MOVING OR MIMICKING THE MARKET?
THE OPPORTUNITIES AND CONSTRAINTS OF STATE PUBLIC
EMPLOYEE HEALTH PLANS

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AARON NANCE MCKETHAN: Moving or Mimicking the Market? The Opportunities and Constraints of State Public Employee Health Plans

(Under the direction of Daniel Gitterman, Jon Oberlander, Sudanshu Handa, Michael Sparer, and Alain Enthoven)

State public employee health plans (PEHPs) are large employer-based health purchasers. Despite their size, little is known about the roles that PEHPs, as major purchasers, can or do play in the state health care environment. This dissertation explores two competing images of PEHPs to understand: 1) what accounts for different views on the roles that PEHP purchasers play within state health care systems, 2) how have different states leveraged the purchasing practices of PEHPs in an attempt to broadly influence aspects of state health care systems, and 3) what factors have characterized the experiences of these efforts.

This dissertation finds that PEHPs represent potentially important actors in very large and sophisticated state health care systems. However, the “purchasing power” of PEHPs is not universal and immutable and is highly contingent on key political and market influences that may likewise drive PEHP policy variation across other states. It remains puzzling that policy scholars have largely ignored the roles that PEHPs, as major purchasers, can and do play in the state health care environment. Based on this initial study of PEHP policymaking
in two states, however, much more research is needed to fully understand the factors driving PEHP policymaking and the roles that PEHPs play in state health care systems.
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Chapter 1: Introduction

Public employee health plans (PEHPs) are large employer-based health plans providing health care benefits for about 13 million people across the United States, including active state employees, covered dependents, and retirees in state governments and participating local governments and other quasi-public entities. PEHPs are financed through general state revenues and premium contributions from participating public sector employers, employees, and their dependents.

As major employers (or more precisely, as the health care purchasing agents of public employers), PEHPs are responsible for an increasingly large share of state health care spending, second only to state Medicaid programs. In fiscal year 2003, the most recent year for which fifty-state comparative data are available, state spending on public employee and retiree health benefits accounted for about 16% of total state health spending (excluding the federal share), on average, up from 10% in FY 1997 (Milbank Memorial Fund 2004). Moreover, this figure does not include employer contributions from a wide range of local governments and other quasi-state entities that also purchase health benefits through PEHPs.
The “Purchasing Power” of Public Employers?

Beyond providing health care benefits for public employees and their covered dependents, it is not clear what, if any, other major roles PEHPs may play in state health policy environment or the health care market. By contrast, given their size and perceived purchasing influences, Medicare and other government purchasers have been the subject of scholarly attention regarding the broad impacts of their purchasing behaviors and contracting approaches. Specifically, such studies emphasize the “market leadership” potential of Medicare and other major public sector health care purchasers to use their purchasing and contracting processes to (instrumentally or inadvertently) induce private actors (such as managed care organizations, physicians, hospitals, and other components of health care delivery systems) to engage in activities or behaviors that they would not have engaged in otherwise.

For example, Gitterman (2000) and Mayes and Berenson (2004 and 2006) describe different aspects of the “purchasing influence” exerted by the Centers for Medicare and Medicaid Services (CMS), which is the largest buyer of hospital and physician services in the United States. Gitterman describes how CMS, by operating in an institutional and political framework under the direct control of elected officials and their political appointees, is not always motivated by the same relatively narrow profit-oriented or cost containment concerns that drive private sector purchasers (Gitterman 2000). Specifically, Gitterman explains that one consequence of the federal government establishing certain purchaser requirements for managed care organizations (MCOs) doing business with the federal
government was to lead MCOs to voluntarily adopt uniform standards for non-government business (even when not explicitly required to do so).

Mayes highlights the similar, but more dramatic (if unintended), case of Medicare’s own purchasing and contracting strategies inducing behavioral responses from private employers, who in turn sought change from providers (Mayes 2004). Specifically, they argue that the key factor influencing the private sector to move away from a fee-for-service indemnity paradigm toward managed care practices was not purely their own cost containment imperatives per se, but rather a new prospective payment system that Medicare introduced to rationalize its own costs. According to Mayes and Berenson, “In other words, before business behavior triggered the managed care revolution, it largely responded to and was an unintended consequence of [federal] government policy making: in this instance, of Medicare payment reforms” (Mayes and Berensen 2006). In turn, the growth of managed care plans stimulated a wave of hospital mergers and the formation of many large physician group practices (Gabel 1997). These examples suggest that large public purchasers can exert influence (instrumentally or inadvertently) and can achieve policy objectives outside of the traditional boundaries of public policymaking.

Other analysts have described how large private purchasers and business coalitions have also been an important “driving force” for health system change. For example, Etheredge and colleagues have suggested that large private “[e]mployers drive the health care market through a tough, price-focused competitive process to select the plans offered to workers” (Etheredge et al. 1996). Other scholars have sounded similar themes regarding the role of large employers and employer coalitions in influencing health system change at a local or regional level (Darling 1991; Lipson 1996; Lichiello 1996). Some health care
leaders have even explicitly called on employers to play a more assertive role in advancing a “high performance” health care system using their own purchasing and contracting requirements with various delivery system entities. For example, the president of The Commonwealth Fund recently wrote that, “As the largest collective purchasers of health insurance, employers can and should drive the fundamental health system reform our country needs—and that Americans want” (Davis 2007).

So what role do PEHPs play at the state level and what forms of influence do they have on the larger market? These issues raise important questions about the degree to which PEHPs, as large employer-based health plans, can leverage their positions within states to pursue varying state-level delivery system “reforms”. Specifically, opportunistic public purchasers may be able to leverage their own market power to seek certain policy objectives not via regulatory fiat or through statutory processes, but rather by exercising their roles as major health care purchasers. However, it is not clear at the outset of this dissertation whether PEHPs are well positioned to exert any such statewide purchasing impacts. The available literature is strangely silent on this issue. Despite the large (and growing) enrollments and budgets of PEHPs at the state level, little scholarly attention has focused on the key drivers of PEHP policymaking. This dissertation seeks to increase our understanding of the important role of public employee health purchasers within state health policy and the broader state health care marketplace.

What Do We Know About PEHPs?

To date, the relevant literature on public employee health plans has largely focused on employer premium contributions, purchasing strategies, and benefit design issues.
Maciejewski (1997) and Long and Marquis (1999) offer comparisons of the health benefit plans sponsored by public and private employers. Both studies find that in general, premiums for state and local governments are roughly equivalent to those found in the larger commercial marketplace. However, the authors find that public employees have been shielded from a greater proportion of premium costs (relative to private employees) as PEHPs typically offer larger employer contributions toward health insurance than private sector counterparts.

More recently, Maxwell and colleagues (2004), using interview data with senior benefit managers from PEHPs in all fifty states, explicitly compared the cost containment practices of PEHPs with large corporations in the private sector (Maxwell 2004). Consistent with other studies, the authors find that public employers typically offer employees a greater choice of carriers and pay a higher percentage of premiums, relative to typical large corporations. The Maxwell study adds that public employees have come to interpret rich health and other benefits as important components of total compensation in lieu of the higher salaries that are typically available in the private sector. While growth in state PEHP budgets is attracting increasing attention at the state level, in general there has been considerable reluctance on the part of PEHP leaders and policymakers to cut relatively generous benefits and cost sharing arrangements or to modify eligibility affecting PEHP members.

Hurley and colleagues (2006) investigate similar trends and find that even in the midst of sometimes difficult state budget challenges, modifications to health care benefits among PEHPs, including levels of cost sharing and coverage and types of offered products, have been modest (Hurley 2006). By contrast, in the private sector, employers have
embraced the thinning of benefits and more aggressive member cost sharing (Moran 2005). Thus, there is a consensus among these studies that the gradual erosion and thinning of private employer-based health benefits compared to the relative stability of public health benefits has created a lingering gap between public and private employers in the actuarial value of health benefits offered.

Only one study to date, by Watts and colleagues (2003), has (briefly) moved beyond benefit design, premiums, and related issues to consider the broader role that public employers play in the state’s health care marketplace (Watts et al. 2003). Watts and colleagues conducted site visits to twelve U.S. communities to investigate how public employers make benefit decisions and how they have altered their decisions in response to rising health care costs. Like previous authors, they explore the premium contribution strategies of state and local government employers, the extent of premium cost sharing with (or “cost shifting” to) PEHP members, and other strategies to reduce the impact of rising premiums on public budgets. The unique contribution of this study, however, lies in the authors’ brief discussion of the leadership role that public employers can play in the larger health care marketplace. As the authors describe, state governments in particular are often among the largest employers in any given state. Thus, public employers may have the potential to be market leaders through their benefit decisions. For example, their purchasing behaviors can reflect existing public values or signal new directions in public policy.

Without explicitly testing a PEHP market leadership hypothesis, Watts argues that public employers are more likely than large private employers to specifically consider the impact of their purchasing decisions on the broader health care market. By contrast, as Trude and colleagues note, the trend toward nationalization of private employers often
results in the centralization of private sector benefit decisions and a lack of direct involvement with or concern for local or state market issues (Trude 2003). By definition, public employers are much more connected to their own states. PEHPs thus have a potentially larger stake in the activities of local markets, creating opportunities and incentives for them to be involved in state and local health care issues over the long term. On the other hand, Watts concedes that public employers face unique constraints “arising from their ‘publicness’” that may limit their ability to effectively exercise forms of market leadership. In general, PEHP health care benefit decisions are made in a much more political context than those of private employers. PEHPs also face fixed budgets set by elected officials who must be cognizant of the impact of their decisions on taxpayers and other public priorities.

The brief presentation in the state health policy literature about PEHPs leaves important questions unanswered about the role that PEHPs play in state health care systems and the other key factors driving PEHP policymaking. As major purchasers of health care, PEHPs may be in a position to exhibit market leadership in important ways that could have spillover effects beyond public employees and other traditional PEHP constituencies. If so, the gap in the literature on PEHPs has overlooked an important opportunity for states considering ways to promote cost containment, health care quality, and other policy goals beyond the uses of state regulation, direct statutory change, and other efforts. On the other hand, given the size and complexity of the larger health care market, with generous (and costly) benefits liabilities, with sometimes difficult state budgetary conditions, and with the “politicization” of benefit decisions that Watts alludes to, perhaps even large and assertive
PEHPs are fairly constrained in their ability to exert market leadership in any meaningful way that could contribute to achieving important policy goals at a state level.

**Exploratory Research**

To supplement the existing knowledge base about PEHPs in preparation for this dissertation, I conducted exploratory research on a subset of twelve of the largest PEHPs in the country. For each of the twelve large PEHPs, I conducted structured telephone interviews with and collected data from PEHP executives and senior staff members. Beyond understanding the sheer enrollment/size of PEHPs, the major purpose of these interviews was to gain a more complete picture of some of the major issues and challenges that PEHPs are addressing than was available in the published literature. Additionally, I sought to better understand what roles state PEHP leaders claim that public employee purchasers play in the larger state health care marketplace.

The PEHPs in the case states collectively provided health benefits for more than 6.6 million people in 2005, including active employees, covered dependents, and retirees in state governments and participating local and other quasi-public entities (Exhibit 1.1).

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*a* A list of interviewees is included in the appendix. The sample states were selected by comparing the results of two recent national surveys (Kaiser Family Foundation/Health Educational Research Trust 2003; Segal Corporation 2003) that reported recent PEHP enrollment data. Given different enrollment accounting strategies and some missing data in these surveys, some excluded PEHPs could have larger enrollments than some that were included.
Exhibit 1.1: Enrollment in Selected State Public Employee Health Plans (PEHPs), By Member Type, 2005

<table>
<thead>
<tr>
<th>State (PEHP)</th>
<th>Employee</th>
<th>Dependent</th>
<th>Retiree</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York State Health Insurance Program</td>
<td>349,405</td>
<td>633,274</td>
<td>222,186</td>
<td>1,204,865</td>
</tr>
<tr>
<td>California Public Employees Retirement System</td>
<td>363,108</td>
<td>647,144</td>
<td>178,585</td>
<td>1,188,837</td>
</tr>
<tr>
<td>New Jersey State Health Benefits Program</td>
<td>241,051</td>
<td>441,569</td>
<td>118,401</td>
<td>801,021</td>
</tr>
<tr>
<td>Georgia Division of Public Employee Health Benefits</td>
<td>240,880</td>
<td>291,004</td>
<td>113,002</td>
<td>644,906</td>
</tr>
<tr>
<td>North Carolina State Employees’ and Retirees’ Health Plan</td>
<td>295,704</td>
<td>153,729</td>
<td>127,692</td>
<td>577,125</td>
</tr>
<tr>
<td>Texas Group Benefits Program</td>
<td>179,123</td>
<td>201,061</td>
<td>68,212</td>
<td>448,396</td>
</tr>
<tr>
<td>Florida Division of State Group Insurance Program</td>
<td>159,598</td>
<td>246,172</td>
<td>31,500</td>
<td>437,270</td>
</tr>
<tr>
<td>South Carolina Employee Insurance Program</td>
<td>172,874</td>
<td>170,931</td>
<td>58,703</td>
<td>402,508</td>
</tr>
<tr>
<td>Illinois Group Insurance Program</td>
<td>113,206</td>
<td>157,971</td>
<td>74,770</td>
<td>345,947</td>
</tr>
<tr>
<td>Massachusetts Group Insurance Commission</td>
<td>76,395</td>
<td>113,429</td>
<td>64,451</td>
<td>254,275</td>
</tr>
<tr>
<td>Mississippi State and School Employees’ Health Insurance Program</td>
<td>118,102</td>
<td>51,050</td>
<td>18,947</td>
<td>188,099</td>
</tr>
<tr>
<td>Minnesota State Employee Group Insurance Program</td>
<td>47,420</td>
<td>63,518</td>
<td>3,577</td>
<td>114,515</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,356,866</td>
<td>3,170,852</td>
<td>1,762,666</td>
<td>6,607,764</td>
</tr>
</tbody>
</table>

Source: Enrollment data provided by each PEHP
*Sequence based on descending order of total enrollment
**Texas data exclude enrollment in health maintenance organizations (HMOs) which account for about 10% of total TGBP enrollment.

According to the U.S. Statistical Abstract, these sample states account for approximately half of state and local government employment in the United States (U.S. Bureau of the Census 2005). I therefore estimate that total PEHP enrollment nationwide—including active employees, dependents, and retirees in all participating government entities—exceeded 13 million in 2005. This estimate greatly exceeds previous estimates that are derived from national surveys on PEHPs because these studies do not include (or project enrollment for) all states and exclude covered dependents and retirees. While counting PEHP members nationwide is a difficult undertaking, it is clear that omitting retirees and/or
dependents from total enrollment figures vastly understates the population of individuals receiving health care benefits through PEHP at a national level.

Financed by state-only dollars, state policymakers exercise broad discretion to design their PEHP administrative and governance structures. Discretion also includes who should be eligible for PEHP benefits, what medical benefits should be provided, and how providers should be compensated. As a result of this discretion, there is variation among states in numerous aspects of PEHPs, including governance structures, eligibility criteria, included populations, and other issues.

Not surprisingly, and consistent with previous studies, the primary and common challenge identified by PEHP leaders was the perennial difficulty of maintaining high quality benefits for a diverse and aging workforce given inflationary trends and occasional state budget shortfalls and/or recessions. As noted above, state budgets have become increasingly dominated by health care spending, most notably on Medicaid programs. PEHP spending (the second largest category of state health care spending) does not compare with spending on Medicaid programs in absolute dollars or as a percentage of total state health spending (Milbank Memorial Fund 2004). Nonetheless, PEHP spending has been growing as a percentage of total health care expenditures. Rising health care costs raise difficult questions for PEHP leaders and state policymakers required to balance state budgets each year.

Given the common challenge of rising health care costs, cost containment is high on the agenda of all PEHP leaders and policymakers. Like major private employers, PEHPs are experimenting with numerous cost containment strategies, including disease and case
management, more aggressive management of pharmacy benefits, and contracting with managed care plans. Cost containment issues and strategies are discussed in more detail in the brief literature on PEHPs discussed above.

Importantly, interviewing state PEHP leaders about their cost containment options and choices revealed different attitudes and views regarding state PEHPs’ roles in their respective state health policy environments. In three of the 12 case states that I examined in exploratory research – including Massachusetts, Minnesota, and California – PEHP leaders described how their recent cost containment and broader purchasing efforts were either designed specifically with the larger state market in mind or were nonetheless expected to have important spillover impacts on the larger state health care marketplace.

For example, facing annual premium increases that averaged 14% per year for the last four years, the California Public Employees Retirement System (CalPERS) recently launched several new cost containment efforts, including the Narrow Network Initiative (NNI) in 2004 (Grevious 2006). Specifically, CalPERS’ NNI has the goal of yielding cost savings and quality improvement by, in conjunction with Blue Shield of California (BSC), restricting the BSC health maintenance organization (HMO) provider network to hospitals and affiliated medical groups that demonstrate lower costs and certain quality process outcomes. The NNI relies on all patient refined–diagnosis-related groups (APR-DRGs) to assess network providers’ relative cost and quality. Affected members must either stop using out-of-network hospitals and affiliated physicians or enroll in different CalPERS plan options that retain these providers in network and cost more.
According to the interview, the NNI initiative is primarily focused on achieving cost savings for constituent employers that purchase health benefits through CalPERS. However, CalPERS is a very large health care purchaser in California. Moreover, private employer groups, not just CalPERS, contract with the Blue Shield network. Thus, CalPERS officials discussed the potential spillover impacts that the NNI is expected to have on the larger health care marketplace in California if the initiative is successful. Specifically, the impacts associated with providers changing their practice patterns to accommodate CalPERS purchaser requirements would presumably affect non-CalPERS members as well since providers and other delivery system stakeholders would be unlikely to differentiate CalPERS members from other patients. Again, this is a theory that requires testing, but it does speak to the broader issue about PEHPs’ potential roles in the state health care arena.

A similar (but still distinctive) initiative is underway in Minnesota. In 2002, the Minnesota State Employee Group Insurance Program (SEGIP) introduced a new self-insured purchasing model (Advantage) that tiers providers at the group-practice level (Haugen 2006). All SEGIP members are enrolled in the program, which grew out of the earlier efforts of a state coalition of large private and public employers in the Buyers Health Care Action Group (BHCAG). The Advantage program ranks more than fifty “care systems” based on their risk-adjusted costs. Care systems are then assigned to one of four cost tiers as determined by claims experience, risk adjustment, actuarial models, and collective bargaining. Members select their care system and pay higher co-payments, deductibles, and coinsurance when using higher-cost clinic groups.

Three private carriers are contracted as third-party administrators providing a uniform and comprehensive set of benefits. Instead of differentiating members’ premiums among
health plans, the Advantage program differentiates price distinctions among care systems at the point of service delivery. PEHP executives in Minnesota claimed that as a result of the Advantage program, the SEGIP experienced no cost increase from 2005 to 2006 (which, if directly attributable to Advantage, is certainly noteworthy). Like the California effort described above, the PEHP effort in Minnesota suggests (but does not confirm) the important role that the PEHP has played by participating in a large employer coalition (the Buyer’s Health Care Action Group) and helping to structure the new Advantage plan in a way that is said to benefit both state government (i.e., the SEGIP) as well as other private employers participating in the initiative. Again, it is important to assess and verify the claims made by PEHP executives that were interviewed. Nonetheless, the Minnesota effort also speaks to a potentially broader role for PEHPs beyond their traditional constituencies.

Finally, the Massachusetts Group Insurance Commission (GIC) recently undertook an initiative to profile and tier individual providers based on their relative quality and cost-effectiveness (Mitchell 2006). The Clinical Performance Improvement (CPI) initiative requires participating private health plans to submit aggregate medical, mental health, and pharmacy claims data to create a consolidated database to support individual-level provider profiling. All participating GIC health plans use this information, based on longitudinal episode treatment groups (ETGs), to assign physicians and hospitals to two tiers. Members pay different co-payments depending on whether they select providers assigned to different tiers. Three of the participating health plans are also tiering hospitals. In sum, the GIC, as a large health care purchaser, requires participating health plans to submit data and adopt new practices in their relationships with consumers and providers. Because the GIC is the single largest customer in Massachusetts for several of the private health plans participating in the
GIC, interviewees claim that the state’s new purchaser requirements are inducing participating health plans to change their contracting relationships with health care providers in ways that, in turn, are affecting the practice patterns of non-GIC delivery system stakeholders. Once again, these claims require further analysis and careful scrutiny, but like the California and Minnesota efforts, they do suggest the broader role that PEHP executives and policymakers have in mind when they make purchasing and other decisions for the PEHP.

These approaches did not originate with state PEHPs in recent years. Private employers experimenting with similar efforts in the last several years have reported major administrative difficulties and other hurdles (Mays 2003; Draper, Liebhaber, and Ginsburg 2007). Similarly, even in brief exploratory interviews, it is apparent that the recent PEHP efforts profiled above have also been technically challenging, necessitating sizable investments to develop the data capacity necessary to collect and analyze risk-adjusted clinical information at the individual provider or group level. Moreover, based on initial exploratory research, these PEHPs have also faced numerous political obstacles, including resistant provider groups wary of methodologies used to rate individual providers based on efficiency.

Despite these challenges and obstacles, given that some PEHP leaders explicitly couch their initiatives with “half an eye on the larger market in the state”, these claims are noteworthy for any examination seeking to better understand the roles that PEHPs play or are perceived to play in state health care markets and policy environments (Mitchell interview 2006). Beyond these three ambitious states, however, most other PEHP interviewees in sample states were less sanguine about the broader roles of PEHPs within the
larger health care market. These PEHPs described their cost containment and other initiatives mainly in terms of achieving policy objectives (e.g., mitigating cost increases) specifically for the state PEHP itself, with much less explicit focus on influencing the larger state health care marketplace or contributing significantly to the larger state health policy goals.

Thus, from the available literature and from my early exploratory research on trends in the twelve largest state public employee health plan purchasers, two competing views emerge of PEHPs and their roles in state health care policy. First, the three “snapshots” of recent PEHP initiatives in California, Massachusetts, and Minnesota derived from early exploratory research suggest a potentially broader role for PEHPs in the larger state health care policy arena than merely providing health care benefits for state workers and other traditional constituencies. Thus, one view is that through their PEHP purchasing and contracting decisions, states may be able to pursue particular statewide policy objectives not via regulatory fiat or through statutory processes, but rather through their roles as health care purchasers. A second view of PEHPs and PEHP policymaking has also emerged. Namely, given myriad financial, political, and market constraints, PEHPs are unable to yield considerable influence in “reforming” the state delivery system or achieving other goals through their purchasing and contracting approaches and other activities. This latter view was expressed by officials in several states, including North Carolina. Interestingly, interviews in North Carolina suggested that even though North Carolina’s was a very large PEHP (with over 600,000 covered lives), previous efforts to use the PEHP as part of a larger state effort to “fundamentally alter the competitive landscape” fell victim to myriad political, market, and other challenges. This dissertation will assess the competing views of the
opportunities and constraints of PEHPs in greater detail, with a specific focus on Massachusetts and North Carolina.

**Overview of Research Questions**

This dissertation explores recent policymaking activities among PEHPs in these two states to gain greater insight into the opportunities and constraints of PEHPs in state health care markets and policymaking environments. Three key policy questions motivating this research are: 1) what accounts for the different roles (or the different views on roles) that PEHPs play within the state health care environment, 2) how have different states leveraged the purchasing practices of PEHPs in an attempt to broadly influence aspects of the health care delivery system, and 3) what factors help to account for the successes or limitations of the experiences of these efforts.

These two case study states were selected to examine PEHP efforts to promote cost containment-related “reform” initiatives within two different policy and political environments (and at different times). Specifically, according to preliminary exploratory research, Massachusetts stands out as a state currently and actively involved in an ambitious effort to exert its purchasing influence to benefit not only the state itself, but also the state’s health care system more broadly. North Carolina, by contrast, stands out as a state that articulated a more limited view of the “role” of the PEHP in state health care policymaking, having previously attempted to use the PEHP as a platform for broad delivery system reform (case selection methods discussed in Chapter 3). Exploring the efforts of these two state PEHPs affords an opportunity to examine PEHP decision-making and development in states of different sizes, states with different reputations for or inclinations toward health reform,
states with different political characteristics, and states with very different health care markets.

This approach also allows for a specific focus on how politics and the features of PEHPs themselves help shape PEHP policymaking. In Massachusetts, for example, the PEHP is driven by a strong-willed executive director and commissioners that exercise considerable political autonomy with little direct oversight from state legislators and the governor. The PEHP in North Carolina, too, is governed by a board of directors, but state legislators historically have wielded much more political influence and oversight over the operations and strategy of PEHP policymaking. Thus, this dissertation will explore how political influences affecting PEHPs are filtered or manifested in different ways in each state in part due to different (and evolving) governance structures and leadership. I will explore how these issues may in turn influence the larger roles that these PEHPs play (or are perceived to play) in states’ health care policy arenas.

In addition to exploring how the political features of PEHPs help shape their policymaking, this dissertation will also assess the degree to which PEHP politics and policymaking is rooted in the broader market environments in which PEHP leaders operate. State market conditions vary from state to state. Notwithstanding the enthusiasm of ambitious PEHP efforts to “reform” the delivery system in their respective states, for example, even the most aggressive and assertive public (or private) purchaser is likely to face significant obstacles to overcome market “inertia” at the state level.

The dissertation is divided into six chapters. After this introductory chapter, Chapter 2 reviews relevant literature on the key factors influencing cross state variation in state
health policy and contains the hypotheses that will be tested in a comparative analysis of the two case states. Chapter 3 describes the research methods and data used in case studies of PEHP policymaking in Massachusetts and North Carolina. These case studies appear in Chapters 4 and 5, respectively. Finally, Chapter 6 provides cross-case conclusions, comparing and contrasting PEHP policymaking in each case state and considering the opportunities and limits of PEHPs as components of state health policy. It also discusses some of the major challenges emerging on the horizon (e.g., new accounting standards) to draw additional conclusions about PEHP politics, public policy, and opportunities for additional research.
Chapter 2: Key Research Questions

Key Questions

As discussed in Chapter 1, there has been a dearth of scholarship focusing on the factors influencing PEHP policymaking and the “purchasing influence” role that PEHPs play within state health care policy environments. Given PEHPs’ large enrollments and budgets, some state PEHP leaders view PEHPs as especially important players in the state health care arena beyond the provision of insurance and other benefits to primary PEHP constituencies (including public employees, retirees, and their dependents). By actively asserting the “purchasing influence” of the state as a major employer, some state PEHPs seek to explicitly use their respective contracting processes to yield cost containment and other benefits that are expected to benefit PEHPs themselves and also the state health care system as a whole. By contrast, preliminary exploratory research also identified other PEHPs whose leaders are much less sanguine about the larger roles that PEHPs play in the state health care marketplace. These state PEHP leaders suggested a more limited ability for state PEHPs to assert meaningful influence to “reform” the state delivery system in various ways.
Three key policy questions are: 1) why do some state PEHPs (and not others) optimistically promote the “spillover effects” that their PEHP purchasing and contracting strategies may have to benefit the state market as a whole; 2) what are the key factors characterizing PEHP policymaking that enable state PEHPs to assert themselves in different ways as part of the broader state health policy environment; and 3) what are the key factors that may constrain or limit state efforts to use PEHPs to pursue broad statewide policy objectives.

This dissertation is not a comprehensive evaluation of the various cost containment and other efforts undertaken by different states per se. Nor is it an exhaustive historical account of PEHP political or institutional development. Rather, it is a political and policy analysis that seeks to understand the different experiences of states in undertaking initiatives with the broader state health care market in mind and the factors influencing these experiences.

This dissertation uses theory developed to explain cross-state policy variation and serves to define a context for better understanding PEHP policymaking. Explaining cross-state variation in numerous policy areas has been viewed and analyzed through the lens of political science and public policy literatures. Specifically, scholars have noted the critical importance of various political, socio-economic, and cultural factors (discussed in detail below) that help to explain state-to-state policy variation. Absent a developed theory of PEHP policymaking, these political science and public policy literatures were used to help develop an explanatory framework about PEHP policymaking and the variation in state experiences using PEHPs to address broad policy problems at the state level.
In addition to state level factors likely to influence variation in state PEHP policy, this dissertation also considers the role of particular PEHP-specific factors or variables (as distinct from state-level issues) that help to influence PEHP policy choices and experiences. These include the systems of governance (formal and informal) that characterize who controls PEHPs and how PEHP policy decisions are made. Specifically, the key variables of interest for this dissertation, which include political, market, “cultural” and other factors, are discussed in specific detail below:

**Political**
- Partisan political landscape
- Interest groups
- State political culture

**Market**
- State wealth
- State health care marketplace

**Cultural/Other**
- State policy innovation
- PEHP governance structure/bureaucratic autonomy
- Policy entrepreneurship and leadership

For the purposes of describing the literatures associated with each of these variables in the remaining portion of this chapter, as well as for analytical purposes in case studies, I have grouped political, market, and cultural/other factors based on their respective levels of analysis, including state- and PEHP-specific factors, as below:
State-level factors:
- Partisan political landscape
- State wealth
- Interest groups
- State political culture
- State policy innovation
- State health care marketplace

PEHP-level factors:
- PEHP governance structure/bureaucratic autonomy
- Policy entrepreneurship and leadership

Some of these variables were used to help select case states by ensuring that variation exists among key independent variables. Other variables were explicitly examined in the case analyses themselves. In the next section, I describe each variable’s treatment in the broader political science and public policy literatures and explain how and why they were expected to play a role in this study. Then, I explore the analytical approach of this dissertation and the rationale for selecting particular case states. Finally, I discuss the expected outcomes of this dissertation and the strengths and limitations of the particular research approach.

The rest of this chapter reviews the relevant political science and policy literatures concerning the factors that appear likely to influence PEHP policymaking, including relevant hypotheses to guide the rest of this dissertation.

**Key Variables**

*State-Specific Factors*
Partisan Political Landscape

A longstanding theoretical tradition in political science, particularly studies of welfare policy variation at the state level, supports the notion that particular policy choices reflect two important features of state electoral systems. The first is the degree of inter-party competition within states. In his classic analysis, *Southern Politics*, Key (1949) argued that the policy process is more likely to respond to the needs of disadvantaged people, for example, when political parties are more evenly matched and forced to contend with one another by mobilizing and swaying voters. According to Key, states in which two vigorously competitive political parties compete with each other are associated with more generous welfare programs than those states in which single parties dominate. While this dissertation does not focus on welfare generosity per se, it incorporates partisan competition and political control within states since these issues represent longstanding explanations for cross-state public policy variation in the political science literature.

Scholars in the 1950s and 1960s investigating similar phenomena reached similar conclusions as Key. For example, Lockard (1959) and Fenton (1966) both found in their studies of regional politics that two-party states were more likely to be associated with particular policy choices relative to states in which one party dominates. While some analysts have cast doubt on the general argument that political party configurations play an important role in different policy outcomes (Dawson and Robinson 1963; Boyne 1985), others have increasingly used fifty-state statistical analyses (as opposed to regional studies) and have continued to reach similar conclusions about the importance of political variables in explaining cross-state variation in public policy choices.
Scholars continued to cite the intensity and nature of state party competition into the late 1980s until the present. For example, recent studies have suggested that states with more competitive elections tend to produce more liberal social policies (Brace and Jewett 1995; Holbrook and Van Dunk 1993). Other analysts have questioned, more generally, whether governments under divided political control can make difficult choices and respond effectively to budgetary crises (Cutler 1989; Sundquist 1988) or coordinate to raise taxes (Roubini and Sachs 1989). Faced with a recession or budget deficit, states with split legislatures may act less aggressively to eliminate deficits more quickly relative to states where one party exercises greater political power (Alt and Lowry 1994; Poterba 1994). Other analysts have found that partisan effects on spending at the state level are more modest (Erikson, Wright, and McIver 1989). Nonetheless, while these larger streams of studies contain numerous sub-debates and issues that scholars continue to explore, the more general insight for the purposes of this dissertation is that the nature of political party competition can contribute to cross state variation in public policy choices at the state level.

In addition, scholars have found that the political performance and domination of particular parties matters as well. For example, Paul-Shaheen has noted in her review of comprehensive state health care reform initiatives that “the predominance of Democrats among them is somewhat striking” (Paul-Shaheen 1998). Democratically-controlled states, it has been argued, are more likely to be associated with the emergence of particular policy efforts (e.g., more expansive regulatory efforts or proposals to expand access to public health insurance coverage) while Republican states are associated with others. For example, when the Balanced Budget Act of 1997 provided states with discretion in how they structured new federally-subsidized state child health insurance programs, Beamer (2004) noted that states
with Republican-led governments were more likely to enact separate children’s health insurance programs rather than Medicaid expansion programs. This difference, he noted, is related to Republicans’ political and ideological concerns about cost cutting and expansive public programs for poor citizens. There may be some validity to the theory that Democrats favor more government intervention than Republicans. However, recent anecdotes in the health policy arena in Massachusetts and California, in which Republican governors and Democratic legislators have worked together to champion comprehensive health care reform initiatives (or proposals), suggest that political domination by one party or another may not be a sole factor in explaining cross state variation in health reform.

Nonetheless, state partisan political environments are expected to impact the policy choices of PEHPs from state to state. Absent a coherent body of theory addressing the politics of PEHPs, it is not clear at the outset whether Democrats or Republicans are more likely to be active participants in PEHP policymaking, and what partisan political configuration and identification might mean for their determination or motivation to leverage the purchasing power of PEHPs to pursue statewide policy goals. Nor it is altogether clear what impact, if any, split legislatures may have on PEHP policymaking. Nonetheless, I hypothesize that states in which Democrats have more dominant and consistent control over state policymaking will be more likely to embrace an “opportunistic” view of PEHPs’ roles within state health policy and market environments.

Accordingly, these states will be more likely to assert the purchasing influence of PEHPs to seek reforms of the state health care environment compared to states in which Republicans have achieved more electoral success. Moreover, I further hypothesize that
split legislatures (in which partisan control of legislative and governor’s offices is split) will be less likely to view state PEHPs as avenues to achieve broad statewide policy reform.

State Wealth

In addition to political dynamics at the state level, another factor that has been evaluated extensively in the state policy literature as a determinant of cross state policy variation is the importance of the socio-economic conditions of states themselves. State wealth has long been a fixture in state policy variation studies. By including socio-economic data along with political data in their fifty-state models, for example, Dawson and Robinson (1963) concluded that variation in states’ per capita income is one of the most important factors influencing cross state variation in policy choices. Others scholars that have supported the socio-economic thesis include Dye (1966), Lewis-Beck (1977), Davidson (1978). According to these and other scholars, variation in the degree of state wealth is the most important predictor of a number of political and policy outcomes. The latter scholar cited above, Davidson, explicitly explored the relationship between state wealth and Medicaid variation, and found that greater wealth is associated with more liberal Medicaid benefits and eligibility. In the 1980s and into the 1990s, fewer scholars cited socio-economic explanations as the predominant factor explaining cross-state policy variation. Rather, scholars have developed models that encompass both political and economic variables (Plotnick and Winters 1985; Barrilleaux and Miller 1988; Reutzel 1989; Peterson and Rom 1990).

The consensus hypothesis with respect to state fiscal health is that the greater the amount of resources available to a state, the more likely it is that the state can afford to
undertake more stringent regulation or adopt policy innovations (Williams and Matheny 1983; Lowry 1992). Here again, the broader insight is that state wealth, or more specifically, the economic status of states’ citizens, are important factors influencing the policy direction of state policymakers. Applied to PEHP policymaking, a state’s economic development and state wealth are expected to similarly influence more wealthy states to view PEHPs as important components of state health policy. These states are likely to more aggressively use the purchasing influence of PEHPs to seek delivery system and other reforms at the state level.

**Interest Groups**

Political scientists have long studied the ability of organized interest groups to play a significant role in the policy process (Smith 1995). The formulation and adoption of public policy is shaped by conflicts and competition between interest groups (Baumgartner and Leech 1998). Thus, according to interest group theory, public policy can be viewed as reflecting the interests of dominant groups at any given time. At the federal level, the classic interpretations about health care policy reform at the national level are dominated by discussions concerning the role of powerful interest groups loathe to have the policy system challenge the status quo. This storyline lies at the heart of the standard view of the failure of Clinton Administration’s national health care plan in the early 1990s, for example. Many scholars (West, Heith, and Goodwin 1996; Weisert and Weisert 2002; Jamieson 1994; West and Loomis 1999) and journalists (Johnson and Broder 1996) suggested that the influence of powerful interests representing the health care industry was an important reason that the legislation was not successful in even being voted upon before being permanently tabled.
At the state level, prior work on state health policy has generated conflicting results about the role of organized interests. Recently, for example, a study by Gray, Lowery, and Godwin (2005) yielded mixed results when examining how the composition of state interest groups (or “interest communities”) influenced the adoption of managed care regulations during the 1990s. However, in their previous examination of drug assistance laws, the same group of scholars found that the composition of state interest communities had little impact on policy adoption (Gray, Lowery, and Godwin 2004).

In other policy areas, organized interests have long been seen as major forces in the policymaking process (Thomas and Hrebenar 1996). According to several scholars, specific interest groups – representing business, labor, agriculture, local governments, and education, among others – dominated state policymaking before the 1960s (Thomas and Hrebenar 1991, 1999; Zeigler 1983). Since the 1960s, however, the number and types of organized interests working at the state level have expanded significantly (Gray and Lowery 1993; Nownes and Freeman 1998; Thomas and Hrebenar 1991, 1999). As devolution has shifted enormous policy responsibility for many programs to the states, state interest group activity has increased correspondingly (Gray and Lowery, 1993; Thomas and Hrebenar 1991, 1996). However, despite the rise of new groups as well as new forms of interest group influence on the policymaking process, research has demonstrated that traditional organized interest groups, such as those representing business, remain the most influential in state policymaking (Thomas and Hrebenar 1991, 1996; Grogan 1994).

Factors that help to influence why interest groups appear to play a more important role in some cases than others has to do with the nature of policy development of interest. Recently, scholars, including Gray (1993) and Grogan (1994) have recognized that the
political and other drivers of policy decisions can vary depending on the particular policy domain in question. Grogan cites as an illustration the proposition that redistributional policies such as tax rates fit the rational-activist model because it is usually a high profile policy area receiving a significant amount of media attention that, symbolically at least, affects all voters.

On the other hand, theories emphasizing interest groups provide more coherent explanations for distributive policies, such as physician or hospital payment issues. Here, the interests of health providers are intense and important (as it directly affects their own incomes). Health care spending represents these interests’ revenue, and hence they typically oppose efforts that threaten their income. Moreover, such groups are typically well-organized, well-funded, and politically connected. They can thus can take advantage of political mechanisms, such as lobbying state legislators directly or via trade associations, to block efforts deemed hostile to their interests. Provider groups are likely to be very interested and aware of issues associated with PEHP cost containment and contracting requirements. After all, at a national level, numerous scholars have classified the American Medical Association (AMA) and the American Hospital Association (AHA) as among the most powerful and influential interest groups (Milbrath 1970; Starr 1982; Marmor 1983). At the state level, provider groups such as medical and specialty societies and hospital associations typically exert strong influence on public policy, particularly when they view policy change as a threat to their income, professional autonomy, or reputation (Begun, Crowe, and Feldman 1981).

By contrast, within this policy domain, the interests of the general public are relatively diffuse. I argue that the public at large is not particularly attentive to the ways in
which PEHP contain costs or enact purchaser requirements, such as provider reimbursement policies. Stigler's (1972) theory of regulation and Lowi’s interest group and policy typologies (1964) are instructive in forming a basic rationale for this political dynamic. The limited involvement of the voting public is due to low levels of public knowledge and limited direct connections to such policies (Stiglar 1972; Begun et al. 1981). Instead of focusing on the rising costs of health care benefits for state workers and their dependents, taxpayers and organizations that are concerned about growing state health care costs typically direct their ire to a much larger component of state health spending: Medicaid. While most voters are not directly enrolled in Medicaid themselves, Medicaid politics generates broader symbolic appeal that is associated with states’ larger roles in welfare provision and budgetary growth. Thus, the voting public is relatively more concerned about Medicaid policy (and specifically, Medicaid budget growth) than PEHP policy.

By contrast, health care provider groups can recognize potentially significant gains or losses associated with PEHP provider reimbursement and other purchaser requirements or contracting approaches. Hence, providers are more likely to engage in the political process over, for example, reimbursement issues. I argue that the activity and mobilization of provider interest groups shape state PEHPs’ perceptions and expectations about the roles that PEHPs play within the larger state health care marketplace. Assertive, well-organized, and well-financed provider groups can thus serve as a major constraint for PEHPs to leverage their purchasing influence seeking policy change at the state level. Thus, I hypothesize that the activity and mobilization of provider interest groups is negatively correlated with state officials’ willingness or assertiveness to leverage PEHPs in ways that are perceived to directly affect providers’ income, professional autonomy, or reputation. PEHP purchaser
efforts that are perceived to pose a serious threat to interests invested in maintaining the status quo (including physicians, hospitals, insurers, and others) are less likely to emerge in states in which these interests strongly influence the political and policy environment.

Health care providers and health plans are not the only stakeholders or “interests” likely to express positions on PEHP policy efforts. According to Zeiglar (1983), the most influential interest groups at the state level tend to be from business and professional associations (Zeiglar 1983). According to Grogan and others, organized labor, including state teachers' associations, also continue to be among the most effective interests in the states (Grogan 1994; Thomas and Hrebenar 1991, 1996, 1999). Research shows that these traditional organized interest groups have been able to retain their influence and power because they have maintained long-standing “insider relations” with state legislators (Thomas and Hrebenar 1999). Traditional “insider” groups have developed symbiotic relationships with state legislators such that state governments have come to depend on them in the long-term.

Labor unions or employee associations represent another type of “interest” present and active in some states and not in others. While private sector union activity has waned in recent decades, many state and local government workforces are unionized to varying degrees, with union representatives playing sometimes powerful roles in employee compensation decisions (Watts 2003). In some cases, union representatives sit on PEHP governing boards. In other cases, union representatives play legally proscribed roles in collectively bargaining benefits and other policy choices. In still other cases, unions have limited, if any, roles. Strong public employee unions may influence the cost containment strategies of PEHPs in myriad ways.
For the purposes of this dissertation, it is not clear at the outset about how the presence of unions impacts state efforts to “leverage” the state PEHP to achieve broad public policy goals for the state. That said, labor unions are unlikely to embrace policy efforts that are perceived to limit or reduce the generosity of benefits, provider access, or other issues for state workers and retirees. States with a strong public employee union presence are likely to be slower (or more reluctant) to modify (heretofore generous) PEHP benefits and cost sharing. According to a recent study of public sector purchasers, the impact of unions in communities with active unions was to maintain a richer benefit package than in the private sector (Watts 2003). Thus, union leadership is expected to influence state PEHPs to focus their policy strategies on efforts that retain generous benefits and cost sharing provisions for PEHP members. Additionally, assertive public unions wary of fewer provider options are also expected to oppose and actively work against any strategies that are perceived to limit provider networks or otherwise limit member access to health care providers (e.g., by higher co-pays for accessing certain providers).

*State Political Culture*

Numerous studies about state politics and policy have incorporated the concept of political culture to help shed light on the variations in state political characteristics or policy approaches (Elazar, Sharkansky and Hofferbert 1969; Sharkansky 1970). In general, states’ political cultures reflect their general levels of ambivalence about government and degree of support for public action in the policy arena. These studies involve presenting evidence that cultural variations, independent from political or economic variations, help account for state political or policy characteristics.
Elazar (1966) famously developed a theory and classification of American political culture that depicts the boundaries of what states historically constitute as proper government action. Specifically, he suggested that culture is a combination of three political sub-cultures: moralistic, individualistic, and traditionalistic. Each embodies a different perspective about the “appropriate” role of government, citizens' roles in government, and the political process. For example, those in moralistic states tend to view political activity as a way to improve the conditions of society. Accordingly, policymakers in such states are most likely to champion or embrace broad public programs. On the other end of the spectrum, public officials in predominantly traditionalistic states view political activity as more limited. Politicians in individualistic states tend to occupy a middle ground between moralistic and traditionalistic states. Individualistic cultures tend to support government intervention to the degree that it can maintain the order of the marketplace.

Other “political culture” theorists criticize Elazar’s typology, arguing instead that classifying states as “liberal” or “conservative” is a more useful measure of political culture. The general argument here is that within the welfare arena, for example, liberal states are more likely to support more expansive or “generous” welfare programs (Klingman and Lammers 1984; Buchanan 1987). Analysts have written about the role of political culture in blocking health care reform at the national level. Importantly, however, political culture is not homogeneous throughout the United States. Previous research indicates that government culture and ideology vary significantly across the states (Berry et al. 1998). Thus, one might expect state policy choices to be shaped by the ideologies of current elected officials, which itself is a reflection of states’ political culture.
Ideology and political culture seem to have played a somewhat varied role in state health and welfare policy over the last two decades. In the state welfare arena, for example, conservative states are more likely to support more meager benefit packages and restrictive eligibility rules (Rom 1999). In the health policy arena, Barrilleaux, Brace, and Dangremond (1994) found state ideology to be the strongest predictor of a set of health policy reforms adopted by states. Gray, Lowery, and Godwin (2004, 2005) found that opinion liberalism was strongly associated with the adoption of pharmaceutical assistance legislation, but had little impact on the adoption of HMO regulations. The same authors found nearly the reverse pattern for partisan control of government, with Democratic control of the governor’s office and legislature having little impact on the probability of adopting pharmaceutical assistance programs, but a significant impact on HMO regulation. Thus, ideology and partisan control can be viewed as separate phenomena for the purposes of investigating the factors influencing policy variation.

In the domain of PEHP policymaking, states are not (as directly) affected by federal rules or financing (relative to Medicaid politics and policy). Thus, states enjoy significant flexibility to make PEHP policy choices in accordance with their own political cultures. Accordingly, this dissertation will incorporate political culture by ensuring that the case states chosen for analysis vary according to Elazar’s (1966) and Sharkansky’s (1969) much-used political culture index measures as well as Klingman and Lammers (1984) and Buchanan’s (1987) liberal-conservative measures. The standard method used to operationalize Elazar’s conception of political culture is to use an additive scale developed by Sharkansky (1969) ranging from 1 (purely moralistic) to 9 (purely traditionalistic). Measures of state political culture operationalized using Elazar’s political culture construct
have not changed much over many decades (Morgan and Watson 1991). Therefore, I will ensure that case states selected for this analysis vary using Elazar’s political culture construct as developed by Sharkansky. With respect to Klingman and Lammers (1984) and Buchanan’s (1987) liberal-conservative typologies, both assign Massachusetts to a “liberal” state and North Carolina as a “conservative” state.

I have mixed expectations about the impact of state political culture on states’ efforts to achieve health care reform through the purchasing practices of state PEHPs. On the one hand, I predict that more conservative, traditionalistic states, whose policymakers are in general more likely than counterparts in more liberal moralistic and individualistic states to have a more limited view of the role of government, will be less likely to hold an opportunistic view about the role of PEHPs in state policymaking. On the other hand, individualistic and moralistic states are probably more likely to engage in innovative efforts wielding the purchasing clout of the state to help achieve broader policy goals.

These expectations are compatible with the rather optimistic views of PEHP purchasing power that I identified in initial exploratory interviews in Massachusetts, Minnesota, and California. However, this view counters what is known at the outset about North Carolina’s previous efforts to use the PEHP to help guide the development of HMOs in North Carolina. Nonetheless, this view does fit the current pattern that emerged from exploratory interviews in traditionalistic states, including North Carolina, concerning the comparatively modest view of PEHPs’ larger roles in state health care policymaking.
Another important tradition in political science research suggests that states are characterized by general orientations toward innovation, with some tending to be policy leaders and others laggards. According to Polsby (1984), policy innovations have three common characteristics: They are highly visible phenomena to political actors and observers, they are representative of a departure from past governmental practices, and they have lasting societal or institutional effects. Most empirical research in this area has focused on the question of what factors predict state tendencies toward innovation (Walker 1969, 1971; Gray 1973; Berry and Berry 1990; Skocpol et al. 1993; Soule and Zylan 1997; Lieberman and Shaw, 2000).

In a 1969 study, for example, Walker argued that states with higher incomes, higher levels of educational attainment, and greater degrees of urbanization are typically the most frequent leaders among states in policy innovation (Walker 1969). By contrast, Gray (1973) responded that to understand state policy innovation, much depends on the particular policy arena under investigation. In general, though, the key claim underlying this and other analyses has been that state responses to particular policy choices are likely to reflect a fundamental and somewhat stable propensity toward innovation (Gray 1973).

While the general ideological and political shifts occurring over time at the state and national levels have been towards a more conservative, incremental politics, there has also been significant interest in some states in policy innovation, particularly in the health policy arena. This dissertation views PEHP policymaking as potential venues for policy innovation. I hypothesize that state policymakers’ interpretations of the role of PEHPs in the
larger state health care marketplace and the innovative uses of PEHPs for larger policy purposes will be associated with states’ general reputations for innovation. That is, states with a stronger tendency toward health and welfare policy innovation in general will be likely to view PEHP as important instruments of state health care policy and will attempt to wield PEHP purchasing power more assertively for broader policy purposes.

State Health Care Marketplace

State health care markets vary considerably from state to state. For example, HMO penetration, a key measure of the structure and organization of state health care markets, is much greater in some states than others. Theoretically, HMOs are designed to hold down the costs of medical care through their ability to restrict provider networks and use numerous medical management techniques. In the early 1990s, HMOs were viewed by many as a key solution to the perceived crisis in health costs care by both liberals and conservatives. However, the severe backlash against HMOs’ restrictive provider networks and other restrictions on services developed by the mid-1990s. As a result, HMO enrollments dropped by the end of the decade in most states.

Today, HMOs more closely resemble open-access preferred provider organizations (PPOs) by relaxing provider network and service restrictions. Nonetheless, even if HMOs have lost much of their cost containment capacity in the post-managed care era, HMOs in some states are still viewed as influential organizations that are subject to state policy attention (Gray, Lowery, and Godwin 2005). Despite rapid change in the HMO market, cross-state variation remains in the degree to which employers and consumers have embraced forms of managed care.
The policy options available to a given state will depend heavily on the nature and structure of the health care marketplace that exists within that state. For example, in states with significant rural populations and few providers per capita, health care purchasers such as PEHPs may encounter greater difficulty negotiating aggressively with local provider groups because doing so could limit access to care for health care consumers. The threat of network exclusion is attenuated when provider groups know that they are the “only game in town”. However, in more densely populated metropolitan states in which numerous hospitals and physician groups compete for patient volume, employers may be able to wield the threat of network exclusion to yield different health care prices or contractual agreements. Thus, different policy options may be available depending on the nature of the market itself.

I expect to find that the political impetus for particular cost containment or other types of reforms using PEHPs will be closely associated with states’ market structures. On one hand, policymakers in states with strong indemnity dominated marketplaces will be more likely than HMO-friendly states to use PEHPs instrumentally to stimulate broad health system change. After all, states characterized by relatively high-cost and inefficient delivery systems have the most to gain by using PEHPs as instruments of reform. On the other hand, the existence of broad health plan competition and overlapping provider groups and delivery systems gives states more options to use HMO competition within PEHPs for broader policy purposes. States with few HMOs or low HMO penetration obviously have fewer opportunities to leverage HMO plan competition in an attempt to contain costs.

The above discussion generates apparently conflicting expectations about how market characteristics (e.g., HMO penetration) may affect the strategies of policymakers to
leverage PEHPs to yield statewide policy or market change. I argue that states with greater HMO market penetration are more likely to use HMOs as part of a broader strategy to yield cost containment benefits for the state as a whole. I also argue, though, that states without a strong HMO presence have a strong political impetus for reform seeking to reduce the domination of traditional fee-for-service delivery systems. This dissertation seeks to test these theories.

**PEHP-Specific Factors**

In addition to the numerous state-level variables described above, this dissertation will also explore the impact of particular design features associated with PEHPs themselves. As noted in the previous chapter, PEHPs are financed by state-only dollars (as well as premium contributions from local employers and PEHP members) and states have broad discretion to make policy choices regarding institutional design, eligibility, benefit packages, and other issues. Therefore, state PEHPs in particular states face different sets of institutional and political challenges according to their particular features. Below I describe several such factors that are included in my analysis of PEHP policymaking.

**Governance Structure and Bureaucratic Autonomy**

Based on exploratory research, states appear to vary in the degree to which governors and legislatures are directly involved in PEHP policymaking and oversight, including the selection of governing boards or agencies. From a cursory and very preliminary review of PEHP policymaking in several states, some state PEHPs appear to be governed by strong boards of directors or commissioners that exercise important powers or autonomy to make policy decisions and are insulated to some extent from day-to-day legislative politics. A
good example of this kind of approach appears to be the Group Insurance Commission in Massachusetts. In other states, such as North Carolina, legislators and other policymakers appear to have more direct involvement in PEHP oversight and decisionmaking than in states in which stronger boards set policy directions under broad mandates from legislative or discretion. While all PEHP boards are subject to oversight from state legislators and governors as explicitly political entities, this oversight appears to express itself differently in different states. I argue that these differences shape the policy options that are available and achievable in different states.

To date, however, little is known about how differences across states in how PEHPs are governed shapes the perception of PEHPs as key actors in the broader state health policy environment of marketplace or in the actual policy efforts undertaken. No study has focused extensively (or at all) on the variation across states in PEHP structures, design features, and degree of bureaucratic autonomy. Thus, it is difficult at the outset of this dissertation to understand the range of variation across states, let alone how PEHP governance structures and other issues might play a role in the development of PEHP approaches or strategies in the larger state policy and market environments. However, ignoring the role of governance structure and PEHP policymaking autonomy seems unwise. Absent a coherent set of theories or empirical base related to the politics of PEPH policymaking and the role of governance structures, it may be helpful to glean some of the insights from the political science literatures on bureaucratic autonomy, which has previously focused mostly on the relationships between Congress and agencies.

Some scholars such as Epstein and O’Halloran (1994) develop models that seek to explain why and when legislators are likely to limit agency discretion. Bawn (1995)
examines a similar set of issues, focusing primarily on tradeoffs between taking advantage of
the expertise that bureaucrats possess and controlling the tendency of agencies to “drift”.
Bawn’s theory suggests that the level of discretion that legislators give to agencies depends
on how closely aligned their interests are. Scholars have explored several strategies
regarding the legislature asserting control over bureaucracies, including the use of budget
processes (Banks 1989; Bendor, Taylor, and Van Gaalen 1987), various forms of routine ex
post oversight (Aberbach 1990 and Weingast and Moran 1983), and ex ante mechanisms
whereby legislators use legislation itself to structure and control bureaucratic decision-
making processes (McCubbins, Noll, and Weingast 1987, 1989; McNollgast 1992; Moe
1990; Macey 1992).

This previous research provides a potentially important foundation for understanding
the degree of policymaking discretion afforded to PEHP leaders, focusing on both the
preferences of the actors and the technical complexity inherent to the policy choice. The
benefits of granting discretion to PEHP governance structures is likely to increase as the
objectives of policymakers and “agents” converge (Bawn 1995; Epstein and O’Halloran
1994). For example, if policymakers and PEHPs want to achieve the same outcomes,
policymakers may grant PEHP boards and staffs with relatively greater political autonomy.
If policymakers and PEHP boards and staffs seek to achieve different outcomes, however,
policymakers may seek to grant PEHP boards and staffs with more limited autonomy and
instead direct in explicit ways the specific policy strategies, policy boundaries, and outcomes
to be pursued.

Thus, understanding how to apply these insights to PEHP policymaking is difficult to
address as it requires a great deal of understanding about the politics of PEHP policymaking
as well as the historical development of how PEHP governance structures emerged. In this dissertation, I seek to better understand how PEHPs in different states are actually governed. In some cases, I expect to find that board members, appointed by governors and legislators, exercise broader control over PEHP policymaking and cost containment strategies than in other states. Likewise, I expect to find variation in the degree of personal autonomy and authority exercised by PEHP staffs (e.g., administrators or executive directors). While the ultimate cause of this variation is associated with historical political and other decisions associated with the establishment of PEHPs themselves (and many therefore might not be explicit strategies by current legislators and governors), I will seek to understand to the extent possible the source of this variation and its role in shaping the roles that PEHPs play as major purchasers.

Understanding how PEHPs are governed, specifically the relationships between PEHP leaders and legislators and other policymakers, is important in understanding how and why policymakers may seek to use PEHPs for broad statewide policy purposes. Moreover, I also argue that understanding issues related to PEHP governance structures and the degree of bureaucratic autonomy granted to PEHP boards and staff is important in understanding why and how particular strategies persist (or not) and their political impacts. For example, to the degree that powerful hospital and other provider interests can essentially “capture” the PEHP policymaking process within the legislature through regular and direct legislative interaction and oversight regarding PEHP cost containment strategies, certain cost containment options may be more politically feasible or durable than others.

A politically connected hospital executive, for example, may be able to use formal or informal legislative and “back channel” processes to forestall PEHP attempts to cut provider
reimbursement or otherwise regulate provider practices if PEHPs are not shielded to some extent from regular, ongoing, and direct oversight and monitoring from the legislature or particular legislators. States in which PEHPs and their boards enjoy relatively more political autonomy may be able to set policy regarding cost containment and other issues in such a way that particular policy options are more feasible or durable. Of course, it is possible that interest groups can also “capture” bureaucracies as well. Nonetheless, the degree of bureaucratic autonomy in how PEHPs are governed is likely to yield differences across states in the political feasibility of certain policy strategies, and the durability of those strategies once implemented.

I expect to find, quite generally, that states in which PEHP boards and staff members exercise relatively more political autonomy and authority in PEHP policymaking are more likely to wield PEHP purchasing power to pursue policy or market change that could threaten provider and other interests in various ways. By contrast, such approaches may not be as politically feasible in states for which PEHP governance structures are more closely associated with political control through the legislative process.

_Policy Entrepreneurship and Leadership_

The presence (or absence) of particular political leaders and “policy entrepreneurs” is also expected to have an important impact on state policy approaches and strategies. Policy change requires key leaders with the political capital to champion initiatives (McDonough 2001). As Thomas Oliver has noted:

“[Policy reform] is driven not only by broad social forces, but also by leaders with specific ideas about the proper direction of public policy. The activities of strategically placed individuals at a critical juncture in system development can
greatly influence the likelihood of policy change and especially the policy options
given serious consideration” (Oliver 2004).

Numerous studies highlight the importance of leadership in health care
policymaking. For example, Paul-Sheehan studied states that undertook various health
reform activities and concluded that leadership is an “essential ingredient” of health reform
and a major determinant of the particular policy paths that states have taken (Paul-Shaheen
1998). She also identified key tasks and strategies used by policy entrepreneurs in selected
states and the important interactions of leadership with ideas, opportunity, and power.
However, if leaders can shape public perceptions of public conditions and stimulate policy
change, they can also serve as deterrents to change. For example, Oliver describes how the
resistance of a key legislative aide to the chair of the U.S. Senate Finance Committee led to
the long delay of HMO options being introduced into the Medicare program (Oliver 2004).

The agenda setting literature within political science has examined the action of
policy entrepreneurs in shaping policy at the state and national levels (Baumgartner and
Jones 1993; Kingdon 1995; Polsby 1984). Policy entrepreneurs may or may not be elected
or state officials. Nonetheless, they seek to promote particular policy innovations using
numerous approaches and efforts to sell their ideas to policymakers and other decision
makers. Policy entrepreneurs must be willing to invest political resources to attract
sufficient support to win approval (Kingdon 1995). Beyond merely interested citizens that
petition government in various ways, policy entrepreneurs are distinguished by their well-
positioned decisions to take risks to skillfully change the terms of political or policy debates
(Schon 1971). These efforts include politically well positioned to argue that proposed policy
innovations will produce more ideal policy outcomes or other benefits than maintenance of
the status quo.
Some scholars investigating the activities of policy entrepreneurs in shaping political and policy outcomes at the state level have conducted surveys of key stakeholders to identify individuals that matched a description of policy entrepreneurship. For example, Mintrom and Vergari (1998) sought to identify policy entrepreneurs and study the role of entrepreneurs so identified in Minnesota school choice policy arena. They found that the presence and role of leaders and entrepreneurs varies by policy area, by state, and by time. Thus operationalizing the impact of entrepreneurs is difficult at best using regression methods.

I expect to find in my analysis of PEHP policymaking that particular leaders inside and outside of state government have exerted their influence in setting the course of policy direction of PEHPs to impact the broader health care marketplace. It is difficult to hypothesize more precisely about the influence and nature of policy leadership and entrepreneurship, but based on a review of the state policy literatures on agenda setting, among others, this is an important variable to consider in order to gain a better understanding of the key drivers of PEHP policymaking at the state level.
Chapter 3: Research Design, Data, and Methods

Research Design Overview

This dissertation focuses on the key drivers influencing PEHP policymaking, with a particular focus on understanding how states “use” PEHPs to achieve broad public policy goals that extend beyond traditional PEHP constituencies. Many of the variables that likely influence PEHP policymaking, discussed in Chapter 2, can be difficult to operationalize neatly into variables amenable to regression and other statistical techniques.

One example of this is the degree to which the governance structures of PEHPs is subject to direct political influences from provider and other groups. In some cases, researchers studying policy variation may have overlooked the degree to which bureaucracies are autonomous in making and/or implementing policy. While fifty-state surveys allow for the testing of particular variables of interest, they can easily overlook idiosyncratic differences within states of important variables that may play a key role in shaping policy at the state level. Moreover, very little is known about PEHP policymaking at the state level. The questions addressed by this dissertation – and the data available on specific variables of interest – are most appropriately addressed using a multi-state case study approach. Such an approach will allow for a clear illustration of recent cost state
policy decisions in included states to investigate why they were undertaken, how they were implemented, and their results within the larger state health care policy and political landscapes.

An important part of this research is to examine the various political and other reactions or effects of such approaches (such as responses from participating health plans, provider groups, and other actors). Thus, I focus not only on the current and recent policy efforts of state PEHPs, but also the “operational links” between policymakers, PEHP leaders, and other actors in the health care landscape that have influenced how and why states have developed or embraced particular strategies (Yin 1989). Thus, the primary method of data collection is structured interviews with a broad range of health care stakeholders at the state level, including current and former PEHP executives and their staffs, policymakers, provider groups, private health plans, and others. Specific interviewees for my early exploratory research and each case state are listed in the appendix.

Several key benefits of case study research are particularly relevant for this study. While I have identified and test key variables of interest to address hypothesized outcomes, the process of case study research itself may help to identify or uncover additional explanatory variables than those presented in Chapter 2. This is particularly true since, absent an existing theoretical base of PEHP policymaking, I am ultimately adapting insights from other substantive state policy areas to a study of PEHP policymaking. The relevance of each variable were not known a priori; thus, additional factors influencing PEHP policymaking may emerge from the study itself.
A case study approach allows for a study of the complex interaction of political influences and policy choices that gave rise to particular uses of the purchasing influences of PEHPs within the broader state health care system. Multiple data sources (primarily via interviews) provide assurance that reasons given for particular events or approaches appropriately reflect influences from different sources (“triangulation”). A comprehensive case-based approach in each state ensures that appropriate market conditions and potentially complex social and political interactions are incorporated into each case study to the extent possible. Conducting multiple interviews with a wide range of stakeholders and comparing results to each other and to published reports and other secondary data assures that any bias resulting from particular self-interests will be reduced to the extent possible.

Primary and secondary data sources are used to test alternative interpretations. I evaluated the quality of the evidence of related conclusions and used pattern matching to distinguish and refine particular explanations for relevant events and policy choices from anecdotes and perceptions. Moreover, this approach benefits from deriving (via structured interviews) the explanations of primary stakeholders in numerous positions, but generalizes from their personal experience by substituting anecdotes of unknown credibility for more objective information from other sources.

**Case Selection**

Specifically, this dissertation presents a comparative case study of PEHP policymaking in two case states: Massachusetts and North Carolina. The selection of these states is based primarily on the desire to test a set of theoretical expectations about the uses of PEHP purchasing power in states with different political, market, and other conditions (Yin 1989; 1993). Specifically, the selection of these states allows for an investigation of
how and whether PEHPs in states with different policy environments and health care markets and PEHPs with different institutional features and governance structures have had different experiences and outcomes attempting to harness the purchasing influence of PEHPs to yield broad delivery system change at the state level.

The relative contribution of some of the key variables identified in Chapter 2 are explicitly evaluated through case studies. Others, however, were used to help justify the selection of particular case states. Exhibit 3.1 below displays how each variable described in Chapter 2 is incorporated in this dissertation.

For the dependent variable, I selected two states in which exploratory interviews revealed differing views of the “purchasing power” of PEHPs. State PEHP perceptions were aligned with specific efforts currently undertaken by PEHPs to yield cost containment and other benefits for state as a whole. Specifically, North Carolina’s PEHP interviewee suggested that state PEHPs can play only a modest role in contributing to or implementing broad changes in the state health care marketplace. This particular perception is consistent with the North Carolina interviewee’s claim that the North Carolina State Health Plan (SHP) is not currently engaged in any efforts that have the potential to specifically influence the state’s broader delivery system. Interestingly, however, the interviewee in North Carolina suggested that the state had, in fact, undertaken a major effort in the past using the SHP as an important vehicle or contributor to broader health system reform. Perhaps North Carolina’s experience with this previous effort revealed important constraints on PEHP purchasing influence that in turn helped to shape a less sanguine view about the role of PEHPs in the broader health care market.
By contrast, the exploratory PEHP interview in Massachusetts revealed a much more optimistic view of the role of PEHPs. In that state, the Massachusetts Group Insurance Commission (GIC) is engaged in a new purchasing and contracting strategy that is designed to yield cost containment benefits for the GIC itself as well as to affect the broader health care delivery system in the state.

Thus, both Massachusetts and North Carolina have sought or are seeking to use the purchasing influences of their respective state PEHP to contribute to broader policy goals within the state. The specific timing and direction of each state initiative varies, but the general notion of using or having used the PEHP as an important vehicle for health system reform is consistent in both states even while PEHP leaders’ in these states hold differing views about the roles that PEHPs can play in the broader state health care marketplace.

For the key independent variables of interest outlined in the previous chapter, these states have different measures or values for several key explanatory variables, providing the ability to test the relative influence of each variable in different policy and market environments. The “Used in Case Selection” column below displays the variables used to help select case states. The “Interviews and Other Data” column shows variables that are specifically examined in detail in each case state.
Exhibit 3.1: Research Design: Use of Key Variables

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Used in Case Selection</th>
<th>Explored in Detail in Case Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions about PEHP purchasing power to influence state health care system (from exploratory research)</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Current or past efforts to use PEHPs to influence broader health care environment</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

Explanatory Variables
(Factors Expected to Influence Variation in PEHP policymaking)

**State-Specific Factors:**
- Partisan political landscape
- State wealth
- Interest groups
- State political culture
- State policy innovation
- State health care marketplace

**PEHP-Specific Factors:**
- Governance structure and bureaucratic autonomy
- Policy entrepreneurship and leadership

Again, these variables were used to ensure that the case states selected vary in important ways. For example, in selecting Massachusetts and North Carolina, I have selected two states with different partisan political environments, measures of state wealth, reputations for policy innovation, political cultures, health care markets, and traditions and/or legacies of policy innovation. Exhibit 3.2 below shows more specifically how the Massachusetts and North Carolina state policymaking environments and PEHPs vary along the key variables defined above.
Exhibit 3.2: Research Design: Measures of Key Variables in Selected Case States

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>North Carolina</th>
<th>Massachusetts</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEHP executives’ perceptions about PEHP purchasing power to influence state health care system</td>
<td>• In early exploratory research, the PEHP interviewee in North Carolina described a “weak” role for PEHP purchasing power to influence state health care market</td>
<td>• In early exploratory research, the PEHP interviewee in Massachusetts described a “strong” role for PEHP purchasing power to influence state health care market</td>
</tr>
<tr>
<td>Current or past Efforts to use PEHPs to influence broader health care environment</td>
<td>• Seeking to realize cost containment benefits for the SHP and for the state as a whole, policymakers encouraged the relocation/development of HMOs in the state by offering the SHP population as a “hospital” base of enrollment</td>
<td>• Seeking to realize cost containment and quality improvement to benefit the GIC and the larger state health care system, the GIC used its contracts with private health plans to induce behavioral changes from the state delivery system</td>
</tr>
</tbody>
</table>

Explanatory Variables
(Factors Expected to Influence Variation in PEHP policymaking)

State-Specific Factors:

Republican governors (1991-2007)  
Solid Democratic House and Senate for decades |
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<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Democratic governors (1993-present)</td>
<td></td>
</tr>
<tr>
<td>Interest Groups</td>
<td>• “Strong” provider interests as defined by early exploratory interviews</td>
<td>• “Strong” provider interests as defined by early exploratory interview</td>
</tr>
<tr>
<td></td>
<td>• Minimal role of service employee unions, but state employee representatives hold seats on board by statute</td>
<td>• Service employee unions hold seats on commission by statute</td>
</tr>
<tr>
<td>State Political Culture</td>
<td>Elazar’s political culture</td>
<td>Elazar’s political culture</td>
</tr>
</tbody>
</table>
index as operationalized by Sharkansky: *Traditionalistic* (Elazar 1984)  
- Klingman and Lammers (1984) and Buchanan (1987)’s liberal-conservative scale: *Conservative*

index as operationalized by Sharkansky: *Individualistic*  
- Klingman and Lammers (1984) and Buchanan (1987)’s liberal-conservative scale: *Liberal*

| Policy Innovation | • Traditionalistic (least policy innovation) (Savage 1987) | • Individualistic (generally relatively more policy innovation than “Traditionalistic”) |

| Health Care Markets | • HMO penetration rate (2005): 9.9%, ranked 36 out of 51 (Kaiser Family Foundation 2005)  
- Uninsurance rate (2005): 15% (Kaiser Family Foundation 2005) | • HMO penetration rate (2005): 38.6%, ranked 3 out of 51  
- Uninsurance rate (2005): 10% (Kaiser Family Foundation 2005) |

### PEHP-Specific Factors:

| Governance Structure\(^b\) | • “Weak” board of directors with relatively strong legislative oversight | • “Strong” commission with minimal direct legislative oversight |

| Leadership and Policy Entrepreneurship | • Unknown at outset | • Unknown at outset |

In addition to general consistency in the dependent variable and variation in most key explanatory variables, the selection of Massachusetts and North Carolina as case states was also based on convenience. I have had prior experience studying different aspects of health policy and/or PEHP policymaking in these two states. This familiarity considerably aided the ability to secure interviews and other data necessary for the dissertation.

Data

I collected data in the form of numerous structured interviews in each case state with current and former PEHP administrators, private health leaders, health policy leaders, scholars, provider groups, consumer advocates, and current and former policymakers and

\(^b\) The assessment about governance structure is subjective based on preliminary interviews given dearth of other data.
senior legislative staff members. Covering a broad range of public and private stakeholders, I used “snowball” techniques to identify appropriate interviewees to ensure that I covered numerous stakeholder positions and perspectives, including current and past executives from private health plans and, where possible, PEHPs. These interviews shed light on the various aspects of the political process associated with management and development of PEHPs. To a limited extent, interviews also covered the historical origins and development of each PEHP and the major political and other factors influencing the historical context of policy decisions for embracing or rejecting particular strategies to achieve broad policy goals.

Following commonly accepted qualitative research methods, I developed detailed interview guides or protocols that facilitated consistent data collection across interviews. In some cases when discrepancies emerged, excerpts from interview notes were independently reviewed, being careful to conceal key interviewee identities as necessary. Then, I categorized responses across interviews mirroring the interview protocols. The resulting analysis entailed comparing and contrasting the responses within each category, noting and discussing dominant themes and divergent opinions, and summarizing findings by topic area.

After creating case studies of each state based on interviews and analysis of secondary data, I circulated relevant excerpts of the case studies among a selected group of diverse interviewees in each state. I then revised the case studies using the comments received. Interviews assisted me in determining whether or not included variables represented the full range of factors that influence PEHP policy choices and the degree of effectiveness of related policy efforts. In some cases, secondary data collection and analysis helped to identify interviewees and new variables to include for further analysis.
Moreover, I used interviews and secondary data to gain as complete a picture as possible about how PEHP policymaking fits within the larger political process at the state level. This helped me to draw conclusions about whether the influences that contributed to the use of policy approaches have been idiosyncratic (e.g., based on particular design features, governance structures, or state-level issues) or whether there are generalizable explanations about why policymakers have acted as they have (and the results of those actions). These results are discussed in Chapter 6.

Interviews and available and related secondary data (e.g., white papers, reports, etc.) also shed some light on a range of issues in each case state to describe the larger context or “windows of opportunity” that emerged among states to use PEHPs in different ways (Kingdon 1995). This necessitated understanding the changing dynamics of states’ larger political or economic environments. State-level contextual issues, including the political and market variables described in Chapter 2, were examined to understand the political impetus and trajectory of PEHP policy efforts and their sources of continuity and change.

The strengths of this research design are its ability to provide in-depth information from a variety of perspectives. Moreover, this approach also permitted a clear understanding of the experiences of two states using PEHPs to achieve similar goals but in different contexts. An important natural limitation of the case-study approach is that the selected cases do not necessarily generalize to the broader universe of states and/or PEHPs. This is a very important point considering that state markets and political environments, as well as PEHP governance and other features, vary from state to state. Other limitations include the limited number of people who could be interviewed, the limited ability to empirically estimate the magnitude of effects of various design features and political influences, and
subjectivity inherent in interpreting complex and often contradictory information. These issues are discussed in greater detail in Chapter 6.
Chapter 4: Massachusetts

Introduction

Scholars and analysts have written much about Massachusetts’ numerous health reform efforts over the last several decades, including efforts to expand access, contain costs, and improve health care quality. However, much less attention has been focused on the state’s Group Insurance Commission (GIC) in purchasing health care benefits on behalf of the state’s largest employer: the Commonwealth of Massachusetts. This chapter explores a new cost containment approach recently undertaken by the GIC called the Clinical Performance Improvement (CPI) initiative that is designed to mitigate rising costs within the GIC as well as to stimulate delivery system reforms to influence the state health care system as a whole. The chapter examines the factors that shaped how and why this particular strategy was implemented, its potential impact on the broader state health care marketplace, and the specific factors that have contributed to the GIC’s influence (as well as the limits of its influence) as a major public purchaser.

Specifically, this chapter finds that the Massachusetts Group Insurance Commission (GIC) has been successful implementing a new network tiering initiative over the strong objections of key providers and related groups. This initiative has induced private actors
(i.e., health plans and provider groups) to engage in business practices that they would not have otherwise engaged in. To do so, the GIC has taken advantage of the state’s reputation for policy experimentation and innovation, the GIC’s favorable position as a major employer within the Massachusetts marketplace, the GIC’s relatively autonomous governance structure that has largely insulated the GIC from political influences from providers and other groups, the broad political consensus supporting efforts to promote cost containment and quality improvement, the GIC’s willingness to compromise with powerful delivery system players, and dynamic and politically savvy GIC leadership.

The first section reviews the recent background of the state’s health care marketplace and policy arena. Not only is Massachusetts reputed for its activist health policy history, strong and influential provider community, and dynamic health plans, the state is also well known for per capita health care costs that significantly exceed national averages. The latter characteristic of the state’s health care system provides an important backdrop in understanding the cost containment efforts that the GIC has introduced in recent years.

The second section briefly describes the basic history and structure of the GIC, including its basic administrative design and governance structure, health purchasing strategy and performance, and leadership. The second section also provides a detailed description of the Clinical Performance Improvement (CPI) initiative. It explores how and why the GIC chose this particular cost containment path as well as the experience of implementing the CPI in the face of opposition from providers and other groups.

The third section explores the potential opportunities and limits of the GIC’s purchasing influence in Massachusetts. Specifically, this section examines the relative
influence of the key variables described in Chapter 2 in providing the GIC with an opportunity as a major health care purchaser to overcome resistance from powerful provider groups and other stakeholders in Massachusetts. This section also discusses the important constraints of the GIC’s influence over the state’s delivery system. The conclusion section of this chapter briefly describes the key lessons learned from the Massachusetts “story” that contribute to a larger understanding of the role and limits of state PEHPs in enacting or pursuing health system reform through purchasing practices and market power.

The Massachusetts Health Care Environment

Policymakers in the Commonwealth of Massachusetts have long been actively engaged in state health care reform efforts, earning the state a reputation as a leading health policy innovator (Paul-Shaheen 1998). Most recently, in 2006, the state’s ambitious new “health reform law” to expand access to health insurance coverage to nearly all uninsured citizens has, according to one active participant in the Massachusetts health policy community, “seal[ed] the Commonwealth’s reputation as a breakthrough innovator” (McDonough 2006).

In addition to its activist policy legacy, Massachusetts is also home to many nationally-acclaimed academic medical centers, biotechnology and pharmaceutical companies, health plans, and other health care organizations in the state (New England Health Institute 2007). Changes in the state’s economic profile in the last two decades have magnified the health care industry’s important role in the economy and workforce of the state and the region even as other industries, such as financial services and technology, have declined as a proportion of total jobs. As Nancy Turnbull (president of the Blue Cross Blue Shield of Massachusetts Foundation) noted, “The aggressiveness of the political process
around health issues and the importance of health care employers to the commonwealth are interwoven as important aspects of the DNA of the Commonwealth” (Turnbull interview 2006).

The Commonwealth’s reputation for leading policy innovation, scientific knowledge, and its major health care workforce, moreover, have not immunized the state from rising health care costs, which numerous analysts, panels, and white papers have in recent years characterized as a “a significant problem” in Massachusetts (Massachusetts Health Care Task Force 2002). Stakeholders described how growing concerns about health care costs (both within the GIC and the state as a whole) have served as a political backdrop allowing the GIC to undertake efforts to use its contracting process with private health plans to experiment with cost containment solutions. These issues are discussed in more detail below.

Group Insurance Commission

The Group Insurance Commission (GIC) was established by the Legislature in 1955 and implemented on January 1, 1956 to provide and administer health insurance and other benefits to the Commonwealth's employees and retirees, and their dependents and survivors. According to the general statutes outlining the legal definition of the GIC, “[The GIC] shall be established within the executive office of administration and finance, but not under its jurisdiction” (General Laws of Massachusetts). The legislation established a framework whereby the governor appoints an eleven-member Commission to govern the GIC. Commission members encompass a range of interests and expertise including labor and retirees, the public interest, the administration, and health economics. GIC Commissioners exercise authority to govern the GIC with the leadership of an executive director and staff, whom they are responsible for hiring.
Before the creation of the GIC, individual agencies and departments in state government issued separate funding requests to the legislature to receive state subsidized health insurance for employees and covered dependents. However, as some agencies (such as the highway department) were able to leverage political clout to receive better funding than other agencies (such as social welfare workers), concern arose that funding and benefit inequities were inefficient and unfair (Johnson 2006). Thus, the GIC was established to unify the disparate health insurance benefits offered to state employees. In 1956, the legislature passed what is now Chapter 32A and 32B of the general statutes, which provided enabling legislation to create the GIC and authorized cities and towns to offer health benefits to their employees and retirees. The legislation establishing the GIC outlined that the state would subsidize all premiums at 50% with GIC members responsible for the remaining 50%. In 1956, the agency issued a request for proposals for a basic indemnity plan. The dominant insurer in the Commonwealth at the time, Blue Cross Blue Shield of Massachusetts (BCBSM), won the first contract from the 40 proposals received from 18 companies to provide insurance to GIC members (Group Insurance Commission Annual Report 2005).

In 1973, the Massachusetts legislature passed a law encouraging the spread of HMOs at about the same time that Congress passed the Health Maintenance Organization Act (Public Law 93-222) that supported the development of prepaid health plans (Brown 1983). According to Johnson, “Even at that point in time, Massachusetts considered itself a highly educated and innovative state, and the relatively new concept of clinic-based medicine caught on well, initially in and around the university system and then across the commonwealth. [HMOs], which we then called ‘HCOs’ had a very natural home here from the beginning” (Johnson 2006). In 1976, the GIC first offered its members a choice of health
plans in addition to the indemnity product administered by BCBSM. Two HMO plans were offered in that first year: Harvard Pilgrim Health Care and Valley Health Plan.

Given the availability of HMOs, a “classic adverse selection spiral” emerged as younger, healthier workers preferred HMOs over the state’s traditional indemnity option (Johnson 2006). At the same time, growing cost trends became a concern to the legislature and the Commission. Dolores Mitchell was hired as the new executive director of the GIC in 1987 and was given a mandate to “cut costs wherever you can” (Carey 2006). In the same year, the GIC received the authority from the legislature to “self insure”, and the GIC did so in 1988. One of Mitchell’s first acts was to convince the Commission to replace longstanding indemnity insurer BCBSM with the John Hancock Company in 1989, which the GIC contracted with on an administrative services only (ASO) basis starting in 1989.

Concerned that one of the drawbacks of self-insuring was that “[the ASO] may not manage the chicken coop as well as they should since they are not at risk, but we are”, the GIC became more assertive in seeking to manage its own cost trends (Slavin 2006). According to several observers who were active in Massachusetts health policy at the time, the hiring of Mitchell and the decision to self-insure and to grant John Hancock the ASO contract (from BCBSM) gave the GIC – and Mitchell in particular – a clear mandate to very vigorously manage costs of the growing program while preserving the value of benefits to the extent possible (Slavin 2006). While the Commission itself was ultimately responsible for setting GIC policy, observers noted that Mitchell very quickly “was determined to be highly capable and thus the legislature and the commission entrusted her with the authority to run the show…legislators had other issues on their plate, like the [cost] trends in [Medicaid] to worry about” (Interview 2006).
Unlike other public employers, such as Massachusetts cities and towns that operate outside of the GIC, the GIC from the beginning has not been subject to collective bargaining. This has provided considerable flexibility for the GIC to negotiate with plans directly and assertively. By contrast, “Some cities have 14 unions; if they want to raise one copay for one plan, they have to negotiate with all 14 unions” (Johnson 2006). Beginning in 1974, however, the legislature required that at least two Commissioners must be representative of public employee unions. Nonetheless, according to several interviewees, the lack of collective bargaining (in an otherwise union-friendly state) has increased the GIC’s ability to directly and assertively negotiate with health plans over prices, cost sharing, and other provisions.

Another noteworthy feature of the original legislation enacting the GIC is that the legislature has been historically responsible for setting employer contribution levels while the GIC exercises responsibility and autonomy to establish other cost sharing and benefits (Carey 2006). According to Johnson, this divided responsibility has “politically, at least, created a perfect balance that has sustained legislative/GIC relations…Each side has an important role to play but the legislature is free to deal with other issues” (Johnson 2006). Today, the GIC offers its 254,000 members an Indemnity plan (with UniCare, a subsidiary of Wellpoint, holding the ASO contract), preferred provider-type organizations (PPO), and multiple HMO plans. These options are discussed in greater detail below. The GIC has a full-time staff of 43 individuals with total annual expenditures of $1.06 billion ($954 million of which is accounted for by medical expenditures (Group Insurance Commission Annual Report 2006). Exhibit 4.1 below displays recent per capita annual medical cost trends.
Clinical Performance Improvement Initiative

This section explores the origins of the GIC’s recently-implemented CPI effort, including the political and other reasons that have jointly shaped how and why the GIC has been able to implement this new initiative in the face of strong opposition from powerful health care stakeholders, namely provider groups.

GIC and Cost Containment

Like all major employers providing or subsidizing health benefits for employees, the GIC has considered and/or experimented with numerous efforts to contain premium growth in recent years. Like most public employers, however, this has not, in general included shifting significant new costs to workers. The GIC’s employer purchaser counterparts in the
private sector, both in Massachusetts and nationally, have embraced the thinning of benefits and more aggressive member cost sharing (Dowan 2005). By contrast, public employers including the GIC continue to pay higher premiums for more comprehensive benefits (Maxwell 2004; Hurley et al. 2006).

According to interviews with former and current GIC staff members and commissioners, several factors explain why the GIC has been reluctant to shift significant costs to workers. First, the GIC Commission has traditionally been “labor oriented…in the sense that we are mindful at all times of the impacts that our decisions have on the public workforce” (Zeckhauser interview 2006). Historically, since the GIC was formally established, the GIC has not faced direct collective bargaining pressure from public unions even though Massachusetts itself is home to many employee unions. However, by statute, two public employee unions are represented on the Commission’s board, albeit in a minority position.

However, according to interviews with current and past commissioners, very rarely do union representatives on the Commission split with GIC staff and other commissioners. In general, according to a representative of the American Federation of State, County, and Municipal Employees (which in turn is part of the AFL-CIO) that has previously served on the commission, “while there are only two unions reps on the commission, there is typically broad consensus among colleagues that concern about protecting rich and affordable benefits for public sector workers and retirees is of paramount concern” (Interview 2006). Secondly, broadly shared goals among GIC commissioners to protect the value of health benefits and avoid cost shifting are also associated with the GIC’s larger public employee recruitment and retention strategy: “We have to do what we can to engage workers on the health care
Moreover, legislators and their families are themselves among the public employees eligible for GIC health insurance benefits. This means, according to a former GIC Director of Policy and Research, that GIC staff and commissioners “do not want to do anything that would provoke the ire of policymakers in a way that would make [legislators] scrutinize the work of the GIC for fear of the loss of independence that GIC has enjoyed” (Slavin interview 2007). Finally, not only would cost shifting not be politically palatable, the GIC staff and commission also expressed concerned that cost shifting could fundamentally alter members’ health care consumption patterns in ways that could ultimately be more costly later: “I don’t want to keep shifting more out of pocket spending to low and middle income people; they avoid getting useful care when you do that, according to the evidence, which could be more costly later down the road” (Mitchell interview 2006).

These factors have together preempted major cost shifting to GIC members, which helps explain the search for other cost containment alternatives. With significant cost shifting and benefit cuts “off the table” (Mitchell interview 2006), the GIC has attempted other efforts, such as disease management, cuts in provider reimbursements, and other strategies to mitigate annual cost increases. In a recent public forum in Waltham, Massachusetts at which health care cost mitigation options were discussed, Mitchell responded to a listing of several potential cost containment options, by suggesting that, “[The GIC has] been there, done that. Been there, done that” (Mitchell speech 2006). In an interview following her speech, Mitchell suggested that these common cost containment
options efforts have been “necessary and important to [GIC], but have by no means been sufficient” to mitigate annual cost increases (Mitchell 2006).

As a result, the major cost containment approach that GIC has selected has been to focus on the relationships between health care quality and cost effectiveness by placing new pressure on both consumers (demand) and providers (supply) side of medical marketplace. The Clinical Performance Improvement (CPI) initiative currently represents the GIC’s predominant cost containment approach. According to the GIC’s 2006 Annual Report:

“The GIC does not wish to adopt some of the cost reduction measures used by other large employers, such as high-deductible plans, or to eliminate retiree health insurance coverage entirely. Instead, three years ago the GIC launched an innovative program called the Clinical Performance Improvement (CPI) Initiative to address the wide disparity in the quality of care delivered by physicians and hospitals as well as the precipitous rise in health care costs (Group Insurance Commission Annual Report 2006).”

Current and former senior level staff members who served at GIC when CPI was formulated believe that the CPI will affect both GIC cost trends as well as cost trends and practice patterns in Massachusetts more generally. However, given the failure of other cost containment initiatives, these claims should be viewed with caution. According to Mitchell:

“We decided to use the power of contracting to begin to think about tiering physicians to give [consumers] incentives to go to the more cost-effective and better-quality providers, which we thought would affect the cost trends not just in our group, but in the state as a whole” (Mitchell interview 2006). From the outset, the GIC’s CPI efforts have been expected to have important market spillover effects allowing the state to pursue cost containment and other policy goals by taking advantage of the GIC’s contracting process with private health plans.
**Philosophical and Programmatic Origins of the CPI**

Beginning in the late 1990s and early 2000s, as the era of tightly managed care came to an end nationwide and in Massachusetts, Mitchell and key GIC commissioners became increasingly influenced and intrigued by the approaches of large private purchasers and purchaser coalitions across the nation seeking to achieve cost savings by addressing the variation in provider practices, costs, and quality. In addition to the direct benefits associated with seeking higher quality, the philosophy of many large purchasers is that quality promotion could ultimately result in lower long-run health care costs, although the evidence for this to date is premature at best (Galvin 1999). Numerous purchasing coalitions, such as the Washington Business Group on Health, the Pacific Business Group on Health, and Gateway Purchasers for Health have attempted to encourage health plans to focus on improving health care quality through data sharing and reporting. Mitchell was intrigued by the philosophical underpinnings of these approaches.

Tiered provider networks involve grouping physicians and/or hospitals into separate tiers based on the cost or efficiency of care they deliver. Consumers receive incentives through lower premiums or cost sharing arrangements to choose the lower-cost or higher performing providers. The underlying strategy of tiered networks is to steer consumers to lower-cost or more efficient providers while also encouraging hospitals and physicians to improve their efficiency or accept discounted payment rates in exchange for preferred tier placement. Thus, providers are expected to be motivated (or threatened) by consumer incentives that reward higher-performing providers with patient volume and public perceptions about variations in quality and efficiency at the provider level.
The concept of using existing contracts with private health plans to develop tiered networks made good sense for the GIC, according to Mitchell, since even in the era of tightly managed care, most Massachusetts health plans did not significantly restrict provider networks to specific hospitals or physician groups. According to Insurance Commissioner Julie Bowler, for example, consumers and employer groups in the state have long demanded that prestigious teaching hospitals and community hospitals alike remain in-network regardless of their geographic proximity or variation in cost and quality (Bowler interview 2006). Thus, given the ambivalence about closed panels of providers and reluctance to cut benefits or shift costs to workers, Mitchell became very interested in developing tiered provider networks as a priority to attain quality promotion and cost savings.

The GIC’s network tiering strategy, called the Clinical Performance Improvement Initiative (CPI), has several components aiming to achieve cost savings and quality enhancement. First, by encouraging GIC members to shift their service use from lower performing providers to more cost-efficient, higher quality “preferred” providers, the GIC expects to realize the benefits of cost containment and quality improvement. Moreover, by creating transparency and motivating all physicians to identify and implement more cost efficient and/or better quality practices patterns, the CPI is designed to promote ongoing performance improvement affecting both GIC and non-GIC patients. Since health plans participating in the GIC collectively contract with every hospital in the state, GIC officials believed that the CPI would have a positive effect on the health care delivery system as a whole.

To achieve these goals, the CPI has several components introduced in different stages. These components included mandating that participating health plan require network
hospitals to participate in surveys characterizing the quality of care received in those hospitals (i.e., the Leapfrog Hospital Quality and Safety Survey). They also included requiring health plans to submit aggregate claims data, and then requiring health plans to use these resulting consolidated data to establish network tiers based on cost and quality outcomes. This strategy was seen by the GIC’s commissioners and staff as a viable option to maintain broad access to providers while steering patients to higher quality and/or more efficient providers.

*Tiering at the Hospital Level*

Led by strong advocacy by Mitchell and GIC staff, in 2000, the GIC Commission voted to seek a hospital network tiering structure to address high costs associated with Massachusetts hospitals. The first step in establishing hospital tiers was to compel hospitals to participate in Leapfrog surveys to collect data on practices and systems within hospitals. Examples of Leapfrog measures included whether hospitals have a computerized system for ordering prescriptions (e-prescribing), whether there are specialists to manage intensive-care patients, and how often certain procedures are performed. In its 2000 request for proposals (RFP) process to contract with health plans, the GIC required that health plans bidding for its business both report hospitals’ adherence to Leapfrog standards and also develop a ranking system to prioritize hospitals according to their costs (GIC RFP 2000). According to David Smith, Senior Director of Clinical Data Policy and Research at the Massachusetts Hospital Association, “[Dolores Mitchell] bullied health plans into saying that if a hospital was going to be a part of their provider network, then the hospital had to respond to the Leapfrog survey. The [GIC] used contracting with health plans as her primary instrument to force hospitals to do this” (Smith interview 2006).
The GIC’s strategy of requiring participating health plans to in turn require hospitals to respond to Leapfrog surveys was initially met with resistance from the hospital community. In meetings with health plans and GIC officials, hospital leaders argued that while they support quality improvement initiatives and transparency at a general level, they did not believe that adherence to Leapfrog standards adequately captured actual measures of quality. Specifically, hospital leaders balked that the GIC’s measures would serve as an inadequate basis on which to compare hospitals while adding unnecessary administrative burdens (Smith interview 2006).

The GIC’s initial goal was for participating health plans to use Leapfrog surveys and other cost and quality data and information to assign each participating hospital to one of three standardized tiers, with $200, $400, and $600 co-pays respectively. However, hospital leaders strongly rejected this approach.

The state’s many academic medical centers were particularly concerned that teaching hospitals would be punished for the relatively high costs associated with serving safety-net populations. According to John Erwin, who represents major teaching hospitals as Executive Director of the Conference of Boston Teaching Hospitals (and former Director of Government Relations at Tufts Health), “[The CPI] methodology doesn’t adjust cases for severity or account for fundamentally different cost structures of teaching hospitals compared to community hospitals, and as a result all of the teaching hospitals will almost always be assigned to the more costly, non-preferred tier” (Erwin interview 2006). An additional concern was that hospitals did not understand how they would fare under the rating system until after the tiering was actually implemented and the tiering assignments were reported publicly to consumers, who in turn would use this information to make health
care choices. According to Smith, hospitals received “no advanced notice on what we are being judged on” and thus could not take measures to improve their scores before the tiering structure was implemented, exposing consumers to different out-of-pocket costs based on their hospital selection (Smith interview 2006). Because of this opposition, 56 of 80 hospitals, including most of the major teaching hospitals, initially refused to provide the specific quality measures that the GIC had required participating health plans to collect. Moreover, some health plans reported Leapfrog survey measures from individual hospitals, while others reported only aggregate figures grouping all participating hospitals together. GIC officials were initially displeased with the perceived lack of cooperation on the part of hospitals, and in turn, the health plans.

The initial controversy over and opposition to the hospital tiering effort motivated the GIC to scale back, but not abandon, its initiative (Kowalczyk 2000). In response to these concerns and the initial lack of participation of hospitals, GIC officials facilitated a new set of negotiations with health plans and hospitals. Plans expressed a strong desire to move toward the hospital tiering approach without requiring uniform implementation in the first year. Thus, the GIC announced that because of ongoing methodological and related concerns on the part of hospitals, health plans could exercise some flexibility to introduce phased implementation of CPI that would allow health plans to modify their respective contracts with hospitals with the goal of adopting tiering over a period of 1-3 years (Kowalczyk 2004). Exhibit 4.2 displays the tiering designations and methodologies that have resulted from the level of flexibility afforded to health plans to implement the hospital component of CPI in a way that made the most sense for individual plans and their respective contracts with hospitals.
### Exhibit 4.2: Clinical Performance Improvement Hospital Tiering Implementation by Health Plan (2007)

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Product</th>
<th>Hospital Tiers?</th>
<th>Hospital Tier Methodology</th>
<th>Hospital Inpatient Deductible or Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health New England</td>
<td>HMO</td>
<td>No</td>
<td>N/A</td>
<td>$200</td>
</tr>
<tr>
<td>Harvard Pilgrim Health Care</td>
<td>PPO</td>
<td>No</td>
<td>N/A</td>
<td>$300</td>
</tr>
<tr>
<td>Tufts Health Plan</td>
<td>PPO</td>
<td>Yes</td>
<td>Cost and Quality</td>
<td>Adults/OB: Tier 3: $500 Tier 2: $300 Tier 1: $150 Pediatrics: Tier 2: $400 Tier 1: $200</td>
</tr>
<tr>
<td>Commonwealth Indemnity Plan Plus</td>
<td>PPO</td>
<td>Yes</td>
<td>Cost/Quality/Access</td>
<td>Tier 2: $400 Tier 1: $200</td>
</tr>
<tr>
<td>(Unicare)</td>
<td>PPO</td>
<td>Select network of hospitals</td>
<td>Community Choice network vs. Other Facilities</td>
<td>Tier 2: $750 Tier 1: $200</td>
</tr>
<tr>
<td>Commonwealth Indemnity Basic I</td>
<td>Indemnity</td>
<td>No</td>
<td>N/A</td>
<td>$150</td>
</tr>
<tr>
<td>(Unicare)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commonwealth Indemnity Basic II</td>
<td>Indemnity</td>
<td>No</td>
<td>N/A</td>
<td>$250</td>
</tr>
<tr>
<td>(Unicare)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>HMO</td>
<td>No</td>
<td>N/A</td>
<td>$200</td>
</tr>
<tr>
<td>(“Direct Care”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>HMO</td>
<td>No</td>
<td>Hospital copay based on tier of PCP</td>
<td>“Value”: $300 “Value Plus: $250</td>
</tr>
<tr>
<td>(“Select Care”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neighborhood Health Care Plan</td>
<td>HMO</td>
<td>No</td>
<td>N/A</td>
<td>$250</td>
</tr>
</tbody>
</table>

**Source:** Data from Group Insurance Commission and Massachusetts Medical Society (as of 04/07)

Some of the health plans, such as Tufts, used this flexibility to assemble expert panels with physicians, economists, and hospital leaders to determine the appropriate cost and quality measures and the appropriate implementation strategy (Kingsdale interview 2006). According to Jennifer St. Thomas, Tufts’ Account Manager responsible for all GIC business, “That flexibility to introduce these concepts into our own provider relations and
contracting strategies allowed us to go along with hospital tiering in ways that made sense for each plan instead of a one-size-fits-all approach that wouldn’t ultimately work” (St. Thomas interview 2007).

Nonetheless, over time, the GIC’s hospital network tiering initiative resulted in health plans developing tiered hospital products that they would not have developed absent the GIC’s influence in this arena. For example, Tufts Health Plan developed a three-tier preferred provider organization (PPO) option called “Navigator” that uses differential co-payments to distinguish high, median, and low-cost institutions. In the Navigator PPO, most acute care facilities in the state are grouped into inpatient co-payment levels based on their quality-cost scores in three categories of care: pediatric, obstetric, and adult medical/surgical care. The Navigator tiering structure also includes a three-tier plan design for obstetrics and adult medical/surgical care. Inpatient pediatric services are grouped into two tiers with varying co-payment amounts.

The methodology underlying the Navigator tier structure includes a number of qualitative and quantitative measures on quality and cost efficiency that form Tufts’ “Quality-Cost Value Index”. The quality score is based on three kinds of quality measures. These include Joint Commission on Accreditation of Healthcare Organizations (JCAHO) core measures for Acute Myocardial Infarction (AMI), congestive heart failure (CHF), and pneumonia. Leapfrog Group measures are used for computerized physician order entry and intensive care staffing, as well as internal inpatient mortality and complication rates. Those measures are aggregated to an overall quality score. Relative cost measures are also included based on data extracted from hospital bills (St. Thomas interview 2007).
Tufts’ Navigator efficiency measures examine how different a hospital is from the average on an adjusted cost per case basis. Several factors are considered, including the contracted rates that a hospital has negotiated with Tufts and average length of stay. According to Dr. John Freedman, Tufts’ Medical Director of Clinical Quality and Informatics, “If two hospitals have comparable per diems negotiated with us, but one gets the patient out in 25% or 50% shorter length of stay, that is a more clinically efficient hospital…a better-performing hospital is treating the patient with fewer complications and/or less administrative delays” (Larose 2004). Hospitals with comparable charge structures, but different utilization of ICU days for similar conditions will, according to Freedman, generate different efficiency measures (Larose 2004). To help provide a fair comparison across the network, these scores are adjusted for the relative severity of patients treated by each hospital and are re-evaluated on an annual basis. Data for case mix and severity come from the Massachusetts All Payer Data Set, which contains detailed data on all hospital admissions in the state (St. Thomas interview 2007).

Beyond Tufts, the only other GIC plan to actually introduce hospital tiering to date is Unicare (owned by Wellpoint), which serves as the third party medical benefits administrator of the GIC’s Commonwealth Indemnity Community Choice and Commonwealth Indemnity Plan Plus products. GIC members that are enrolled in Unicare’s “Plus” plan are presented with a three-tier hospital structure.

The GIC’s original goal of establishing a robust and standardized hospital tier structure implemented through all participating health plans has not fully materialized. Beyond Tufts and Unicare, the other health plans participating in the GIC have not yet implemented a hospital tiering structure with actual differential co-payments. Moreover, the
hospital tiering structures of Tufts and Unicare are not uniform; they each are based on plan-specific methods to develop hospital tiers and different co-pays associated with selecting hospitals in selected tiers. However, Unicare has the largest GIC enrollment of any plan operating in the GIC; in 2006, over half (54%) of GIC members were enrolled in one of the GIC’s indemnity plan options. After Unicare, Tufts is the largest health plan operating in the GIC. Approximately 23% of GIC members were enrolled in Tufts’ plan in 2006. Together, Unicare and Tufts account for 77% of total GIC membership (GIC 2006). Thus, the fact that only two plans operating within the GIC established hospital network tiering programs is countered by the fact that over three out of four GIC members are enrolled in a plan that includes network hospital tiering for hospitals.

Moreover, by developing the CPI, the GIC was one of the chief organizers within the state’s employer community to compel hospitals to comply with the quality standards recommended by The Leapfrog Group and other national quality standards. As a result, according to the Massachusetts Hospital Association’s David Smith, “hospitals in Massachusetts have been viewed as early adopters compared to hospitals in other states…and [the GIC’s] emphasis on [gaining compliance with Leapfrog surveys and standards] definitely caught people’s attention in the state and also put the GIC in the spotlight as the driving force behind this” (Smith interview 2006).

Dr. Jeff Levin-Scherz is Chief Medical Officer of Partners Community Healthcare, Inc., the largest integrated provider organization in Massachusetts, which includes Brigham and Women’s Hospital, Massachusetts General Hospital, and other prominent providers. According to Dr. Levin-Scherz, “As a result of what the GIC has done around Leapfrog standards and hospital tiering, Massachusetts looks very good in terms of complying with
Leapfrog and other quality-related issues compared to the rest of the country. That is largely because [the GIC] has been very ‘determined’, shall we say, in these efforts over the last several years” (Levin-Scherz interview 2006).

**Tiering at the Individual Physician Level**

Starting in 2004, the GIC expanded the CPI to expand network tiering to individual physicians. The physician tiering effort is similar to and emanated from the GIC’s earlier effort to rank hospitals and offer incentives for consumers to select preferred institutions. Like the GIC’s hospital tiering effort, the GIC’s primary tool to implement CPI is its contracting process with participating health plans. Unlike the earlier hospital tiering effort, however, the GIC has played a more active role in facilitating the development of individual physician tiering structures, mainly by consolidating and then funding the analysis of claims data across plans to be used as the basis for provider profiling and ultimately, tiered networks. In 2004, the GIC required participating health plans to submit three cumulative years of aggregate medical, mental health, and pharmacy claims data to a third party actuarial vendor hired by GIC, Mercer Human Resource Consulting.

Importantly, health plans were required to submit all of their claims data, not solely their claims information from their GIC book of business. This has resulted in a very large database of claims from which to support individual physician profiling, with significantly more data than any one GIC health plan could have based any individual plan-specific initiative. Under direction from the GIC, Mercer, using the Episode Treatment Grouper (ETG) methodology and quality measures from Resolution Health, Inc. (RHI) and other measures, integrates all claims data from participating plans into a single massive database,
runs the ETG analysis on the resulting data file, transfers files to RHI for application of its quality measures model, and then returns the large dataset with the results of both these analyses to the health plans contracting with the GIC.

The primary cost effectiveness measures used by the physician tiering component of CPI, ETGs, compare the relative resources expended by physicians to treat similar procedures (e.g., treating a broken leg). In addition to ETGs, the GIC database is also modified by data and other measures from Resolution Health, Inc. (RHI), the Health Plan Employer Data and Information Set (HEDIS), the Agency for Healthcare Research and Quality, and specialty society best practices to incorporate numerous quality measures to ETG efficiency measures (Draper, Liebhaber, and Ginsburg 2007). The GIC’s intention is for participating health plans to use the resulting database as the basis for establishing individual physician tier assignments.

Participating health plans include Harvard Pilgrim Health Care, Tufts Health Plan, Fallon Community Health Plan, Neighborhood Health Plan, Health New England and UniCare. Like the earlier hospital tiering effort, tiering physicians at the individual level has generated controversy from the standpoint of physicians and physician advocates. The Massachusetts Medical Society and other provider groups have voiced serious concern about CPI, ranging from challenging the basic philosophical premise of the initiative to expressing significant concerns with aspects of implementation and methodologies underlying the initiative. According to Partners’ Levin-Scherz, “physicians are angry and are absolutely right to be angry” for a number of key reasons (Levin-Scherz interview 2006).
The first source of opposition on the part of physicians and physician advocates is the traditional concern among provider groups about transparency regarding cost and quality data. According to Society President Dr. Kenneth Peele, “Today's attempts to impose transparency on our health care system, through public reporting, pay for performance, and performance measurement, are being done ‘too fast, too soon, with inaccurate information, and with untested tools” (Massachusetts Medical Society 2006). According to Peele, related concerns about transparency also reflect concerns about threats to professional autonomy among providers.

Second, physician groups have expressed serious practical concerns about the methodologies used to assign physicians to preferred and non-preferred tiers. The Massachusetts Medical Society, for example, commissioned researchers to challenge the methodological basis of ETGs for rating physicians at the individual level. This report, for example, highlights the lack of a uniform tier assignment protocol and very small absolute differences in performance differences as one of several methodological concerns about the CPI’s tiering methodology (Greene, Beckman, and Thomas 2006). The Medical Society has broadly publicized the results of this study to cast doubt on the CPI.

Third, physician groups cited the administrative and operational burdens that the CPI has created for medical practices. For example, according to an interview with Elaine Kirschenbaum of the Massachusetts Medical Society, rating physicians at the individual, rather than at the group level, makes it difficult for physician practice staffs to know which co-pays to charge patients depending on which doctors they see, particularly if they see more than one physician in a particular group (Kirschenbaum interview 2006). Another physician leader agreed, saying individual physician tiering is “big trouble operationally for practices,
creating a need to charge $30 for one provider in a group and $10 for another doctor in the same group if they ended up in different tiers” (Levin-Scherz interview 2006).

Third, like the earlier hospital tiering effort, the manner of the CPI’s implementation did not allow physicians to understand how they would fare under the rating system until the tiering was actually implemented and in some cases, until consumers were forced to make decisions based on the rating system. According to Kirshenbaum, physicians received no advanced notice about what the results of this tiering would look like and could not therefore change anything about their practice patterns before [CPI] was implemented” (Kirshenbaum interview 2006). Another physician advocate added that, “[The CPI] doesn't appear to be fair, it's not transparent, and if there's misinformation, physicians don't have a chance to correct it before it's put in print or publicly released” (Lee interview 2006).

Like provider groups, health plans also had problems with the original vision for the physician network tiering effort, or more precisely, the rapid pace that the GIC envisioned implementing CPI at the individual physician level. In negotiations with participating health plans, health plan leaders argued that while they would participate in the conditions of the RFP, they sought the flexibility to use the consolidated cost efficiency and quality database to make their own plan-specific tiering decisions. Health plan leaders argued that since each health plan had developed different contracting strategies and approaches with provider groups, each health plan should have the flexibility to work within those provider contracts and relationships to establish tiering as a goal over time.

Like the earlier hospital tiering component of the larger CPI, the GIC’s goal regarding the physician tiering effort was to establish a standardized tiering methodology
that all participating health plans would use to place all individual physicians into standardized tier structures. As a result of pushback from health plans and provider groups and the ensuing negotiation process with the GIC, however, the GIC did not abandon its plans, but afforded health plans a degree of flexibility to phase in implementation of the tiering structure over time and to do so in a manner that is consistent with health plans’ provider relationships and contracts to the extent possible. As Erwin noted, by allowing flexibility, the GIC acknowledged that “the secret recipe of Tufts is different than secret recipe of Unicare, and so forth” (Erwin interview 2006). According to Suzanne Bailey, Manager of Financial Analysis and Company Licensing in the Department of Insurance (who sits on the Group Insurance Commission as an appointed representative of the Department of Insurance), this flexibility was an important concession for health plans since their corporate structures and strategies and relationships with provider groups are different: “If you’ve seen one health plan in Massachusetts, you’ve seen one health plan” (Bailey interview 2006).

As a result of this flexibility, health plans’ tiering practices vary from plan to plan, with some tiering at the group level only, others tiering only specialists at the individual level, and still others tiering primary-care physicians as well. In 2006, the first year in which physician network tiers were implemented, three of the six plans tiered physicians at the group level, one plan tiered physicians based on hospital affiliation (Tufts), one plan (Unicare) tiered physicians at an individual practitioner level as was originally envisioned by the GIC, and one plan (Neighborhood Health Plan “Community Care”) did not tier at all. Several changes to scoring and tiering methodologies were implemented for the 2007 plan
year (e.g., weighting recent data more heavily in the three-year efficiency measure and removing certain specialties from tiering).

Unicare, which is administrator for the Commonwealth Indemnity Community Choice and Commonwealth Indemnity Plan Plus products, is the only participating health plan that opted to implement CPI exactly as the GIC had originally required, with individual-level physician tiering. The Tufts Health Plan chose to gradually extend its Navigator hospital tiering product, but does not directly rate physicians at the individual level. Instead, physicians in nine surgical specialties are ranked according to the rating of the hospital with which they are affiliated. Co-payments for office visits with physicians in preferred tiers are $15, and others are $25. Harvard Pilgrim Health Care, which does not tier hospitals, has a tiered physician product, called “Independence” that ranks physicians in five specialties: Allergy, Ophthalmology, ENT, General Surgery, and Neurology. HPHC’s differential copayments are $15 and $25 for the respective tiers. Exhibit 4.2A and 4.2B below display specific features of health plans’ physician tiering methodologies.
### Exhibit 4.3.A: Clinical Performance Improvement Physician Tiering Implementation by Health Plan (2007)

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Physician Tiers</th>
<th>PCP Tiers? By Individual or Group?</th>
<th>Specialist Tiers</th>
<th>Specialty Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health New England</td>
<td>Yes</td>
<td>Yes, by site level for family practice and internal medicine; pediatricians are not tiered</td>
<td>Yes, by individual for 5 specialties</td>
<td>Cardiology, Dermatology, Gastroenterology, Orthopedics, ENT</td>
</tr>
<tr>
<td>Harvard Pilgrim Health Care</td>
<td>Yes</td>
<td>N/A</td>
<td>Yes, by individual for 5 specialties and by group for 4</td>
<td>Individual Level: Allergy, Ophthalmology, ENT, General Surgery, and Neurology Group Level: Cardiology, GI, Dermatology, and Orthopedics</td>
</tr>
<tr>
<td>Tufts Health Plan</td>
<td>Yes</td>
<td>N/A</td>
<td>Yes, by individual for five specialties and by group for four</td>
<td>Individual Level: Neurology, GI, Ophthalmology, Endocrinology, Dermatology, Orthopedics, and ENT Group Level: Cardiology</td>
</tr>
<tr>
<td>Commonwealth Indemnity Plan Plus (Unicare)</td>
<td>Yes</td>
<td>Yes, by individual</td>
<td>Yes, by individual</td>
<td>All PCP’s and specialists are tiered (radiology, emergency medicine, pathology, and anesthesiology and mental health are not tiered)</td>
</tr>
<tr>
<td>Community Choice (Unicare)</td>
<td>Yes</td>
<td>Yes, by individual</td>
<td>Yes, by individual</td>
<td>All PCP’s and specialists are tiered (radiology, emergency medicine, pathology, and anesthesiology and mental health are not tiered)</td>
</tr>
<tr>
<td>Commonwealth Indemnity Basic I (Unicare)</td>
<td>Yes</td>
<td>Yes, by individual</td>
<td>Yes, by individual</td>
<td>All PCP’s and specialists are tiered (radiology, emergency medicine, pathology, and anesthesiology and mental health are not tiered)</td>
</tr>
<tr>
<td>Commonwealth Indemnity Basic II (Unicare)</td>
<td>Yes</td>
<td>Yes, by individual</td>
<td>Yes, by individual</td>
<td>All PCP’s and specialists are tiered (radiology, emergency medicine, pathology, and anesthesiology and mental health are not tiered)</td>
</tr>
</tbody>
</table>
Fallon Community Health Plan ("Direct Care") | N/A | N/A; “Selective Network” | N/A; “Selective Network” | N/A
---|---|---|---|---
Fallon Community Health Plan ("Select Care") | Yes | Yes, by group (physicians within Tier 2-"Value" group rated at individual level) | Yes, by group (physicians within Tier 2-"Value" group rated at individual level for three specialties) | GI, Cardiology, and Endocrinology (N/A for Tier 1- "Value Plus" physicians)

Neighborhood Health Care Plan | Yes | Yes, by group for three specialties | Yes, by individual for three specialties | Cardiology, Endocrinology, and OB-GYN

Source: Data from Group Insurance Commission and Massachusetts Medical Society (as of April 2007)

### Exhibit 4.3.B: Clinical Performance Improvement Physician Tiering Implementation by Health Plan (2007)

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Physician Co-Pay by Tier</th>
<th>Physician Co-Pay for non-Tiered Specialties</th>
<th>Physician Tier Methodology</th>
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<td>Health New England</td>
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| PCP: | Tier 3: $25 Tier 2: $15 Tier 1: $10 | All Non-Tiered Specialists Co-Pay is $15 | • IMs and FPs will be tiered using Efficiency (ETGs) and Quality Measures (HEDIS).  
• Specialists will be tiered using quality measures from Resolution Health and HNE |
| Specialist: | Tier 2: $25 Tier 1: $15 | | |
| Harvard Pilgrim Health Care | Tier 2: $25 Tier 1: $15 | PCPs: $15 Specialties not Tiered is $25 | • Quality measures are used as the first threshold followed by efficiency measures (ETGs) |
| Tufts Health Plan | Tier 2: $25 Tier 1: $15 | PCPs: $15 Specialties not Tiered is $25 | • Efficiency measures (ETGs) and Quality measures (including use of patient satisfaction, use of e-prescribing and/or EMRs) |
| Commonwealth Indemnity Plan Plus (Unicare) | Tier 2: $20 Tier 1: $10 | All PCPs and Specialists are tiered | • Efficiency measures (ETGs) and Quality metrics (including Resolution Health) |
| Community Choice (Unicare) | Tier 2: $20 Tier 1: $10 | All PCPs and Specialists are tiered | • Efficiency measures (ETGs) and Quality metrics (including Resolution Health) |
| Commonwealth Indemnity Basic I (Unicare) | Tier 2: $20 Tier 1: $10 | All PCPs and Specialists are tiered | • Efficiency measures (ETGs) and Quality metrics (including Resolution Health) |
| Commonwealth Indemnity Basic II (Unicare) | Tier 2: $20 Tier 1: $10 | All PCPs and Specialists are tiered | • Efficiency measures (ETGs) and Quality metrics (including Resolution Health) |
| Fallon Community Health Plan | Specialist: $15 PCP: $10 | N/A | N/A |
By allowing each plan to tailor individual physician tiering to be as compatible as possible with each plans’ own contracting relationships and corporate strategies, the GIC also effectively preempted any potential litigation from provider groups related to the potential anti-trust aspects of the initiative (Slavin interview 2006). Health plans did not have to worry about violating any state or federal antitrust laws in combining their claims information because they did not collaboratively spearhead the project on their own but simply did so in response to their largest customer (the GIC). However, as a large employer contracting with numerous health plans, the GIC can and did include purchaser requirements in its health plan contracts that plans should use the consolidated claims database that includes cost efficiency (ETG) and quality (RHI) measures.

However, more than one health plan executive noted (off the record) that insisting that all health plans ultimately provide a standardized tiered product based on the same data and methodology could provoke legal action on the part of hospitals and physicians against the GIC for shaping the market in unfavorable ways in collaboration with health plans. As one interviewee noted (on the condition of anonymity), “It’s not clear whether Dolores

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<tr>
<td>Fallon Community Health Plan (“Select Care”)</td>
<td>Efficiency measures (ETGs) and Quality metrics (including Resolution Health)</td>
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<td>Non-tiered specialist copay based on PCP tier</td>
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**Source:** Data from Group Insurance Commission and Massachusetts Medical Society (as of April 2007)
would actually lose such a case, but the fact is that she is pushing the plans as far as she can without getting to the point where litigation from providers is even a real possibility” (Interview 2006).

**The GIC and Purchasing Influence**

This section explores and summarizes what can be learned from the GIC’s efforts in introducing CPI, specifically the GIC’s impetus to structure a new networking tiering system with an eye toward mitigating cost increases for the GIC and the state as a whole.

The jury is still out on the effectiveness of the CPI in achieving its goals to promote the efficient and high quality delivery of care within the domain of the GIC, much less on the larger delivery system in Massachusetts. As has been the experience of similar initiatives in the private sector, delivery-system reforms of this type are politically and technically difficult and will take years to fully structure, implement, and take full effect before conclusive evaluations are possible. Private employers experimenting with similar network tiering efforts in recent years have reported major administrative difficulties and hurdles (Mays, Claxton, and Strunk 2003). Similarly, these efforts have also been technically challenging, necessitating sizable investments to develop the data capacity necessary to collect and analyze clinical information at the individual provider level (McKethan, Gitterman, Feezor, and Enthoven 2006). Moreover, such efforts have also faced numerous political obstacles, including resistant provider groups wary of methodologies used to rate providers based on efficiency.

Despite the dearth of empirical evidence attesting to the impact of the CPI on long term premiums and quality, it is still worthwhile to consider how the GIC chose this
particular cost containment path and what the implementation of CPI reveals about the political and market influence of the GIC as a major public purchaser. I find that the interaction of several factors together explain the how and why the GIC has been able to exert influence to implement the CPI in ways that are designed to benefit the GIC and the broader state health care market. The next section addresses these key factors or issues that have influenced PEHP policymaking by exploring in detail the relative contributions of the key variables outlined in Chapter 2.

Partisan Political Landscape

Democrats have historically dominated both the House and the Senate in the Massachusetts legislature (or “General Court”). However, since 1991 until 2007, Massachusetts has had a Republican governor. Thus, it would be tempting to explore how the split partisan divide between Republicans and Democrats in the legislature and the Governor’s office may have been important characteristic of the GIC’s policymaking environment. After all, both the governor and legislature have key roles in GIC policymaking, the governor appointing GIC commissioners, and the legislature responsible for setting employer premium contributions and passing a state budget that finances the GIC.

However, as many interviewees pointed out, while the governor has the statutory authority to wield influence over the GIC through appointments to the commission, governors have historically not been heavily involved in the details of GIC policymaking besides making commission appointments. Moreover, commission appointments are open-ended such that governors do not have to formally appoint commissioners on a regular basis
when terms expire. Rather, many commissioners have served for many consecutive years, even outlasting governors themselves. Exceptions exist as, for example, the Commissioner of Insurance represents a statutorily automatic GIC appointment, and thus turnover in that office necessitates turnover in the Department’s representation on the commission.

In sum, historically it has been the Democratically-controlled legislature, not the governor, which has wielded relatively more influence over GIC-related issues. While Massachusetts has been a “split” state with Republicans (until recently) controlling the governor’s office and Democrats dominating the legislature, the purview of GIC policymaking largely has rested within the Democratically-controlled legislature.

Providers, including prestigious academic medical centers and community hospitals and physicians, have been opposed to the GIC’s CPI initiative on many grounds. Thus, given that the legislature historically exerts more influence (relative to the governor) over GIC policymaking, it makes sense that provider groups would seek to wield influence within the domain of the legislature to block or change GIC efforts that threaten provider income, professional autonomy, or reputation. However, three factors have effectively blocked the legislative influence of providers opposed to the CPI.

First, there is a “universal appeal” within the legislature related to GIC efforts to address cost containment and quality improvement. One interviewee with close ties to the legislature noted, “You’re able to tamp down criticism you might get if you were just shifting cost from state to enrollee or to providers because [the CPI] seeks to address cost and quality and create real value in the health system” (Interview 2006). Another interviewee agreed, noting: “It rings hollow with these guys [in the legislature] if you’re a hospital and you’re
paying your CEO $900,000 a year and you’re complaining that this initiative to cut costs is going to really hurt you from a financial standpoint” (Interview 2006). Regardless of party affiliation, there is a degree of general support for the underlying goals of CPI even if provider groups oppose its implementation.

Second, Democrats that control the legislature may be less susceptible to the influence of provider interests than a Republican-controlled legislature would be. Several interviewees noted that Democrats controlling the legislature in general seek to be supportive of the state’s health care system and its reputation for innovation and “breakthrough medicine”. However, provider interests are more historically aligned with Republicans. According to one: “[The Massachusetts Medical Society], which has been very vocal against this initiative, is not a particularly strong supporter of Democratic legislators in general” (Interview 2006). According to a different interviewee, this applies to hospitals as well as to physicians: “Hospitals are not heavy financial contributors to Democrats anyway, so it’s easier for Democrats to snub their nose at hospitals complaining about [the CPI]” (Interview 2006).

Third, for the last twenty years, the legislature itself has largely focused its policymaking efforts and time on other issues (e.g., Medicaid), leaving the commission and staff to govern the GIC (Carey interview 2006). According to an interviewee that is representative of several others, “The legislature, relative to the governor, typically exerts control over issues related to the GIC within the political scene in Massachusetts…but in reality [legislators] are very comfortable with Dolores and therefore it’s the GIC itself that pretty much makes decisions without a lot of hand holding from Beacon Hill” (Interview 2006).
In sum, the state’s historically split partisan control over the legislature and governor’s office belies the reality that it is the legislature, not the governor’s office, that is more active in GIC policymaking. However, as noted, the legislature itself defers a great deal to GIC commissioners and its staff. The “partisan” dimension to the GIC’s influence in implementing the CPI is that it is politically easier for Democratic legislators to ignore or overlook the concerns expressed by provider groups about the likely impacts of the CPI. Interviewees noted that providers may be able to “flex their political muscles” if the legislature was controlled by Republicans. That said, given the broad (Republican and Democratic) interest in innovative health policy solutions that can achieve cost containment and quality improvement in the state, it does not appear that, on balance, the particular political configuration of the legislature or governor’s office has been a big factor affecting the GIC’s efforts to implement the CPI. Below, I describe these issues in greater detail when I explore the relative influence of the GIC’s governance structure providing additional political insulation for the GIC to implement CPI absent a substantial degree of direct oversight from the legislature.

The GIC’s Position Within the Larger State Health Care Marketplace

In this sub-section, I describe three aspects of the GIC’s position within the broader Massachusetts health care market that have jointly influenced the development of the GIC’s CPI initiative and its impact on the state’s delivery system (i.e., health plans, hospitals, and physicians and their respective associations). These aspects include the GIC’s market power, its bargaining power, and the vacuum of employer leadership in the health care arena in Massachusetts.

Market Power
The GIC purchases health insurance on behalf of the state’s largest employer. With over 254,000 covered lives, stakeholder interviews from broad perspectives explained that the GIC has considerable market power in Massachusetts. For most health plans in the state that contract with the GIC, the GIC represents their largest single customer. The sheer size of the GIC membership gives the GIC considerable influence in negotiations with participating health plans. Charlie Slavin, who was formerly Director of Policy and Research at the GIC who is now Director of Network Management at Unicare, “When you’re the 800 pound gorilla, you get what you want without much negotiation” (Slavin interview 2006). According to the Conference of Boston Teaching Hospitals’ Erwin, “Dolores [implemented CPI] knowing that her key pressure point for health plans was her massive purchasing power….with that many covered lives, you can often get what you want” (Erwin interview 2006).

While GIC did not invent the idea of physician or hospital tiering and was not the first to introduce the concept nationally, the GIC’s activity in this area was the primary impetus for several participating health plans to establish tiered network products. The relative importance of the GIC membership to participating health plans has shaped the willingness of participating health plans to accede the GIC’s goals and contracting strategies. According to Jon Kingsdale, Executive Director of the Commonwealth Health Insurance Connector Authority and formerly a senior executive at Tufts, the fact that Tufts has historically been the most dependent on GIC for its HMO business explains why Tufts was one of first HMOs to introduce a tiered health insurance plan that corresponded closely to the GIC’s stated goal for CPI (Kingsdale interview 2006). With over 32,000 of its 287,000
HMO members belonging to GIC, Tufts was eager to be responsive to the desires of its largest single customer.

Importantly, by pursuing its policy agenda via contracts with health plans, the GIC has effectively given health plans the negotiating advantage they need to, in turn, contract with providers in ways that health plans would not otherwise. Indeed, the market power of the GIC was not lost on provider groups, with whom there are no direct contracts, and Tufts and other health plans were empowered to use this knowledge to shape provider contracts in ways that would not have been possible or feasible absent the GIC’s market power.

According to Kingsdale,

“[Mitchell’s] determination to do this provided a lot of leverage for [Tufts] with providers. We used her as the bogeyman in our provider relations even as sometimes she used us as the whipping boy. The bottom line is that she was pushing us to do things with providers that we couldn’t get from them on our own. We caught a lot of grief for doing this from physicians and hospitals, as well as the Massachusetts health plan family. It damaged our relationships with hospitals, but that was, for Tufts, the price we had to pay for staying in the GIC pool. Tufts is number three in the market and cannot afford not to be in the GIC. I readily admitted that we only reason we did [participate in CPI] is that we had this crazy lady [Dolores Mitchell] driving the bus” (Kingsdale interview 2006).

A current Tufts executive, Brian Pagliaro, Senior Vice President of Sales and Client Services (who effectively “owns” Tufts’ relationship with GIC) agreed:

“While [Tufts] may have philosophically promoted the principle of transparency and so forth, we would have walked a very fine line of pissing off some very powerful and influential hospitals by pushing forward on the development of Navigator without a major external influence forcing us go in this direction. Without GIC, we wouldn’t have gone in this direction, at least not as quickly as we did…there’s no question about that” (Pagliaro interview 2006).

After implementing Navigator in 2005, the GIC was Tuft’s lone customer of the Navigator product for over a year. However, at the beginning of 2006, four large private employer
accounts, including defense contractor General Dynamics, purchased the Tufts’ Navigator hospital tiering product. Other major accounts are anticipated for 2007 and 2008 as more employers get accustomed to this type of product and as consumers become increasingly engaged in making cost/quality/preference trade-offs.

According to Jay Curley, Senior Vice President of Blue Cross and Blue Shield of Massachusetts (which does not participate in GIC):

“From a contracting perspective it can be difficult for health plans if a major third party is driving you to achieve certain contracts with providers, but on the other hand [such pressure] might make it more palatable to make those changes by blaming the third party. There is no question that the GIC’s market influence has empowered health plans in their negotiations with providers” (Curley interview 2006).

A second aspect of the market power associated with the GIC’s initiative is related its ability to consolidate claims from numerous health plans for all their respective books of business. Smaller health plans establishing network tiering is problematic given the lack of comprehensive data on provider practices. Leapfrog CEO Francois de Brantes has said of the GIC’s initiative, “What's unique about [the CPI] is the scope; because of its scope, in one state and in one area, I think we're going to finally be able to measure whether it makes a difference. The CPI will be able accomplish what individual plans can’t on their own, even if they have attracted big individual memberships” (de Brantes 2006).

Partners Community HealthCare, Inc., for which Dr. Thomas Lee is CEO, is part of a Boston-based integrated health system founded by Brigham and Women's Hospital and Massachusetts General Hospital. According to Dr. Lee, “[Dolores Mitchell] is big enough to single-handedly drive this market by, for example, forcing everybody that contract with her
to submit all data – not just GIC data – but all data – which is much bigger than just the GIC data” (Lee interview 2006).

The fact that the GIC made some concessions on the implementation of CPI does not necessarily suggest its underlying weakness in achieving its goal of introducing a controversial new initiative in the face of powerful payer and provider interests. While the GIC has not achieved everything it set out to achieve, health plans and providers were ultimately forced to move in directions that they would not have moved in otherwise.

As Mitchell remarked about her perspective on allowing health plans some measure of flexibility to implement CPI, “We said you can innovate to some degree within the principles that I outline but you must give me something that moves in the direction I want to go in” (Mitchell interview 2006). And they did.

**Bargaining Power**

Massachusetts’ competitive marketplace is another source of the GIC’s influence. Because there are numerous hospitals and competing health plans in Massachusetts, the GIC is able to wield the threat of exclusion from GIC participation if payers and/or providers do not ultimately agree to participate with particular contract provisions or requirements. Thus, the GIC’s bargaining power (as opposed to its market power) is shaped largely by its ability to contract with (or to decide not to contract with) willing health plans. Bargaining power in this context is a function of the Massachusetts market itself. As the Massachusetts Hospital Association’s David Smith noted about Dolores Mitchell,

“Her tool has been her request for proposals from health plans that want to offer their products to GIC members. Since she doesn’t have to welcome them all into the GIC,
she has been able to say that if you’re going to have a piece of my population, you have to offer products that address my issues” (Smith interview 2006).

The ability to include some health plans and to exclude others represents an important component of the GIC’s influence. By contrast, if the nature of the Massachusetts market did not allow for the opportunity to exclude certain health plans from participation, either for political or market reasons, the GIC’s bargaining power would be limited because there would be few if any plans it could exclude without facing political backlash or compromising access to care on the part of GIC members. While it would likely be unpopular from the standpoint of GIC members and constituent employers to actually exclude popular academic medical centers or health plans from its membership, the Massachusetts market does nonetheless allow the threat of exclusion to be taken seriously.

Mitchell’s tenure at GIC and her “tough” negotiating tactics have earned the GIC a reputation as being an assertive purchaser whose threats should be taken seriously.

According to Slavin, formerly the GIC’s Director of Policy and Research:

“In the early to mid-1990s, Bay State Health contracted with GIC and at one point, they came in with a one-year 22 percent rate increase proposal. In negotiations, Dolores asserted that she was going to negotiate that really big rate increase downward and wanted to know from Bay State what was driving such an astounding rate increase. Their CEO said ‘Our proposal is not up for negotiation, and the way we run the plan is none of your business.’ Mitchell kindly but abruptly ended the meeting. This was the GIC’s single largest plan and it was fairly popular with members. But she went back to the Commission and strongly recommended not accepting their contract and ending the relationship with Bay State. There was a vigorous discussion on the Commission with some commissioners saying there would be hell to pay from members. But the commission was ultimately persuaded by Dolores and we first froze Bay State’s enrollment in GIC for a year, and then later dropped them altogether. Bay State people went to the legislature and complained and there were a few inquiries. Later there was an internal battle on the Bay State board of directors. Within six months Bay State went out of business. This reinforced to the health plan community that Dolores was a serious person and learned to take her suggestions…or threats….very seriously” (Slavin interview 2006).
Other interviewees agreed that the ability to threaten health plan exclusion (and Mitchell’s reputation her willingness to execute on those threats) has contributed significantly to the influence of the GIC in its negotiation efforts. This is the combined function of the GIC’s market power as a major employer and its bargaining power associated with the characteristics of the state’s health care market.

“Weak” Employer Community

A third component of market influences on the GIC is related to its position of leadership within the Commonwealth’s community of large employers. The GIC represents the largest employer in the state of Massachusetts. This provides the GIC with an important platform from which to assert and mobilize employer leadership in state health policy and related discussions. According to Richard Lord, President of Associated Industries of Massachusetts, “No other employer in Massachusetts has the kind of heft in terms of employer leadership potential as Dolores” (Lord interview 2006). Moreover, numerous interviewees described how the state’s changing economic landscape has created a vacuum in employer leadership focused on health care reform issues. Numerous mergers, acquisitions, and the increasing nationalization of employers have, in the last two decades, transformed the state business community, once dominated by large technology and financial services firms and their headquarters.

For example, in the last twenty years, the state lost the major corporate headquarters of once-prominent financial institutions, such as Shawmut Bank, BayBank, Bank of New England, and Bank of Boston. In 2004, Bank of America, based in Charlotte, North Carolina, acquired FleetBoston Financial. Recent mergers and acquisitions have not been
limited to financial services sector. In 2005, for example, Proctor & Gamble, based in Cincinnati, Ohio acquired Gillette. According to Smith, “In the last twenty years, and even in the last few years, business leaders that had previously contributed significantly to the business leadership’s interest in health care issues fell apart as the economics of the state changed” (Smith interview 2006). According to Lord, “There used to be a coalition of very effective businesses that really showed some muscle and took a stand and drove reform here, but it has been pretty quiet except for the GIC, they’re the real driving force in terms of the employer community” (Lord interview 2006).

Today, the state’s largest employers are in the health care industry, predominantly pharmaceuticals and biotechnology. Others, according to the New England Health Institute’s Wendy Everett, are smaller manufacturing firms or satellites and local production facilities for national or international organizations, so as a consequence their leaders aren’t all that visible in this environment” (Everett interview 2006). As one interviewee noted (anonymously),

“These newer firms care about health care at the state level, but the big shifts in the business landscape has meant that in the net, we have lost a lot of employer leadership in the health care community; that core of health care leadership from the business community that was previously active in the ’70s and ’80s has disappeared and hasn’t re-emerged in any real strong sense since then” (Interview 2006).

As a result, the GIC has played an increasingly important role representing the business community in health care policy and related discussions. According to Curley,

“The GIC in Massachusetts is the organization being looked at by purchasers in the business community as the entity that really has the ability to influence in the health arena. There are not a lot of companies with the resources or time doing any serious thinking around impacting health care as GIC does. The remaining Massachusetts employers with major headquarters here just don’t have expertise in human resources and don’t want to dedicate capital to consulting services” (Curley interview 2006).
Michael Bailit, former Massachusetts Medicaid Director and president of Bailit Health Purchasing (a national consulting firm based in Boston), added, “Massachusetts is unusual in that the leading health care purchaser voice is the GIC. This is rarely seen in other states but it is due both to the fact that the GIC is particularly innovative and assertive and because there is a real vacuum of employer leadership in this state” (Bailit 2006).

As Trude and colleagues have noted, the trend (in Massachusetts and elsewhere) toward nationalization of employers can result in a centralization of health care benefit decisions and a lack of involvement with or concern for local or state market issues (Trude 2002). State public employee health plans by definition are connected to their states and communities. Local government employers and state government employers in state capitals in particular have a larger stake in the activities of local and state markets (Watts et al. 2003). Thus, the GIC’s position within the employer community in Massachusetts has contributed to its position of employer leadership in negotiations with other actors in the state’s health care delivery system.

This employer leadership, in turn, has placed the GIC in a position of strength in negotiations with health plans. According to Lord,

“Many companies out there are watching GIC’s negotiations with the plans very carefully [as they relate to CPI]. The HMOs know that Dolores [Mitchell] doesn’t just represent state employees, she represents the state’s employer community. If the GIC is pushing for something, you can bet that Dolores has already carefully vetted the idea with much of the employer leadership in the state. The [health] plans know this. Massachusetts companies have been hard hit by premium increases since the end of the managed care era, and I think they will start to sign up for CPI because they are looking for any way to direct consumers to hospitals and doctors that provide the best medical care at the lowest prices. Most companies are really going to wait a couple years to watch the GIC’s tiering effort play out, but a lot of them will ultimately follow the GIC’s lead and embrace this themselves” (Lord interview 2006).
Influence/Role of Interest Groups, Unions and other Stakeholders

Participating health plans and other stakeholders were quick to cite the GIC’s influence in stimulating the movement toward tiered network products among participating health plans. However, many also noted at the same time that the final results that have emerged through the negotiation process between GIC, health plans, and provider groups has not been precisely what GIC originally sought or envisioned. The GIC clearly has thus far been unable to compel payers and providers to adopt the CPI exactly as it had been originally envisioned. Both the hospital and physician tiering efforts stimulated loud protests from providers and health plans wary of standardization and rapid implementation of an initiative that would assert that some providers are able to achieve better levels of cost and quality than others. Thus, payers and providers were able to extract important concessions that gave them some degree of flexibility in the implementation of CPI.

As discussed previously, some health plans have not even introduced differential co-pays at all. This suggests a limitation of the GIC’s ultimate market influence to “reform” the delivery system in particular ways. While it has been influential in setting the agenda and making known its strong preferences for what the CPI should look like, plans and hospitals have implemented CPI in ways that are consistent with their own corporate goals and values and provider network strategies.

For example, Kingsdale, responsible for creation of Tufts’ tiered network product (“Navigator”), explained:

“Despite the powerful position that Dolores [Mitchell] has had to introduce the CPI, Tufts was still able to customize Navigator to fit Tufts instead of some one-size-fits-all approach. For example, in the second year, we decided to tier primary care physicians (PCPs). We ended up ranking or ‘gold starring’ on cost and quality but not
differentiating co-payments. We investigated this but the backlash against us would have been terrible among our providers and members. PCPs are in short supply anyway. This approach doesn’t ultimately satisfy [Mitchell], who wants physicians individually tiered, period. But there are just a whole lot of reasons why that doesn’t make sense for us. In some ways we are caught between a rock and a hard place but Tufts is going to be moving in that direction out of necessity” (Kingsdale interview 2006).

In fact, of the GIC’s participating health plans, only Unicare has thus far introduced network tiering at the individual physician level precisely as GIC originally envisioned. UniCare is the only plan to do exactly what GIC wanted because it has nothing to gain and everything to lose from deviating from GIC’s vision for CPI. This is because the GIC represents Unicare’s only business in the Commonwealth. According to Commissioner Bowler, “GIC is not simply Unicare’s largest customer, it is Unicare’s only customer, so they’ll do whatever their sole customer wants them to do since they face no repercussions on other lines of business” (Bowler interview 2006).

All other participating health plans are in varying stages of introducing tiering or concepts related to tiering. That different plans have different tiering methods means that different doctors are potentially rated or evaluated differently, which is a fundamental problem that several stakeholders identified.

The GIC has been successful in promoting the underlying concepts of the CPI even though not every health plan has yet fully implemented the initiative. However, the origins of the CPI were borne out of an inherent limitation of the GIC’s (and other employers’) influence in negotiations with health plans and provider groups. Specifically, the GIC and other employer groups in Massachusetts have been unable or have been unwilling to actually restrict providers from their networks. According Commissioner Bowler, health plans in Massachusetts “have historically been reluctant to restrict their networks to particular
physician groups or hospitals because they understand the market and know that customers will vote with their feet if they can’t get what they want” (Bowler interview 2006). Even in the managed care era that culminated in the 1990s, several interviewees noted that managed care had a big impact in Massachusetts, but it was always “managed care light” since managed care never featured closed panels of providers. As one interviewee noted, “There has been a lot of emphasis on utilization review, prior authorization, et cetera et cetera, but not restricted networks as they might have been in California or other places” (Interview 2006).

The Department of Insurance’s Pinion noted that, “There are 8 teaching hospitals in a 7 mile radius in the Boston metro area. From a health plan’s standpoint, if you don’t have each of them in your network, your product gets defined as inadequate and substandard and you have difficulty selling that product. Tight networks are a challenge if not an impossibility in this state” (Pinion interview 2006). Thus, while the GIC’s CPI effort has provoked the ire of health care providers, the GIC and other employers have not seriously considered network exclusion fearing the potential backlash from GIC members that desire broad access to health care providers of their choice. This suggests an inherent limitation of the GIC in the face of provider popularity and strength.

**Governance Structure of the GIC**

While much of the GIC’s influence is related to the personality of its current executive director, it is also derived, as one legislative insider put it, from the “government structure in which it is been placed” (Hager interview 2006). According to the general statutes outlining the legal definition of the GIC, “[The GIC] shall be established within the
executive office of administration and finance, but not under its jurisdiction” (General Laws of Massachusetts). Thus, while the GIC formally sits within the Department of Administration and Finance, the GIC exercises quasi-independence from the department. According to Mitchell, “The GIC is ‘within but not under’ the jurisdiction of the Department of Administration of Administration and Finance. I always like to tell the incoming Commissioner [of Administration and Finance] that ‘You can’t fire me! Only my Commission can do that!’” (Mitchell interview 2006).

The quasi-independent commission is governed by eleven commissioners with overlapping three-year terms. The Commissioner of Administration and Finance and the Commissioner of Insurance (or their respective designees) serve on the Commission. In addition to these automatic statutory appointments, the Governor makes several additional appointments. This includes at least one retired state employee, at least one health economist (currently Harvard’s David Cutler), at least three full-time state employees, two of whom are union members and one of whom is a member of the Massachusetts State Employees Association (General Laws of Massachusetts).

The Commission is fully responsible for appointing its Executive Director and setting and executing on its agenda. The general statutes establishing the GIC grant the commissioners broad discretion to make policy decisions that affect health care and other benefits:

“The Commission shall negotiate with and purchase, on such terms as it deems to be in the best interest of the commonwealth and its employees from one or more insurance companies….group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance benefits covering persons in the service of the commonwealth and their dependents” (General Laws of Massachusetts).
The governor, through Commission appointments, has the actual authority to formally control the agenda of the GIC. The reality, though, is that governors from both parties have historically deferred to the Commission. According to the Commonwealth Connector Authority’s Carey, formerly with the GIC, “New governors come in, and they have so much other shit on their plate, if [the GIC is] not broke, they’re not going to go out looking for trouble. That’s how they’ve viewed Dolores and the GIC” (Carey interview 2006).

While the governor makes appointments to the Commission and therefore could exercise some authority over the GIC, the legislature has no formal control over the selection of the executive director or in setting the agenda of the Commission. The GIC regularly submits its annual budget request to the governor’s office and legislature, and each year it is approved with little modification, regardless of party affiliation of the governor (Mitchell calls herself a “liberal Democrat”). As elected officials responsible for the Commonwealth’s budget, members of the legislature and the Governor could wield more direct influence over the GIC’s budget through the state budget and appropriations process. However, according to the health policy aide of the Massachusetts Speaker of the House,

“Policymakers know that tinkering with the GIC’s budget or proposing big cuts or changes would result in political backlash from the public employees and their constituents. It is easier to kick around an entitlement program for poor people (MassHealth, the State’s Medicaid program) than to mess with public employees. Plus, everybody throughout the legislative process knows that Dolores is straight on these issues. She’s a cost cutter, so there’s no reason to go toe to toe with her when there are bigger fish to fry in other areas of state government” (Hager interview 2006).

The Blue Cross Blue Shield Foundation’s Turnbull agreed: “Health care has long been identified as a budget buster for the state. Dolores has been a very active and strong
willed politically astute director who wants to drive reform. Nobody on Beacon Hill really wants to disturb that…in fact they want to encourage it” (Turnbull interview 2006). The relative independence from legislative influence also means that state’s powerful payer and provider interest groups are effectively constrained from exercising direct legislative influence or using personal connections with legislators to directly affect the work of the GIC or, for example, block the CPI. According to Hager, “Most [legislators] know enough to not be combative with [Mitchell], so they would say to powerful provider groups and others that the Commission is an autonomous structure governed by a separate Commission and cannot be influenced through the legislative process, period” (Hager interview 2006).

Furthermore, the relative insulation from direct political pressure from the legislative arena is derived in part from the specific goals of the CPI and similar initiatives. Legislators are reluctant to be responsive to any provider or health plan “concerns” if the underlying issue is compatible with larger goals, such as cost containment or quality promotion. Thus, the GIC’s relative autonomy may be confined to particular policy areas. Carey describes the potential boundaries of the political insulation exercised by the GIC:

“Dolores has couched the CPI in terms of cost containment and [quality improvement]…therefore she has been able to tamp down any serious criticism you might get from the hospitals and docs because the legislature has historically been interested in cost containment and maintaining the Commonwealth’s reputation for innovative quality health care. If she came forward with a proposal to just shift costs from the state to state employees, then the legislature would get involved because that would generate lots of constituent concerns. But couching her initiative in terms of cost and quality, she has been able to mitigate potential criticism. The docs and hospitals really have no avenue to vent on this one other than the occasional op-ed in the Globe” (Carey interview 2006).

Thus, as long as the GIC undertakes a effort construed as being designed to contain costs or enhance health care quality in ways that do not disturb the health care benefits of
state workers, the GIC exercises relative autonomy. Unicare’s Slavin recalled an example from his days as GIC’s Director of Policy and Research that illustrates how the Commission’s political independence and authority is shaped in part by the constraints that health plans and other interest face attempting to invoke the legislative or political process to control GIC policymaking. According to Slavin:

“Harvard [Pilgrim Health Care] thought of themselves as the best health plan in the world. In 1994, Harvard came to the GIC with what was seen by [Mitchell] as an unacceptable rate proposal. [GIC staff] went before the Commission with our analysis about how out of line Harvard’s rate proposal was. Harvard refused to negotiate. They basically presented their rate proposal on a ‘take it leave it basis.’ Therefore [Mitchell] recommended to the Commission that we freeze Harvard’s enrollment in the GIC – we wouldn’t dump people off their health plan but also wouldn’t allow Harvard to enroll more of our members until the next contracting period when Harvard could re-submit a bid. The Commission accepted Mitchell’s recommendation, and [Harvard] almost shit a brick. They were totally stunned. On the night after the meeting, Harvard’s senior people started calling [GIC] commissioners at their homes and at their places of business, they even called legislators to encourage them to make the Commission reverse its decision. But it didn’t matter. It was too late and there was nothing that legislators could or would do because no legislator was going to be seen as carrying the water for a health plan that cost too much against the GIC” (Slavin interview 2006).

According to the Department of Insurance’s Pinion, there was no formal political or administrative channel for Harvard or other health care stakeholders to plead its case: “The Commission receives the GIC staff’s recommendations on the day before a meeting, there is a sometimes healthy and legitimate debate, and then the Commission votes, almost always unanimously in favor of what Dolores recommended. That’s it” (Pinion interview 2006).

All interviewees insisted that the Commission is strong and “real”, as former commissioner Richard Zeckhauser put it, and that it engages in “authentic” debate and discussion that contributes to GIC policy decisions (Zeckhauser interview 2006). According to Charles Baker, who served as a Commissioner from 1992-1999,
“Most board don’t work very well. This board actually functioned quite effectively representing both constituents and the public at large.....Why? Because it was of the government, but not wholly within the government and GIC has been fortunate to have first-rate staff and executive leadership” (Group Insurance Commission Annual Report 2005).

However, others also emphasized Mitchell’s personal influence in setting an agenda that is palatable to the Commission, giving them an authentic voice, and then leading them to adopt her positions on critical matters, such as contracting issues.

This influence and autonomy have, according to the Connector Authority’s Kingsdale, contributed to Mitchell’s ability to propose and implement the CPI: “Her position gives her enough independence and latitude to be able to make what other people might term as outrageous or difficult decisions” (Kingsdale interview 2006). According to one interviewee with close contacts in the legislature,

“I suspect there are a lot of other states that would have been susceptible to political backlash and pressure from providers to trim the sails. Dolores is well established and vocal on Beacon Hill and known to have strong will and determination and a lot of political connections in Massachusetts. But maybe as important to all of that, she also is significantly politically insulated, and everybody knows it” (Interview 2006).

The result of the political insulation enjoyed by the GIC is that there is very little direct influence exerted on behalf of the legislature on GIC policymaking. According to Mitchell:

“In my nearly twenty years of service, only once or twice has a legislator applied political pressure to me to give a contract to a certain vendor or change a contract, and in those cases I listen carefully, but then ignore it unless the suggestion can stand on its own merit. There are no real consequences for me if I don’t simply exercise my own discretion about what I think is best, subject to the will of my boss, the Commission” (Mitchell interview 2006).
Policy Leadership and Entrepreneurship

Virtually all interviewees attributed the importance of the GIC’s influence in state health policy discussions generally, and the implementation of the CPI specifically, as a direct reflection on the political influence and personal savvy of its Executive Director, Dolores Mitchell. Given her “reputation as a cost-cutting enthusiast,” according to Carey, “Most everybody has absolute respect for Dolores, but also some fear” (Carey interview 2006). Mitchell’s influence and reputation is not associated with her partisan allegiances. As executive director, Mitchell has worked under seven different governors (3 Democrats and 4 Republicans) over a period of nearly 20 years.

After each gubernatorial election, Mitchell somewhat famously submits a formal letter of resignation to each incoming governor, only to have her letter ignored. The governor does not appoint the executive director (the Commission does), but Mitchell’s letter is intended to symbolize her “respect for the new governor and the fact that I don’t want this job unless I have strong support from the new governor” (Mitchell interview 2006). According to the MHA’s David Smith, “Both Democratic and Republican administrations in Massachusetts have embraced her, going back to the Dukakis administration….she is now serving under the fourth consecutive Republican governor. They just let her do her thing” (Smith interview 2006).

Numerous interviewees depicted Mitchell as a fierce negotiator who enjoys and is particularly skillful in the process and art of negotiation. Commissioner Bowler explained, “Most employers in Massachusetts take rate renewal and say ‘thank you very much’ to whatever the health plans propose. Mitchell uses rate renewal proposals as merely a starting
place” (Bowler interview 2006). As one (anonymous) health plan interviewee noted, who has been on the receiving end of Mitchell’s aggressive negotiation efforts,

“Dolores has outlived most health plan CEOs. When it comes to negotiating rates or other issues that involve costs to the GIC or the taxpayers, she doesn’t spare her friends. In negotiations with health plans, even those senior executives that she knows personally, she kicks the shit out of all of them equally” (Interview 2006).

Former GIC staff members noted that staff members have recommended a “satisficer” approach in negotiations with health plans; however, Mitchell’s approach is to treat small and large health plans alike:

“Negotiating aggressively to take the costs of an enormously popular health plan down by 1% gets you a lot more savings than if you take a smaller, less popular plan down by 20%. It’s a basic ‘satisficing’ negotiation strategy. I remember her response to this staff recommendation. She said, ‘Every one of these plans is going to sacrifice. We’re going to negotiate with every one of them equally aggressively. While some of them may be smaller than others, proportionally they may all be rolling in dough’” (Carey interview 2006).

Another health plan executive interviewed (anonymously) concurred, noting, “Her approach is ‘nothing is good enough.’ Wrestle them to the ground. Push them into the floor until their nose bleeds. Then politely, and with a big smile, ask them to leave. She can be very funny and gentle and at the exact same time, very devastating” (Interview 2006).

While health plan executives and other interviewees were quick to point out Mitchell’s fierce negotiating approach and tough personality, they each also conveyed a great deal of personal respect and heartfelt understanding of her efforts. According to Slavin, “she is not particularly ‘showy’, her pomp and circumstance is not about ‘her’, she just wants to get the job done, and everybody knows that” (Slavin interview 2006).

Current and past GIC commissioners cited Mitchell’s longstanding desire to provide a generous health care benefit at the lowest possible cost as the source of her political support among both Republicans and Democrats. Hager, chief policy aide for the
Massachusetts Speaker of the House Speaker, concisely summed up the basis of Mitchell’s political support on Beacon Hill as attributable largely to respect and support for her efforts and methods on a bi-partisan basis:

“Her seriousness and legacy about containing costs and driving every penny out of the negotiation process is the basis of her support at the Legislature for the CPI. It doesn’t matter what party you’re in or if you have a powerful hospital in your district. This is an expensive state for health care, and any backchannel efforts of the powerful provider groups or insurance lobbies fall on deaf ears because of a strong respect for Mitchell’s commitment to cost containment and the kinds of think she is doing with the CPI” (Hager interview 2006).

Mitchell has put her negotiating tenacity and reputation for cost containment to work in proposing and implementing the CPI. Marisa Fusco, Tufts’ Director of Client Services, noted, “Dolores Mitchell has done a good job spearheading this….she has pushed and pushed and pushed to get [CPI] done, even when she hits an obstacle like a technical problem or a particularly frustrated provider group” (Fusco interview 2006).

According to Barbara Rabson, Executive Director of the Massachusetts Health Quality Partners:

“[Mitchell] is absolutely devoted and dedicated and passionate about this initiative and she has a lot of political capital built up over 20 years in which she has proven herself a serious policy leader who wants to drive the delivery system to provide higher quality, lower cost care. [Mitchell] has single handedly pushed the CPI on the power of her own personality and reputation” (Rabson interview 2006).

Virtually all interviewees highlighted Mitchell’s personal role in implementing CPI in the face of strong resistance from powerful hospitals and provider groups as a function of her reputation and leadership with the Legislature. Bailit summed up the general consensus among interviewees about how Mitchell’s leadership has been instrumental in implementing GIC:

“The ability to navigate around the powerful groups like the teaching hospitals and Partners and other physician-oriented groups is almost all due to Dolores Mitchell’s
‘one person show’ and correspondingly, her strong support from her commission and the legislature” (Bailit interview 2006).
Conclusion

This chapter set out to analyze the GIC’s experience launching a new initiative designed to mitigate rising costs within the GIC as well as to stimulate delivery system reforms that would influence the state health care system as a whole. Accordingly, it examined both the factors that shaped how this particular strategy was implemented and also the factors that have contributed to the GIC’s influence (as well as the limits of its influence) as a major public purchaser.

The GIC’s Clinical Performance Improvement initiative is based on leveraging the Commonwealth’s contracts with private health plans participating in the GIC to establish a “high performance” network tiering structure. In launching the CPI, the GIC has realized that contracts can be valuable instruments in the hands of sophisticated purchasers. Specifically, contracts with private health plans can use participation requirements to impose unequivocal standards, set detailed performance goals, demand more and better data, promote and reward quality improvement, generally convey to health plan participants a heightened sense of accountability, and in effect, change the business practices of contractors (i.e., health plans) and those with whom they contract (i.e., providers).

When implemented, the CPI initiative was highly unpopular with health plans. Interviews with health plans revealed that they may have considered the concept of network tiering absent the GIC’s requirements that health plans move in this general direction, but none of them had active plans to actually implement network tiering due to the technical and administrative hurdles of doing so as well as the concerns about the potential backlash from provider groups.
Despite their protests, health plans have by and large grudgingly acceded to the GIC’s wishes at a basic conceptual level if not in a specific programmatic level. All participating plans are participating in the GIC’s required data submission component of the CPI even if they have collectively extracted concessions from the GIC to phase in network tiering implementation in a manner that is consistent with each health plans’ provider relations and contracts and corporate goals. Moreover, the GIC’s contracts with several participating health plans have, in turn, forced health plans to re-structure their own contracts with provider groups. This has proven to be highly unpopular with health care providers. This unpopularity has manifested itself in different ways, including public complaints about the initiative and its design elements. However, even provider groups that have enjoyed the perception if not the reality of being highly politically popular (to the extent that they have been successful in avoiding restrictive provider networks even at the height of the managed care era) have been unable to exert political or other influence to effectively block the CPI.

So what accounts for the GIC’s success in overcoming resistance from key stakeholders in the Massachusetts health care system, including health plans and provider groups? The analysis contained in this chapter argues that several issues help explain the GIC’s impetus to introduce the CPI and its basic success in doing so. There is a broad political consensus within the legislature, governor’s office, and commission itself that maintaining the quality of health care benefits for public workers and their families is of paramount concern, notwithstanding the erosion and thinning of health care benefits that has characterized the employer-based health system in the private sector. With cost shifting effectively “off the table”, the GIC has had to search for alternative ways to contain costs.
The CPI purports to contain costs and improve health care quality. The legislature has long been dominated by Democrats, who interviewees said were not as responsive to provider interest concerns and complaints as Republicans typically are. Moreover, the legislature has historically deferred much of GIC policymaking to the GIC itself. The GIC’s relatively autonomous governance structure has effectively eliminated a possible mechanism through which providers and other groups may be able to leverage political influence through legislative channels to block or modify the CPI.

This chapter finds that characteristics of the state health care market play a very important role in explaining the GIC’s relative influence as a major purchaser. First, the GIC enjoys significant market power because it purchases over $1 billion of health care benefits every year. One interviewee said that “the GIC is the biggest employer-based purchaser in all of New England” (Carey interview 2006). Second, the GIC enjoys bargaining power, which is a testament to the relatively vibrant health care marketplace of Massachusetts, with its many teaching and community hospitals, physician groups, and many competing health plans. Notwithstanding its reluctance to do so, the GIC is in a position to exert bargaining power because it can realistically threaten not to contract with certain health plans or provider groups if these groups do not accede to contract terms that the GIC finds acceptable. Finally, the changes in the economic landscape of Massachusetts specifically, as well as the “nationalization” of employers on a broader level, mean that the GIC is positioned within a larger vacuum of employer leadership in the state. Given that other private and public employers in Massachusetts look to the initiatives of the GIC as a potential testing ground for new ideas, health plans and provider groups are forced to
address the concerns of the GIC as the GIC functions as a de facto leader among employers in the Commonwealth.

As mentioned above, the GIC’s historical system of governance has created a powerful position in the GIC’s executive director. With the governor and legislature content to allow the GIC to exercise relative independence in its policymaking activities, the Commission has attracted talented staff and commissioners who exercise their duties with the broader market of Massachusetts in mind. Finally, a very important ingredient in the success of the GIC has been the effectiveness, political acumen, and leadership of its executive director for the last twenty years, Dolores Mitchell. Not only does the GIC’s governance structure grant Mitchell considerable latitude to experiment with new and innovative initiatives, she has also earned an impressive level of personal trust given her stewardship of the GIC and reputation for being a fair, if forceful, cost cutter. It is unlikely that an executive director lacking Mitchell’s skill and political influence would have been successful navigating the technical, administrative, and political challenges that Mitchell has addressed since the CPI was implemented four years ago. Leadership matters.

The key factors that help to explain the GIC’s success in implementing the CPI over resistance from key provider and health plan interests in Massachusetts also suggest some of the limitations of PEHPs’ “purchasing power” to induce private actors to behave in ways that they would not have otherwise. First, the political dynamics present in Massachusetts (with Democrats dominating the legislature) helped to reduce providers’ ability to exert influence to block or modify the CPI. This suggests the possibility that in states with political dynamics that are more hospitable to the plight of provider groups, PEHPs may be constrained in important ways from engaging in innovative purchasing initiatives that are
perceived to harm health care providers. This could be the case, for example, in states with hospitals that face serious financial challenges being affected by PEHP “reforms” that are perceived to exacerbate those challenges.

More importantly, however, much of the GIC’s influence is associated with its governance structure, which provides as much political autonomy as could reasonably be expected for a political entity like the GIC. The GIC’s governance structure has somewhat insulated its decisionmaking from political pressure from providers and other groups since the legislature does not actively assert control over the GIC’s specific initiatives or purchasing requirements. In states with different forms of PEHP governance, however, PEHPs may be more relatively limited in their ability to exert considerable influence introducing initiatives similar to the CPI that seek statewide delivery system reforms that are controversial. This is because provider groups in such states could leverage political processes through the legislature, for example, to effectively block or modify such initiatives deemed hostile to provider interests. Nonetheless, even independent governance structures can be captured by providers and other interests. Thus the specific degree of political independence that PEHP commissioners or board members enjoy vis-à-vis the legislature may not entirely explain the effectiveness of governance structures. More research is needed to better understand the role of governance systems.

Moreover, that the Massachusetts “story” is to a large degree a function of its dynamic health care market suggests that in states with less health plan or provider competition, PEHPs may be disinclined or unable to enact purchasing requirements that explicitly affect the broader state health care system. For example, in largely rural states with limited provider and health plan competition, PEHPs may not be in a position to exert
bargaining power and induce private actors to engage in the same types of behaviors that the GIC has been able to influence. Further, in states with other large private employers and other purchasers that demonstrate strong interest in the broader state health care market, PEHPs may not be able to exert the “solo leadership” as the GIC and may instead need to couch its efforts in a more collaborative coalition-based manner. This may ultimately reduce the ability of PEHPs to exert its preferred types of market influence as PEHPs would need to coordinate with other large purchasers instead of engaging in these efforts alone.

Finally, as noted above, a large measure of the GIC’s success in implementing the CPI has been associated with the charisma and skill of its executive director. Leadership matters. This suggests the possibility that in states whose PEHPs are not led by dynamic or especially talented or politically connected leaders, PEHPs may be effectively constrained in important ways from leveraging the many characteristics that together contribute to the relative “purchasing influence” of the PEHP.

It is too soon to tell what real impacts, if any, the CPI initiative will have on cost containment and quality both within the GIC and statewide. However, the GIC has in fact implemented the CPI in a way that is likely to gradually change the behaviors of private actors, possibly including consumers, within the state’s delivery system. At the very least, health plans have had to collect new data that illustrates the relative efficiency and quality of health care providers in the state. At the other extreme, however, some plan options have actually implemented the CPI specifically as the GIC proposed, via hospital co-pay differentials for different tiers and via physician tiering at the individual level for a number of key specialties. It is possible that this initiative may change practice patterns and may induce other employers to purchase or experiment with tiered network or “high
performance” products. A highly optimistic view would even suggest that this initiative could lead health care consumers (both GIC and non-GIC consumers) to play a more direct role in making health care choices that balance costs with quality.

It should be pointed out, however, that the CPI has been introduced in a fairly limited way to date. The “purchasing influence” of the GIC has not been unlimited by any measure. Its intended goal has been met with substantial backlash from the provider community and for that reason, from health plans. Providers and health plans convinced the GIC to back down from its original ambitious goal to introduce a standardized tiering structure across all participating health plans.

The activities of the GIC are somewhat impressive (even if the actual results of the initiative are unknown) and they do suggest an important policy role for states as major health care purchasers. However, even under the most optimistic scenario, the policy research community should resist any urge to couch PEHP purchasing influence as capable of fundamentally re-shape the state’ health care market without much more research. To the contrary, this case has demonstrated that while public purchasers are important and do have mechanisms to exert influence in the market, they are also constrained and limited in many important ways. In sum, based on the Massachusetts experience to date, PEHPs play an important role in the broader health care market and policy environment but are shaped by and subject to political, market, and other influences and constraints.
Chapter 5: North Carolina

Introduction

Scholars and policy analysts focusing on state health care policy do not typically consider North Carolina as a particularly ambitious reform-oriented or innovative state. Partly as a result, practically no policy and research attention has been focused on the North Carolina State Health Plan (SHP) and its role in purchasing or subsidizing health care benefits on behalf of the state’s leading employer, the state of North Carolina. This chapter addresses this gap by focusing on the efforts of policymakers and SHP officials in recent years to use the SHP as a vehicle to help contribute to broader delivery system reform, seeking to confer cost containment benefits on the SHP itself as well as the health care system as a whole.

Fitting within the larger scope of this dissertation, this chapter’s primary analytical and policy focus is on how policymakers have used the SHP in a larger effort to pursue policy objectives that affect more than the SHP’s traditional constituencies. As noted in a previous chapter, this dissertation is not a formal evaluation regarding the extent to which states have actually achieved cost containment or other goals. Rather, it is largely a political
and policy analysis seeking to understand the factors influencing SHPs to select their chosen strategies and the factors shaping their experiences with those strategies.

Specifically, the key questions addressed by this chapter include how and why the SHP first decided to offer its members multiple private health plan options in the late 1980s and throughout the 1990s. It explores the experience of this policy and also briefly discusses how and why the SHP’s experience with private health plans changed considerably by the early 2000s. Given that policy and political officials in North Carolina had high hopes for the ability of the SHP’s experience with health plan “choice” to usher in a new era of delivery system reform in the state, while also yielding cost containment benefits for the SHP itself, this chapter also explores aspects of the “role” of the SHP (and the limits of its role) in the state’s larger health care policy arena.

This chapter finds that the state’s use of the SHP to help encourage HMO competition in the state was successful in the sense that HMOs such as Kaiser did locate or expand HMO operations in North Carolina in part due to their ability to market to and within the state’s large SHP group. The state engaged in several activities in structuring an environment of multiple health plan choice that were perceived to favor the state’s indemnity plan over HMO options. However, it is unlikely that HMOs entered North Carolina exclusively because of the offer to use the SHP as a base of enrollment. It is also unlikely that HMOs failed in the state solely because of perceived unfavorable market conditions within the SHP. While state policymakers sought to use the SHP to help move the market toward alternative delivery systems, the SHP’s operating environment came to mimic the broader market instead.
The next section briefly describes the history and structure of the SHP, including its basic administrative design and governance structure. The third section describes the rise and fall of one of the SHP’s high profile cost containment efforts in recent years by analyzing the relative influence of each of this dissertation’s key variables of interest. The chapter concludes by describing the lessons learned from the North Carolina case that contribute to a broader understanding of the key factors influencing PEHP policymaking and the roles they play as major purchasers in state health care environments. As with the previous chapter on Massachusetts, more detailed conclusions are presented in the final chapter in which I make explicit comparisons of the North Carolina and Massachusetts cases.

**Background**

**North Carolina State Employee Health Plan**

The North Carolina State Health Plan (SHP) provides health care benefits to over 615,000 state employees, retirees, and their dependents. Specifically, those eligible for coverage under the SHP include teachers, state employees and state retirees, current and former lawmakers, University of North Carolina System and state community college system employees, state hospital staff, and eligible dependents who choose to participate. The SHP is financed through general state revenues and premium contributions from participating public employers and dependents. The SHP is governed by a nine-member board of trustees. Three members of the board are appointed by the governor, three are appointed by the president pro tempore of the senate, and three are appointed by the state House. As discussed in greater detail below, while the governor makes statutory appointments to the board, the legislature over time has asserted much more direct control over SHP operations.
The SHP was established in 1968 under the administration of Governor Bob Scott, who sought to move the authority to contract for health insurance for employees from individual government departments and agencies to a consolidated office. Between the time that the SHP was formally established in 1968 until the early 1980s, state employees, retirees, and dependents were offered traditional indemnity insurance through the SHP’s contract with a single risk-bearing insurance carrier. In response to the federal Employee Retirement Income Security Act (ERISA) in 1974, many private employers started replacing their fully-insured products with “self-funded” insurance administered by third-party administrators (TPA) to avoid benefit mandates, liability, and premium taxes (Enthoven 2002). During this time, state legislative and agency dissatisfaction with BCBS's handling of the SHP and its cost “overruns” compelled the state in 1982 to become one of the first state PEHPs in the country to “self-insure” (Feezor interview 2005).

By self-insuring, state officials desired to no longer subsidize the outsourcing of risk via fully insured products and instead elected to pay a TPA to administer benefits and pay claims. Thus, starting in 1982, all SHP members were enrolled in a self-insured traditional fee-for-service plan, the state Comprehensive Major Medical Plan (CMMP). Texas-based Electronic Data Systems (EDS), which for part of the 1970s had handled claims administration in North Carolina’s Medicaid program, was chosen as the SHP’s first TPA.\(^c\)

\(^c\) However, former state officials in retrospect argued that “asking” EDS to submit a bid for the newly self insured program (in response to previous dissatisfaction with BCBS) was a poor choice given that EDS did not previously have a TPA service line and thus had little experience in this arena. Hence, EDS’s “poor service and too many cost overruns” compelled the SHP to seek new TPA bids in 1987.
In 1987, BCBS submitted a winning proposal to the state that effectively wrested the SHP’s TPA contract away from EDS.

The transition from full insurance to self-insurance with an outsourced TPA contract was not the only change that took place during this period in the life of the SHP. As is described in more detail in the next section, beginning in the early to mid 1980s, the state undertook a new approach of offering its members the option of selecting from numerous private HMOs. The general approach had two related goals. The first goal was to use the SHP’s base of enrollment as a recruitment tool to encourage private HMOs to establish operations in the state in an effort to “reform” the state’s delivery system. The second and related goal was to use HMO competition within the SHP to help mitigate annual cost increases incurred by taxpayers and public employers (Byrd, 2006).

From 1986 until 2001, SHP members had the option of choosing from as many as twelve private HMO options in addition to the state’s traditional CMMP. By the early 2000s, however, all HMOs exited the SHP after incurring significant financial losses. The next section describes this experience in detail, including the key factors that compelled the state to undertake this approach and the factors that explain why and how it unraveled by the early 2000s.

**The SHP’s Experience With Private Health Plan “Choice”**

Beginning in the mid-1970s, North Carolina state government officials became increasingly skeptical that the state’s indemnity-dominated health care marketplace was adequately equipped to mitigate rising health care costs (Byrd interview 2006). Employers and taxpayers were “starting to feel the crunch” of rapidly escalating health care costs
The growing concern in North Carolina was part of a broader national uneasiness about health care inflation. Both the Nixon Administration and liberal policymakers, including Senator Edward Kennedy, described cost containment as a “crisis” issue that demanded attention (Starr 1982).

Policymakers in North Carolina sought to be responsive to growing concern among the business community and the public at large (Hunt interview 2005). Specifically, state policymakers began to consider whether the HMO model gaining popularity in other parts of the country (and explicitly encouraged by the Nixon Administration) could serve as a viable cost-containment model that would encourage a more efficient allocation of health care resources in the state. Previously, several high-profile and successful prepaid group practice (PGPs) efforts around the country (including Kaiser Permanente [Kaiser] based in Oakland, California) compelled Congress to pass the HMO Act in 1973. This law greatly expanded the small but growing movement toward alternative delivery systems by statutorily defining HMOs, providing some capital financing to support the start-ups of non-profit HMOs, and importantly, requiring all employers of 25 or more employees to offer at least one PGP and one Independent Practice Association (IPA)-based HMO as health insurance options (where they were available). This federal action was a big boost to the development of HMOs throughout the country and provided an important backdrop for state-level reform efforts in North Carolinas in the late 1970s and early 1980s (Starr 1982).

The increasing growth and potential of HMOs that was generating much policy and political attention nationally also had the same effect in North Carolina. In 1979, the General Assembly established the Commission on Prepaid Health Plans to study alternatives for organizing and financing health care (North Carolina Commission 1979). The
commission examined several models of prepaid health care delivery and concluded that
delivery system reforms could introduce health plan competition to control costs. Based on
the Commission’s recommendations, the General Assembly enacted several legislative
reforms designed to establish a supportive environment for alternative delivery systems in
North Carolina, including provisions to allow HMOs to acquire facilities and contract with
medical groups and traditional insurers (North Carolina Commission 1979). This legislative
activity catalyzed the entry and development of HMOs in North Carolina, which in turn
eventually allowed the SHP to offer multiple HMO options to its members.

In 1982, Governor James Hunt established the Foundation for Prepaid Health Plans
designed specifically to attract new HMOs to North Carolina. The Foundation’s initial
recruitment efforts were focused on encouraging Kaiser to launch a regional expansion in the
state since Kaiser was one of the nation’s largest and fastest-growing HMOs and because of
its reputation as a leading model of PGP (Gitterman et al. 2003). The Foundation, with the
active support of Governor Hunt, recruited Kaiser to North Carolina just as the state
typically recruits large employers (Hunt 2006; Wade 2006). The Foundation met several
times with Kaiser officials and provided information about the state’s demographics,
business community, and health care trends, specifically in the Raleigh-Durham-Chapel Hill
Triangle and Charlotte metropolitan areas.

State officials, including the Governor, encouraged Kaiser to enter the North
Carolina market by, among other things, suggesting that the HMO could submit a bid to
enter the SHP and use it as an initial base of enrollment. As Kaiser had previously
developed and leveraged influential local organizational support (e.g., public employee
groups and labor unions) in its other expansion region, the state’s courtship of Kaiser and its
willingness to offer the SHP as an initial base of Kaiser’s enrollment was one of several factors that ultimately influenced the HMO’s decision to expand to North Carolina (Gitterman et al. 2003).

Moreover, the state’s recruitment of Kaiser coincided with Kaiser’s interest in expanding into new markets. At the same time that elected officials and policy reformers in North Carolina were trying to make the state a hospitable environment for alternative health care delivery systems, Kaiser was seeking to expand regionally. Specifically, Kaiser sought to branch out from its West Coast presence in order to compete more effectively for national corporate accounts. To Kaiser, the southeastern United States offered a great deal of market potential and thus it eventually expanded to Raleigh-Durham, North Carolina and Atlanta, Georgia.

Kaiser formally established North Carolina operations in 1984 as the first and only true prepaid group practice in North Carolina. In 1985, the General Assembly formally authorized the SHP to allow the entry of health maintenance organizations (HMOs) into the SHP.

HMO Choice in the SHP (1986-2001)

After establishing operations in North Carolina in 1984, Kaiser entered a successful bid to join the SHP in 1985. SHP members residing in the Raleigh-Durham area could select Kaiser as their health plan beginning in the 1986 contract year. In addition, in 1985 the SHP also approved BCBS and Prudential to provide HMO products in the SHP after these carriers, with Kaiser, were successful in the SHP’s first competitive bidding process. In contrast to Kaiser’s group practice HMO model in which members were treated
exclusively by Kaiser physicians (through the Carolina Permanente Medical Group), BCBS and Prudential and other entrants in North Carolina were network-model HMOs that contracted with IPAs and/or community primary care physicians not exclusively serving Kaiser patients. Prudential, which based its “mixed-model” HMO\(^d\) on the Nalle Clinic in Charlotte, offered its “PruCare” product while BCBS offered its “Personal Care Plan” (PCP). The emergence and activity of these three HMOs – Kaiser, Prudential, and BCBS – were the first HMO players in the SHP in what became a flurry of HMO activity in the later part of the decade (in both the SHP and the state as a whole).

Kaiser, Prudential, and BCBS built a modest base of enrollment within the SHP but did not remain the only HMOs operating in the SHP for long. Carolina Physicians Health Plan (CPHP), a physician-owned and -directed HMO was created in response to Triangle-area physicians “feeling coerced to participate in [North Carolina’s] growing HMO movement” (Bilbro 2003). CPHP attracted over 6,000 SHP members by 1993.\(^e\) In addition, Maxicare, Physicians Health Plan of North Carolina, and Partners National Health Plan of North Carolina entered the SHP in the early 1990s. Despite the new HMO options available to SHP members, however, Kaiser continued to have the highest enrollment of any HMO option in the SHP. Its 26,928 SHP members accounted for about 6% of total SHP membership in 1993.\(^f\) Kaiser’s SHP business constituted about 23% of its total statewide enrollment in 1993 (NCSHP 1993–1998).

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\(^d\) A mixed-model HMO contracts both with medical groups and IPAs.

\(^e\) In 1994, Healthsource entered the SHP after acquiring Carolina Physicians’ Health Plan.

\(^f\) Importantly, Kaiser was only available to SHP members in the Triangle and Charlotte markets – not statewide.
Despite the flurry of new HMO options available in the SHP, the state’s self-insured CMMP continued to dominate, with nearly 84% of members opting to remain in the CMMP in 1994. Nearly 20% of SHP members were enrolled in one of seven HMO plans in 1994, up from 14% in 1993. HMO activity in the SHP reached its apogee in 1997, when twelve HMOs provided health plan alternatives to the CMMP. Nearly 27% of SHP members chose HMOs that year (NCSHP 1983-1988).

In the case of Kaiser, by 1996 the HMO began to lose SHP market share and members due in part to the intensifying competition of newer lower-priced entrants (e.g., Wellpath) in the state and within the SHP (Lore 2007; Soper 2007). By 1996, Kaiser served slightly more than 20,000 SHP members, accounting for 16% of Kaiser’s total enrollment (down from about 23% in 1993). By 1998, Kaiser served only 18,157 SHP members (15% of Kaiser’s total enrollment). Finally, in December 1999, Kaiser closed down and sold its North Carolina operations, leaving only 4,399 members who had opted to remain in the plan until their contracts expired (NCDOI 2000).

Exhibit 5.1: Distribution of SHP Enrollment by Health Plan Choices (1997)

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Enrollment</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Major Medical Plan (CMMP)</td>
<td>389,860</td>
<td>73.1%</td>
</tr>
<tr>
<td>Personal Care Plan (BCBS)</td>
<td>47,425</td>
<td>8.9%</td>
</tr>
<tr>
<td>Wellpath Community Health Plans</td>
<td>23,432</td>
<td>4.4%</td>
</tr>
<tr>
<td>Healthsource North Carolina</td>
<td>19,622</td>
<td>3.7%</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>18,401</td>
<td>3.4%</td>
</tr>
<tr>
<td>UnitedHealthCare</td>
<td>11,223</td>
<td>2.1%</td>
</tr>
<tr>
<td>PruCare</td>
<td>10,604</td>
<td>2.0%</td>
</tr>
<tr>
<td>Partners National Health Plan</td>
<td>4,406</td>
<td>0.8%</td>
</tr>
<tr>
<td>Maxicare Health Plan</td>
<td>2,623</td>
<td>0.5%</td>
</tr>
<tr>
<td>Qualchoice Health Plan</td>
<td>2,546</td>
<td>0.5%</td>
</tr>
<tr>
<td>Doctors Health Plan</td>
<td>2,016</td>
<td>0.4%</td>
</tr>
<tr>
<td>Cigna Healthcare</td>
<td>1,178</td>
<td>0.2%</td>
</tr>
<tr>
<td>Optimum Health Plan</td>
<td>225</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>533,561</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

**Source:** Author’s calculation based on State Health Plan Enrollment Figures, 1997.
The SHP’s experiment with private health plan options ended with all remaining HMOs exiting the SHP by 2001. For the next five years, all SHP members would be enrolled in the CMMP. However, in February 2006, SHP officials announced that beginning in October of the same year, SHP members would be able to once again select an alternative plan option to the CMMP. Unlike the previous experience in the 1990s in which the SHP contracted with private health plans (which were at risk), however, the preferred provider organization (PPO) options are state-based self-insured plans administered by BCBS.\(^g\)

Specifically, SHP members selecting a PPO option can select from among three varying PPO options with different co-pays, coinsurance, deductibles, and premium contributions to be attractive to populations with different risk and health profiles. Since SHP members were able to select a new PPO option in October 2006, about 260,000 existing SHP members (42%) have chosen to stay in the traditional CMMP while 360,000 opted (58%) to move into a PPO plan (Soper interview 2007).\(^h\)

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\(^g\) The SHP discussed the new PPO network contract with several companies (including BCBS, United, Aetna, Cigna) to make their PPO networks and administrative services available for the new PPO plans. Given its large statewide network, BCBS won the PPO contract. Thus, BCBS retains the ASO contract for the CMMP as well as the separate contract serving the SHP’s PPOs.

\(^h\) According to SHP officials, the availability of the segmented PPO products has induced approximately 30,000 individuals that had been eligible for SHP benefits but previously chose not to participate to enroll in a PPO (primarily dependents). Thus, adding new 30,000 members means that approximately 60% of total SHP members are enrolled in a PPO option and 40% remain in the CMMP. The inclusion of presumably younger,
The SHP projected that the new PPO options would save the state $30 million in the first year (Soper interview 2007). The primary basis of these savings is the lower provider reimbursements made available through the BCBS’s “Blue Options” network. That is, given that PPOs offer wide-access provider networks and little utilization management (relative to traditional HMOs), “immediate” savings projections are based largely on simply lowering reimbursements to participating providers through the BCBS PPO network.

Despite the apparent popularity of the new PPO options (relative to the CMMP), the current strategy is markedly different from the previous experimentation with broad health plan choice. Encouraging private HMO options to enter North Carolina and the SHP had been designed to stimulate competition between the traditional indemnity-based marketplace and the new, more integrated delivery systems available through HMOs. In contrast, the current environment of SHP plan options is designed to make new benefits and cost sharing options available to different segments of the SHP population and to leverage provider reimbursement as the primary cost containment mechanism. While the state may realize short-term savings associated with lower provider reimbursement contracts, the PPO option is unlikely to stimulate significant long-term economizing as wide-access PPO options are subject to the same cost drivers as traditional indemnity insurance.

Factors Influencing the SHP’s HMO Cost Containment Strategy and Its Experience

This section explores and summarizes what can be learned about the SHP’s experience with private health plans, specifically the rise and fall of private health plan healthier dependents is likely to improve the problem of adverse selection that has concerned SHP officials and policymakers (and earlier, HMO executives participating in the SHP).

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options in the 1980s and 1990s that ended by 2001. The goal of this section is to better understand the key drivers of PEHP policymaking in North Carolina and what, if anything, the implementation of the effort reveals about the political and market influence of the SHP as a major public purchaser.

HMOs that participated in the SHP sought to use it as a base of enrollment that would assist them in developing other business in North Carolina. In the case of Kaiser and other new HMOs in the state, marketing products to a large employer group like the SHP were expected to reduce the initial costs associated with acquiring new membership and help amortize the fixed costs of expanded operations to the Triangle and Charlotte metropolitan areas. Secondly, participation in the SHP was also expected to demonstrate the low-cost HMO model “alive and working” to other employers in North Carolina considering adding HMO options for their employees (Elting interview 2005). For incumbent carriers already doing business in North Carolina, such as BCBS, providing HMO options in the SHP was also seen as a strategy to avoid losing significant market share to new HMO entrants while also growing their own HMO products to serve employer groups’ interest in experimenting with managed care options.

State’s Political Party Configuration

For the most part, North Carolina has had a Democratic governor and a Democratic legislature in the last three decades. Republicans controlled the governor’s mansion when Republican Governor Jim Holshouser was in office from 1973-1977 and Republican Governor Jim Martin served from 1985-1993. Republicans briefly held the North Carolina House between 1985-1988. Otherwise, Democrats have dominated state party politics
Regardless of party affiliation, however, North Carolina governors have historically not played a major role in SHP policymaking (Long interview 2006). Aside from making three statutory appointments to the board of trustees, the governor “has largely taken a back seat on matters of [SHP] oversight and policymaking “(Interview 2005). Thus, despite Governor Hunt’s active involvement recruiting Kaiser and other HMOs to the state using the SHP as a base of enrollment, the partisan affiliation of the state’s governor has not played an important role in PEHP policymaking (Kaplan interview 2007).

Moreover, no interviewee directly attributed political competition between Republicans and Democrats in the legislature or the particular political configuration of the legislature at any given time as having played an important role in the effort to promote HMOs within the SHP or in HMOs’ inability to achieve and retain profitability in the SHP.

More generally, in North Carolina, SHP politics does not generate particular recurrent or ongoing partisan cleavages. As one key market observer noted, “Looking back over the years, I don't really recall any clear partisan issues, at least capital D or R type disputes with the [SHP]. Politics has long played a big role in the [State Health] Plan for sure, but competition between political parties isn’t really what’s it’s all been about” (Mahoney interview 2007). Another interviewee agreed, noting, “I honestly cannot recall any explicit partisan battles over the State Health Plan or any related issues” (Kaplan interview 2007).

Several interviewees articulated a “Medicaid crowd-out” thesis in which the lack of political partisanship regarding the SHP has been due in part to relatively more legislative interest in and concern about the state Medicaid program. One such interviewee noted that,
“The much bigger elephant in the room, Medicaid, has served to preempt a lot of high profile attention on most aspects of the SHP” (Interview 2007).

Indeed, compared to the SHP, the Medicaid program is more symbolically important as a program that generates the partisan political conflict endemic to social welfare programs. Throughout the 1990s, Republican state legislators by and large sought to limit budget growth in the Medicaid program by resisting Democratic efforts to liberalize eligibility criteria for the program, by seeking to limit benefit expansions, and by focusing intently on perceived savings associated with “fraud and abuse” in the Medicaid program (Cansler interview 2006). By contrast, Democrats have sought to take advantage of federal matching funds available to expand Medicaid eligibility and covered benefits to additional populations. These respective positions, which have stimulated recurrent partisan debate and competition within the legislative arena, particularly within the budget process, have allowed policymakers in both parties to garner political benefits, with Republicans claiming that they are promoting cost controls and with Democrats seeking to use public programs to cover uninsured low income individuals. (Fuquay interview 2006).

Moreover, the focus on Medicaid makes sense given that compared to the SHP, Medicaid itself is more important in total covered lives and in dollar terms. Medicaid provides comprehensive health care benefits to about 1.5 million state residents (Kaiser Family Foundation 2006). Financed in part by general state revenues, the Medicaid program has consumed an increasingly large slice of state health care spending as well as total general fund spending in North Carolina. Moreover, the program has been growing rapidly from a cost perspective. From 1986 to 1997, expenditures for North Carolina's Medicaid program grew at an average rate of 18% per year before decelerating to single digit annual growth for
much of the later part of the decade (North Carolina Division of Medical Assistance 2000). In 2000, (the state share of) Medicaid spending accounted for 65% of North Carolina's total health care expenditures, compared to just 12.2% for the SHP (Milbank State Expenditure Report 2003). Thus, partisan competition over aspects of the Medicaid program has been an important aspect of state policymaking in the last decade, while high-profile legislative attention on the SHP has been comparatively limited.

A final reason that Medicaid politics has generated relatively greater partisan competition within the state legislative arena, compared to the SHP, relates to the particular constituencies served by the respective programs. Medicaid is a “poor person’s program” providing health care benefits to low-income and otherwise uninsured individuals that are perceived to have limited electoral or political power (Brown and Sparer 2003). This frees policymakers, primarily Republicans, to promote cost containment without fully enduring political backlash from Medicaid recipients themselves.¹

By contrast, the SHP’s primary constituency is state employees and retirees. The state views health care benefits as important components of total compensation to recruit and retain public workers. With some exceptions, there has been broad political consensus to avoid cutting benefits or limiting eligibility to this politically important and well-organized group (Cope interview 2007). Hence, despite annual cost increases, the actuarial value of

¹ That said, owing to its size and importance to the larger health care policy arena, Medicaid has developed constituencies that have protected it from deep cuts during state budget crises. For example, physicians and hospitals, particularly those in underserved communities, have a vested interest in ensuring the resiliency of the program as Medicaid reimbursement represents an important source of provider revenue.
benefits offered to SHP members exceeds the average private employer-based health plans (McKethan et al. 2006). Consistent with national trends, even as private employers have “thinned” benefits and shifted new costs to workers, the value of the SHP’s benefits have remained relatively stable. As one interviewee noted, “It’s much easier to at least talk about finding ways to trim Medicaid than it is to go up against what is considered a fairly strong and vocal public employee constituency. Nobody really wants to mess with that unless we have to” (Interview 2006).

The “Medicaid crowd-out” thesis was well-articulated by a longtime health care lobbyist in North Carolina: “Most legislators have bigger fish to fry in trying to wrestle Medicaid cost growth to the ground rather than worrying about state employee benefits” (Kaplan interview 2007). As a result, partisan cleavages in SHP policymaking have not characterized SHP policymaking nearly to the extent as in the Medicaid program and other areas of health care policy. In summary, it is not that politics per se did not play a key role in the development and experience of the SHP’s effort to promote HMO competition. Rather, contrary to theoretical expectations, the politics of SHP policymaking has not been explicitly a partisan issue with Republicans seeking particular policy goals and political advantages and Democrats others. Nonetheless, politics has emerged in other ways as the more detailed discussion below on the SHP’s governance structure describes.

The State’s Changing Health Care Marketplace

During the state’s period of experimentation with private HMO options, SHP members could choose to remain in the state’s own fee-for-service plan (CMMP) or select one of several participating HMOs. Despite the significant number of HMO choices offered
in the SHP by the mid-1990s, most members chose to remain in the CMMP. Several overlapping market-related factors help explain both the resilience of the CMMP in an environment of multiple HMO options as well as the demise of HMO choice in the SHP.

First, despite new HMO activity in the state generally and in the SHP in particular, North Carolinians had very little experience with managed care, particularly “true” prepaid group practice options such as Kaiser. Even at the height of the “managed care era” that swept the country, North Carolinians were enrolled in HMOs at rates well below national averages. Market observers and regulators described how, in general, most North Carolinians were unaware of the concept of managed care and had very virtually no experience with HMOs when they became available. According to Paul Sebo, the SHP Program Manager who led the first HMO enrollment meetings with state employees and retirees to explain the new HMO options in the SHP, a frequent source of confusion among state employees involved:

“…getting people to stop saying ‘HBO’ because during that same time, cablevision was becoming very popular and attendees thought they were attending the enrollment meeting to talk about ‘HBO’ instead of ‘HMOs’…That’s how ‘back-woodsy’ North Carolina was in terms of managed care” (Sebo interview 2005).

Despite great interest among the state’s political and policy community in ushering in a new era of managed care in the state, this effort relied upon an assumption that consumers would eventually select for managed care options when confronted with a choice. For the most part, the market was never fully conducive to the more restrictive forms of managed care. A relatively inexperienced consumer population (regarding managed care) took cues from both national discussions about the problems of managed care as well as an aggressive effort by the provider community to “brand” HMOs as “low quality” or “inadequate” health
care, as described in greater detail below. For most SHP members, then, the relative comfort of staying with the CMMP (particularly active employees and retirees that paid no premiums and had no cost advantage to choose lower-cost health plan options) factored into their choice to remain in the CMMP despite the myriad choices available.

Second, while the SHP population is widely distributed across the state, not all HMO plans were available statewide. For example, Kaiser’s markets were in the Raleigh-Durham metropolitan area and later the Charlotte metropolitan region. While multiple HMO options were available in the state’s metropolitan areas, such options were not available to a significant proportion of the SHP population, especially in rural areas. SHP purchaser requirements obligated participating HMOs to make their plans available to their full provider networks in the state. This (understandable) requirement prevented HMOs from “cherry-picking” from their most profitable markets and excluding regions where provider contracting or networks were more difficult or expensive. However, most HMOs in the SHP did not have a statewide provider network and thus generally did not have to serve non-metropolitan markets. This put as many as twelve HMOs in a position of engaging in intense competition for relatively fixed enrollment within confined geographic areas within the state and limited the ability of HMOs collectively to attract market share even remotely comparing with the statewide CMMP.

Third, many North Carolina HMOs themselves faced market-related operational and business challenges that were not directly related to their SHP membership, including insufficient capital, marketing problems, lots of smaller employers in a very tough and costly market, resistance from the medical community (discussed below), poor internal business decisions, and high fixed costs associated with the geographically-dispersed North Carolina
market (Bilbro 2003; Greene 2003). It was also the case that there were few other large employers that offered a choice of multiple HMO options, which under different circumstances could have translated into more enrollment for HMOs and reduced the importance of HMOs gaining adequate market share in the SHP.

Fourth, the rise and fall of HMO choice in the SHP mirrored the much broader managed care “backlash” in the nation in which growing national disillusionment with various forms of highly managed care led to greater regulatory scrutiny of HMOs. This discontentment led employers and consumers to demand that HMOs increase the number of providers in their networks, expand the geographic coverage of networks, loosen restrictions on in-network referrals to specialists, reduce other utilization management controls, and give employees the option of going out of network for care at affordable out-of-pocket costs. In response, the HMO marketplace rapidly moved away from a closed HMO model toward less-restrictive forms of HMOs, PPOs, point-of-service (POS) products, and other direct access HMO products that offered enrollees broader provider networks and fewer service restrictions. Several HMOs in the SHP, including Kaiser, attempted unsuccessfully to stem enrollment losses by transforming traditional HMO products into less restrictive PPO-like products for SHP members (Wolf 2000; Fisher 2002). As one former HMO executive put it, “by then, it was too little, too late” (Lore interview 2005).

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Ironically, when Americans were surveyed about the satisfaction of their health plans, a majority suggested that they were generally satisfied with their care; however, a plurality nonetheless responded that managed care resulted in lower quality health care and that managed care organizations should be subjected to greater regulation.
Further, federal payment pressures loomed large in the general financial performance of HMOs in the 1990s, including those participating in the SHP. Before 1997, government reimbursement rates generally gave health care providers enough margin and flexibility to respond to the pricing pressures attributed to managed care. However, in 1997 Congress passed the Balanced Budget Act (BBA), which effectively cut government reimbursements to hospitals and physicians.

Squeezed by pressures from the BBA, many providers “pushed back” on HMOs in the late 1990s, becoming less willing to concede to significant provider discounts (Cunningham 2001). As HMOs were squeezed on non-SHP business, they became less able to withstand the losses from their SHP participation. Thus, larger non-SHP market considerations exacerbated pressures that HMOs were facing operating in the SHP.

Moreover, HMOs faced intensified competition from new entrants struggling to quickly gain market share in North Carolina. In particular, the more mature “incumbent” HMOs (including Kaiser) were discriminated against because of pricing strategies adopted by new market entrants. Newer carriers such as Wellpath gained market share within the SHP by initially offering their HMO options at prices significantly lower than those of earlier entrants. According to Commissioner Long, “many HMOs were stretched, from a financial standpoint, as a result of the heightened level of competition following the rapid expansion in the number of HMOs during the 1990’s, and this only magnified the effect of financial losses that may have come as a result of contracting with the SHP” (Long 2006).

By the middle of the 1990s, as losses mounted and HMO enrollments started to decline, the state’s managed care marketplace experienced rapid organizational change. In
fact, the state’s HMO environment between 1997 and 2002 has been characterized as a period of “shakedown and reorganization” as the number of full-service HMOs declined rapidly due to mergers and closings (Greene 2003). For example, Kaiser Permanente sold its Triangle membership to Partners National Health Plans of North Carolina and its Charlotte membership to Principal Health Care of the Carolinas (now Coventry). Greensboro-based Physicians Health Plan (distinct from “Carolina Physicians Plan”), which along with Kaiser had been one of the most popular HMO options in the SHP, was sold to United Health Care. BCBS later acquired Partners Health Care, and Carolina Physician Health Plan was bought by HealthSource, which in turn was later acquired by Cigna. These mergers and acquisitions were related to the broader market evolution of HMOs at the broader state and national level and not entirely or mostly due to the SHP.

The opportunity to use the SHP as a base of enrollment played an important role in encouraging Kaiser and perhaps other HMOs to enter North Carolina. However, it became very clear by the middle part of the 1990s that SHP business alone was not sufficient on its own to help HMOs sustain their livelihoods in North Carolina. The above market factors affecting the SHP business in particular, as well as the state’s and nation’s changing health care marketplace more generally, did not allow the SHP to serve as the safe base of enrollment that was intended. Thus, instead of the SHP’s experiment with HMO options reforming the state’s market, the SHP largely came to mimic the market as the state’s larger experience with HMO options deteriorated nearly as quickly as it arose.

**SHP’s “Politicized” Governance Structure**
The underlying politics and governance structure of the SHP created (real and perceived) challenges that limited HMOs’ ability to effectively use the SHP as a favorable base of enrollment. All stakeholders interviewed acknowledged that the General Assembly exerts significant political and operational influence over the SHP, specifically the Committee on Employee Hospital and Medical Benefits. The direct legislative role in determining specific rates, benefit designs, and generally shaping SHP policy is “as strong as any [state employee health plan] in the country” according to a former acting SHP administrator (Feezor interview 2005). Under the SHP’s enacting law, all benefits are included directly in state statutes and can only be adjusted through legislative procedures. Given how cumbersome it can be to amend state statutes through the political process, this arrangement has been criticized for removing flexibility for the staff and trustees of the SHP to quickly respond to costs and other factors that arise (McKethan and Gitterman 2005).

While the SHP is formally governed by a board of trustees, numerous interviewees explained that “[the board] has been more of an advisory board…the real power over most aspects of the [SHP] has historically resided directly in the legislature” (Interview 2006). According to the Commissioner of Insurance, the direct political role of the General Assembly in making health benefits and other decisions “adds complexity and politicizes issues faced by the SHP…This is not a judgmental statement but is a simple fact” (Long 2006). More generally, the SHP’s “politicized” governance structure places the General Assembly in a position of being directly involved in many of the details of SHP policymaking. This means that provider and other interests have a direct avenue by which to

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\(^k\) The Committee on Employee Hospital and Medical Benefits is established by statute (see GS 135-38).

\(^l\) North Carolina General Statutes Chapter 135
lobby for and against certain SHP policies, subjecting SHP policymaking to the political legislative process.

Specifically, the politicization of the SHP contributed to policy choices being made that, from the standpoint of several market observers interviewed, effectively favored the state’s own traditional indemnity plan (the CMMP) over HMOs. First, benefits offered by HMOs had to be at least comparable to those offered under the SHP’s indemnity plan. To HMO executives, this provision limited HMOs’ ability to tailor their benefits designs even while the state sought to ensure that adverse selection did not occur. However, more than one HMO executive and a regulator reported that the SHP purchasing requirements for HMOs ensured that HMO benefits were actually richer than the CMMP. The concern within the HMO community was that this policy would raise the possibility that higher risk members may be attracted to the relatively generous package of benefits available in HMOs.

Requirements of richer benefits and the need to provide lower member costs to attract enrollment led to adverse selection in some HMOs (White interview 2003). According to White, who served as President of CIGNA’s North Carolina operations, relatively high-risk members were better off choosing HMOs, despite having to pay an extra monthly premium, since 100% of their medical bills were covered under HMOs. The SHP’s risk adjustment mechanism, discussed below, was not capable of mitigating this burden. As one market observer described, “So they were willing to bring HMOs in, but right from the beginning with the richer benefit requirements we could start to see that they brought HMOs in only under conditions that basically forced [HMOs] to subsidize the retirees and older state employees in the [CMMP] who generally avoided HMOs” (Mahoney interview 2007).
A related example concerned mental health and substance abuse benefits. After aggressive lobbying in the legislature from the North Carolina Psychological Association (NCPA) and other mental health and substance abuse advocates, the SHP did not allow HMOs to place the same limits on mental health or substance abuse treatments that were in the CMMP (and relative to the benefits HMOs offered in their non-HMO business). As a result, HMO mental health and substance abuse benefits were actually more generous than the CMMP’s benefit. Thus, members expecting to have greater health care needs were more likely to select HMO coverage over the CMMP. The SHP’s governance structure, in which the legislature played a direct and assertive role in myriad details of SHP policymaking, meant that these and other benefit design issues were subject to legislative politics with various interest groups gaining the opportunity to find a political supporter on the legislative oversight committee. Even after hiring influential lobbyists\textsuperscript{m}, HMOs struggled to secure what HMO executive perceived would be “basic neutral” conditions operating within the SHP.

Second, a longstanding implicit agreement has existed in which SHP members would always have employee-only health coverage through the SHP without paying a premium contribution. However, the state makes no premium contributions toward dependent coverage, which means that those seeking dependent coverage are responsible for the full average cost of coverage.\textsuperscript{n} Based on utilization/claims and on the availability of reserves,\textsuperscript{m}

\textsuperscript{m} For example, Kaiser hired Zeb Alley, a longtime lobbyist who is perennially at the top of the North Carolina Public Policy Institute’s ranking of most effective lobbyists in the state.

\textsuperscript{n} In other words, the state makes a 100% employer premium subsidy for active employees/retirees and 0% for dependents. However, as a SHP official remarked, “There is a belief by certain General Assembly members
the General Assembly sets premiums and cost sharing provisions by statute for the CMMP. When the SHP offered multiple health plan options to its members, it maintained its employer premium contribution strategy of fully subsidizing each “employee-only” premium with an amount equal to the full cost of the CMMP premium (with zero employer premium contributions for spouses and other dependents). Thus, SHP members were not rewarded with savings by selecting health plans with lower total premiums than the CMMP premium. In addition, they had to pay the price difference to enroll in plan options with higher total premiums than the CMMP. This policy was likely not designed to specifically favor the CMMP. However, it had the effect of doing so as it created virtually no reason for members (particularly lower-risk members) to select HMO options.

The state’s employer-contribution strategy led to very expensive dependent coverage in the SHP compared with similar coverage outside the SHP. This situation contributed to adverse selection since dependents would have a strong incentive to obtain coverage elsewhere and those who could not would likely include some members who were unable to do so because of their health status (Sebo interview 2005). Importantly, however, this artifact of the SHP situation preceded (and has persisted after) the period of HMO options in the SHP and thus was not designed in response to HMO options. However, it did contribute to a difficult market environment for HMOs offering their products to SHP members and had the effect of favoring the CMMP over participating HMO plans.

that, well, the subsidy for the employees in North Carolina comes largely from the fact that their employee premium is paid at 100%. If you’re paying everybody’s employee premium, therein lies the subsidy” (Soper interview 2007).
Perhaps more importantly, only when the General Assembly acted to modify the premiums for the CMMP would the HMOs know how much premium revenue from the state could be expected. However, the General Assembly did not raise the CMMP’s base premiums at all from 1991 to 1998. This fueled the belief among HMO executives that higher risk members may have been exiting the CMMP and being attracted to HMOs, resulting in adverse selection on the part of HMOs.

However, according to one interviewee:

“The key issue was that it was politically difficult to significantly raise [legislative] appropriations to the SHP while there were still millions in reserves. So rather than small, incremental bumps over that period, [legislators] spent down the reserves and then had to very sharply increase appropriations [to the CMMP] in each of the next few years” (Mahoney interview 2006).

As the interactions between the Fiscal Research Division and legislators are confidential, it is not known what, if any, actual consideration was given to the impact of frozen CMMP premiums on HMOs. However, HMOs and other more neutral market observers speculated that legislators knew that freezing the CMMP base premiums would hurt the HMOs: “They knew what they were doing. It was in some ways similar to Medicaid HMOs: welcomed with open arms to lose all the money they wanted to” (Interview 2006). Regardless of why the CMMP premium remained flat during this period, the effect was to make premiums relatively and increasingly costly for SHP members enrolled in HMOs. Again, this generally goes against the standard model of HMOs being able to compete as among the lower-cost plan options.

Third, despite the dominance of the CMMP, SHP officials and legislative leaders became concerned in the early 1990s that SHP members migrating to HMO options were
younger and healthier relative to those remaining in the CMMP. The concern was that such a migration could leave the CMMP at risk for a higher proportion of high risk members. Legislators sought guidance from the General Assembly’s Fiscal Research Division to seek a way to ensure that the SHP was compensated for the relatively “good” risk that migrating away from the CMMP toward HMO options.

Accordingly, the state levied a risk adjustment of $10 per member per month on all HMO enrollees aged one to 40.° The state’s one-way risk adjustment was based on age, ensuring that the younger employees choosing HMOs would end up subsidizing older workers remaining in the CMMP. However, the risk adjuster was one-way, which meant that that HMOs were not compensated for any unfavorable risk that they might have attracted. This was especially problematic given that HMOs offered rich (or richer) benefits relative to the CMMP and, unlike the CMMP, had no benefit maximums.

HMO executives and government leaders interviewed cited the SHP’s particular method of risk adjustment as one of several sources of financial strain for HMOs in the mid-late 1990s. The HMO community generally did not object to a risk adjustment mechanism per se. In fact, several interviewees welcomed an opportunity (which never came) to be compensated for “bad” risk they themselves attracted. Rather, their contention was with the state’s particular one-way, age-based risk adjustment formulation, and the fact that the state did not modify this methodology after better experience data became available over time.

° This $10 PMPM risk adjustment, which increased in value in later years, was applied to the CMMP’s reserve fund.
That the risk adjustment was one-way meant that HMOs that enrolled high-risk members received no adjustments themselves even while HMOs had to compensate the CMMP for younger members enrolling in HMOs. The Commissioner of Insurance generally agreed that the risk adjustment mechanism should have been modified over time:

“The impetus for imposing this [risk adjuster] in the early years of HMO offerings is understandable, [but it] likely caused more harm than good and probably should have been computed differently [such as age/sex], once comparative claims data became available, in order to be a more sensitive and accurate compensation for any adverse risk that occurred” (Long interview 2006).

HMO executives protested the methodology underlying the state’s risk adjuster and suggested alternative methodologies. Alternatives included models that would be two-way to compensate HMOs when they in turn attracted higher risk members as well adjustments computed not on the basis of age only, but also on the basis of sex and actual claims experience. However, legislators, with support from the legislature’s Fiscal Research Division, resisted changing the risk adjustment methodology. As one HMO executive concluded, “It was a political thing [to protect the CMMP] more than a medical thing” (Interview 2006).

The age-only adjustment, on top of zero co-payments and benefit mandates, reduced HMOs’ ability to offer competitive bids to SHP participants. HMOs eventually raised their prices to cover these extra costs. This created a “perverse incentive” that further undercut HMOs’ strategy to offer lower-cost health plan options relative to the CMMP. Taken together, the above issues contributed to an unfavorable operating environment for HMOs. Over time, as one former HMO executive summarized, “by the late 1990s, the [risk adjustment], the CMMP premium contribution situation, and other factors meant the numbers just no longer added up [to remain in the SHP]…the hemorrhaging that we all
experienced in the [SHP] was certainly not helping us expand our business in the rest of the state” (Interview 2006).

Legislators and SHP officials extending to the Governor’s office had recruited HMOs and welcomed HMO activity in the SHP. However, once HMOs entered the state and the SHP, the perception developed among a broad range of stakeholders that the SHP operating environment strongly favored the state’s own traditional indemnity plan, the CMMP, over HMOs. Importantly, this is not to suggest that the politics of the SHP necessarily entails sinister “smoke filled rooms” and questionable motives. Rather, it means that the SHP’s governance structure did not create a strong degree of insulation from legislative politics, which effectively meant that many of the often competing pressures and challenges that legislators face made their way to PEHP policymaking. A prominent example is the desire among legislators not to appear to favor HMOs to avoid provoking the ire of key provider groups that lobbied the General Assembly (discussed in greater detail below).

Some of the policy choices that the SHP made certainly may not have been explicitly designed to favor the CMMP or to hurt HMOs. For example, most employer groups providing multiple health plan options, not just the SHP, grappled with issues of risk adjustments and other issues during this time. However, perception (even if not linked to reality) is important in structuring a vibrant marketplace of multiple health plan choice. That HMO executives came to strongly perceive that the SHP’s politicized governance environment was unfavorable to HMOs in relation to the CMMP is an important limitation of the SHP even if the perception is largely unwarranted.
A key state senator with a long tenure on the Committee on Employee Hospital and Medical Benefits (which exercises control over many aspects of SHP policymaking) remarked: “Does the legislative committee control the state health plan? Yes it does. Does the committee make decisions [concerning the SHP] that are political, that are based on politics? Yes it does” (Rand interview 2005). In the experience of HMO “choice” in the SHP, these issues had important implications for the performance and governance of the SHP more broadly.

Provider Interest Groups

In North Carolina, as in other areas of the country in fee-for-service dominated-markets\(^p\), provider organizations, including physicians and hospitals, were quite hostile to restrictive forms of managed care. For example, the North Carolina Medical Society was generally opposed to HMO expansion in the state and some specialist medical societies organized against HMOs. Several other professional organizations, including the North Carolina Psychological Association (NCPA), objected to specific elements of the expansion of managed care in the state. Specifically, NCPA was against HMOs’ utilization review of provider practices and favored requirements that the SHP cover their services without restrictions. Similarly, the North Carolina Hospital Association and some of the larger hospital systems opposed HMO expansion as well, fearing administrative burdens associated with many of the techniques of managed care as well as the threats to their sources of revenue.

\(^p\) Which is to say, virtually everywhere
The General Assembly had been directly involved in opening the way for HMOs to enter North Carolina hoping that a “reformed” delivery system and cost containment would emerge. However, many political observers argued that the organized resistance of the provider community to the spread of managed care, which increased along with the number of new HMO entrants into the state, resulted in legislators eventually playing a more neutral posture toward HMOs, including those within the SHP.

Moreover, the state’s politicized governance structure, discussed above, meant that the strong anti-HMO sentiment among the organized provider community fueled the legislature’s ambivalence toward HMOs even after legislators had previously allowed the entry of HMOs into the SHP. For example, a hospital executive that lobbied the legislature on behalf of other large hospitals, expressed the consensus of several provider-oriented stakeholders:

“When the select committee made the decisions that it did, in the back of the mind of several of them was the very clear sense that hospitals and docs absolutely hated [HMO expansion], so [legislators] were careful not to be seen as explicitly favoring the HMOs …in fact they did some things that flat out hurt HMOs ostensibly to protect the fee-for-service environment in the SHP. Beyond that, though, there was this paranoia in the provider community that we were headed down a ‘dark road’ to heavy managed care in the state, and some of the members on the legislative committee overseeing the SHP didn’t want to be seen as directly championing that given fierce resistance from hospitals and docs” (Interview 2006).

Another interviewee noted that the combination of providers’ concerns about managed care’s expansion and the legislature’s role in SHP policymaking influenced the policy decisions of the SHP: “It is certainly true that politicians wanted to protect the indemnity plan. This was led by a fight of providers who didn’t want to come under the market pressures that HMOs were providing. [The executive administrator] at the time didn’t have
the autonomy. So these discussions took place quietly in the legislature” (Cope interview 2007).

In sum, the SHP’s relatively politicized governance structure, in which the legislature plays a direct and often assertive role in SHP policymaking, provided a venue for providers and other groups to influence the process of developing and maintaining an environment of multiple health plan choice in the SHP.

**Policy Entrepreneurship and Leadership**

Compared to the case of Massachusetts described in Chapter 4, the dozens of interviews conducted in North Carolina did not suggest the “obvious” influence of personal leadership or policy entrepreneurship in shaping the SHP’s experience with multiple health plan choice. This is not to suggest that North Carolina is lacking in high quality leaders in the health policy or political arenas. In general, North Carolina’s health care policy environment includes many prominent and influential leaders, policymakers, and public officials. However, no single candidate stood out in interviews as having played a key singular role – formally or informally – in shaping the experience in the state.

Governor Hunt was certainly involved in the origins of the health choice experiment in the SHP and in the state as a whole. His administration studied alternative delivery systems and recommended key regulatory and other changes that facilitated the expansion or growth of HMOs in the state. Governor Hunt was also directly involved in recruiting Kaiser to come to North Carolina. One interviewee recalled the Governor inviting executives from Kaiser onto the Governor’s helicopter to highlight the state’s major metro areas just as the Governor did the same for other companies considering expanding operations to North
Carolina. However, others suggested that Kaiser’s entry in the state was based on myriad factors, including but not limited to the ability to “open up” the SHP to provide multiple health plan options to members. Governor Hunt was an important player in the experience of the SHP, but his leadership and his administration were generally more focused on education initiatives, such as the “Smart Start” program that has won national acclaim for the state.

Several interviewees cited Sam Byrd, the now-retired Director of the General Assembly’s Fiscal Research Division, as having been an important player in the legislature. Byrd earned a reputation for effectively translating legislators concerns or ideas into policy. He was a key player that helped to develop the SHP’s risk adjustment methodology and to resist the alternative risk adjustment models proposed by Kaiser and other HMOs. While a popular and important figure, none of the interviews suggested that Byrd single-handedly drove SHP policymaking.

There are other important figures that could be mentioned, including Senator Tony Rand who has wielded considerable legislative influence over the SHP over the years. However, the data collected in dozens of interviews did not support the general thesis that particular leaders single-handedly “drove” the SHP policymaking process or were responsible for the success or failure of the SHP’s experience with health plan choice.

**Conclusions**

This chapter set out to analyze the SHP’s experience offering its members multiple HMO options. Encouraging HMOs to enter the SHP was part of an initiative that state policymakers and public officials expected would yield cost containment benefits for the
SHP itself. The initiative was also part of a broader strategy to help stimulate delivery system competition within the state as a whole. Accordingly, the chapter examined the political and other factors that shaped how this particular strategy was implemented and the experience of the SHP with this initiative.

In developing the SHP’s multiple health plan environment, state policymakers and public officials believed that the SHP’s very large population of covered lives would benefit HMOs by allowing them to gain traction in a state that had little previous experience with managed care. Indeed, thanks in part to the ability to market and sell products within a very large SHP population, HMOs like Kaiser set up expansion regions in the state. Other incumbent carriers within the state developed HMO products within the SHP to begin participating in the growing managed care movement that was developing nationally and, it appeared, in North Carolina. In this sense, the state’s effort can be viewed as a success in that it did provide an initial base of enrollment for HMOs within the state. However, the state’s broader market change proved to be short-lived as all HMOs eventually exited the SHP convinced that despite its relative size as a major employer group, the PEHP contract terms and (more importantly) the state’s market and political conditions were not conducive to broad HMO participation.

What accounts for the SHP’s experience offering its members multiple HMO options starting in the late 1980s only to return to an indemnity-only health plan option by the late 1990s? The analysis contained in this chapter shows that the SHP’s experience offering its members HMO choice was highly unpopular with health care providers. Provider discontentment was based on the lower reimbursements available from a public purchaser (the SHP) that has historically provided more generous provider compensation than other
public programs, such as Medicaid. More broadly, however, providers’ frustrations about HMOs operating within the SHP were fueled in part by concerns that managed care may ultimately compete with the state’s indemnity-dominated health care marketplace. Not only would a more managed care-friendly marketplace involve lower provider reimbursements (relative to fee-for-service reimbursement), but this possibility was also perceived to pose threats to physicians’ professional autonomy with “third party HMOs interfering with the practice of medicine” (Interview 2006).

This case demonstrated that provider discontentment with HMOs operating in the SHP manifested itself in several ways, including public complaints about the initiative and the perceived low quality of care available from “doc in the box” HMOs. Moreover, providers also expressed strong resistance to state HMO expansion to key legislative staff and members. As the legislature played an important and direct role in SHP oversight and governance, provider wariness about the spread of managed care contributed to policymakers making decisions affecting the SHP’s multi-health plan choice environment that were perceived to favor the state’s incumbent indemnity product over new HMO options.

Other aspects of the SHP’s “politicized” governance structure affect system performance as well. For example, according to a 2003 state auditor’s report, the General Assembly’s fairly sporadic meeting schedule and the intense workload of legislators does not promote continuous oversight of the SHP and compromises flexibility in responding to cost and other factors (North Carolina Office of the State Auditor 2003). Moreover, with two-year legislative terms and two-year budget cycles, even well intentioned, public-minded legislators may focus on short-term political considerations.
An important caveat, though, is that many large public and private purchasers during this time struggled to develop a market of multiple health plan competition that featured, for example, “fair” and adequate models of risk adjustment, premium contribution strategies, and benefit standardization in ways that could avoid adverse selection. Indeed, concern about adverse selection was a very vivid and valid fear of legislators and key staff members within the General Assembly’s Fiscal Research Division, even beyond concerns from the provider community. The opposition of providers groups to HMO expansion certainly made the experience of SHP competition more difficult for HMOs. However, interpreting the experience of HMO choice in the SHP as merely the result of powerful provider and other interests “capturing” legislative oversight and control over the SHP is much too simple.

Importantly, this chapter finds that characteristics of the state health care market play an important role in explaining the SHP’s experience with multiple health plan options. The vanishing of HMO “choice” within the SHP also mirrored the larger retreat and evolution in managed care from the state and national marketplace. Importantly, HMOs did not grow their products within North Carolina exclusively because of the ability to market to the SHP, although this did initially help them to establish a modest base of enrollment. Moreover, HMO market penetration also did not decline in the state solely because of perceived or actual unfavorable market conditions within the SHP (although the difficulties that HMOs experienced in the SHP did not help). In addition to issues of governance processes discussed above, the underlying story in North Carolina is that while state policymakers sought to use the SHP to help move the market toward alternative delivery systems, the SHP’s operating environment came to mimic the broader market instead.
The key factors that help to explain the SHP’s experience with multiple health plan options, including the influence of key provider groups in North Carolina and the larger market changes taking place at a state and national level, suggest some of the limitations of PEHPs’ “purchasing power” to induce private actors to behave in ways that they would not have otherwise. State PEHPs with governance structures that are subject to direct political influences from providers and other groups through legislative or other channels may be constrained in important ways from structuring major reform efforts that are feasible and sustainable. This could include relatively “autonomous” governance structures that are nonetheless “captured” by provider and other interests.

Nonetheless, even the relative autonomy of governance structures and systems from outside political influences does not guarantee by any means that states can be successful leveraging the purchasing influence of PEHPs to achieve broader policy purposes. As the North Carolina case points out, PEHPs are important purchasers, but they are also subject to important market related constraints described in this chapter. Even the most ambitious large state purchaser with even the most autonomous governance structure cannot easily overcome the movement of a much larger and sophisticated health care marketplace. To be effective as major purchasers in “moving the market”, PEHPs may have to define their goals more modestly and coordinate their efforts with other public and private employers and purchasers. In sum, based on the North Carolina experience to date, PEHPs play an important role in the broader health care market and policy environment, but PEHPs themselves are subject to important political, market, and other influences that constrain their ability to serve as major or singular vehicles of reform.
Chapter 6: Discussion and Conclusions

Overview

This dissertation set out to understand whether PEHPs could and should be viewed as “opportunistic” public purchasers that can wield their purchasing influences and contracts with private health plans and relationships with providers to contribute to broad state policy goals. The alternative view is that PEHPs should be viewed as perhaps important employer-based purchasers, but purchasers that are not large enough, groups that are encumbered by political influences from strong provider and other interests, and groups that are dominated by rising costs associated with relatively generous benefits and other constraints. The answer to this question, suggested by this dissertation, is that under certain conditions, PEHPs can indeed serve as important components of the larger health policy environment and can contribute meaningfully to health system change at the state level. That said, evidence from case studies presented in this dissertation does suggest that any lofty claims about the “purchasing power” of PEHPs are perhaps unwarranted on a grand scale. Notwithstanding their position as large and relatively stable health care purchasers, PEHPs are subject to certain political, market, and organizational challenges that can constrain their efforts to pursue meaningful health policy or market change at the state level. These
political and market forces create both opportunities and constraints to successful reform efforts.

In preliminary exploratory work, some PEHP executives (e.g., Massachusetts) optimistically claimed that their initiatives have the potential to affect real change in the states’ health care delivery systems. In other states (e.g., North Carolina), PEHP executives were less sanguine about even very large PEHP purchasers’ ability to use their market clout to stimulate significant delivery system reforms.

In the case of Massachusetts, a new networking tiering initiative was implemented over the objections of private health plans and provider groups in a way that has in fact induced private actors within the state’s delivery system to change their business practices when they had no plans to do so otherwise. These changes are likely to affect non-PEHP consumers as well as PEHP members alike to varying degrees. Thus, the opportunistic view of the role of PEHPs in state health policy, suggested by Massachusetts exploratory interviews, is warranted within certain conditions discussed in Chapter 4.

In the case of North Carolina, a multi-faceted effort to stimulate broad health system change in the state’s delivery system included a strategy to position the PEHP to be a hospitable base of enrollment for large HMOs. This effort did in fact help to encourage early HMOs (e.g., Kaiser) to enter the state while other incumbent carriers likewise sought to use the PEHP as a base of enrollment to grow their new HMO products. However, due to myriad market, political, and administrative challenges discussed in Chapter 5, the state’s market change proved to be short-lived as all HMOs eventually exited the SHP convinced that despite its relative size as a major employer group, the PEHP contract terms and (more
importantly) the state’s market and political conditions were not conducive to broad HMO participation.

The initiatives profiled in Massachusetts and North Carolina are quite different from one another: one purported to change a product and networking strategy available to consumers while the other much more ambitiously set out to contribute to a new era of delivery system competition within the state as a whole. Despite these differences, much can be learned from the examination of PEHP policymaking in these two states, as suggested by this dissertation.

**Alternative Explanations**

The political science and policy literatures have identified a number of key factors that influence policy choices and outcomes within states and, consequently, cross-state policy variation. These factors were examined in this analysis of PEHP policymaking activity in the two case states.

*Partisan Political Configuration*

In Chapter 2, I explored the political science literature’s development regarding the impact of states’ partisan political configurations on state public policy choices and outcomes. Based on this literature, I hypothesized that states in which Democrats have more dominant and consistent control over state policymaking will be more likely to embrace an “opportunistic” view of PEHPs’ roles within state health policy and market environments. Accordingly, these states are more likely to assert the purchasing influence of PEHPs to seek reforms of the state health care environment compared to states in which Republicans have achieved more electoral success. Moreover, I hypothesized that split legislatures (in which
partisan control of legislative and governor’s offices is divided) would be less likely to view state PEHPs as avenues to achieve broad statewide policy reforms.

In both Massachusetts and North Carolina, states have at different times been controlled by both Democrats and Republicans. However, the political scene in Massachusetts has much more consistently been characterized by a “split” government between the governor and legislature. North Carolina, by contrast, has for the most part been dominated by Democrats in both the legislature and governor’s office. However, I found in this research that the roles of governors in PEHP policymaking in both states have been limited. Governors in both states make appointments to the governing bodies of the respective PEHPs (a commission in Massachusetts and a board of trustees in North Carolina). However, their respective roles in ongoing PEHP policymaking are limited. Relative to governors, by contrast, legislatures play a much more assertive and active role in PEHP decision-making, particularly in North Carolina.

Given the relatively limited role of governors in PEHP policymaking (including Republican governors in Massachusetts and Democratic governors in North Carolina), my hypothesis regarding the “split” partisan balance of power between governors and legislatures turns out to be largely irrelevant. That said, it was Democratic Governor Jim Hunt in North Carolina who was actively involved in an effort to encourage the development of HMOs in the state by, in part, offering Kaiser and other HMOs the opportunity to use the SHP as a hospitable initial base of enrollment. It is impossible to know whether a Republican governor, hypothetically elected instead of Governor Hunt, would have been as eager to stimulate broad delivery system reform using HMOs, and whether a Republican
governor or Republican-dominated legislature would have been ultimately supportive of using the SHP as an initial base of enrollment for HMOs.

Within the legislative arena, Democrats have largely controlled legislatures in both states. In Massachusetts, interviewees cited the ability for the Democratic legislatures to “snub their noses” at provider groups concerned about the CPI initiative’s perceived adverse impact on physicians and hospitals because of the historically closer ties between Republicans and provider groups. However, it is not apparent that partisan identity per se played a major role in the development of PEHP efforts in either state. More generally, it is not clear from this dissertation that partisan identity and partisan influence play a substantial role in states’ efforts to use PEHPs as instruments of health reform at the state level or had any meaningful impacts on the development of PEHP policymaking. The dissertation’s research design focusing only on two states makes broad generalizations quite difficult in this regard. Further research is needed within a broader mix of states with different experiences with PEHP policymaking to fully examine the impact of partisan political configuration on PEHP policymaking and perceptions concerning the roles of PEHPs within the larger state health care policy and market environment.

**State Wealth**

The political science and policy literatures have also suggested that policy variation from state to state can be explained in part by examining the relative wealth of different states. The conventional hypothesis with respect to state fiscal health is that the greater the amount of resources available to a state, the more likely it is that the state can afford to undertake more stringent regulation or adopt policy innovations (Williams and Matheny
Applied to PEHP policymaking, I hypothesized that a state’s economic development and state wealth would influence more wealthy states to view PEHPs as important components of state health policy. These states are likely to more aggressively use the purchasing influence of PEHPs to seek delivery system and other reforms at the state level.

In this dissertation, I used state wealth as one of several criteria to select the two case states, ensuring that there was variation in this variable in the two states selected. Like political party configuration and systems, however, I argue that state wealth played a limited role in the different views of PEHPs roles, their uses as instruments of health policy reform, and the experiences of those efforts. It turns out that PEHP executives in North Carolina – the lower-income state compared to Massachusetts – had developed a more modest view about the role of PEHPs within the broader state market environment in large measure for reasons unrelated to its degree of wealth. Namely, SHP leaders’ more limited views about the role of the SHP in the broader market was due to the state’s previous effort to promote delivery system competition in the state using, in part, the SHP. Thus, the hypothesis that state wealth influences states’ policy PEHP policymaking activities does not appear to be borne out in these two states. Both a relatively lower-income state (North Carolina) and a higher income-state (Massachusetts) sought to use the PEHP in an instrumental way (albeit differently from one another) to initiate health care reform in the state as a whole. From a two-state comparison, it is difficult to fully ascertain the precise role of state wealth in influencing the views that state PEHP leaders hold about their roles in state policy and market environment or in their uses of PEHPs for broader purposes. However, even within these two states, state wealth appears to be a minimal (direct) factor.
Rather than playing a direct role in PEHP policymaking, it is more likely that state wealth, combined with other factors such as states’ policy cultures or inclinations toward innovation, may have played an important historical role in the development of the configuration PEHP itself, including aspects of its governance structure. Thus, governance structure and other PEHP political influences may be an important intervening variable that is itself explained by political culture, wealth, and other factors identified here. Further research is needed to better understand the historical development of PEHPs and the role played by state wealth in PEHPs’ resulting political trajectories.

*Interest Groups*

Political scientists and other scholars have examined how the formulation and adoption of public policy is shaped by conflicts and competition between interest groups (Baumgartner and Leech 1998). This is particularly true within the arena of health care policy in which provider interests and other groups are able to mobilize the appropriate levels of political influence to block systematic reforms.

I argued in Chapter 2 that the activity and mobilization of provider interest groups would be likely to shape state PEHPs’ perceptions and expectations about the roles of their PEHPs within the larger state health care marketplace. Specifically, I hypothesized that the activity and mobilization of provider interest groups is negatively correlated with the state officials’ willingness or assertiveness in developing purchasing or contracting approaches in ways that are perceived to directly affect providers’ income, professional autonomy, or reputation. I further hypothesized that public policies that pose a threat to interests invested in maintaining the status quo (including physicians, hospitals, insurers, and others) are less
likely to emerge in states in which these interests strongly influence the political and policy environment.

In both Massachusetts and North Carolina, provider interests (including medical societies, hospital associations, and other groups representing providers) are politically powerful players in the state health care policy environment in both states. In Massachusetts, prestigious academic medical centers and community hospitals, as well as well-organized provider groups (i.e., via the Massachusetts Medical Society), are perceived to wield important influence within the legislative arena. After all, even in the era of strong HMO popularity nationwide, Massachusetts HMOs have never fully embraced restrictive provider networks or closed panels of physicians because consumers and employers were loathe to be restricted to their broad choice of providers. This is associated with considerable clout for providers.

Moreover, within North Carolina’s predominantly indemnity-dominated marketplace, health care providers, too, play an important role in shaping health care policy. Providers groups were directly involved in actively resisting the tide of managed care in the state. For example, some county medical societies actively established competing provider-owned HMO plans to compete with carrier-owned HMOs (Bilbro 2003). Provider groups also helped to “characterize”, as one interviewee put it, HMOs as “bad” or “low-quality medicine” (Interview 2007).

Thus, provider groups exert much political influence in both North Carolina and Massachusetts. However, in Massachusetts, provider groups have been ineffective in ultimately blocking implementation of the CPI even though it is perceived to be anathema to
provider interests for numerous reasons described in Chapter 4. Provider groups and health plans together have sought and received important concessions regarding the technocratic details or timing of CPI implementation. While provider interests are said to exert important political influence within the legislative arena in Massachusetts in a general way, the particular governance structure of the GIC has effectively curtailed this political influence from being channeled to shape the development (or blocking implementation) of the CPI.

By contrast, in North Carolina, the legislature plays a much more direct and active role in ongoing operations of the SHP. The governor, legislators, and SHP officials were successful in inviting Kaiser and other HMOs to develop products in North Carolina by, in part, using the SHP as a base of enrollment. However, once private “HMO choice” emerged within the SHP, provider interests were able to wield legislative influence to impact the development of specific design features that HMOs interpreted as legislators’ efforts to “protect” the SHP’s indemnity plan. Several interviewees claimed that legislators were reluctant to create a “level playing field” for HMOs in the SHP for many reasons, including concerns that they would be seen as actively “favoring” HMOs in ways that would undermine the provider community’s preferred indemnity dominated marketplace. In contrast to the GIC’s governance structure, which affords some measure of political insulation from legislative politics for the GIC Commission and staff, the SHP’s system of governance in North Carolina affords provider interests an opportunity to play a key role in shaping SHP policy development through legislative processes.

However, it is important to note that political dynamics and systems of governance are not static. Provider interests have not permanently “captured” SHP policymaking even if the SHP’s governance structure provides them with an important voice in the PEHP
policymaking environment. For example, five years after the experiment with health plan choice ended within the SHP, the SHP established new PPO options that achieved cost containment premised solely on the ability of the SHP to cut reimbursement rates to doctors and hospitals. This effort was strongly supported by the legislature as a mechanism to constrain rising costs within the SHP and strongly opposed by provider groups. As the SHP’s Soper explained, “Some health care providers in this state have even said that by doing this [cutting provider reimbursement via new PPO contracts], we have broken the ‘social compact’ in this state” (Soper interview 2007). Of course, that North Carolina has for the last five years only had a conventional indemnity health plan for SHP members suggests, among other things, the residual political power of provider groups that strongly favor the traditional CMMP with its relatively rich reimbursement arrangements. On the other hand, that providers groups’ efforts to block the new PPO structure were ultimately frustrated suggests that, while politically influential, state policymakers and SHP officials must balance competing interests in making PEHP policy. Provider interests are powerful but not immutable.

The larger point is that the degree to which provider interests are directly involved and influential in PEHP policymaking appears to be dependent on the governance structures of SHPs themselves. The particular role of governance structure and bureaucratic autonomy (and the interaction with provider legislative influence) is described in greater detail in the sub-section on governance structure below.
Political Culture

Numerous studies about state politics and policy have incorporated the concept of political culture to help shed light on the variations in state political characteristics or policy approaches (Elazar, Sharkansky and Hofferbert 1969; Sharkansky 1970). In general, states’ political cultures reflect the level of general ambivalence about government and support for public action in the policy arena. This dissertation used political culture as one of several criteria for selecting the two case states, using both Elazar’s (1966) famous typology and also Klingman and Lammers (1984) and Buchanan’s (1987) liberal-conservative scales.

At the outset of this dissertation, I had mixed expectations about the impact of state political culture on states’ efforts to achieve health care reform through the purchasing auspices of state PEHPs. On the one hand, I predicted that more conservative, traditionalistic states, whose policymakers are in general more likely than counterparts in more liberal, moralistic, and individualistic states to have a more limited view of government’s role, would be less likely to hold an opportunistic view about the role of PEHPs in state policymaking. On the other hand, individualistic and moralistic states are probably more likely to embrace an “opportunistic” view of PEHPs and thus will be more likely to engage in innovative efforts wielding the purchasing clout of the state to help achieve broader policy goals.

These theoretical expectations are compatible with the rather optimistic views of PEHP purchasing power that I identified in initial exploratory interviews in Massachusetts, Minnesota, and California. These states’ political cultures contribute to each of their respective general reputations for policy innovation and experimentation. Accordingly, in
Massachusetts, GIC officials and policymakers tend to hold a fairly ambitious view of the relative influence of the PEHP within the state health care marketplace and policy environment. While not naive to the realities that such efforts can be and have been difficult for numerous reasons, GIC officials expressed confidence that the GIC is well positioned to exert purchasing influence that could impact the rest of the state beyond the GIC’s traditional constituencies. By contrast, PEHP officials and stakeholders in North Carolina expressed a much less sanguine view of the SHP’s role in the larger state health care marketplace. This could be associated with the underlying political culture of the more conservative, traditionalistic state. However, it is more likely the case that this view has been shaped more directly by the state’s previous experience with implementing a structure of HMO options in the SHP designed to create a hospitable base of enrollment for HMOs within the state as a whole. Thus, the “political culture” thesis appears to be a positive but fairly weak explanation for PEHP policymaking and in general the “role” of the PEHP in the state. Additional research with more states with varying measures of political culture is necessary to fully investigate the relative influence of political culture in shaping PEHP policymaking.

Another explanation of the role of political culture is that it, in combination with other state-level factors described in this dissertation (and others), may have played an important historical role in the development of the configuration PEHP itself, including aspects of its governance structure. Thus, governance structure may be an important intervening variable that is itself explained by political culture, wealth, and other factors identified here. Further research is needed to better understand the historical development of PEHPs and their resulting political trajectories.
Another important tradition in political science research has suggested that states are characterized by general orientations toward innovation, with some tending to be leaders and others laggards. I hypothesized at the outset that state policymakers’ interpretations of the roles of PEHPs in the larger state health care marketplace and the innovative uses of PEHPs for larger policy purposes are associated with states’ general reputations for or inclinations toward innovation. That is, states with a stronger tendency toward health and welfare policy innovation in general will be likely to view PEHPs as important instruments of state health care policy and would attempt to use PEHPs’ purchasing power more assertively.

In selecting Massachusetts and North Carolina, I purposefully selected two states with decidedly different reputations for policy innovation. Massachusetts is viewed by scholars and analysts as a particularly innovative policy state, taking the lead on health care policymaking and experimentation. By contrast, North Carolina’s health care policy environment is not viewed as particularly innovative.

I argue that states’ traditions and reputations for innovation have played an important, though not dominant, role in PEHP policymaking in Massachusetts and North Carolina. In Massachusetts, GIC officials and policymakers embrace the Commonwealth’s reputation for policy innovation and experimentation. The GIC certainly did not invent the concept of network tiering. Nonetheless, the GIC is one of the first major public or private purchasers (and is certainly one of the largest) to experiment with such an innovation, particularly given that the GIC has effectively combined the claims data of otherwise competitive health plans that participate in the GIC. Massachusetts stakeholders’ view of
the PEHP and its role in the larger state health care marketplace and policy environment is somewhat shaped by a desire to be, as one interviewee put it, “constantly on the cutting edge” (Slavin interview 2006).

By contrast, in North Carolina, the state policy and political communities have embraced a more modest, conservative view of the role of government and correspondingly, views the SHP as an important entity serving public employees and retirees, but not necessarily as a key agent for health care reform. Unlike Massachusetts, the state does not, by and large, have a reputation for or tradition of policy innovation in the health policy arena. The fact that the state PEHP only recently moved away (once again) from a traditional indemnity plan to embrace the more popular PPO plans suggests that in contrast to Massachusetts, the SHP does not find itself on the “cutting edge”.

That said, the major initiative discussed in Chapter 5 does suggest that state policymakers and public officials in North Carolina at one time viewed the SHP as part of a larger strategy to help stimulate broader health system change in the state. The effort to promote HMOs in North Carolina suggests the desire to embrace what at the time was a fairly innovative approach to health care financing and delivery. However, this initiative appeared to be mostly focused on the desire for viable strategies to contain costs than a concerted desire to develop a reputation for innovation or experimentation. On balance, it appears that states’ reputations for policy innovation do play a role in shaping perceptions about the potential uses for PEHPs and other government resources to affect broader market change. This generally fits the pattern that emerged from early exploratory research in which highly innovative states (i.e., California, Minnesota, and Massachusetts) stood out among the 12 states examined in implementing somewhat innovative strategies to control
costs in a way that could have important spillover effects on the broader state health care marketplace.

However, it is not altogether clear, absent additional research in other states, whether the “innovation” thesis plays a central role in dividing innovative from non-innovative states in their view of PEHP’s “opportunistic” abilities to affect delivery system or other reforms at the state level. As noted above, it is possible that states’ inclinations toward policy innovation, combined with state wealth, political culture, and other variables – may have played a key historical role in shaping the development of PEHPs themselves (including governance structures and traditions) in ways that are more directly important to variation in how states are viewed within the larger state health care marketplace and policy environment. Further research is needed to understand the historical development of PEHPs and the key drivers of continuity and change.

_Governance Structure and Bureaucratic Autonomy_

Previous research on systems of governance and bureaucratic autonomy in areas of public policy has laid a foundation for understanding the degree of policymaking discretion afforded to PEHP leaders, focusing on both the preferences of the actors and the technical complexity inherent to the policy choice. Even with a two-state case study approach, this dissertation demonstrates that state PEHP governance structures and systems can vary in important ways that can influence the degree to which PEHPs enjoy relative autonomy to exercise discretion in policymaking. PEHPs in Massachusetts and North Carolina are governed by different structures that exercise different levels of authority or autonomy to make policy decisions. On paper, the governance models in each state appear very similar.
Each state establishes, by statute, a role for the governor (and in North Carolina, the legislature as well) in making appointments to a commission (Massachusetts) or board of trustees (North Carolina). The respective governance structures in each state are responsible for hiring an executive director (Massachusetts) or executive administrator (North Carolina). These entities meet regularly, deliberate, and vote on important policy matters affecting health care benefits and cost containment efforts and other policies.

However, in practice, state legislators in North Carolina are more directly involved in day-to-day PEHP oversight and decision-making than are legislators in Massachusetts. Unlike in Massachusetts, health benefits and cost sharing provisions are set by statute and involve sometimes cumbersome legislative processes to modify. Beyond that, at a strategic level, interviewees in North Carolina described how “nothing of any real significance really gets done unless [the Committee] is really involved in it” (Interview 2006).

As a result of the relatively assertive legislative influence over the SHP in North Carolina, SHP policymaking is subject to a relatively greater level of political influence from provider and other groups that have a strong interest in PEHP policymaking. The most clear example of this is related to the SHP’s experience offering multiple health plan options. A key reason that legislators with oversight over the SHP acted to effectively “protect” the state’s own indemnity plan option (described in more detail in Chapter 5) was to be responsive to political pressure from providers and other groups that had a strong antipathy for the possibility that managed care could expand substantially within the state. As legislators did not want to be seen as “promoting the HMOs” within the SHP or more broadly, legislators were cautious about broadly promoting HMOs as a “replacement” delivery system. As a result, HMO executives suggested that the state “would not even set a
level playing field, much less a ‘hospitable’ operating environment for [HMOs]” (Interview 2006).

Of course, it is important not to put too much emphasis on what is ultimately a simple point. After all, legislators, like people in general, are influenced by myriad factors in making decisions. In addition to being responsive to pressure from provider groups fearing managed care, legislators also understandably sought to ensure that the CMMP did not become a magnet for adverse selection for reasons that had little to do with political pressure from provider interests. Nonetheless, the North Carolina legislature’s relatively active role in SHP policymaking has provided an important avenue for providers and other interests to exert influence through the legislative process over SHP policy direction, strategy, and other issues.

By contrast, in Massachusetts, the commissioners governing the GIC themselves enjoy much more authority and relative political insulation from direct legislative politics. This has given the GIC the flexibility to set policy and strategic direction for the CPI and other issues. Importantly, it has also countered any direct desires of provider interests to effectively block the CPI. As Slavin noted, “Dolores was able push this forward because the commissioners back her, and beyond that, nothing else really matters” (Slavin interview 2006). However, it is important to offer the caveat that the legislature could be more actively involved in GIC policymaking if key members decided to be more involved. After all, the legislature controls the state budget and the financing of the GIC and could use the budget process to question the validity of certain activities or suggest new strategies for the GIC. The governor, which controls appointments to the commission, could likewise be more directly involved in day-to-day GIC policymaking. However, the current executive director
has earned a degree of respect from legislators who are impressed with her hard-charging cost-cutting persona and they are loath to interrupt her. Thus, the governance “structure” per se may not provide the political protection and insulation that the GIC currently enjoys. Rather, the GIC’s tradition of governance is itself somewhat the function of the level of trust that the political actors place in the commissioners and in the executive director.

This “chicken and egg” phenomenon goes even further, however. Several interviewees noted that the GIC has been successful in keeping talented and professional commissioners and staff, including Dolores Mitchell, because of the perception that the GIC has the authority to exercise judgment and independence. As the Commonwealth’s political process has historically granted a measure of political insulation and autonomy to the GIC, the GIC has been successful in attracting certain commissioners and staff, which in turn has served to reinforce the level of trust that the legislature and governor have placed in the GIC to act autonomously. As one interviewee noted regarding the GIC’s relationship with the legislature: “We would never have had Dolores sticking around this long if just any elected nobody on Beacon Hill simply pushed her around and told her what to do” (Interview 2006).

Nonetheless, the practical effect of the degree of autonomy enjoyed by the GIC is that provider and other interest groups have been heretofore unable to leverage enough political influence within the legislative arena to effectively modify or block the CPI in a significant way. The GIC has made important concessions in both the timing and flexibility of the CPI’s implementation that have afforded health plans and provider groups the ability to comply with “general principles” rather than standardized directives. However, in general, the GIC has effectively mediated concerns from providers, health plans, and other
groups due to its relative autonomy from the legislative arena in setting and implementing policy.

The differences in systems of governance in North Carolina and Massachusetts have a temporal component and yet are also rooted in the historical developments of PEHPs themselves. The “temporal” nature of PEHPs’ relationships with legislative processes is related to the existence of particular people and particular circumstances, both of which can change over time. For example, it is not clear what, if any, changes in the GIC’s relationship with the legislative process will result when Mitchell retires and a successor is chosen. The legislature may be more directly involved in GIC policymaking until a similar “level of trust” is established with the new leader and his or her capacity to govern. The temporal nature of the PEHP/political process can also be observed by examining the changing dynamics in leadership that have taken place in North Carolina since the experiment with HMO choice in the SHP ended in 2001. In 2005, a new executive administrator, George Stokes, was appointed. Stokes made several new senior-level hires within the SHP. Early indications are that the legislature is pleased with Stokes and his team and “we have already visibly seen a change in the flexibility granted to Stokes [by legislators] that was not granted to his predecessor” (Cope interview 2007).

The dynamic or “temporal” nature of PEHP governance structures and systems is consistent with the findings of Bawn (1995), Epstein and O’Halloran (1994), and others arguing that the benefits of granting discretion to PEHP governance structures is likely to increase as the objectives of policymakers and “agents” converge. For example, if policymakers and PEHPs seek to achieve similar outcomes within a framework of personal trust, policymakers may grant PEHP boards and staffs greater political autonomy. If
policymakers and PEHP boards and staffs seek to achieve different outcomes, however, policymakers may seek to grant PEHP boards and staffs more limited autonomy, and instead choose to direct in explicit ways the specific policy strategies, policy boundaries, and outcomes to be pursued.

While the relationship between PEHPs and the state political process has a definite temporal component, it may be also rooted in the contrasting historical development of each state policy environment and each PEHP. While both the GIC and the SHP were established in the 1950s, several key historical aspects of their development continue to characterize their respective relationships with their states’ political processes. For example, in Massachusetts, the legislature “from the very beginning” retained the authority to set employer premium contributions and granted the GIC itself with the authority to make health benefit, cost sharing, and other decisions. Thus, aspects of the political autonomy and governance systems of the GIC today may be traced back to the GIC’s origins and development. In North Carolina, SHP health benefits and other specific policy areas have long been maintained by statute, which means by definition that the legislature has long been actively involved in SHP policymaking.

Furthermore, as noted above, some of the variables discussed in this dissertation (e.g., political culture, innovation, state wealth, etc.) may have played important roles in the historical development of PEHPs and their systems of governance. Regardless of their direct impacts on current PEHP policymaking, the contributions of these (and other) variables may have been manifested in the manner in which PEHPs developed over time. This dissertation did not include an exhaustive exploration of the historical evolution and political development of respective PEHPs, but further research (i.e., research treating governance
structures as dependent rather than independent variables) could elucidate the ultimate sources of variation in systems of governance that characterize modern PEHP policymaking.

At the outset of this dissertation, I expected to find, quite generally, that states in which PEHP boards and staff members exercise relatively more political autonomy and authority in PEHP policymaking are more likely to wield PEHP purchasing power to pursue policy or market change that could threaten provider and other interests in various ways. I argued that such approaches may not be as politically feasible in states for which PEHP boards are more closely associated with political control through the legislative process. It would be tempting to claim that my theoretical expectations about systems of governance were correct, and by and large, they appear to be. It is true that the GIC in Massachusetts fits the pattern of a state granting its PEHP much policy autonomy. It is also true that the GIC has effectively used this autonomy to structure a system of tiered networking over the objections of politically powerful interest groups. However, in North Carolina, the failure of “choice” in the SHP, I argue, is less a testament to the governance structure of the SHP as much as it is a testament to the market dynamics at play in the state at the time.

I do argue and acknowledge that the North Carolina SHP’s system of governance allowed providers and other interests to help make the SHP a less hospitable environment than the HMOs had hoped for. Moreover, I acknowledge that several policy decisions were probably made that, in retrospect, could or should have been made differently, such as the one-way risk adjustment mechanism that HMO executives spoke at length about (though it is certainly true that other large employers – not just PEHPs – struggled with issues of risk selection and adjustment). However, as I will describe in more detail below, I do not believe the evidence supports a rather simple thesis that the state’s system of SHP governance
necessarily allowed providers to “capture” the process and thereby ruin the HMOs’ chances of successfully operating within the SHP (or much within the state more generally).

Furthermore, it could be argued that the SHP experiment was actually successful in the sense that offering HMOs an opportunity to use the SHP as a base of enrollment did in fact stimulate frenzied HMO activity within the SHP even if operating within the SHP was not the “safe harbor” that HMOs had hoped for. More broadly, however, as I will argue in the next section, fundamental market dynamics, both within the SHP and statewide, simply did not support (for long) broad scale delivery system reform in North Carolina. HMOs did not fail in the state simply because of the SHP’s governance structure, although governance issues certainly played an important role in characterizing the state’s experience with health plan choice.

State Health Care Marketplace

In Chapter 2, I offered what are ultimately competing theories about how a state’s health care marketplace may impact how PEHPs are viewed and how or whether they are used to contribute to larger health policy goals beyond the traditional purview of public employees, retirees, and their families. Generally, I argued that the policy options available to a given state will depend heavily on the nature and structure of the health care marketplace that exists within that state. I expected to find that the political impetus for particular cost containment or other types of reforms using PEHPs will be closely associated with states’ market structures. On one hand, policymakers in states with strong indemnity dominated marketplaces will be more likely than HMO-friendly states to use PEHPs instrumentally to stimulate broad health system change. After all, states characterized by
relatively high-cost and inefficient delivery systems have the most to gain by using PEHPs as instruments of reform. This theoretical explanation helps to understand the experience in North Carolina. With its indemnity dominated marketplace, state policy officials sought to use its PEHP as part of a broader strategy to establish a strong presence of HMOs in the state.

On the other hand, I also argued that the existing availability of broader health plan options and competition and also more provider groups and delivery systems would give other states more options to use HMO competition within PEHPs for broader policy purposes. States with few HMOs or low HMO penetration obviously have fewer opportunities to leverage HMO plan competition in an attempt to contain costs. This expectation explains the Massachusetts experience implementing the CPI. The Commonwealth of Massachusetts is generally recognized as friendly territory for managed care. Thus it is not surprising that private health plans have been a critical fixture in the GIC’s provider tiering strategy.

Based on an examination of PEHP policymaking in Massachusetts and North Carolina, I argue that the market dynamics of states play a big role in shaping the types of reforms to which PEHPs can meaningfully contribute. Specifically, the nature of the state marketplace can severely constrain the sets of choices available to states and the abilities that PEHPs have to contribute meaningfully to state health care system reform more broadly. As Chapter 4 demonstrated, key characteristics of the Massachusetts market have effectively given the GIC considerable market power (given the size of the GIC’s population), bargaining power (since the state can realistically wield the threat of provider or health plan exclusion), and an important leadership position within the employer community in the state.
(given the dearth of other major private or public employers active in health policy issues in the state). These factors have provided considerable opportunities for the GIC to play a meaningful role in a state initiative to promote cost containment and quality promotion (even if the impacts of those initiatives are not yet known). Private stakeholders in the health care system in Massachusetts – including physician groups, health plans, and hospitals – are being forced to change their patterns of behavior in order to comply with contract terms from the GIC. Existing market characteristics explain a great deal of the GIC’s market leverage.

By contrast, it is not surprising that in an indemnity-dominated marketplace such as in North Carolina, state officials sought to usher in an era of delivery system reform given that fee-for-service payment systems are the most costly and least efficient in the available. As discussed above, the state’s initiative to encourage the spread of HMOs in North Carolina by, in part, offering the SHP as a base of enrollment was successful in some ways and less so in others. However, the SHP would face considerable obstacles if it tried to implement the same network tiering structure that the GIC in Massachusetts has developed. While the SHP does have market power (in that it purchases health benefits for over 600,000 covered lives in the state, the state’s Blue Cross Blue Shield-dominated marketplace means that there are many fewer health plan options available to structure a network tiering initiative. There are also many fewer competing hospitals and provider groups relative to, for example, the Boston metro area.

As a result, the state as a major employer has much less bargaining power. If the SHP chose to launch a CPI-like initiative in North Carolina today, health plans could wield much more influence over the direction of the initiative (if they even supported it at all)
given the dearth of vigorous competition found in Massachusetts. There, health plans went along with the initiative knowing that if they chose not to, the GIC (led by an assertive executive director) could effectively remove them as a plan option. In North Carolina, while several major health plans operate within the state, only Blue Cross Blue Shield operates statewide. Moreover, with some exceptions in the few densely populated metropolitan areas of the state, the provider community has limited competition. The SHP has no choice but to contract with providers in certain areas where access to care would be compromised otherwise.

More broadly, market dynamics play a major role in shaping the choices available to PEHPs and their larger roles as major purchasers in the state health care marketplace. This is not to say that PEHPs cannot exert their influence as purchasers to pursue particular policy goals in states whose health care marketplaces do not resemble the key characteristics of the Massachusetts market. It is to suggest, however, that the market plays a major role not only in the options available to states, but also in their experience implementing market strategies. As noted above, the experience with HMO “choice” in the SHP failed if one takes a “long view”, but largely because HMOs failed more broadly in the state. Even a large purchaser like the SHP could not have fundamentally altered the state’s market movement away from HMO options. Instead of reforming the market, the SHP’s experience with HMO options came to mimic the market.

Policy Entrepreneurship and Leadership

The agenda setting literature within political science has examined the action of policy entrepreneurs in shaping policy at the state and national levels (Baumgartner and Jones 1993; Kingdon 1995; Polsby 1984). Policy entrepreneurs seek to promote particular
policy innovations using numerous approaches and efforts to sell their ideas to policymakers and other decision makers. Policy entrepreneurs must be willing to invest political resources to attract sufficient support to win approval (Kingdon 1995). Beyond merely interested citizens that petition government in various ways, policy entrepreneurs are distinguished by their well-positioned decisions to take risks to skillfully change the terms of political or policy debates (Schon 1971).

In Chapter 2, I outlined a very general hypothesis, derived from the literature on policy leadership and entrepreneurship, that particular leaders inside and outside of state government have exerted their influence in setting the course of policy direction of PEHPs to impact the broader health care marketplace. Consistent with theoretical expectations, in Massachusetts, virtually all interviewees attributed the importance of the GIC’s influence in state health policy discussions generally, and the implementation of the CPI specifically, to the political influence and personal savvy of its executive director.

As discussed in Chapter 4, Mitchell has earned a reputation for her desire to maintain generous health care benefits at the lowest possible cost. According to the chief policy aide for the Massachusetts Speaker of the House, Mitchell’s “seriousness and legacy about containing costs and driving every penny out of the negotiation process is the basis of her support at the Legislature for the CPI” (Hager interview 2006). Thus, Mitchell’s leadership role and the trust that she has earned over many years in her position have generated personal support for her within the legislature.

As described above in the section on governance structure, the high degree of trust in Mitchell has helped to reinforce the political autonomy that the GIC has enjoyed in recent years, including its effort to establish the CPI. Moreover, it has also helped to preempt or
limit the effects of provider and other groups seeking to leverage political influence to block
or seriously modify the implementation of CPI. According to Hager, “…any backchannel
efforts of the powerful provider groups or insurance lobbies fall on deaf ears because of a
strong respect for Mitchell’s commitment to cost containment and the kinds of thing she is
doing with the CPI” (Hager interview 2006).

It is difficult to know whether the GIC would have been successful in launching the
CPI if Mitchell were not in her current position. It is also impossible to know whether
additional or different personal leadership and policy entrepreneurship in North Carolina
would have changed the experience of the SHP in developing a framework of multiple HMO
plan choice (although it seems unlikely). But consistent with previous studies on the
importance of leadership, it is apparent that Dolores Mitchell’s leadership has been
instrumental in effectively exerting the purchasing influence of the GIC, which in turn has
led numerous delivery system stakeholders to engage in practices that they would not have
engaged in otherwise. Personal leadership is not the sole factor at work in Massachusetts,
but its importance should not be overlooked. PEHPs with dynamic leaders are probably
more likely than others to be successful in using the PEHP to contribute to larger health
policy goals at the state level.

**Limitations of PEHPs**

The above analysis also implies some potential weaknesses or limitations of state
efforts to wield PEHP purchasing influence that can contribute to broad state health policy
goals. Thus far, the GIC has been largely successful implementing the CPI over the
objections of key providers and related groups. Specifically, it has taken advantage of the
state’s reputation for policy experimentation and innovation, the GIC’s favorable position
within the Massachusetts marketplace, the GIC’s relatively autonomous governance
structure that has largely insulated the GIC from political influences from providers and other groups, the broad political consensus in favor of efforts supporting cost containment and quality promotion, and dynamic and politically savvy GIC leadership. Each of the above factors, if lacking, would reduce by varying degrees the GIC’s ability to implement the CPI or similar initiatives designed “with the larger state market in mind” (Mitchell interview 2006). Thus, states seeking to leverage the purchasing influence of their own PEHPs to pursue similar initiatives may not achieve similar levels of success if some or all of the above factors are not present. Of course, additional research in more states is needed to make this point more confidently.

In North Carolina, state policymakers and SHP officials sought to stimulate delivery system reforms in the state by, in part, offering HMOs hospitable SHP operating environment allowing HMOs to further develop and promote their products to other employer groups within the state. This initiative was successful in that HMOs such as Kaiser did locate or expand HMO operations in North Carolina in part due to their ability to market to the state’s large SHP group. At one time, in fact, the rapid entry and development of HMOs had provided SHP members with as many as 13 health plan options. The state engaged in several activities in structuring an environment of multiple health plan choice that were perceived to favor the state’s indemnity plan over HMO options. However, it is unlikely that HMOs entered North Carolina exclusively because of the offer to use the SHP as a base of enrollment (although it helped). It is equally unlikely that HMOs failed in the state solely because of perceived unfavorable market conditions within the SHP (although they undermined the “hospitable” operating environment that HMOs had planned for). Rather, the story in North Carolina is that while state policymakers sought to use the SHP to
help move the market toward alternative delivery systems, the SHP’s operating environment came to mimic the market instead. While the SHP did play a role in the development of HMOs in North Carolina, the experiment with health plan choice could not survive the much larger market movement away from restrictive HMOs toward the end of the 1990s.

Policy Implications

Weaving the lessons of Massachusetts and North Carolina together, it is clear that the “purchasing power” of PEHPs is not universal and immutable. Rather, PEHPs represent one important actor in very large and sophisticated state health care systems. In particular, this dissertation suggests that PEHP purchasing influence is largely contingent upon conditions of PEHP governance structure, state market conditions, and political and administrative leadership.

Within the arena of governance structure, there are inherent tradeoffs associated with outsourcing political authority to unelected governance boards and commissions in an effort to provide political insulation in PEHP policymaking. For one, a fundamental tradeoff between democracy and efficiency characterizes the choices that states must make when developing or modifying systems of governance within PEHP (or other) arenas. In a democracy in which elected representatives are ultimately responsible for state spending and policy decision-making, how much authority is appropriate to confer on un-elected individuals with no direct accountability from the voting public? Indeed, these are tradeoffs that political scientists and others have described in other policy contexts. Perhaps the most famous in recent memory is the decision of Congress to establish a Base Realignment and Closure Commission (BRAC) to make policy choices affecting the future of military infrastructure in order to create incentives for efficient policy choices to supercede local
political concerns about losses of military bases or investments. Within the health policy arena, Congress has granted CMS broad authority, within limits, to make policy choices regarding Medicare and Medicaid, including payment policy and other technocratic but potentially controversial issues. Similarly, states confront somewhat difficult choices about the appropriate level of bureaucratic autonomy regarding PEHP policymaking. That said, it is clear that much of the success that the GIC has achieved in leveraging its contracts with private health plans to build “high performance” networks is based on the degree of flexibility and political insulation of its governing commission. This suggests rather clearly that other states seeking to implement similar initiatives should anticipate how the politics of PEHP governance may characterize the experience of engaging in difficult negotiations with political powerful health plan and provider interests.

This dissertation also described how the purchasing leverage of PEHPs is also highly contingent on the markets in which PEHPs operate. I explored three elements of health care markets: the degree to which PEHPs enjoy market power, the degree to which PEHPs enjoy bargaining power, and the degree to which PEHPs exercise leadership among other large employers in the state. In Massachusetts, the GIC took advantage of each of these factors in ways that are not possible in other states. In North Carolina, the health care marketplace – including the configuration of employers, health plans, providers, and the perceptions and preferences of consumers – helped to characterize the PEHPs efforts to promote delivery system reform in the state. These two cases illustrate the importance for state policymakers to anticipate the opportunities and limits PEHPs face in constructing policy efforts or purchasing strategies designed to promote cost containment, quality improvement, or transparency at the state level. In general, states are major purchasers, but they are also price
and quality “takers” to some extent as well. While PEHP purchasing and contracting strategies may be able to influence the direction or basic contours of the medical marketplace to some extent, states operate in distinct market environments and thus should construct policy efforts accordingly. This suggests that states seeking to adopt a purchasing initiative similar to the one that GIC has introduced should seek to import particular principles of reform rather than specific and detailed “recipes”. While the experiences of other states can and should help to inform states’ policy efforts, policymakers should seek to import new models in ways that are sensitive to their own state market conditions.

Within the arena of leadership, this dissertation concluded rather generally that “leadership matters”. Of the three principal findings in this dissertation, the policy and political implications of leadership are the most difficult to operationalize and apply to other states or other contexts. However, it is clear that dynamic leadership is needed to promote ambitious policy efforts in ways that anticipate and address strong political opposition and technical and other challenges. As noted previously, there is also an interaction effect between systems of governance and PEHP leadership. That is, governance structures that provide opportunities for genuine executive leadership and authority are more likely to be attractive to particular types of leaders that have the characteristics needed to effectively leverage PEHP purchasing influence at the state level. This suggests another dimension of governance structure that policymakers should consider when making decisions about how best to structure bureaucratic autonomy.

On balance, state policymakers have an opportunity to take advantage of an aspect of state government that has largely been overlooked in many states as a potential vehicle for state health care reform. While much more research is needed to fully examine the
opportunities and limitations of PEHP purchasing power at the state level, this dissertation finds that states may be able to leverage their positions as major employers and purchasers of health care to contribute to broader state health policy goals. Beyond simply enacting policy affecting primary PEHP constituents (i.e., state employees, retirees, and their families), the case states included in this dissertation sought to wield the purchasing influence of the respective PEHPs to produce policy spillover effects on the rest of the health care marketplace. PEHP leaders have confronted numerous challenges along the way, but their experiences suggest a new way of thinking about the role of states as major health care purchasers within broader state health care systems.

**Opportunities for Further Research**

That policy scholars have largely ignored the roles that PEHPs, as major purchasers, can and do play in the state health care environment remains puzzling. The results of this dissertation suggest that additional research is needed to explore the roles that PEHP purchasers play as major purchasers in state health care policy environments. In order to improve the external validity of this dissertation’s findings regarding the importance of systems of governance, market conditions, and leadership, additional research is needed in a broader number of states that have undertaken efforts to leverage PEHP purchasing influence to promote cost containment, quality improvement, and delivery system reform.

Moreover, while this dissertation profiled two states’ efforts to use PEHPs to explicitly reform elements of the state delivery system through contracting and purchasing practices with health plans, there are several other ways that states have attempted to use PEHPs to achieve broader policy purposes. These other uses will be examined in further research to gain a broader understanding of the roles that PEHPs play in state health care
markets and policy systems. In North Carolina, for example, the PEHP was used as the platform for SCHIP/NC Health Choice for children when the Balanced Budget Act created the program in 1997. States had the option of structuring SCHIP as a Medicaid expansion program, creating/using a separate program, or using a combination approach. Governor Hunt and the Democratic-led Senate sought a Medicaid expansion program to establish an “entitlement” to health benefits for covered populations and to take advantage of existing outreach and other infrastructure. At the time, however, the House of Representatives was controlled by Republicans, whose leaders preferred using the SHP as the program platform for SCHIP children, giving enrollees a “private insurance look-alike” program and importantly, giving the state the ability to control spending when state revenues fell short of anticipated cost growth. The Republican-led House had its way as due to political compromise, the new program was structured around the SHP.

In Massachusetts, the GIC has historically not provided health care benefits to cities and towns. The same legislation that created the GIC in 1955 also authorized cities and towns to purchase insurance on their own, subject to collective bargaining. Partly as a result of union involvement which limits program flexibility and partly given their relatively small size as employer-based plans, many cities and towns are struggling to finance rapidly escalating health care costs. A recent report characterized the health care costs of cities and towns as “unsustainable” (Boston Municipal Research Bureau 2006). As a result, the report calls on the legislature to enact a law that would authorize cities and towns to join the GIC. There are several other examples (e.g., in Kentucky and West Virginia) of state efforts to leverage the PEHP as a platform to expand access to public coverage, with varying degrees of success. Much more research is needed to understand these and other uses of PEHPs as
vehicles to expand or consolidate access to health insurance coverage for public employees and non-public employees alike.

A longer-term research agenda will include further analysis on the roles of PEHPs as major purchasers to leverage contracts with private health plans, providers, and other entities to pursue broader policy goals. In addition, this research agenda will also consider other ways that states have leveraged or could leverage PEHPs to pursue other policy goals as well, such as expanding access to health care for other public constituents as in Massachusetts or more importantly, in making health care coverage available to those that currently do not have it.
APPENDIX

List of Interviewees

Exploratory Interviews

1. **Paul Campbell**, Illinois Group Insurance Program [2006]
2. **Bob DuBois**, New York State Health Insurance Program [2006]
3. **Jarvio Grevious**, California Public Employees Retirement System [2006]
4. **David Haugen**, Minnesota State Employee Group Insurance Program [2006]
5. **Julie Kerlin**, Georgia Division of Public Employee Health Benefits [2006]
6. **John Matthews**, Florida Division of State Group Insurance [2006]
7. **Teresa Planch**, Mississippi State and School Employees’ Health Insurance Program [2006]
11. **Thomas Vincz**, New Jersey State Health Benefits Program [2006]
12. **MaryJane Wardlow**, Texas Group Benefits Plan [2006]
Massachusetts Interviews

1. **Susanne Bailey**, Department of Insurance (Designee for Department of Insurance on Group Insurance Commission) [2006]

2. **Michael Bailit**, President, Bailit Health Purchasing [2006]

3. **Julie Bowler**, Massachusetts Commissioner of Insurance [2006]

4. **Marylou Buyse**, President, Massachusetts Association of Health Plans [2006]

5. **Ray Campbell**, Executive Director & CEO, Massachusetts Health Data Consortium [2006]

6. **Robert Carey**, Massachusetts Connector Authority (formerly Director of Policy and Research, Group Insurance Commission) [2007]

7. **Jay Curley**, Vice President for Public Affairs, Blue Cross Blue Shield of Massachusetts [2006]


9. **Anne Doyle**, Director of Public Policy, Government Affairs and Compliance, Tufts Health Plan [2006]

10. **Rob Egan**, Senior Vice President, Marketing & Product Development, Tufts Health Plan [2006]

11. **John Erwin**, Executive Director, Conference of Boston Teaching Hospitals [2006]


13. **Marisa Fusco**, Director of Client Services, Tufts Health Plan [2006]


15. **Robert Johnson**, Deputy Director, Group Insurance Commission [2007]

16. **Jon Kingsdale**, Massachusetts Connector Authority (Former Senior Vice President, Tufts Health Plan) [2006]

17. **Elaine Kirshenbaum**, Vice President for Policy, Planning and Member Services, Massachusetts Medical Society [2006]

18. **Bruce Landon**, Assistant Professor of Health Care Policy, Assistant Professor of Medicine, Harvard Medical School [2006]
19. **Thomas Lee**, Chief Executive Officer, Partners Community Health Care [2006]


21. **Jeff Levin-Scherz**, Medical Director, Partners Community Health Care [2006]

22. **Amy Lischko**, Tufts University (former Commissioner of the Division of Health Care Finance and Policy within the Massachusetts Executive Office of Health and Human Services) [2006, 2007]


24. **John McDonough**, Executive Director, Health Care for All (Formerly a state legislator) [2006]

25. **Brian Pagliaro**, Vice President for Sales, Tufts Health Plan [2006]

26. **Barbara Rabson**, Executive Director, Massachusetts Health Quality Partners [2006]

27. **Charlie Slavin**, Vice President, Unicare (Director of Policy and Research, Group Insurance Commission) [2006, 2007]

28. **David Smith**, Massachusetts Hospital Association [2006]

29. **Nancy Turnbull**, President, Blue Cross Blue Shield Foundation [2006]

30. **Richard Zeckhauser**, Professor, Harvard University (Former commissioner, Group Insurance Commission) [2006]
1. **Bradley Adcock**, Vice President of Government Affairs, Blue Cross Blue Shield of North Carolina [2005]

2. **William Atkinson**, President and CEO, WakeMed Health and Hospitals [2005]

3. **Sam Byrd**, Former Director, Fiscal Research Division, North Carolina General Assembly [2005]

4. **Lanier Cansler**, President, Cansler & Fuquay Solutions, Inc. (Former Deputy Secretary [NC DHHS] and former state legislator) [2006]

5. **Leslie Bevacqua Coman**, Director of Government Relations, Capstrat (Formerly Vice President of Governmental Affairs, North Carolina Citizens for Business and Industry) [2005]


7. **Geoff Elting**, Former Executive Administrator, North Carolina State Employee Health Plan [2005]

8. **Allen Feezor**, Chief Planning Officer, University Health Systems of Eastern North Carolina (Former Senior Deputy Commissioner of the SHP) [2005, 2006, 2007]


10. **Marlowe Foster**, Former President, North Carolina Association of Health Plans [2005]

11. **Gary Fuquay**, Vice President, Cansler & Fuquay Solutions, Inc. (Former North Carolina Medicaid Director) [2006]


15. **James Long**, Commissioner of Insurance [2005]

16. **Anna Lore**, Government Affairs Representative, Duke University (Formerly CEO of Wellpath’s North Carolina operations) [2006, 2007]

17. **Paul Mahoney**, Account Director, Capstrat (Formerly Executive Director of the North Carolina Association of Health Plans) [2005, 2006, 2007]
18. **Kenneth Morris**, Chief Financial Officer, Duke University Medical Center [2005]


22. **Adam Searing**, Project Director, NC Health Access Coalition [2006]


24. **Pam Silberman**, President, North Carolina Institute of Medicine [2005]

25. **Daniel Soper**, Chief Operating Officer of the North Carolina SHP (Formerly Chief Financial Officer of Kaiser’s North Carolina expansion region) [2006, 2007]

26. **David DeVries**, former Executive Administrator, North Carolina State Health Plan [2005]

27. **Steve White**, President of CIGNA’s North Carolina operations [2005]

28. **Chuck Willson**, Clinical Professor of Pediatrics, ECU (Former President, North Carolina Medical Society) [2006]
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