

# ***Primer on Pooling***

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## **Session 6: “Purchasing Strategies to Increase Value and Access”**

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### **Cool, Pool**

#### **But What Kind of Pool?**

Who's In, Who's Out?

Who's In Some Doubt?

Who's In Charge there?

Who's Charged What Where?



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## Some Critical Factors for Any Pool's Success

- **Sensible/Workable Target Population**
- **Level playing field for pool's vs. outside market rating of (unsubsidized) population**
- **Reality / appearance of stability**
- **Credibility of sponsoring organization in market**
- **Competent, responsive operations**
- **Cohesion**

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## Many States Interested in Small Employer Pools: Difference Between a Large Employer and a Pool for Small Employers and/or Individuals

- **A large employer group** constitutes an attractive pool of people to insure because it is what carriers often refer to as a **“natural group”**—a group that is constituted for purposes other than health insurance.
- **Such a “natural group” includes a healthy share of low-risk persons.** They participate in the pool largely because the employer contribution is applicable only there and the workers net cost of coverage is lowest there.
- **Individual small employers** by definition do not have large populations, so a given small employer is **more likely to have a disproportionate share of low or high risks.**
- **A group of small employers, and/or individuals each having choices about where, how, and whether they obtain health insurance is not a “natural group.”**

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## Broader Risk Spreading Is Important: The Most Expensive 5% of the Population Accounts for Over Half of Total Health Care Costs

(Percent of Total Expenditures Incurred by Top x% of Population, Ranked by Total Payments for Health Services)

Percentile	Total Population, 1987	Total Population, 1996	HMO Enrollees, 1996*	Privately Insured All Year <65	Uninsured All Year <65
Top 5%	56%	55%	51%	51%	60%
Top 10%	70%	69%	64%	65%	75%
Top 50%	97%	97%	95%	95%	99%

\* Includes only HMO enrollees under age 65 with employment-based coverage.



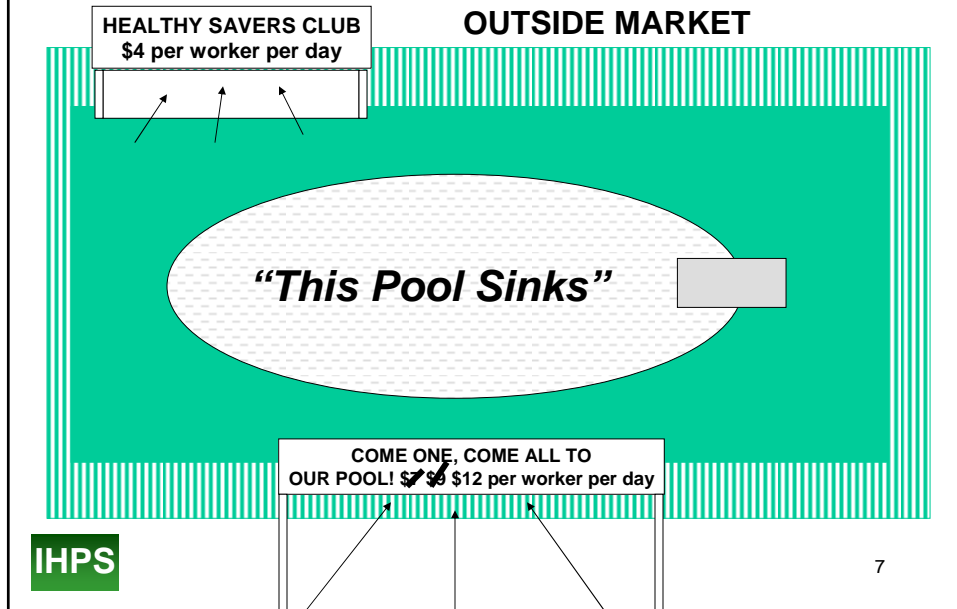
Source: Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditures, Revisited," *Health Affairs* 20:3 (March/April 2001), pp. 9-18, Exhibits 1, 2 and 3.

## Pools, Market Rules and Risk Spreading

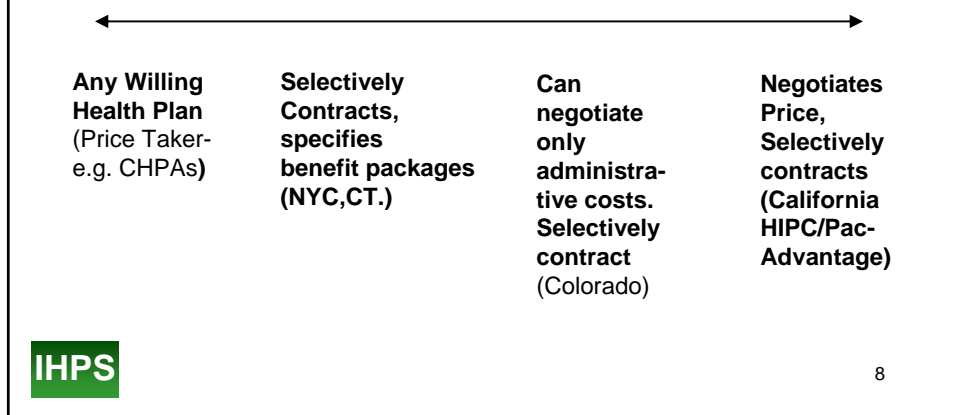
- If only the pool charges those presenting high risk the same as those presenting low risk--
  - Those who are currently healthy and can obtain a lower price elsewhere will do so.
  - Those who present higher risks and would be charged more elsewhere would come to (and often be aggressively referred to) the pool.
  - As a result, the pool's costs would be higher, not lower, than those in the open market-- leading to "death spiral"
- This dynamic played out due to policy constructs in a number of states.



## Avoid “Poolish” Pricing Policies: Pooled Rates Won't Work If Healthy People Can Get Preferred Rates Elsewhere



## ALTERNATIVE SMALL EMPLOYER POOL PURCHASING ROLES IN STATES WITH TIGHT RATING RULES



## **?Magic Bullet Effects on costs and coverage?**

**Tighter versus looser small employer rating rules\*  
and small employer purchasing pools  
With No Subsidies and No Mandates**

**The objective research literature finds little to no effect on**

- health insurance costs or
- coverage rates

\*e.g., Findings and references: Marquis, S.M., & Long, S.H. (2001)  
Effects of “second generation small group health insurance  
market reforms, 1993-1997, *Inquiry*, 38(4), 365-380.



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## **Experience indicates that:**

- **Health plans won't offer lower prices in a pool that largely competes against plans' own direct contracting with small employers.**
  - Some exceptions, e.g. provider-system based plans may view employee choice pool as attractive.
- **Most health plans strongly prefer direct contracts with whole employer groups over enrollment through a purchasing pool, eg. a choice pool**
- **Health plans generally don't want to cede administrative roles like enrollment to pool-- often making pool administration duplicative rather than cheaper**



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**A Win-Win Option: Target Subsidies for low income employees of small firms exclusively through the pool.**

- Large employer groups and federal/state employee programs "work" because employer contributions cannot be used to buy insurance elsewhere.
- If significant subsidies for low-wage small firm workers were available only through the pool.
  - A sizable new group could be reached through the pool, making it an attractive competitive opportunity.
  - The subsidies would play the role that large employer contributions play for their employee plans (create cohesion similar to that which a "natural" group enjoys).



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- *Nine out of ten workers whose employer does not offer coverage to any workers are in small (size 2-49) firms.*

*Over half of such workers are in a firm where the majority of workers earning less than \$9.50 per hour.)*

- *Thus, small low-wage & uninsured firms are one very sensible target for purchasing pools intended to cover the uninsured*

- *Federal matching dollars can be used for premium assistance for low income workers in such groups (e.g. HIFA waivers approved for ) ---*

*so defined modest employer contribution and sliding scale premium assistance for workers/families could make sense*

- *But wait- isn't premium assistance too burdensome*



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## A purchasing pool can simplify federally matched premium assistance for job-based health insurance

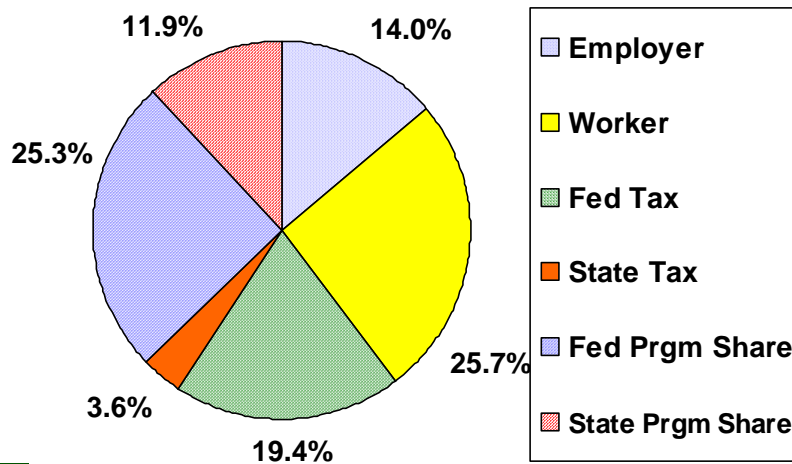
- One-time cost-effectiveness evaluation of pool specified benefit structure and cost-sharing levels.
- Specify plan options that meet State policy goals for population.
- Pool automatically knows subsidized families are enrolled in plan. And either pool defines or tracks employer contribution levels.
- Collect premium contributions from employer groups, combine with subsidies on behalf of the State (and, if worker choice of plans ala FEHBP route them to the health plan chosen by the enrollee.

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### Limited State and Employer Contributions Can Leverage Multiple Financing Sources for Coverage of Uninsured Small Employer Groups Example pool includes some non-subsidized group members

Illustrative % of Total Program Premium Cost Paid by Different Sources



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## **Some Other State POLICY WHYS**

### **Subsidies for Uninsured Low-Wage Small-Firm Workers and Families Through a Purchasing Pool.**

- Utilizes payroll withholding, other efficiencies unique to job-based coverage, lower costs of group coverage
- Potential to serve as hybrid between group and individual coverage, interface between private employer contributions and public subsidies
- Can extend coverage to uninsured workers above subsidy income eligibility line at no state cost
- Could strengthen social expectation/market demand for job-based coverage
- Reinforces work, job stability, career development



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## **Critical Characteristics**

for reaching uninsured low-wage small employer groups.

### **Experience to date indicates:**

- **Affordable, predictable and easily understood employer contribution requirements** (e.g. \$60 per worker per month);
- **A stable source of subsidies for low-income workers that will not leave employers “holding the bag”** for coverage they otherwise cannot afford to maintain;
- **Simple employer roles that minimize burden**, e.g. do not involve them in family income tests or subsidy administration;



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## Critical Characteristics

for reaching uninsured low-wage small employer groups.

- **Equity among similarly situated workers;**
- **Group coverage (with attractive benefits and provider networks) available for the business owner and for all full-time workers in the group** whether or not they are subsidy eligible ; and
- **Employer's contributions reduce costs for their workers (and families) below what coverage would cost workers to obtain on their own.**

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## Income Eligibility Standards and Single Workers

**If uninsured employers with low-income workers are a priority . . . It is critical to make coverage affordable for childless as well as parents**

- **Traditional state program income standards are often too low to reach childless workers.**
- **Even at minimum wage, a 40-hour per week childless single worker earns:**
  - 115% FPL at the national minimum wage (\$5.15)
  - 151% FPL in California (\$6.75 per hour)
  - 159% FPL in Connecticut (\$7.10 per hour)

**To work, some “headroom” above minimum wage is needed.** Alternative approach-- allow alternative

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Income standard tied to wage measures

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## What Doesn't Work? Examples

- **Involving Employers in Family Income Testing:** Neither workers nor their employers want this; Several states learned this the hard way with premium assistance approaches
- **Varying Employer Contributions with Individual Worker's Family Income:** What they don't know can hurt them. Employers know wages, not family incomes. (One difficulty with SacAdvantage plan)
- **Employer Contributions Don't Reduce Their Workers' Costs:** Past Basic Health Plan and current Medicaid employer contribution schemes for coverage available to workers at no employer cost--  
You Gotta Get Incentives Right

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**A choice pool that is not the exclusive venue for subsidies, and competes with carriers that underwrite and/or selectively market, has three bad choices:**

- **Do not underwrite**, and suffer severe adverse selection (if even get to point of offering plan(s))
- **Adopt a compromise underwriting approach** Death Spiral Wish in face of competition from individual carriers who are more adroit and aggressive at risk selection than pool can be; or
- **Let each carrier in the pool underwrite each individual applicant.**
  - Consumers could not readily compare prices (defeating a basic purpose of choice pools)
  - the administrative dynamics and costs of the individual market would likely be increased, with the added cost of pool administration.

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## **They had that sinking feeling**

- **Previous examples of worker choice pools that failed in such environments include those in:**
  - Chicago, Illinois (run by a business and industry association),
  - Texas (a private non-private authorized by the state), and
  - North Carolina (essentially run by the state with local business association sponsors and enrollment).

## **SELECTION & COHESION ISSUES**

**Are critical and are inter-related--**

- **If there is a strong source of cohesion for the pool, e.g. subsidies, selection concerns can be greatly reduced**
- **But, Selection problems & issues will emerge & evolve whenever there is**
  - ✓ **choice among competing plans & benefit levels, or**
  - ✓ **choice of outside market with**
- **Critical for purchasing pool to have latitude to develop & modify pertinent program rules, e.g., re: group eligibility (e.g., participation standards), rating policies, benefit packages, choice**

### **What Kind of Pool:**

**E.g. High Risk Pools**

- **Constituted for different purpose than purchasing or pools to reach uninsured**
- **Purpose here is residual mechanism for high risk “uninsurable individuals”**
  - Spreads costs or “losses” to broader sources
- **Sensible in context of a voluntary unsubsidized individual market subject to adverse selection**
  - Both systemic and intra-market adverse selection
  - May be suitable as residual mechanism for high risk employer groups in a state with low employer market participation rates and significant health rating.
  - Can achieve access for groups that need it most. Question is source of cross-subsidies to cover losses.

**What kind of pool--** issue even with Mandatory coverage--

e.g. if flat rating were to be used under a construct like SB2 in California, selection dynamics with outside market similar 23

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### **Conclusion**

- **A purchasing pool might improve health insurance cost, coverage rates, and choice for vulnerable small firms and their workers but it would require state policy changes.**
- **Options involve premium assistance and/or exclusive venue approaches.**
- **A carefully crafted combination of some of these concepts has potential to meet these goals.**
- **But to achieve broader coverage and access goals, adequate subsidies and broader measures conveying consistent, constructive incentives are needed**

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**Percent Distribution of Full-Time, Full-Year Adult Wage-and-Salary Workers by Annual Earnings at Longest Job within Family-Income-as-a-Percent-of-Poverty Categories, United States**

		%FPG	%FPG	%FPG	%FPG
Annual Earnings	TOTAL	< 133%	133-199%	200-249%	250%+
< \$15,000	12.8%	76.8%	43.2%	13.5%	4.0%
\$15,000 - \$19,999	11.4%	15.4%	31.0%	37.9%	5.5%
\$20,000 - \$29,999	23.3%	7.5%	19.9%	34.2%	23.7%
\$30,000 - \$39,999	18.5%	0.3%	5.3%	10.6%	22.5%
\$40,000 +	34.0%	0.0%	0.6%	3.9%	44.3%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%



Source: IHPS analysis of the March 2000 Current Population Survey. Data analysis was supported by grants from the David and Lucile Packard Foundation and the California Health Care Foundation.

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**Percent Distribution of Full-Time, Full-Year Adult Wage-and-Salary Workers by Family Income as a Percent of Poverty within Annual-Earnings-at Longest-Job Categories, United States**

		%FPG	%FPG	%FPG	%FPG
Annual Earnings	TOTAL	< 133%	133-199%	200-249%	250%+
< \$15,000	100.0%	34.1%	33.0%	9.1%	23.8%
\$15,000 - \$19,999	100.0%	7.7%	26.7%	28.9%	36.7%
\$20,000 - \$29,999	100.0%	1.8%	8.3%	12.8%	77.1%
\$30,000 - \$39,999	100.0%	0.1%	2.8%	5.0%	92.1%
\$40,000 +	100.0%	0.0%	0.2%	1.0%	98.8%
<b>TOTAL</b>	100.0%	5.7%	9.8%	8.7%	75.9%



**Source:** IHPS analysis of the March 2000 Current Population Survey.  
Data analysis was supported by grants from the David and Lucile Packard Foundation and the California Health Care Foundation.

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