their employees. They did, however, permit employers to offer greater choice in the number and types of plans.

California

A single, originally state-sponsored alliance, the Health Insurance Plan of California (HIPC) was formed in 1993 to serve as a statewide purchasing alliance for small firms (defined as between two and 50 employees; no businesses of one were included). HIPC served as an intermediary between 19 participating health plans and 137,000 workers and dependents (Yegian, Buchmueller, Robinson, & Monroe, 1998; Kahn & Pollack, 2001). In 1997, HIPC offered standard benefit packages, initially with slightly advantageous premiums ($130 alliance v. $154 non-alliance). After studying five years of operations of the HIPC, Yegian et al. concluded that voluntary purchasing alliances were not the solution to the large and growing problem of the uninsured in California (1998). The vast majority of the firms that enrolled in HIPC had already been insured, indicating that its features were not

appealing enough to attract small firms that had not previously offered insurance to their employees (only 2% of small employers in the state participated). Also, in a move to save administrative costs and keep premiums down, the initial HIPC structure and compensation plan left out insurance agents, alienating them and creating animosity, thus adversely affecting growth. Many agents saw the alliances as a threat to their businesses and refused to promote the alliance products to employers. Third, there were limits on provider organizations, which limited freedom of choice for the consumer, and may have negatively affected growth as well. Finally, with 19 health plans initially participating, there were not enough individuals participating in each plan to create volume and keep prices low. Economies of scale that were expected to drive down costs never materialized.

In 1999, according to the original authorizing legislation, HIPC was privatized. The Pacific Business Group now operates HIPC under the name PacAdvantage. While current market share numbers are unavailable, it claims to be the country's largest non-profit health insurance purchasing pool. It now offers plans ranging from $151/month for an individual to $543/month for standard family HMO coverage. It still excludes employers of one from participating (Pacific Business Group, 2003).

Connecticut

The Connecticut plan, called Health Connections, was sponsored by the Connecticut Business and Industry Association (CBIA), and was open to all small businesses in Connecticut with three or more employees. In 1997, it offered employers a choice of 16 options - four insurers, two plan types, and two benefit levels - and its premium cost was essentially no different from comparable products ($188/month alliance for individual coverage vs. $189/month non-alliance). The Connecticut alliance recognized the importance of agents to the success of the plan and tried to develop good relationships with agents, even

establishing an agent advisory board. In fact, in contrast to California, Connecticut required employers to work with agents. In spite of these positive relationships, the Connecticut plan, like the California plan, was unable to achieve significant market penetration by 1997 (only 6% of small employers in the state participated). The likely factor, according to Kahn & Pollack (2001), was the cost issue.

In 2003, CBIA still had two products for small employers and offered a choice of five carriers. It also offered two pricing structures: Health Connections 3-50 for employers with between 3 and 50 employees, and Health Connections 51+, for employers with between 51 and 100 employees. One and two-person businesses remain ineligible. Rates for coverage ranges from $154 per month for single coverage to three or four times that for family coverage. Rate structures are also dependent upon which of four areas of the state that the enrollee lives in; all areas are covered. CBIA currently has 4,000 small employers participating (CBIA, 2003).

Florida

The Florida plan, known as Florida Community Health Purchasing Alliances (CHPA), was structured as 11 area CHPAs, each a separate private nonprofit organization. These were begun with seed money from the state and functioned under a state charter with state agency oversight and management. All employers had to enroll through an agent. Like Connecticut, the premium difference between alliance and non-alliance plans was not advantageous; in fact, premiums under the alliance plans were slightly more ($155/month alliance for individual plans vs. $151/month non-alliance). In 1997, those employers participating in the alliance totaled only 5% of all eligible small employers in the state (Kahn & Pollack, 2001).

In October 1998, the Florida legislature's Office of Program Policy Analysis and Government Accountability released a report on the CHPAs. The report found a number of barriers to the CHPAs' success, such as the inability of CHPAs to negotiate the most competitive plans, and low agent commissions. With diminished purchasing power and poor agent participation, enrollment fell and the participating carriers eventually withdrew. The report concluded that the law should be changed to allow individual CHPAs to negotiate directly with health plans in order to offer competitive products and prices (Florida Legislature, 1998).

As a result of the program's lack of success, the 2000 Florida legislature repealed the CHPA legislation, and in October 2000 a new law went into effect authorizing a single health insurer to issue a group policy to a single small employer health alliance. The individual CHPAs could continue as non-profit entities, but would be unaffiliated with the state (Texas Department of Insurance, 2001).

Texas

In 1995, Texas began a statewide program called the Texas Insurance Purchasing Alliance (TIPA). Like California, Texas had a "guaranteed issue" provision requiring insurers to provide coverage to all employer groups regardless of the health condition of group members. In order to reduce costs, TIPA initially marketed its plans directly to businesses, bypassing insurance agents. Agent commissions were eventually paid in an effort to reach more employers; however, the commissions were limited and attracted few agents to market the plans. In addition, the program's advertising budget was inadequate (Texas Department of Insurance, 2001).

Designed for 2-50 employees, at its peak it covered 13,000 people (Texas Department of Insurance, 2001). TIPA, like Florida's program, dissolved in 1999. In addition to the

problems with agent participation, researchers found that agents directed young, healthy, low-risk groups into private plans they represented and directed costly, high-risk groups that had individuals with pre-existing conditions into the TIPA plans. Over time, the high proportion of high-risk members caused premiums to increase significantly. Eventually, carriers dropped out of the alliance and it folded. This phenomenon of adverse selection is sometimes referred to as the "death spiral."

Lessons Learned from Other States

The conclusions of the HIPC California study (Yegian, Buchmueller, Robinson & Monroe, 1998) and the Project Hope study of California, Connecticut, and Florida (Kahn & Pollack, 2001) were that small-group purchasing alliances did not entice more small-businesses to offer health insurance, and consequently, did not increase rates of health insurance provision for their employees. Both concluded that these programs were unable to obtain the critical mass of small employers needed to provide negotiating leverage with providers, which would have resulted in lower premiums, high levels of benefits, and, thus, further market share.

Kahn & Pollack (2001) suggested certain factors that could favor the future success of health care purchasing alliances: 1) allowing individual alliances to negotiate directly with carriers to encourage competition and obtain lower prices, 2) attracting greater market share by establishing and maintaining full agent cooperation, 3) changing regulatory mechanisms to allow more flexibility, and 4) providing substantial public subsidy support.

The Texas study echoed the Kahn & Pollack recommendations and further recommended: 1) that alliances should place limits on both the number of plans and the number of carriers and 2) that additional funds be made available for marketing and outreach to small employers. Brandel & Pfannerstill, in their 2001 report to the Arizona Health Care

Cost Containment System Administration on efforts in California, Florida, and other states, stressed the importance of a large enrollment base for long-term viability. Larger enrollment, they stated, is crucial to attracting health plans, achieving economies of scale, mitigating adverse selection, and increasing negotiating power.

Minnesota Employer Insurance Program

Minnesota's current regional purchasing alliance program is not the first attempt at providing a program to help Minnesota's small employers. The Minnesota Employees Insurance Program (MEIP) was established in 1993 as part of the 1992 MinnesotaCare health care legislation (Minnesota Statutes, Section 43A, 2002). It was intended to be a statewide program to provide employers with the advantages of a large pool for insurance purchasing and was administered by the Department of Employee Relations (DOER).

The program was abolished in 1998 after an impact study prepared for the Minnesota Legislature by DOER (DOER, 1998). The study concluded that MEIP was not financially viable. Several reasons were cited. First, participating health plans used "worse case" assumptions in rating MEIP's employer groups, resulting in higher than market premium rates and putting the program into a downward spiral. Second, the program offered a choice of multiple health plans, driving up administrative costs. Third, the program initially was not marketed through insurance agents, and subsequent commissions paid were viewed as too low; agents had little incentive to market the program and the relationship with brokers suffered.

Minnesota has had the benefit of learning from other states' efforts at developing and maintaining health care purchasing alliances, and has taken its own lessons from the demise of MEIP. The resulting design of Minnesota's regional health care purchasing alliance

program may, in the end, make it a win for Minnesota's small employers and their employees.

Health Care Purchasing Alliances in Minnesota: History and Legislation

The health care purchasing alliance movement in Minnesota began in the mid-1990s, following other widespread health reform efforts that took place earlier in the decade. The biggest such reform was the 1992 establishment of MinnesotaCare, a state-subsidized health care program for Minnesota residents without health insurance (Minnesota Statutes Chapter 256L, 2002). Any individual is eligible for MinnesotaCare if they meet income guidelines and if their employer does not offer health insurance or offers insurance but pays less than 50% of the monthly premium (DHS, 2002).

The Drivers

The major driver behind the development of health care purchasing alliances in Minnesota has been Advocates for Marketplace Options (AMOM), a coalition of health care providers and business representatives, founded in 1996. Its mission has been to create more options for community health care providers and small business purchasers of health care (AMOM, 2003b). AMOM is guided by these principles: 1) mainstreet businesses and farm families should be allowed to form alliances to purchase health care services directly from local health care providers (hospitals, clinics, and health professionals); 2) health care providers should be allowed and encouraged to work with communities; and 3) community needs and resources should be a focus for government and for health plans.

In 1996, AMOM began working with community groups to assist them in the initial stages of planning for regional health care purchasing alliances, and in 2003 it continues to provide technical assistance to the alliances and to advocate on their behalf at the state legislature and with administrative agencies. This broad coalition-type approach appears to

be a unique factor in the development of Minnesota's health care purchasing alliances. (The four other states' programs were all initiated and administered by statewide non-profit or public organizations.) This may be the one factor that stands out if Minnesota's program proves viable in the long term.

The political will for exploring health care purchasing alliances did not come from AMOM alone. In November 1998, the *Minnesota Policy Blueprint*, a comprehensive study of Minnesota government published by the Center for the American Experiment, a conservative think tank, recommended a return to community-based health care delivery. Specifically, it recommended regional coalitions of providers and employers. Further, it suggested that regional purchasing alliances be explored nationally, and that they be allowed to cross state lines.

In his 2002 gubernatorial campaign, Governor Tim Pawlenty named the rising cost of health insurance as one of his top health concerns. In an October 2002 article in *Minnesota Physician* highlighting candidates' positions, Pawlenty stated that "in order to increase competition and make health care insurance more affordable and accessible, I support legislation to encourage and enable more small businesses and individuals to form and join purchasing pools." (*Minnesota Physician*, 2002). Governor Pawlenty's concern and policy recommendation would seem to bode well for public support of the Minnesota program as it unfolds.

Legislative History

After a DFL-sponsored bill to begin the process of local health care purchasing was vetoed by Governor Carlson in 1996, a bipartisan bill, which expanded on the earlier attempt, was presented in 1997. In spite of vehement opposition by the Minnesota Council of HMOs, the bill passed and was signed into law (AMOM, 2002d). Minnesota Statutes Chapter 62T,

also known as The Community Purchasing Arrangements Act, was thus born (Minnesota Statutes Section 62T, 2002). Further technical enhancements to the act were passed in the 1998 and 2000 legislative sessions. This law allows small businesses to join together to negotiate benefits packages from health care insurers.

Minnesota's law, unlike those of other states, allows purchasing alliances to include employers of one; as of this writing, no other state has adopted this provision.

The legislation also introduced the Accountable Provider Network (APN) option, which allows groups of community physicians and other health care providers to directly contract with health care purchasing alliances to provide services and benefits packages. This model is different from traditional health care products because employers are allowed to share risks with the local providers. The law also allows the commissioner of health to grant waivers for requirements otherwise imposed on health plans in the areas of solvency reserves, quality assurance, marketing, and financial reporting (AMOM, 2003a)(Minnesota Statutes, Section 62T, 2002).

In 1999, the Minnesota legislature appropriated funds to the Department of Health to support the development of the first regional health care purchasing alliances in Minnesota (Minnesota Sessions Laws, 1999). A two-year $100,000 start-up grant was made to each of the two groups in the southwest and northwest regions to coordinate the development of alliances in their regions: one to the Southwest Regional Development Commission and the other to the University of Minnesota-Crookston.

In 2001, one-year, additional $50,000 grants were extended to the two original grantees in order to complete their projects. In addition, a one-year $50,000 start-up grant was made to the Arrowhead Regional Development Commission to support the development of a northeast Minnesota purchasing alliance, and a two-year $100,000 start-up grant was

made to the Brainerd Lakes Area Chamber of Commerce to support a north central purchasing alliance (Minnesota Session Laws, 2001).

By 2001, the regional alliances in the southwest and the northwest, with the help of actuarial consultants, had identified a problem with the issue of risk when recruiting enrollees who had previously been uninsured. Actuarial studies showed that those without insurance for a long period often had pent-up medical needs, and thus used many services in the initial period after receiving insurance. Both of these regional alliances were told that premium rates could spiral upward if they recruited currently-uninsured businesses and farm families, thus placing pressure on other participants. Still, the leaders of the purchasing alliances believed in the importance of decreasing the number of uninsured, citing both social and community economic reasons for this position (AMOM, 2003d; Office of Rural Health & Primary Care, 2003).

In response, the 2001 legislature enacted legislation authorizing the Purchasing Alliance Stop Loss Pilot Project in northwest, north central, and southwest Minnesota, and appropriating $1.7 million to fund the stop-loss fund. This fund allowed health plans contracting with a rural health care purchasing alliance to receive reimbursement from the fund for 90% of the portion of any enrollee's claims between $30,000 and $100,000 per year (Minnesota Session Laws, 2001), thus mitigating an insurer's high medical claims that fall under the $100,000 minimum for commercial reinsurance benefits. This measure addressed the actuarial likelihood of higher initial medical claims of previously-uninsured individuals and families. A qualified employer under this law must have between one and 10 employees, and must not have offered employer-subsidized health care coverage for which it paid 50% or more of the cost to its employees for at least 12 months prior to its joining the purchasing alliance.

This provision, which follows the recommendations of the Project HOPE study, appears to be another significant difference between Minnesota's plan and the programs in California, Connecticut, Texas, and Florida. It communicates the social and economic value that Minnesota places upon protecting health care purchasing alliances by removing most of the risks associated with bringing in enrollees that have been uninsured for some time. The economic benefit to rural communities and their working families is considered to outweigh the costs of providing this public reinsurance program; this could be a critical factor in its long-term success.

Additional legislation in 2002 modified a previous statute on health maintenance organizations (HMOs) to permit five HMO rural demonstration projects to "extend coverage to a health improvement and purchasing alliance coalition located in rural Minnesota" (Minnesota Session Laws, 2002). This special legislation was a necessary and timely response to a specific issue that arose in the northwest region (and which will be discussed later), but which may have implications for other regions as well.

Pending Legislation

Efforts spearheaded by AMOM are underway in the 2003 legislative session to allow the commissioner of human services, who administers the stop-loss fund, to accept grants from other public or private entities for the purpose of expanding the fund (Minnesota Senate, 2003). This legislation has passed both houses and is poised for signature by Governor Pawlenty.

Minnesota's Regional Health Care Purchasing Alliances

Four of Minnesota's regional health care purchasing alliances benefited from grant appropriations in 1999 and 2001. Details regarding their formation, structure, progress, and

barriers to progress will be discussed below. Other regional groups are beginning discussions of health care purchasing alliances; those efforts will be described below as well.

Southwest Health Care Purchasing Alliance: Prairie Health Care

The Southwest Health Care Purchasing Alliance began in 1999, after receiving a two-year $100,000 start-up grant from the Minnesota Department of Health (MDH) (Minnesota Session Laws, 1999). According to the files maintained by the MDH Office of Rural Health and Primary Care (2003), the Southwest Regional Development Commission, the lead organization and grantee, gathered representatives from the nine most southwestern counties in Minnesota to form a board of directors and begin the work of planning its health care product, including structure and administration, by-laws, benefit design, exclusion and limitations, cost-sharing, eligibility, provider network relationships, and pricing. The board hosted a set of community forums, and gathered input from local employers about the possibility of a joint purchasing arrangement. By the spring of 2000, it was clear to the board that a survey of small businesses would assist in planning the program, and a joint effort with the northwest purchasing alliance was initiated.

Survey of small employers. In the summer of 2000, as part of a collaboration among the University of Minnesota's Carlson School of Management, AMOM, Minnesota Medical Group Managers Association, Southwest Regional Development Commission, the University of Minnesota-Crookston, and the Center for Rural Policy and Development, a survey was mailed to businesses and health care provider organizations in rural southwest and northwest Minnesota. The survey asked questions about health insurance, access to local health care providers, provider payment and service trends, and collaboration among and between local businesses and local providers. The March 2001 survey report indicated that 48% of businesses with 10 or fewer employees did not offer health care coverage.

Moreover, small businesses reported a decreased ability to recruit and retain employees because of their limited ability to provide and pay for health care coverage (Connor, 2001). The survey was an important planning tool for both the northwest and southwest alliances as they moved forward.

By the spring of 2000, the board entered into discussions with Blue Cross Blue Shield of Minnesota (BCBS) and Sioux Valley Health Plan in Sioux Falls, South Dakota (Sioux Valley) regarding administration of the proposed health plan. Several months later, the board decided to proceed in negotiations with Sioux Valley after BCBS encouraged the group to abandon the purchasing alliance efforts and focus instead on consumer wellness/education with financial support from the BCBS Foundation. Part of the issue driving this recommendation was concern over how to include farm families and businesses of one. The alliance and Sioux Valley struggled with this same issue over the next several months. By November of 2000, AMOM recommended that changes to state regulations be considered in order to make it possible for the program to work for farm families and businesses of one. In April 2001, after continued negotiations regarding employers of one, Senator Sheila Kiscaden (IR-Rochester) met with the group and expressed her interest in resolving the issue through legislative means. These discussions contributed to the passage of the Purchasing Alliance Stop Loss Pilot Project (Minnesota Session Laws, 2001).

Contract negotiations. In May 2001, the board projected a tentative product launch by October 1, 2001. By July, a draft master contract with Sioux Valley was completed, and the name of the alliance was changed to Prairie Health Purchasing Alliance. The health care product was named Prairie Health Care.

In September 2001, the Alliance entered into a second grant contract with MDH for $50,000 in continuing development support. Negotiations with Sioux Valley continued into

January 2002, with the following "dealbreaker" issues remaining: 1) counties of licensure - Sioux Valley was not licensed in Redwood County; 2) a target launch date – Sioux Valley was still concerned about admitting businesses of one; 3) annual premium increase limits; and 4) network providers – the contract and the purchasing alliance needed to either protect providers that were not affiliated with Sioux Valley Health System or prevent Sioux Valley from denying claims for these providers without cause. The board took the position that all providers in the area should be included (Office of Rural Health & Primary Care, 2003).

By April 2002, three of the issues had been resolved. Sioux Valley obtained licensure in Redwood County. The alliance was considering adding language that would 1) limit businesses of one to a specific percentage of the total, and 2) limit the annual enrollment period for businesses of one to a set number of months per year. The third issue, premium increases, was limited to 15% per year. A product launch target date of no earlier than July 2002 was established (Office of Rural Health & Primary Care, 2003).

Only one "deal-breaker" issue remained in the negotiations: the provider network issues. Avera Health, a competing system of hospitals, clinics, and health plans, and Sioux Valley's major competitor in southeastern South Dakota and southwestern Minnesota, ran three hospitals in the southwest region, in the communities of Tyler, Ivanhoe, and Pipestone. In each of these communities, there were no providers available other than the Avera affiliates. In January 5, 2003, a representative of the Prairie Health Alliance claimed that "Avera is refusing to participate because it doesn't want to help its competition, Sioux Valley Hospitals & Health System, which is cooperating with the alliance" (Howatt, 2003). The alliance petitioned the Federal Trade Commission (FTC) and the Minnesota attorney general to attempt to force Avera to participate. Neither the FTC nor the attorney general took action.

Current status. The provider issue remains unresolved as of this writing (May 6, 2003). Although the alliance had stated publicly that it would offer a plan by March 2003 if no deal was reached with Avera (Howatt, 2003), the dispute has apparently delayed the final product. According to Robin Weiss of the alliance, the board has decided that if the issue cannot be resolved by July 2003, the revised date of product launch, the alliance will go forward without the Avera providers, and attempt to bring them in later (R. Weiss, personal communication, April 3, 2003). The parties are currently considering revised contract language that will resolve the issue, and a prompt resolution is anticipated.

The alliance recently received approval of its three benefit plans and premium schedule from the Minnesota Department of Commerce. Application for state approval of the plans for an HMO demonstration project was anticipated for submission in early April of 2003, and approval was expected shortly thereafter (R. Weiss, 2003).

The products will only be available through agents of Great Plains Insurance Brokerage located in Sioux Falls, South Dakota; three training sessions for brokers are planned for the summer of 2003.

The alliance is hoping to enroll a minimum 1,000 insured members within the first year of operation.

Northwest Health Care Purchasing Alliance: RuralCare Partners

In 1994, the Northwest Minnesota Civic Health Initiative was organized as an "Active Citizenship" demonstration project, one of several projects designed to provide an opportunity for citizens to actively engage in work on contemporary civic problems. The initiative, a bipartisan effort led by Senator Roger Moe and Lt. Governor Joanne Benson, organized civic forums on rural health care that involved local governments, health care providers, educators, helping professionals, and others.

In 1999, in recognition of the work of the Northwest Minnesota Civic Health Initiative, a two-year $100,000 grant for development was awarded to the extension program at the University of Minnesota-Crookston (Minnesota Session Law, 1999), which provided initial organizational support for the alliance.

The seven counties involved in the development of the purchasing alliance - Kittson, Lake of the Woods, Marshall, Pennington, Polk, Red Lake, and Roseau - have a combined population of 86,000, with a 2001 uninsurance rate ranging from 2.5% (Roseau County) to 9.3% (Marshall County), and averaging about 7% (Health Economics Program, 2002b). This is an area of sparse population, with an economy based primarily on agriculture and natural resources.

In the fall of 1999, 27 people from these counties met to create goals, guiding principles, and an organizing framework for a purchasing alliance. During the month of October, community meetings were held in six communities and attended by 100 people; out of those meetings, 30 people volunteered to become involved in planning. A Northwest Purchasing Alliance (NWPA) 14-member board was elected in February 2000. This board had representatives from all seven counties and included farmers, small business people, industry representatives, bankers, insurance agents, educators, health care providers, nonprofits, and representatives of local government. Formal documents of incorporation were filed in March 2000. The ambitious target date for offering health care coverage was January 1, 2001.

The board held monthly meetings throughout 2000, with a focus on product design and marketing strategy. Three committees were formed to 1) develop a wellness component, 2) explore options for product identity, and 3) refine the product design. The NWPA partnered with the southwest alliance, the University of Minnesota's Carlton School of

Management, and the Center for Rural Policy and Development to conduct the previously-mentioned survey of businesses and health care providers in the two regions. The study reinforced the need for new options for health coverage (Center for Rural Policy and Development, 2000).

Additional grant funds of $50,000 were appropriated in 2001 by the state legislature to help the northwest region complete its work. However, in the fall of 2001, the NWPA experienced a setback. The Northwest Regional Healthcare Alliance, a network of providers in the area that had been in discussions with the alliance, decided to end the talks, leaving the alliance with no insurer. The board immediately voted to meet with George Halverson, CEO of HealthPartners, to explore the idea of pursuing a partnership. A meeting with Senior Vice President Ted Wise on January 22, 2002, began the relationship that would eventually become formalized (Office of Rural Health & Primary Care, 2003).

Small employer health coverage survey. Between December 2001 and February 2002, the University of Minnesota-Crookston conducted a survey on behalf of the alliance to study health care coverage provided by small employers in the region. The results supported the 2000 larger regional survey conducted by the Center for Rural Policy and Development. The survey found that over half of respondents were considered small (2-50 employees). Thirty-seven percent of respondents were businesses of one. Responses indicated that only 44% of the small businesses surveyed offered any form of health care coverage to their employees. The 2000 survey indicated that 48% of businesses did not offer health care coverage; the northwest follow-up survey indicated an increase in this number to 56%. Furthermore, over half of the businesses reporting had experienced premium increases of 10-35% from the previous year, and thus needed to arrange for reductions in covered services, higher deductibles, and/or bigger co-payments to contain premium costs. Finally, 11% of

businesses that offered employer-sponsored coverage at the time of survey said they planned to drop it within one year (University of Minnesota, 2002). Northwest Minnesota was clearly ready for some good news.

HMO rural demonstration project. By early 2002, it became apparent that legislative and regulatory changes to existing HMO law would be necessary in order to allow HealthPartners to become the health plan administrator for the alliance. A bill was introduced in the Minnesota Senate to permit demonstration projects allowing health maintenance organizations to extend coverage to a health purchasing coalition "located in rural Minnesota" (Minnesota Session Laws, 2002). With the passage of this act in April 2002, HealthPartners became the first health plan in Minnesota to receive authority to work directly with a rural purchasing alliance. NWPA and HealthPartners began working on the design of the benefit package.

By September 2002, letters were sent to insurance agents in the region, inviting them to an introduction of the product, RuralCare Partners Health Plan. Agents were offered the opportunity to apply for agent contracts with HealthPartners and would be listed in an agent directory for alliance members. Eighteen area agents participated in the training sessions. (This move on the part of the alliance was responsive to some of the agent issues encountered other states.) (Office of Rural Health & Primary Care, 2003).

In October 2002, HealthPartners staff and RuralCare Partners representatives presented Commissioner of Health Jan Malcolm with a formal application for the HMO demonstration project. The plan was approved by MDH, and soon thereafter, the alliance began enrolling members for an effective date of January 2, 2003. Letters were sent out to all eligible employers, and six employer informational meetings were held in two days. In addition, presentations were made to the region's hospital and physician clinic provider

groups, and contracts were signed with nearly all of the providers in the northwest region (D. Larson, personal communication, April 3, 2003).

The product. The purchasing alliance wanted a benefits design that involved consumers in the process and that created increased consumer awareness of costs. Instead of a flat-fee co-pay, each insured was asked to pay a percentage of the cost of the services (Berne & Aebischer, 2003).

Employers were asked to sign up through a RuralCare-affiliated agent for a three-year commitment. "Working as a group over a longer period of time…gives employers the opportunity to focus together to improve health problems that are increasing…costs," said Lola Underdahl, purchasing alliance board member (*Kittson County Enterprise*, 2002b).

Three benefit plans, which included various levels of coverage and deductibles, were offered to employers of 1-50, although employers of one were limited to 10% of the plans' total enrollment. The average 35 year old could expect to pay between $75-$122 per month for an individual plan with the highest deductible and $145-$240 for no deductible. Members were assigned to a primary care clinic, and provided care within the HealthPartners Network for primary, hospital, specialty, mental health/chemical health, urgent care, and chiropractic care. HealthPartners also sought contracts with regional clinic and hospital providers currently not in the network. Finally, a center for health promotion was established to provide health and wellness information through a network of advisors, a patient education resource catalog, weight-loss self-study courses, a web site, and a staffed phone line.

The northwest alliance was included in the stop-loss fund legislation, allowing for partial reinsurance for employers of 1-10 employees with individual annual claims of between $30,000 and $100,000. As Brian Johnson described to the *Kittson County Enterprise* on October 23, 2002,

> The experts told us what we didn't want to hear. They told us we should not try to add uninsured people to our purchasing group or the rates for all employers might go up. We said, if our working families can't get health insurance, they may leave our town, our schools and our labor force…We want our workers insured because it will help this region economically.

As Scott Abeisher, senior vice president of customer service and product innovation for HealthPartners, told the *Enterprise*, "If this project works as we think it will, the people in this are will have greater access for very necessary health care" (*Kittson County Enterprise*, 2002a).

Donna Larson, of RuralCare Partners, discussed the northwest alliance's progress to date (personal communication, April 3, 2003). According to Larson, the alliance expected 1,000 people to initially enroll. However, enrollment since January 1, 2003, has been significantly slower than anticipated - only about 150 people. Larson acknowledged a limited marketing efforts thus far, mainly attributed to the fact that one large provider, with clinics in two communities, will not enter the network until July 1, 2003. Because this provider is not yet in the system, the alliance is unable to advertise that "all" providers are on board. It has had input from employers that until that provider is part of the alliance, they will wait to consider enrolling. Larson noted that marketing is key to enrollment, and until the provider issue is resolved, a full-out marketing campaign would be counterproductive. The alliance anticipates total enrollment of 2,000 people by January 1, 2004.

Central Minnesota Healthcare Purchasing Alliance

The Central Minnesota Healthcare Purchasing Alliance (CMHPA) was formed in 2001, following a two-year $100,000 grant appropriated to the Brainerd Lakes Area Chamber of Commerce (Minnesota Session Laws, 2001).

CMHPA covers the counties of Crow Wing, Cass, and Aitkin, and parts of Mille Lac, Morrison, Todd, and Wadena counties. According to the Brainerd Lakes Area Chamber, there are around 7,000 small businesses in the area. The 2001 uninsurance rates in those counties ranged from 5.4% in Mille Lacs County to the state's second highest rate of 12% in Cass County (Health Economics Program, 2002b).

The CMHPA has been in an advantageous position to move forward more quickly than the southwest and northwest alliances, as it was able to build upon the experience gained by the other two. In addition, statutory changes put into place prior to and early in the planning of the CMHPA addressed issues that would have been of concern, including stop-loss funding and HMO regulatory clearance to work with a rural alliance.

As a result, the CMHPA made substantial progress in a relatively short time. By June 2002, less than a year into the process, the alliance had already hosted three informational sessions for area hospitals and physicians, developed membership criteria, received letters of interest from four health plan companies, and begun discussions and negotiations with two. In addition, it developed a draft product design and completed an actuarial pricing analysis (Office of Rural Health & Primary Care, 2003).

By December 2002, the alliance had moved even closer to launching a product. Area providers decided to form an accountable provider network (APN), defined as a "group of health care providers organized to market health care services on a risk-sharing or non-risk-sharing basis with a health care purchasing alliance" (Minnesota Statute 62T, 2002). Four hospitals and clinics serving the region agreed to participate, and hired a third-party administrator. In addition, the CMHPA placed numerous radio and newspaper ads introducing the purchasing alliance, and distributed a survey to 8,000 employers within the area to identify their health insurance needs and help formulate the final draft of the product.

As of this writing, according to the alliance's coordinator, Lisa Paxton (personal communication, April 3, 2003), the alliance is continuing to negotiate with the four local independently-owned hospital/clinic providers in the communities of Brainerd, Staples, and Crosby to form an accountable provider network (APN), which would act as the health care provider/insurer for the alliance. Forming an APN is no small feat; barriers which must be overcome include 1) coming up with the initial investment required to manage regulatory solvency requirements and pay legal start-up costs, and 2) establishing a risk pool. Providers are weighing a number of short-term and long-term considerations. They see the benefits to their communities of having a local provider system, of decreasing the number of uninsured, of reducing uncompensated or charity care, and of improving local health care in general. Yet they are concerned about the long-term sustainability and the initial investment costs. The providers have contracted with an outside source to develop a business plan that would address these issues. Paxton is reasonably confident that the issues will be resolved in time for a fall 2003 product release.

One option being considered is a partnership with UCare Minnesota, an independent, nonprofit health maintenance organization that administers health care programs for the State of Minnesota (including MinnesotaCare) and offers affordable health care options for seniors (UCare Minnesota, 2003). The provider group is currently considering either having UCare become part owner, thus sharing risk as well as providing plan administration, or simply contracting with the UCare for administrative services, with no ownership involved.

Meanwhile, the alliance is working with UCare, employers, providers, and insurance agents on product design, and is committed to offering a value-added product for small employers. When the product is designed, it is planning to test market the plan with focus

groups of small employers. When the product becomes widely available, the alliance anticipates that 2,000 insured members will form a baseline for long-term viability.

Northeast Health Care Purchasing Alliance: Breakwater

In early 2001, a small group of people from Duluth-area nonprofit organizations began discussing the need to provide affordable health insurance to their employees. They soon began exploring the feasibility of developing a health care purchasing alliance. Recognizing a broader application for such an alliance, the group expanded to include the Duluth Area Chamber of Commerce, Northland Sustainable Business Alliance, and Northern Lakes Health Consortium. The committee then went to the state legislature to seek support for planning and development activities (AMOM, 2003d). In the 2001 legislative session, the alliance received a $50,000 one-year grant to develop a health care purchasing alliance product for the northeast region (Minnesota Session Laws, 2001).

Like the central Minnesota group, the northeast effort was streamlined considerably by the work already done by the southwest and northeast alliances and by the statutory supports already in place. The Arrowhead Regional Development Commission was designated as the lead agency. The alliance sought to provide a health care coverage option for small employers in northern Pine County, and in Carlton, St. Louis, and Lake counties. Uninsurance rates in 2001 for those counties ranged from 5.5 – 8.7% (Health Economics Program 2002b).

Timeline. In September 2001, the group had established a steering committee and adopted guiding principles, a work plan, a budget, data collection strategies, and membership criteria (Office of Rural Health & Primary Care, 2003). The alliance's ambitious work plan timeline projected the initial enrollment of members in the fall of 2002, with a product ready for market by January 2003.

Table 3. Northeastern Minnesota Health Care Purchasing Alliance Work Plan Timeline – September 2001

Target Date	*Product*
November 2001	Collect data on uninsurance needs
July 2002	Identify interested health plans and potential provider networks
July 2002	Complete design of benefits package
October 2002	Complete marketing and communication plan
November 2002	Enroll members
January 2003	Offer health care product to members

Goals. The goals of the alliance were to offer a plan that would result in lower and more stable premium rates for small businesses, nonprofits, and self-employed people in northeastern Minnesota; attain a group size large enough to absorb risks and create purchasing leverage; provide quality patient care at a reasonable cost; and promote healthy lifestyles (AMOM, 2003d)

Progress. Early signs indicated that the alliance was on track with its work. By April 2002, the benefits committee presented its draft of the health plan and its intention to conduct focus groups of consumers, employers, and providers. By July 1, the committee had met with regional health care providers, had selected a name (Breakwater Purchasing Alliance), and had a coverage plan well underway. However, issues such as attaining nonprofit incorporation, obtaining federal tax-exempt status, and completing negotiations with providers proved to be more time-consuming than originally planned. It became incorporated on October 11, 2002. In late November, the alliance requested and received from MDH an extension of its development grant to March 31, 2003.

In an April 3, 2003, telephone interview, Kathy VonRuden, a Breakwater board member and an employee of North Star Physicians, provided an update on progress to date. The alliance recently experienced a setback involving the provider network. In late March 2003, the alliance was informed that the providers that had been considering formation of an

accountable provider network were backing out. Ultimately they did not want to accept the risk of forming their own health plan or the costs required for start-up. They concluded that they could simply not afford it. According to VonRuden, however, another health plan has been "in the wings" and the alliance will now turn its attention to negotiations with that plan.

The alliance remains committed to providing a viable and unique product for small employers in the area, including employers of one. Like the northwest alliance, the Breakwater Alliance wants to involve the consumer by making choices that ultimately will result in lower premiums for everyone. For example, rather than a flat-fee co-pay system of primary care referrals, the plan will ask enrollees to pay 20% of any doctor visits and tests. Another interesting innovation is a plan to encourage wellness and consumer responsibility by requiring every adult to have four basic screening tests every year – fasting blood sugar, cholesterol, blood pressure, and tobacco use – and providing financial incentives for consumers to comply with these screening measures and resultant recommendations.

A recent employer survey mailed to 6,700 employers in the alliance coverage area indicated that 90% of respondents employ 20 or fewer people. Ninety percent also expressed a strong interest in an alternative health care product. VonRuden said that the board is planning to roll out a product to employers by fall 2003.

Other Health Care Purchasing Alliance Initiatives

West Central Minnesota. Twelve counties in west central Minnesota - bordered by Traverse and Grant Counties on the north, Kandiyohi County on the east, and Renville and Yellow Medicine County on the south - have begun exploring the possibility of a health care purchasing alliance for the area. The average uninsurance rate for residents of the twelve counties is 6.2%, with a range from a low of 2.4% in Lac Qui Parle County to a high of

10.4% in Renville County. An estimated 75% of businesses in the twelve counties have fewer than 10 employees (WCRSDP, 2003).

The West Central Regional Sustainable Development Partnership recently hosted community forums and is in the process of forming an initial purchasing alliance board (Berne & Aibescher, 2003). Four forums were held in Montevideo, Alexandria, Willmar, and Morris, with a total participation of 179. Among issues of strongest concern were stabilizing health care premium costs, maintaining or strengthening health care facilities in local communities, and promoting better accountability in the health care delivery system.

Of those in attendance at the forums, 93% thought it would be wise to form a regional health care purchasing alliance. Thirty-five people signed up to participate in a steering committee to begin the work of developing a west central regional product (S. Brickweg, personal communication, April 4, 2003).

South Central Minnesota. Early discussions are underway, led by three member groups of the United Farmers Cooperative, to form a purchasing alliance in the south central part of the state for member/owners, many of whom are businesses of one (Berne & Aibescher, 2003).

Summary and Recommendations

Small employer purchasing alliances have obviously met with mixed success in other states and in Minnesota's own earlier attempt with MEIP. There are reasons, however, that the idea continues to surface among policymakers and among constituents. Small employers are gradually being priced out of the health insurance market. The result is that many small employers are left with few choices for taking care of themselves, their employees, and their families. Uninsurance rates are rising. Past and current options have proven inadequate for the unique needs of small employers and self-employed individuals. Which new health care

solution will prove viable in the long-term is unknown, but it is obvious that creative, bold options must be considered.

Small employer alliances have been conceived to provide small employers with health insurance products that are affordable and have adequate benefits. They have attempted to allow small employers to jointly act as a large pool for the purposes of risk-sharing and administrative cost savings. While small employer allowances have had their share of problems, the idea of working to strengthen this model is well placed.

Minnesota's health care purchasing alliances appear to be off to a solid start, showing an intent to take the lessons learned from other states and from MEIP and to develop unique and sustainable programs. Table 4 below summarizes some of the problems identified in other states' small employer purchasing alliance programs and Minnesota's earlier attempt at a statewide purchasing pool (MEIP), and contrasts them with Minnesota's strategies thus far. It is a long and impressive list.

Table 4. Issues Identified and Minnesota's Regional Strategies for Small Employer Purchasing Alliances

Issue	*Strategy*
Statewide or state-administered program.	Regionally-based programs respond to unique needs of region.
Inability of purchasing alliances to negotiate directly with health plans.	Regional alliances negotiate directly with health plans.
Agents left out of relationships between programs and employers.	Requirement for employer to purchase product through designated brokers.
Poor relationships with agents and undercompensation.	Brokers involved early on in planning. Agent training sessions, marketing sessions. Competitive commissions.
Top-down planning leaves employers out, less vested in success.	Employer-driven design means employers are vested and concerned about long-term viability and health of employees.
Multiple health plans offered.	One health plan or APN reduces administrative costs; creates a larger pool; and allows for ease of utilization review and responsive redesign of benefits.

Adverse selection.	Employers required to sign on for a minimum 3-year commitment; encourages stability, lowers administrative costs.
Flat co-pay discourages consumer/ enrollee responsibility for costs.	Percentage-of-total co-pay educates consumer, encourages responsibility for holding down costs and premiums.
Poor health behaviors drive up costs.	NE alliance proposal: 4 health screenings and incentives tied to results encourage healthy behaviors.
No employers of one.	Employers of one are included.
Insufficient planning funds.	State-funded planning grants to regional alliances has helped alliances meet actuarial and legal expenses of planning products.
Lack of state subsidy for ongoing operations. Health plan hesitancy to make previously uninsured eligible due to backed-up health needs.	State-funded stop-loss fund provides reimbursement to health plans for those enrollees uninsured for previous 12 months with total claims between $30,000 and $100,000.

Minnesota's regional alliances have benefited greatly from start-up funding from the legislature and technical assistance and guidance provided by AMOM, but, more importantly, from community leaders committed to delivering health care products that meet the needs of their regions. This final ingredient, unique to a regionally-delivered system that has its roots among the people it serves, may bode well for the success of the program in Minnesota.

Another factor that strengthens the concept is that later projects were able to benefit from issues identified by the southwest and northwest alliances, thus speeding up the development process and avoiding pitfalls. The stop-loss funding issue and the HMO demonstration project concept were invented and passed by the state legislature while the alliance purchasing movement was in its relative infancy, thus eliminating the need for others to reinvent the same wheels. The incrementalism of this approach also allowed for adjustments to be made before any major investments of time and resources were expended.

There are some cautions, however. One big factor that may impact the success of any good plan is the fluctuating economic picture. As attractive as the regional health care purchasing alliance concept may be to local employers, they still must have the resources to provide a health insurance benefit to employees. The program simply won't work if small employers can't afford any program at all.

Recommendations

1) Based upon the repeated problems with agent relationships in previous efforts in Minnesota and elsewhere, it is important that the alliances continue to build upon the model of **strong agent involvement and ongoing training**.

2) A decision to devote adequate resources to **marketing and advertising** is paramount. Marketing should not be seen as an extra, but as a vital piece of a successful program. If possible, professional marketing should be considered in order to reach as many potential small employers as possible, since program strength will depend upon volume.

3) Programs that are in still in the beginning stages of planning must have access to **development funds** (i.e., state grants) similar to those made available to the earlier alliances. Even though many legal issues have been addressed by other alliances, each alliance is unique and must develop its own legal and actuarial structures in order to deliver a plan to market.

4) A final issue that will require scrutiny, energy, and financial resources is maintaining a **strong stop-loss fund**. With a current value of $1.7 million, it could quickly become swamped or expended. Passage of the 2003 law allowing private contributions may address this concern.

As Minnesota's efforts at developing regional purchasing alliances unfold, other states will likely be watching. Minnesota's alliances could indeed serve as models for other rural parts of the country, or other areas where there are higher concentrations of small employers and employers of one. The community or regional model could be duplicated, as well as the models for state government involvement and/or support. Regional health care purchasing alliances may or may not ultimately be the model that succeeds. But Minnesota's health care purchasing alliances are making a serious attempt at crafting the kind of innovations that will lead to long-term success.

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