

MEDICAID AND COOPERATIVE HEALTHPLAN PURCHASING ORGANIZATIONS

*Prepared for the Innovations in State Health Reform Program
an initiative of the Henry J. Kaiser Family Foundation*

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December 1996

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INTRODUCTION

For most of its history, Medicaid has operated as a distinct health-financing program for discrete low-income populations. Until recently, most of its beneficiaries were receiving welfare and had little or no tie to the workforce. The providers from who they obtained care were often different from those serving the employed population. Medicaid beneficiaries were more likely to use hospital outpatient departments and emergency rooms or safety net providers such as community health centers. Even when Medicaid contracted with HMOs or other prepaid plans to serve beneficiaries, the plans were often developed specifically for the Medicaid population. Commercial HMOs were historically reluctant to enter into Medicaid contracts.

In recent years, however, there has been a gradual – if still limited – convergence of Medicaid and the private health insurance sector, in at least two respects. First, Medicaid eligibility has been extended to pregnant women and children with higher incomes in the last decade. Most of these newly eligible beneficiaries have family ties to employment, and often to employment in firms that offer health benefits to workers and their families. Second, managed care plans have shown increasing interest in the Medicaid market. To a greater extent than in the past, Medicaid beneficiaries are enrolling in plans that also serve employer groups.

One consequence of these trends is that state Medicaid agencies are increasingly performing functions that are also being performed by private purchasers, including large employers, employer coalitions, and healthplan purchasing cooperatives (HPCs). For example, both the Medicaid agency and private purchasers are selecting health plans, negotiating contracts, providing

information on available choices to beneficiaries or consumers, and processing enrollments and payments. And both are engaged in ongoing monitoring of the plans with which they contract, collecting quality and consumer satisfaction data and assessing performance.

These overlapping functions raise the possibility of greater cooperation or collaboration between public and private purchasing efforts. One option, being pursued, for example, in Minnesota, is for the state to coordinate health plan purchasing activities for Medicaid beneficiaries and state employees. A second option, also part of Minnesota's strategy and the focus of this paper, is for the Medicaid agency to coordinate with or delegate some activities to an existing organization that serve private employer groups. This paper will use the term cooperative healthplan purchasing organization (CHPO) to refer both to organizations formed by coalitions of large employers and to HPCs, which serve multiple smaller employers and may have been developed through state enabling legislation.

At minimum, the Medicaid agency might agree with the CHPO on common quality standards or formats for performance reporting. The two might work together on common quality standards or formats for performance reporting. The two might work together on certain activities, such as developing comparative quality information for consumers. The state might contract with the CHPO to perform some administrative functions previously performed by the Medicaid agency, such as contract negotiation or monitoring. Most broadly, the CHPO could serve as the actual purchasing entity for both Medicaid and employer groups.

For reasons to be discussed below, the extent to which Medicaid functions could be shared with or delegated to a private entity is likely to vary for different types of Medicaid beneficiaries. This paper will generally assume that coordination is most feasible for Medicaid parents and children, and less so for the aged, disabled, and other beneficiaries with special needs. Other factors, such as state procurement rules, may also affect the feasibility of the joint purchasing approach. However, there is clearly considerable room for collaboration, and there are numerous potential benefits for both the Medicaid program and the CHPO:

- Combining functions for Medicaid and employer groups could reduce duplication of effort and offer economies of scale. Medicaid and the

CHPO could share technical capabilities, for example in data analysis, that might be too costly for either to acquire on its own. Outsourcing could also give the Medicaid agency access to more highly skilled personnel than it could employ directly.

- If actual purchasing were conducted jointly, the combination of the Medicaid and CHPO populations might offer significantly enhanced bargaining power.
- By adopting common standards or data requirements, Medicaid and the CHPO could promote quality improvement by sending a unified message to health plans.
- Opportunities may exist for improving continuity of coverage for individuals or families who might shift between Medicaid and private coverage because of changing circumstances, such as pregnancy or minor fluctuations in income.
- Finally, combining Medicaid and private purchasing activities could promote the inclusion of Medicaid beneficiaries in mainstream health plans and help to reduce the welfare stigma that is still often attached to Medicaid.

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