Arizona Health Care Cost Containment System
Issue Paper on Purchasing Pools

Prepared by:

Shelly S. Brandel, A.S.A.
Associate Actuary

Larry J. Pfannerstill, F.S.A.
Actuary

August 27, 2001

Arizona Health Care Cost Containment System
Issue Paper on Purchasing Pools

Table of Contents

Arizona Health Care Cost Containment System
Issue Paper on Purchasing Pools

I. EXECUTIVE SUMMARY

Purpose and Description

Milliman USA, Inc. was retained by the Arizona Health Care Cost Containment System (AHCCCS) to provide a policy paper examining the role of health insurance purchasing pools for small groups and individuals and their dependents and their effectiveness in improving access and affordability to health insurance.

Purchasing pools are nonprofit or governmental entities that allow small employers to offer their employees a choice of several health plans. They were intended to lower premiums for small employers through economies of scale and greater negotiating power. The ultimate goal was to reduce the number of uninsured by making health insurance more available and affordable and promote competition in the small group market as a whole.

Purchasing pools have been successful in allowing small employers to offer individual choice to their employees without running up prohibitively high administrative costs. However, they have not been able to accomplish many of the other objectives their creators had in mind, such as reducing the number of uninsured employees or lowering prices. Typical challenges have included low enrollment, lack of participation by health plans and agents, and controlling adverse selection. However, they have provided value to about a million people nationwide and have been an object of renewed attention in today's environment of escalating health care costs, the continuing problem of the uninsured, and other health care reform issues.

It is possible for purchasing pools to play an important role in the future. They are ideal vehicles for combining public and private funds for purchasing health insurance. If health costs continue to escalate, employers may be more interested in limiting their premium contributions. Purchasing pools might also be able to expand into the individual health insurance market. However, purchasing pools must be able to increase enrollment to achieve economies of scale, attract health plans, and become more attractive to small employers. There are actions both purchasing pools and governments can take to increase participation.

In this paper, we examine the purchasing pools in a number of states, analyze the role of purchasing pools in general, outline their successes and failures, and comment on the issues

involved in setting up a purchasing pool. In addition, we analyze public policy and other methods to promote purchasing pools in the current environment.

This paper was developed for the Arizona Health Care Cost Containment System as part of the Arizona State Planning Grant, which is funded by the Health Resources and Services Administration. It provides summary information about health care purchasing pools. A more detailed analysis of this subject was beyond the scope of this paper but should be completed before designing or implementing a health care purchasing pool. This paper assumes that the reader is familiar with the design of health insurance plans offered through small groups or on an individual basis and the health care system in the United States. It should be reviewed only in its entirety.

II. INTRODUCTION – WHAT ARE PURCHASING POOLS?

Health insurance purchasing cooperatives were created to promote the availability and affordability of health insurance for small employers and individuals. They are typically private nonprofit or governmental entities that offer health insurance from several health insurers to the employees of small businesses (under 50 employees). Although referred to by many names, we will refer to them as health purchasing cooperatives (HPCs) for the remainder of this paper.

A number of HPCs were established in the early 1990s as part of larger market reforms aimed at moving closer to the goal of universal coverage. These other market reforms vary state to state, but most included guaranteed issue, portability of coverage, elimination of excessive pre-existing exclusions, and restrictions on rate variations. Since a large proportion of the uninsured represent the employees of small businesses, these reforms were largely aimed at the small group market.

Initial Objectives

The main goal of HPCs was to expand coverage by making health insurance more accessible and affordable for small employers. It was hoped that HPCs could help to meet this goal by:

- *Centralizing administrative functions* – In the small group market, the administrative component of health insurance premiums is significantly higher for small groups than large groups due to higher per-employee administration costs. By centralizing the administration for a large number of small groups, HPCs were expected to produce the economies of scale enjoyed by large groups. In particular, HPCs hoped to reduce agent commissions, which were perceived as excessive relative to the large group market.

- *Increasing the negotiating power of small groups* – In the 1980s, large employers demonstrated that they could get health plans to give them price concessions and shift to cost-saving managed care structures as a result of their size. By pooling their purchasing power, small employers could potentially influence both the price and the delivery of their health care.

- *Promoting competition in the small group market* – HPCs could potentially stimulate competition in several ways. HPCs provide convenient and fast price quotes, since multiple plans are available through a single source. This makes benefit and gross premium comparisons easier. Some HPCs offer standardized benefit plans, also facilitating price comparisons on an equivalent benefit plan basis. Health plans might lower their prices in anticipation of competition with (and within) a HPC. Also,

HPCs could serve as a convenient way for new managed care plans with limited capital to enter the market.

- *Increasing coverage options for individual employees* – outside of a HPC, it is often not feasible for small employers to offer their employees a choice of health plans due to the significantly higher administrative burden such choice would create. Also, an employer currently offering indemnity coverage could find it difficult to switch to managed care because some workers and their families would be forced to change providers.

  The HPC structure would make it much easier administratively for small employers to offer a variety of health plans to their employees. An employer could shift to managed care with less disruption for their employees. The employees without established relationships with their doctors could choose the less expensive HMO plans, while others could choose richer coverage or plans with a broader provider network. Employers could also offer a choice of plans while limiting their financial liability. For example, they could tie their premium contributions to the least costly plan and allow employees to pay the difference if they selected richer coverage, leaving employees to absorb some or all of future premium increases.

- *Reducing the number of uninsured* – by making health insurance more accessible and affordable, reformers hoped to entice small employers who previously did not offer health coverage to participate in the HPCs.

It is important to note that most HPCs were created in an environment of major changes in the small group health insurance market. Many expected the passage of national health care reform legislation, characterized by universal coverage, mandatory participation in HPC-type structures, underwriting and rating reform, nationally standardized benefits, the elimination of indemnity plans, and federal tax subsidies. HPCs were not expected to meet the goal of reducing the uninsured alone, but instead were to be established along with other small group market reforms.

Characteristics

Pooled purchasing could be defined broadly to include HPCs, private business coalitions, multiple-employer trusts (METs), multiple-employer welfare associations (MEWAs), and other trade or professional membership organizations. In this paper, we concentrate on HPCs only because other types of pooled purchasing mechanisms do not focus on increasing coverage for small employers and reducing the number of uninsured. Instead, they mainly focus on providing alternative coverage options for employers that already provide health insurance for their

employees. HPCs also typically differ from other pooled purchasing mechanisms in the following respects:

- HPCs offer coverage to all small businesses that meet group size requirements. Some types of pooled purchasing arrangements, such as trade or professional associations and METs, often restrict membership to specific industries or other criteria. Others, such as private business coalitions, have typically been attempted with large employer groups within a defined metropolitan region.

- HPCs offer insured benefits only. MEWAs are self-insured.

- Employers can choose from at least two health plans in a HPC. Other arrangements may represent a single insurer only.

- Individual employees can generally choose from different health plans in a HPC. HPCs are virtually the only vehicle that allows individual choice for the employees of small employers.

The characteristics of HPCs vary. The implications are explained later in the paper, but the major areas of variation include:

- *Employer eligibility qualifications* – Typically, all small employer groups of 2 to 50 employees in the HPC's service area are eligible for membership. Many HPCs offer coverage to self-employed individuals as well.

- *Number of participating health plans* – While most HPCs are allowed to limit the number of participating health plans, some must accept any health plan that meets certain minimum standards.

- *Level of negotiation with health plans* – Some HPCs can negotiate with health plans over price. Some states limit negotiation to the administrative component of premiums only. Other states do not allow negotiation with health plans over any aspect of premiums, including administration.

- *Degree of employee choice* – Most HPCs allow individual employees to choose from several health plans. In addition, most health plans offer at least two benefit plans. Although employees prefer benefit plans with out-of-network coverage, health plans have been reluctant to offer PPO or POS plans due to fears of adverse selection.

- *Agent structure* – Initially, many HPCs wanted to reduce or eliminate the role of agents in the small group market. Agent commissions for small groups were perceived as excessive relative to the amount of effort needed to administer their health insurance. However, most have now changed their position and pay agents the same commissions as they receive outside the HPC.

- *Employer contribution and employee participation rules* – Most HPCs require that employers pay a minimum of 50% of the least costly plan and also require that 75% of employees elect coverage through the HPC. Where HPCs have implemented less stringent requirements, they have generally experienced adverse selection.

- *Level of government association* – State governments often provide start-up capital for HPCs and may also operate them. The law may or may not require privatization after several years. Others were founded and operated privately. Both government and private HPCs are typically organized as non-profit.

III. SUMMARY OF STATE PURCHASING POOLS

Overall Summary

In this section, we summarize the HPCs in several states. Most of the HPCs in these states were created as part of small group reforms in the early 1990s. While we did not analyze all HPCs in operation at this time, the HPCs in the states listed below are a representative sample of the various types of HPCs along with their advantages and disadvantages. We will analyze the characteristics, successes, and failures of the programs in each state. In each state, we will comment on the following:

- Enrollment
- Health plan participation
- Agent participation
- Price
- Employee choice
- Impact on competition
- Adverse selection
- Impact on the number of uninsured

Section IV discusses the overall successes and failures of HPCs and what changes might make them more successful in the future.

Florida

Overview

Community Health Purchasing Alliances (CHPAs) were established in Florida in 1993 as part of other small group reforms including; eliminating the use of medical underwriting (guaranteedissue) for state-mandated benefit plans, imposing limits on rate adjustments for health status, and the establishment of a state high risk pool. Initially, there were eleven regional state-chartered CHPAs in the state. Each CHPA was a private, non-profit organization. The organizations initially received subsidies from the state government, but must now be financed entirely by member premiums and fees. Small employer groups (less than 50 employees) as well as self-employed individuals can participate in CHPAs. Employers must pay at least 50% of the cost of the least expensive plan, and employees must be given the choice of at least two health plans.

CHPAs must accept any health plan that meets minimum standards and wish to participate. Although health plans must pool together their business inside and outside CHPAs for purposes of setting rates, state law does allow negotiation on the administrative component of premiums for plans offered through CHPAs. Also, if the health plan has enough membership inside a CHPA, it can rate the CHPA pool separately (only one insurer has enough enrollment to do this). Unlike HPCs in other states, CHPAs do not contract directly with the plans. The contract is between the health plan and each individual employer. All CHPA sales must be conducted through agents.

Enrollment

Enrollment in CHPAs peaked at about 5% of the small group market. This was higher than in most other states, although it was still far less than expected. Enrollment has been dwindling since and is now about half of that amount. Possible reasons for the decreasing enrollment could be decreasing health plan participation and inefficient use of marketing funds, which were spread over a number of CHPAs. In addition, the health plans within CHPAs do not offer traditional indemnity or PPO options, which are attractive to employers.

Health Plan Participation

Health plan participation was initially strong. More than 45 plans participated in the first several years of operation. There was strong political pressure for plans to join CHPAs in the environment of possible national health care reform. In addition, legislators hinted that CHPAs might be the future vehicle of coverage for both Medicaid and state employees. Although plans were not generally supportive of the concept, most willingly participated for these reasons.

The number of plans has fallen dramatically to five plans as of early 2000. Reasons for the decline in participation include less political pressure to participate, financial reasons, and fears of adverse selection. Plans are particularly reluctant to participate because of the high proportion of very small groups in CHPAs. Health plans contend that these groups are higher risks because they tend to delay buying insurance until somebody in the group needs expensive care. CHPAs have responded to these fears by eliminating employee choice for groups of less than 5 employees and considering allowing all plans to pool CHPA business separately. These changes may make the small group size more acceptable to health plans, although the impact remains to be seen.

Agent Participation

All CHPA sales are required to go through an agent. However, agents have still been reluctant to promote CHPA business. Agents are suspicious of HPCs in general since many have tried to reduce or eliminate their role. CHPAs have worked hard to win over the agents by educating

them about the potential rewards of participating and referring potential customers to agents that sell CHPA products, and are succeeding to some extent.

Agents have generally used CHPAs for the smallest employers, possibly because it is easier to obtain price quotes from a number of health plans using CHPAs.

Price

Since prices must be the same both inside and outside CHPAs for most plans, the only way to obtain lower prices inside CHPAs is to reduce administrative costs. Prices were initially lower in CHPAs because health plans gave administration discounts in anticipation of economies of scale. However, the level of enrollment has been too small to justify health plans' changing their administration systems, so they duplicate the administrative functions performed by CHPAs. Some plans believe they actually have higher administrative costs on their CHPA business since they need to do separate rate filings. In any case, evidence suggests that prices are currently about the same both inside and outside CHPAs.

Employee Choice

CHPAs were designed to promote individual employee choice of health plans. Employers must offer the choice of at least two health plans to each employee. However, with the drop in health plan participation, this benefit is greatly reduced. Even when there were more participating plans, employee choice was generally restricted to HMO and PPO plans, since the indemnity plans withdrew from CHPAs within the first few years, citing adverse selection as the major reason.

Impact on Competition

The ability to obtain convenient price quotations from a number of plans may have promoted competition in the small group market as a whole. Small group reforms also encouraged competition in the market. With the number of health plans down to five, the current competitive impact is very small if it exists at all.

Adverse Selection Problems

CHPAs contain a high proportion of very small groups. As mentioned above, health plans believe these groups represent a serious threat of adverse selection. Health plans also generally see CHPAs as competitors for their business. They fear that healthy employees will choose other plans, leaving them with the sicker and more expensive employees. (Of course, this means some health plans will have healthier than average employees, but the fear of adverse selection seems to outweigh the potential benefits). Outside of CHPAs, the potential for adverse selection in a dual

choice environment is not as great because the health plans will enroll the entire group, even if they choose different benefit plans. Indemnity plans were particularly affected by adverse selection, and all indemnity plans have withdrawn from CHPAs.

Impact on the Number of Uninsured

There is no direct evidence to date that CHPAs have reduced the number of uninsured. The proportion of small groups previously without insurance is the same inside and outside of CHPAs. However, CHPAs maintain that they have helped very small groups find coverage, a portion of the market not served well prior to the establishment of CHPAs. It is also important to note that the impact of HPCs on the number of uninsured is very difficult to measure. Since HPCs were typically established along with other small groups reforms, there is no easy way to isolate the impact of HPCs. Also, although the number of uninsured may not have decreased, it may be that there would be more uninsured in the absence of HPCs.

California

Overview

Like the CHPAs in Florida, the Health Insurance Plan of California (HIPC, now known as PacAdvantage) was established in the early 1990s against the backdrop of small group reforms including; requiring guaranteed issue and renewal on all plans, restricting the use of pre-existing condition limitations, and imposing restrictions on the use of health status for rating purposes. The major differences between the HIPC and CHPAs in Florida include the following:

- The HIPC was initially funded and operated by state government, although it was recently privatized. The Pacific Business Group, a non-profit private organization, now runs the pool and renamed it PacAdvantage.

- The HIPC can negotiate prices directly with health plans and segregate HIPC and non-HIPC business for rating purposes. The HIPC is also allowed to exclude health plans if their prices are too high, while CHPAs can only exclude health plans that fail to meet minimum criteria.

- Enrollment is not open to self-employed individuals.

- Instead of regional alliances, the HIPC operates statewide and provided centralized administration functions.

- Employers are permitted to enroll directly through the HIPC, while Florida requires the use of agents.

- The HIPC implemented a risk adjustment mechanism to reduce adverse selection and spread risk between health plans.

Enrollment

Enrollment in the HIPC has been a modest success at best. Although it has a large amount of enrollees (about 145,000 as of July, 1999), it represents only about 2% of the total small group market.

Health Plan Participation

The HIPC initially hoped to limit participation to five or six large, prominent health plans in order to guarantee larger market shares while still providing reasonable employer choice. However, Blue Cross, one of the largest insurers in the market, declined to participate, and in fact, was openly hostile to the idea. Blue Cross was worried that participation would be a threat to its relationship with agents and was suspicious of a government-run HPC. Blue Cross even changed its products to offer more employee choice to offset this potential advantage of the HIPC.

As a result of Blue Cross' actions, the HIPC did not make an effort to limit the number of health plans. Instead, participation was opened to all plans that sought to participate in the HIPC. One could argue there are too many plans. In 1998 and 1999, six plans out of a total of nineteen accounted for about 80% of total enrollment, so administrative costs could be lowered without major disruption for members if the other plans were eliminated.

The HIPC has had trouble attracting and maintaining PPO plans, which has probably hindered its growth. The PPO plans that originally participated withdrew, citing losses due to adverse selection. The HIPC introduced a risk adjustment mechanism (the only HPC to do so) in its third year of operation to compensate health plans that experienced biased selection. Each plan was given a "risk assessment value" (RAV) based on the number of members that were hospitalized in the prior year with one of a specific set of diagnoses. Funds were reallocated if any plan had a RAV more than five percent above or below the average of the RAV for all plans. Although the PPO plans received significant transfers as a result of the risk adjustment mechanism, they were insufficient to cover the losses they experienced.

Finally, the association with government made health plans reluctant to participate in the HIPC. Government-run HPCs are also generally less able to adapt to changing market conditions because changes often require legislation.

Agent Participation

Initially, the HIPC tried to reduce the role of agents by allowing employers to enroll in the HIPC directly, paying them lower commissions than the outside market, and itemizing agent commissions on employers' monthly bills. However, management soon realized that agents are crucial to the health insurance process for small employers, who lack the resources to hire a benefits manager and depend on agents for coverage decisions and continuing support. The HIPC has realized its mistake and changed the features agents disliked. Employers can still enroll directly but receive no price advantage for doing so. In addition, agent commissions have been increased to be comparable to the outside market and are no longer itemized on the monthly bills. The HIPC now actively attempts to educate and attract agents.

Price

Prices in the HIPC were initially less than in the outside market. As mentioned above, the HIPC is allowed to negotiate prices directly with health plans, and the health plans can rate their HIPC and non-HIPC business separately. The initial discounts were based on expected economies of scale and reduced administration costs. As with the CHPAs in Florida, premiums have increased because enrollment has been too low to produce economies of scale and if administration costs have been lowered, the savings have not been passed on in the form of lower premiums. Prices are now comparable to the outside small group market.

Employee Choice

The ability to offer employee choice was a major selling point for the HIPC, especially when it was able to offer PPO plans. Without PPO plans, employee choice is currently less of an advantage because many insurers have begun to offer dual-choice options, where employees can choose either an HMO or PPO plan. However, the HIPC is still the only vehicle for offering benefit plans from more than one insurer. Although the HIPC currently offers a couple of POS plans, they are priced much higher than the HMO plans.

Impact on Competition

The HIPC actively displays health plan premiums, allowing direct comparisons between health plans. The health plans have an incentive to keep their non-HIPC premiums in line with the HIPC since they would rather enroll the whole group outside of the HIPC. Proponents of the HIPC argue that this has had a general downward impact on small group premiums in the market. The impact is difficult to measure, however, since broader small group reforms were passed at the time the HIPC was established.

Adverse Selection Problems

The small group rating laws in California allow a plus or minus 10% for health status rating. The HIPC did not take advantage of this rating flexibility. As a result, health plans believe they experienced adverse selection, as healthier employer groups could presumably obtain lower prices outside of the HIPC. However, the adverse selection experience did not impact rates enough to drive them higher than rates in the rest of the small group market.
A risk adjustment mechanism was introduced to spread any higher risks across all participating health plans. The majority of plans did not make or receive transfers. As mentioned above, the PPO plans did receive significant transfers as a result of risk adjustment, but they were not sufficient enough to convince them to stay in the HIPC.

Impact on the Number of Uninsured

As in Florida, the evidence to date does not indicate that the HIPC has reduced the uninsured percentage of the population in California.

Colorado

Overview

An existing private association of large employers established the Cooperative for Health Insurance Purchasing (CHIP) in Colorado in 1995. CHIP is unique because it has never received subsidies from the government and is open to employers of all sizes, not just small employers. CHIP also serves self-employed individuals.

Participating employers must offer their employees the choice of any of the four health plans within CHIP, and they must pay 50% of the least costly plan. Like Florida, CHIP can only negotiate on the administrative component of premiums.

Enrollment

CHIP enrollment grew quickly in its first year and has been increasing slightly since then. As of late 1999, CHIP accounted for about 2% of the small group market in Colorado and small groups represented about 60% of the total membership. There is a high proportion of one-life groups within CHIP although the average group size is about ten since it allows large groups to participate. The "standard" HMO plan offered within CHIP is about the same as the insurers' street plans, which helps to attract employers who wish to offer their employees competitive

benefit levels. However, CHIP's growth may be limited in the future due to its inability to offer PPO plans. Health plans have been unwilling to offer PPOs, fearing adverse selection if healthy employees choose HMO benefits and sicker employees choose PPO benefits. Also, although CHIP does offer *employers* a choice of HMO or POS benefits for their employees, individual employees cannot make this choice.

Health Plan Participation

From the beginning, CHIP has attracted four out of the five largest and most prominent health plans in Colorado. CHIP staff deliberate sought the advice and concerns of health plans during the establishment process, unlike the HPCs in some other states. Even if health plans are not enthusiastic participants, they are generally not losing money and feel they are socially obligated to continue to participate.

Agent Participation

Even though employers are permitted to buy insurance directly from CHIP, the level of agent hostility has been lower in Colorado than in other states. Employers do not receive a price advantage by buying insurance directly. Instead, they are charged a fee equal to the amount an agent would be paid in commission. Agent commissions are in line with the outside market, and CHIP openly encourages employers to use agents. In addition, CHIP's marketing efforts have been directed mainly to agents.

Price

CHIP has not been as successful as other HPCs in negotiating lower prices. Originally, the law permitted CHIP to negotiate with health plans over prices. Due to a conflict with other small group reforms, the law was changed to allow negotiation over administrative costs only. Health plans believe CHIP has not reduced administrative costs and have actually increased the amount of administrative duties they must perform. As a result, the prices within CHIP are slightly higher than prices outside of CHIP.

Employee Choice

CHIP is an employee choice model. Employers must offer their employees the choice of any of the four participating health plans. Employers can choose to offer either the standard HMO plans or a POS plan. Initially, employees within the same group could choose either an HMO or POS plan, but the health plans removed this option due to fears of adverse selection. CHIP would like to offer a PPO plan, but so far the health plans have been willing to offer this choice, again due to

fears of adverse selection. CHIP does not offer an indemnity option either, but this has not been perceived as a disadvantage as much as the absence of a PPO plan.

Impact on Competition

The enrollment in CHIP has probably not been large enough to have a significant impact on the small group market. However, CHIP has been a proponent of health plan report cards to allow employees to analyze the health plans in areas other than price. CHIP intended to tie performance guarantees to financial penalties and rewards, but this has not occurred.

Adverse Selection Problems

Colorado does not allow health status to be used as a rating variable either inside or outside CHIP. This has helped CHIP meet the social mission of making insurance accessible and affordable for higher risk as well as lower risk groups. However, insurers within CHIP have stopped offering both HMO and POS options to the employees in a given group, and do not offer PPO plans due to concerns about adverse selection.

Impact on the Number of Uninsured

As in most other states, CHIP has not had a measurable impact on the number of uninsured employees in Colorado.

North Carolina

Overview

Similar to many other states, Caroliance, the HPC in North Carolina, arose out of small group market reform including guaranteed issue for state-mandated benefit plans, limits on rate variation, and the establishment of a state high risk pool. Caroliance began offering insurance in 1995 and was modeled after the CHPAs in Florida, with the following main differences:

- Caroliance cannot negotiate with health plans over any component of premiums including administrative costs. They must accept the prices quoted by participating plans.

- While there were originally regional purchasing pools within Caroliance, they were eventually consolidated into one statewide pool.

Enrollment

Enrollment in Caroliance has been much lower than expected, peaking at less than one percent of the small group market. As with Florida, marketing resources spread over several regional pools have been inadequate. However, Caroliance has improved access for higher risk groups. With dwindling government funds and a failure to become self-supporting, the future of Caroliance is uncertain.

Health Plan Participation

Health plan participation in Caroliance has been disappointing from the start, and by the middle of 1999 only one statewide insurer and two regional insurers were left. This is partly because the political pressures that arose from the expectation of national health care reform have dissipated, but also because of concerns about adverse selection and the failure of Caroliance to implement a risk adjustment system. Finally, Caroliance has not been successful in reducing administrative costs and enrollment has been too small to entice insurers.

Agent Participation

As in Florida, Caroliance required the use of agents but paid lower commissions than the rest of the small group market. The association with government also made agents suspicious. However, agents have found it easier to obtain quotes for higher risk groups within Caroliance than in the rest of the market. Before HIPAA, Caroliance was the only place these higher risk groups could find more comprehensive coverage on a guaranteed-issue basis than the standardized basic and standard plans available statewide. This is still true for self-employed individuals.

Price

The premiums within Caroliance are higher than premiums in the rest of the small group market. Caroliance does not have the ability to negotiate with health plans over prices. Unlike some other states, health insurers can also charge different premiums for Caroliance business. Caroliance charges member fees on top of the higher premiums as well. Finally, Caroliance rating rules are more restrictive than the state's general small group rating rules. Caroliance does not use the lower part of the range of allowed rate variation due to health status.

Employee Choice

Due to the lack of health plan participation, employee choice has not been a distinguishing feature of Caroliance. While employers are required to offer their employees at least two benefit plans to choose from unless they contribute at least 70% of the cost of the least expensive plan, the two

benefit plans can be from the same insurer. Only about 5% of employer groups enrolled with more than one plan. This is partly due to the large number of very small groups, but also because of the limited number of participating insurers.

Impact on Competition

Standardized benefits within Caroliance have improved the ease of cost comparisons between health plans, although this advantage has decreased significantly due to the lack of health plan participation. Also, enrollment has probably been too small to have any significant impact on competition in the small group market.

Adverse Selection Problems

There have been significant adverse selection problems for Caroliance:

- Before HIPAA, Caroliance was the only place where coverage other than the state mandated basic and standard plans was offered on a guaranteed-issue basis. This made it attractive to higher risk groups. In addition, Caroliance marketed its guaranteed-issue plans more actively than insurers outside of Caroliance.

- State law allows health plans to adjust rates by plus or minus 20% for health status. However, Caroliance rating rules do not permit the use of the lower part of this range. Therefore, healthier groups of employees are generally charged less outside of Caroliance for the same benefit plan. Also, Caroliance initially used only two rating tiers (single and family), while the rest of the market used multiple family tiers. This drove smaller families to the outside market.

There is evidence of adverse selection between health plans as well as in Caroliance as a whole relative to the rest of the market, measured by the percentage of underwritten business (a higher percentage of underwritten business implies a healthier mix of employees).

Impact on the Number of Uninsured

The percentage of employers that previously did not offer insurance is significantly higher within Caroliance than the rest of the small group market. This implies that Caroliance was relatively successful in reducing the number of uninsured. However, this success came at the cost of higher adverse selection.

Ohio

Overview

The Council of Small Enterprises (COSE) in Cleveland, Ohio, has been in operation since 1973. Unlike other HPCs, the main goal of COSE was not to reduce the number of uninsured, but to offer lower prices to small employers who already purchased insurance for their employees. The definition of a small employer, less than 150 employees, is more expansive in Ohio than in other states. Like CHIP in Colorado, COSE is a private organization with no government funding. Although limited to a regional area, COSE has been one of the most successful HPCs and is worth analyzing to determine why it has been so successful.

Enrollment

COSE dominates the small group market in Cleveland, unlike other HPCs who have achieved a 5% market share at most. While exact measurements of market share are difficult, COSE represents somewhere between 60% and 80% of the small group market in Cleveland. Enrollment is also increasing steadily. The prices within COSE are lower than the rest of the market, and since small employers base coverage decisions mainly on price, COSE is an attractive option.

Health Plan Participation

In the past, COSE offered plans from several insurers, but has decided to focus on one large insurer, allowing only one other insurer to participate. This philosophy:

- guarantees market share for participating insurers, who are then more willing to grant volume discounts and experiment with new, innovative ways of delivering care
- decreases the administrative burden associated with including many different insurers
- provides rate stability for the participating insurers
- decreases insurers' adverse selection fears, because they are more likely to enroll all of the employees of a given employer
- helps maintain a close relationship between COSE and the insurers

Although the philosophy decreases the number of choices available to employers and employees, COSE feels the benefits outweigh the decreased amount of employee choice.

Agent Participation

COSE has traditionally sold coverage directly, without the use of agents. This has resulted more from the main insurer's policy than that of the COSE. COSE is now experimenting with the use of agents for larger employer groups.

Price

The prices within COSE are significantly lower, as much as 12% to 14% lower, than those in the rest of the market. The large enrollment base has enabled COSE to obtain significant discounts from the main participating insurer. In addition, the underwriting and rating rules within COSE have been identical to those in the rest of the market. As a result, the health status within COSE is equal to or slightly better than the rest of the market.

Employee Choice

As discussed above, employee choice is less of a feature in COSE than it has been in other plans. Employers are not required to offer more than one health plan to their employees, and they can only select one benefit plan for each type of coverage (HMO, PPO, POS, etc.). COSE has been proactive in offering innovative features, including out-of-network coverage and medical savings accounts.

Impact on Competition

Since COSE includes only two health plans, it has not generated the level of price competition of other HPCs. However, since COSE offers a full range of benefit types (including indemnity, HMO, PPO, POS, and even medical savings accounts), it may have led non-COSE insurers to offer more of these products.

Adverse Selection Problems

COSE has experienced less adverse selection than some other HPCs. Possible reasons include:

- COSE uses the same underwriting and rating rules as those that are used outside COSE. This decreases the probability that healthy groups will find cheaper coverage outside COSE.

- Employee choice is restricted to one benefit plan for each type of coverage offered. This decreases selection based on benefits.

- There are only two participating insurers. Since there is a high probability that the same insurer will enroll the entire group, there is less chance of adverse selection between health plans.

Impact on the Number of Uninsured

Although COSE may have improved access for one-life groups, it has discouraged the enrollment of very small groups by requiring 100% participation for groups with fewer than five members and imposing a flat annual enrollment fee for employers. The percentage of employers who did not previously offer insurance is not different than the rest of the state.

Other States

The HPCs discussed in the states below are similar to the HPCs already summarized in detail. We present a few notable points about each state below.

Texas

The Texas Insurance Purchasing Alliance (TIPA) was modeled after the HIPC in California, although it was a non-profit versus a government organization. TIPA grew out of support for insurance reform in 1993 when two-thirds of small employers did not offer health coverage. Initial enrollment and plan participation was promising, but soon fell. When the largest insurer decided to withdraw, TIPA disbanded in 1999.

The biggest problem with the TIPA was the adverse selection problems and resulting rapid premium increases. There were several practices within TIPA that contributed to adverse selection problems:

- TIPA initially offered a community rated product that was not available in the outside market. This may have made coverage more affordable for higher-risk groups.

- After HIPAA took effect, TIPA used modified community rating even though the state allowed more rating flexibility. This attracted high-risk groups and drove healthier groups away.

The inability to reduce administration costs and low enrollment exacerbated these problems.

Iowa

The Independent Health Alliance of Iowa (IHAI) disbanded in 1995. The problems leading up to its disbanding were similar to the problems in Texas:

- IHAI did not use the full rating flexibility allowed by state law.
- IHAI actively marketed its guaranteed-issue plans to employers and agents.
- The employer contribution and employee participation rules were more lenient within the IHAI than in the rest of the market.
- The two largest insurers in the market did not participate, so employers were not attracted to the IHAI.

Although the IHAI did promote market competition and employee choice, these benefits were not enough to overcome the problems listed above.

New York

The Long Island Association Health Alliance (LIAHA) is similar to the COSE in Cleveland. It is a private organization founded with start-up capital mostly from participating insurers. It has survived and become self-sustaining, operating on premium and fee income. Its success is attributed to:

- Identical underwriting and rating rules inside and outside of the LIAHA, minimizing the impact of adverse selection
- Superior leadership and non-government sponsorship free LIAHA from the conflicts of interest inherent in many HPCs (the social mission of increasing access to insurance often conflicts with business concerns)
- An ideal market due to its heavy concentration of small businesses, making it feasible to convince insurers to provide significant start-up capital

IV. ANALYSIS OF PURCHASING POOLS

Have Original Objectives Been Achieved?

Despite promising beginnings, few HPCs (if any) have achieved their original objectives:

- *Centralizing administrative functions and producing economies of* scale – In general, HPCs have not reduced administrative costs. The bulk of administrative savings were to come from reduced agent commissions, and HPCs have realized that agents are crucial to the process of marketing to small employers. Enrollment has been too low to produce the economies of scale expected in HPCs.

- *Increasing the negotiating power of small groups* – Enrollment has been too low to induce health plans to grant price discounts to HPCs. In addition, HPCs are often not allowed to negotiate over anything but the administrative component of premiums.

- *Promoting competition in the small group market* – Standardized products and quick price quotations have enabled employers and employees to make health plan comparisons more easily. This may have helped to make the small group market in general more competitive since prices within the HPC have generally been in line with prices in the rest of the market.

  Insurers may have also offered more multiple-choice products outside of HPCs as they realized the importance of employee choice. However, it is difficult to isolate the impact of HPCs on competition since they were often implemented along with other small group reforms. The other reforms, including guaranteed issue requirements, limitations on pre-existing condition exclusions, limitations on rate variation, and state-mandated benefit plans have also promoted competition. These reforms are discussed in the "Incentives / Regulatory Mandates to Increase Health Coverage" issue paper.

- *Increasing coverage options for individual employees* – Offering employee choice has been the biggest success of HPCs. Before their existence, it was not feasible for small employers to offer their employees a choice of health plans because it was too administratively complex or not allowed by the health plans due to fears of anti-selection. HPCs have proven they can offer employee choice without running up much higher administrative costs and without experiencing major adverse selection, even without government subsidies or mandated HPC participation. Since HPC prices are generally comparable to non-HPC prices, the employee choice and adverse

selection experienced within the HPCs have not affected prices enough to make them significantly higher than non-HPC prices.

With HPCs, employers can make the transition to managed care products without alienating their employees, by offering them a choice. They can also limit their liability for health care premiums by tying their contributions to the least expensive plan or offering fixed contributions to their employees and requiring them to pay the difference.

Although HPCs have increased employee choice, they have also been dominated by HMO plans. Most have attempted to include PPO and POS plans as well, health plans have not been willing to offer them. The plans are wary of indemnity and managed care plans with out-of-network benefits because they fear the healthier employees will choose HMO plans, leaving the indemnity, PPO, and POS plans with the sicker and more expensive employees. This fear seems to have materialized somewhat, since PPO plans initially participated in several HPCs, only to withdraw after a short time.

As with many of the original objectives, it is difficult to provide employee choice within a HPC without being able to attract health plans to participate. Some employees within HPCs have limited choice, especially in rural areas, due to a lack of health plan participation. Even with these limitations, however, HPCs have generally been able to provide greater employee choice than that offered in the rest of the small group market.

- *Reducing the number of uninsured* – Most HPCs have not had a measurable impact on the percentage of uninsured employees. The percentage of employers in HPCs that did not previously offer health insurance is not significantly different than the rest of the market. Where HPCs have increased coverage, it has been mainly to very small and higher risk groups.

  The small employers that do not currently offer health insurance to their employees often cannot afford it, even through HPCs. HPCs have not been able to lower premiums enough to induce small employers to purchase health insurance for the first time. Most would agree that significant subsidies would be needed to reduce the number of uninsured employees. We will explore this possibility in the next section.

Typical Challenges

Most HPCs have experienced problems in one or more of the following areas:

Low Enrollment

The enrollment in HPCs has generally fallen far short of expectations. Large enrollment in HPCs is crucial to achieving many important objectives such as increasing negotiating power, reducing administrative costs due to economies of scale, and attracting health plans. However, it is difficult to build a large enrollment base without these achievements.

HPCs have not been particularly effective in marketing to employers. Agents have generally been reluctant to promote HPC business largely because of early efforts to reduce or eliminate their role in the health care purchasing process for small employers. In addition, marketing funds have been used inefficiently in a number of HPCs, especially when there is more than one HPC within a state.

Even though enrollment has been lower than expected, the HPCs still represent a large population of employees to insurers that should be worth competing for. Also, HPCs have begun to realize that building a large enrollment base will take time even if they offer a superior product, since their enrollment depends on taking away business from other insurers more than creating new business.

Health Plan Participation

It is crucial for HPCs to persuade large, prestigious health plans to participate in order to make HPCs attractive to employers. Health plan participation in HPCs was initially promising. They were under political pressure to join in the environment of market reforms, and they expected large enrollment and economies of scale within the HIPC. However, participation has been dropping since then for a variety of reasons:

- With the failure of national health care reform, the political pressure to participate in HPCs has lessened dramatically.

- Increased competition in the marketplace has forced health plans to focus on business lines with the most potential to produce profits. For many health plans, it is not worth the extra effort to join HPCs with their small enrollment bases, especially since profits for small group business have been traditionally low.

- Health plans are generally wary of HPC business. They would rather enroll an entire group outside of the HPC instead of a portion of that group inside the HIPC (because some employees would presumably choose other health plans) due to fears of adverse selection. Some HPCs have reinforced adverse selection concerns by actively marketing to very small groups or not utilizing the full rating flexibility allowed by law.

  With standardized plans and convenient price quotes, HPCs force health plans to compete directly on price. Health plans prefer to compete on service and quality rather than price. Finally, they are reluctant to promote vehicles that might give small employers the same negotiating leverage as large groups.

- Health plans have been unwilling to alienate agents they have good relationships with by joining a HPC since agents are generally hostile towards HPCs for reasons discussed in the next section. They also fear that agents they do not have relationships with will steer the "bad risks" towards them in lieu of other insurers.

Unwillingness of Agents to Promote HPCs

When most HPCs were established, many of them perceived agent commissions in the small group market as excessive relative to the extra administrative costs small groups produced. Many HPCs initially tried to reduce or eliminate the role of agents. It is not surprising then that most agents have been openly hostile to the idea of HPCs and have not actively promoted their products to small employers. Even the HPCs that required the use of agents eliminated the role of general agents, whose hostility filtered down to independent agents.

HPCs soon realized that agents were crucial in marketing to small employers. These employers do not have the resources to hire a benefits staff, so agents help them make coverage decisions and provide continuing service. Most HPCs have reversed their actions and now actively recruit, educate, and reward agents for selling HPC business. Even though the initial hostilities have lessened, they have not disappeared.

Adverse Selection

Most HPCs were established with the social mission of reducing the number of uninsured employees. This social mission often conflicts with the realities of the small group market and produces adverse selection. For example:

- In many states, HPCs did not take full advantage of the rating flexibility allowed by the law in order to make coverage more affordable for higher risk groups. Several

HPCs did not permit health plans to adjust rates for health status even though it was allowed and insurers outside of the HPC used health status as a rating factor. As a result, high risk groups are more likely to find better rates within a HPC, while low risk groups will find a better rate outside the HPC.

- Some HPCs actively market their products to higher risk groups. Caroliance's marketing efforts focused on the availability of guaranteed-issue products that appealed to high-risk groups. In addition, Caroliance was the only place prior to HIPAA where groups could obtain comprehensive coverage (with richer benefits than the standardized plans available outside Caroliance) on a guaranteed-issue basis.

In addition, the small group rating regulations in certain states were not the same for HPCs and other small group insurers, making it more difficult for HPCs to attract good risks.

Many plans believe that offering employee choice introduces adverse selection among the participating health plans. When they enroll the whole group outside of the HPC, the health plans get the healthier as well as the sicker employees even if they choose different benefit plans. However, inside the HIPC, a health plan could potentially enroll only the sicker employees while the healthier employees choose another health plan.

Environmental Changes

The small group reforms introduced along with HPCs, such as guaranteed issue and portability, have made the small group market more competitive than it was in the early 1990s. As a result, profit margins are lower and there is less "fat" for HPCs to trim in order to produce lower administrative costs. The absence of political pressures to join HPCs has also reduced health plan participation.

The "managed care backlash" has made HMO coverage less popular because employees value large, inclusive provider networks. Therefore, employee choice may be less important now than it was several years ago since competing health plans tend to have similar provider networks.

Ability to Offer PPO and POS Plans

As mentioned above, tightly managed health care products such as HMOs have become less popular in today's "managed care backlash." Employees prefer PPO and POS plans with out-of-network benefits. However, health plans participating in HPCs have been reluctant to offer these types of plans due to concerns about adverse selection.

Association with Government

Most HPCs have been associated with government at least indirectly. Even the private HPCs are often funded with government seed money. These HPCs may be at a disadvantage relative to completely private HPCs because:

- Government-associated HPCs may find it harder to implement changes needed in today's dynamic market. Changes often require legislation, which takes time. Private HPCs can implement changes quickly.

- Agents and insurers are generally suspicious of government associations.

Are Purchasing Pools Viable Options for the Future?

Although HPCs have not been able to achieve most of their original objectives, HPCs have provided value for small employers. They have proved that small employers can offer their employees a choice of health plans without incurring significantly higher administrative costs. They have also proven that employee choice does not inevitably lead to serious adverse selection. HPCs have served about a million employees with voluntary participation and without government subsidies other than start up costs.

It is important to remember that the original objectives of HPCs made more sense in the environment in which they were created. The enactment of national health care reform including universal coverage and federal subsidies was expected, and HPC-like organizations were to be the method of insurance distribution. If HPCs are to be successful in the future, their objectives should be modified in light of the current environment.

HPCs must be able to increase their enrollment base to be viable in the future. Larger enrollment is crucial in attracting health plans, achieving economies of scale, mitigating adverse selection, and increasing negotiating power. There are several ways to help achieve higher enrollment in HPCs. These are discussed in the next section.

HPCs continue to receive attention today. Several proposals circulating since the 1990s enable the creation of HPC-like organizations such as HealthMarts and Association Health Plans (AHP). These organizations would serve the same general purpose as HPCs, but would be allowed more flexibility on organizational form and structure and would have more operational freedom. For example:

- Both HealthMarts and AHPs would be permitted to waive virtually all state mandated benefits and set rates based on the claims experience in each pool.

- AHPs would be allowed to offer self-insured coverage. Insurers that sell through AHPs would not have to sell in the outside market and state rating rules would not apply. While insurers would have to meet HIPAA's portability and guaranteed-issue requirements inside the pools, they would be able to cancel groups without offering alternative coverage.

HPCs may be the ideal vehicle to combine public and private funds for the purpose of purchasing insurance. Additionally, HPCs could be used to administer public programs such as the State Childrens Health Insurance Program (SCHIP) or Arizona's Premium Sharing Program (PSP). For example, the Kansas legislature passed the Kansas Business Health Partnership Act in late 2000. This bill will allow the Alliance Employee Health Access in Kansas to combine employee and employer contributions with state subsidies for the purpose of purchasing health insurance. The State subsidies are for low- and moderate-income employees of small businesses.

In addition to serving small employers, HPCs may provide value in the individual market. If defined contribution plans become more of a reality and employer contributions are less of a percentage of total premiums, more employees may decide to purchase individual coverage. HPCs could provide administrative savings for this market. They could also combine employer and employee contributions, along with any potential tax credits effectively. However, HPCs offering insurance to individuals should not be any more liberal in accepting risks than insurers in the outside market in order to avoid adverse selection. The individual market poses other potential problems as well, such as the high rate of turnover and younger, healthier employees deciding to forgo insurance and put employer contributions to other uses.

Analysis of Purchasing Pools and Task Force Guiding Principles

Principle #1 - We should seek to make available Basic Benefits

HPCs typically offer comprehensive benefits to the employees and dependents of small employers. HPCs are also subject to state mandated benefits, so any mandated benefits will be included in all benefit plans offered within the HPC.

Principle #2 - Health care should be Available and Accessible

HIPAA legislation increased the availability of coverage to all small groups. In addition, HPCs have in some cases increased availability for self-employed individuals as well. HPCs typically

offer several health plans in each geographical area, but some HPCs have had difficulty attracting enough health plans to offer more than one health plan in rural areas.

Principle #3 - Health care should be Affordable and Properly Financed

In general, prices within HPCs are the same as prices in the rest of the small group market. They have typically not been able to lower prices within the HPC, so they have not been successful in encouraging small employers that could not afford health insurance for their employees before HPCs were created to purchase it through a HPC. If significant subsidies were to be implemented for low-wage small employers and/or employees, HPCs may be able to decrease the number of uninsured employees of small businesses significantly. As mentioned above, Kansas has passed legislation to combine state subsidies and private funds to purchase insurance through the HPC.

Principle #4 - Health care should be provided through a Seamless System

To minimize fragmentation and duplication of administrative services, HPCs should be organized into one central organization versus several regional HPCs. HPCs have provided small employers a convenient method of purchasing insurance, especially when they win the support of agents. Currently, most HPCs do not need to combine private and public funds, although they have the capability to do so. HPCs would be a source to purchase insurance coverage for small groups. They would neither directly improve or impede the current delivery of health care services

Principle #5 - Health care should be done in Collaboration and in Cooperation with the various stakeholders, both public and private sector, and it should foster Competition

One of the goals of HPCs is to foster competition in the small group market. Because prices inside and outside of HPCs have tended to be in line, providing easy price quotations for various health plans can inform consumers and promote price competition. HPCs can also provide a convenient entry point into the small group market for insurers.

Principle #6 - Public and Private Partnerships should be sought

Several HPCs were initially funded by the government but changed to be run by private non-profit organizations. Governments could also promote the HPC to distribute marketing materials to small employers to make HPCs more visible to potential members. HPCs could be used to administer state health care programs or to combine public and private funds for the purchase of health insurance. These possibilities are explored further in the next section.

V. ISSUES TO CONSIDER IN ADOPTING A PURCHASING POOL

This section addresses structural and operational issues to consider when establishing an HPC. Many lessons have been learned with the successes and failures of HPCs in the past, and these lessons have the potential to make future HPCs able to serve small employers, health plans, and agents successfully.

Structural Issues

Limited Association With Government

Insurers and agents tend to be suspicious of HPCs that have a close government association. Government start-up funds are very helpful because it is difficult to raise start-up capital without otherwise, but it is harder to implement changes due to the need for legislative changes in HPCs that are also run by the government.

One Centralized Organization

If the HPC in a state is comprised of several regional HPCs, each HPC will have its own governing board, staffing, and perhaps administration system. It is important to provide operational uniformity, which is difficult to do with more than one HPC. In addition, each HPC will have its own marketing budget. It would probably be more effective to combine resources and focus marketing efforts in areas with the greatest enrollment potential.

Put Experienced and Knowledgeable Leadership on the Board of Directors

The leadership on the boards of some HPCs were not knowledgeable or experienced in the small group market. Often, social missions such as reducing the number of uninsured employees conflicted with financial business concerns. It would be helpful to put insurers, agents, and small employers on the board. Knowing that their concerns are represented within a HPC may also help to persuade more health plans and agents to participate.

Limit the Number of Participating Plans

If a HPC does not have the ability to exclude health plans, they must accept any health plan interested in participation that meets minimum standards. If the number of plans is too large, the extra administrative costs may not justify the added amount of employee choice. Limiting the number of participating plans accomplishes the goal of offering employees a choice of health plans while controlling administrative costs, especially if the participating plans have a significant

market share in the non-HPC small group market. Additionally, it guarantees market share for each plan, perhaps making them more willing to negotiate discounts.

Allow HPCs to Negotiate with Health Plans

If HPCs cannot negotiate with health plans and must accept whatever price the health plans provide, there is more potential for higher prices inside the HPC, especially if state law does not restrict rate differences between HPC and non-HPC business.

Offer Employee Choice

Employee choice has been the defining feature of most HPCs. Although limiting this feature would reduce insurers' fears of adverse selection, it would also eliminate the biggest advantage the HPCs currently have. However, HPCs may wish to limit the choice of benefit options within each health plan.

Incorporate Agents Into the Purchasing Process

Although many HPCs initially tried to reduce the role of agents, they have found that agents are very important in attracting small employers. Some have now found it is more effective to market to agents than to individual employers. Even if employers are allowed to purchase insurance directly from the HPC, there should not be an incentive to do so (i.e., require employers to pay the same amount of commission whether they enroll directly or through an agent).

Developing an Administration System

Administrative inefficiencies in the HPC have not been a particular problem in the past. However, most health plans participating in HPCs continue to perform the same administrative functions as they did in the past, both because they may not trust the administrator or changing their systems doesn't make sense with HPC business being so low.

If possible, HPCs should try to match the administrative systems of participating plans as closely as possible. Also, if HPCs in different states could combine their resources, they could develop a national administrative system.

Operational Issues

Attracting Health Plans

Attracting large and prestigious health plans is crucial to maintaining employer membership and providing employee choice. HPCs must address the needs and preferences of health plans in both their structure and operations.

Attracting Agents

Agents are needed to promote HPCs to individual employers. Without their cooperation, HPC enrollment will probably not increase substantially without incentives such as government subsidies or mandated participation. HPCs should accommodate agents' concerns to the extent possible.

Mitigating Adverse Selection

HPCs can lessen potential adverse selection problems by:

- Utilizing the same underwriting and rating rules as those used outside the HPC. Otherwise, healthy groups may be able to find less expensive coverage outside of the HPC.

- Limiting the number of benefit options within each health plan. This would help avoid the sicker employees choosing very rich coverage and the healthier employees choosing leaner coverage.

- Implementing effective risk assessment and risk adjustment systems. California is the only state to implement risk adjustment to date. Effective risk adjustment that transfers adequate funds to health plans with higher risk groups may convince them to continue to participate in a HPC.

- Avoiding inadvertently marketing to higher risk groups. The HPCs in a few states actively marketed their products to very small groups or emphasized the availability of guaranteed-issue products (although the passage of HIPAA has lessened this risk).

- Allowing health plans to offer more than state mandated basic and standard plans. Often, these plans are less comprehensive than the benefit plans largely sold in the rest of the small group market and therefore more attractive to higher risk groups. If a HPC offers only the basic and standard plans, it could potentially enroll a higher proportion of higher risk groups than the rest of the small group market.

Ways to Promote HPCs

Many of the problems associated with HPCs could be fixed if they could attract and maintain a large enrollment base. Several ways to promote HPCs both with and without the use of public policy are listed below.

Promoting HPCs Using Public Policy

Without significant subsidies from the government, HPCs will probably not be successful in reducing the number of uninsured employees. Even if they were able to reduce premiums relative to the rest of the small group market, it would not be enough to persuade many employers to offer insurance for the first time.

There are several ways to increase enrollment in HPCs using public policy, although many of them may be too controversial to be currently feasible, or may cause other problems outside of the HPC market. Please note that Milliman does not necessarily endorse any of these concepts, but rather offers a complete listing of possibilities for the reader to consider.

- Mandating that health plans can sell small group insurance only through HPCs. This would also eliminate the need for health plans to keep separate administration systems for non-HPC small group business, but would currently violate the guaranteed-issue provisions of HIPAA and other state laws.

- Require that all health plans that sell small group insurance must participate in a HPC. Alternatively, implement a "pay or play" rule where plans can either participate in a HPC or pay a flat fee if they decide not to participate. This option would require very little government funds, but rules would have to be put in place to ensure that insurers couldn't price HPC business high enough to turn the HPC into a high risk pool.

- Require that all employers that provide health insurance offer their employees a choice of health plans. HPCs would be the most convenient vehicle to do this since they have already proven they can offer employee choice without significantly higher administrative costs.

- Provide subsidies for employers that purchase insurance through HPCs. Once enrollment reached a large enough number, the subsidies could be gradually phased out.

- Allow health plans to cover public employees only if they participate in HPCs. Additionally, HPCs could be used to administer SCHIP or other public programs.

- Grant subsidies for low-wage employers that purchase insurance through HPCs. This option might be less controversial than those listed above. If the subsidies were large enough, HPCs might be able to significantly reduce the number of uninsured employees.

Promoting HPCs Without Using Public Policy

In the absence of government subsidies or mandated HPC participation, there are several ways individual HPCs can promote themselves:

- Obtain the support of agents and health plans. Consider putting health plan representatives in HPC leadership positions.

- Focus marketing efforts on areas with the greatest enrollment potential, such as bigger cities.

- Combine HPC resources to develop uniform marketing strategies and administration systems.