

# **Barriers to Small- Group Purchasing Cooperatives**

*PURCHASING HEALTH COVERAGE FOR SMALL EMPLOYERS*

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# Contents

<b>About the Economic and Social Research Institute</b> .....	<b>iii</b>
About the Authors .....	iii
Acknowledgements .....	iv
Advisory Panel .....	iv
Economic and Social Research Institute Board of Directors .....	iv
<b>Executive Summary</b> .....	<b>1</b>
Measuring Success .....	1
Impediments to Success .....	2
Future Prospects and Supportive Policies .....	5
<b>Introduction</b> .....	<b>7</b>
Methodology .....	9
The Promise — Better Coverage for Small Employers .....	10
Measuring Success .....	13
Impediments to Success .....	14
<b>Florida Community Health Purchasing Alliances</b> .....	<b>15</b>
Brief History .....	15
Measuring Success in Florida .....	16
Impediments to Success in Florida .....	19
<b>The Health Insurance Plan of California</b> .....	<b>33</b>
Brief History .....	33
Measuring Success in California .....	34
Impediments to Success in California .....	38
<b>The Alliance in Colorado</b> .....	<b>47</b>
Brief History .....	47
Measuring Success in Colorado .....	48
Impediments to Success in Colorado .....	51
<b>The Texas Insurance Purchasing Alliance</b> .....	<b>59</b>
Brief History .....	59

Measuring Success in Texas .....	60
Impediments to Success in Texas .....	62
<b>Caroliance: North Carolina's Purchasing Alliance .....</b>	<b>71</b>
Brief History .....	71
Measuring Success in North Carolina .....	72
Impediments to Success in North Carolina .....	75
<b>COSE: The Council of Smaller Enterprises of Cleveland, Ohio .....</b>	<b>83</b>
Brief History .....	83
Measuring COSE's Success .....	84
Explanations for and Impediments to COSE's Success .....	88
<b>Assessing the Success of HPCs .....</b>	<b>99</b>
<b>Identifying Impediments to Success.....</b>	<b>105</b>
The Crucial Role of Health Plans .....	114
Agent Hostility to HPCs .....	120
<b>Future Prospects.....</b>	<b>125</b>
Can HPCs Offer Lower Premiums than the Outside Market?.....	125
What Might Be Done to Make HPCs More Successful?.....	129
Lessons for Collective Purchasing Arrangements — HPCs and Others .....	135
Summary .....	137

# About the Economic and Social Research Institute

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**The Economic and Social Research Institute** (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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# Executive Summary

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The idea of having small employers collectively purchase health insurance has intuitive appeal, and it has been supported by thoughtful health analysts and politicians with widely different philosophical perspectives. Yet the experiments with the concept have proved less successful than expected. Perhaps only 20 or so health purchasing cooperatives (HPCs) have been formed since the idea gained prominence in the early 1990s, and only one or two have captured as much as 5 percent of the small-group market. The purpose of this study is to determine why HPCs have not been more successful and to determine whether the barriers to HPC success can be overcome.

We focused our research on collective purchasing arrangements that are open to all small employers (those with 50 or fewer employees) and that offer individual employees a choice of at least two independent health plans. Our approach was to interview health plan executives, HPC staff, state regulators, state legislators, and insurance agents. We did extensive research on HPCs in California, Texas, Florida, North Carolina, Cleveland, and Colorado, and we also interviewed health plan executives in Connecticut, Long Island, and New York City.

## Measuring Success

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HPC success can be measured in a number of ways. We employed five measures, and found the following results:

1. *Market share.* For the most part, HPCs ability to capture market share has been disappointing. HPCs' market share has generally been below 5 percent, except for COSE (Cleveland) and perhaps CBIA (Connecticut). In ab-

solute terms, however, enrollment is large in some areas. The California HPC has a current enrollment of about 150,000, and Florida peaked at 92,000. But the Texas TIPA failed, and North Carolina and Florida have serious problems, with very small or rapidly dropping enrollment.

2. *A new product.* The biggest selling point for HPCs has been their ability to allow employers to offer individual employees a choice of several health plans, an option that was not practical for small employers previously. But HPCs have generally not been able to continue to offer PPO products because health plans fear adverse selection.
3. *Price.* Prices are generally not lower than in the non-HPC market, though they may have been initially in some cases. On the other hand, prices are not generally much higher either (contrary to what some early critics expected).
4. *Competitive effect on the market.* Health plans do not admit to making any changes in response to HPCs. A number, however, are now offering small-firm *employees* the option of choosing from the single health plan's HMO, PPO, or indemnity offerings. This may be a response to the employee-choice feature of HPCs. The ready availability through HPCs of immediate price quotations from several health plans for essentially identical products has probably helped stimulate price competition in some areas.
5. *Reduction in the number of uninsured workers.* There is no convincing evidence the HPCs have had a major impact on reducing the number of uninsured. HPCs typically enroll about the same proportion of previously uninsured groups as the rest of the small-group market. However, it was unrealistic to expect that, even under the best of circumstances, HPCs could bring down premiums sufficiently to attract large numbers of firms previously not offering health coverage. Several HPCs cover a large proportion of very small "micro" groups (five or fewer employees), which they believe would otherwise often be uninsured because insurers prefer to avoid such groups.

## Impediments to Success

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Our research led us to identify a number of impediments to HPC success, which we group in four main categories.

*The initial concept may have been somewhat flawed.*

- Gaining market share has proved more difficult than anticipated. The HPC concept does not sell itself; health plans have generally not promoted it,

and agents have often opposed it. In a number of cases, HPCs greatly underestimated how important agents were to the HPC's success and thus proposed or adopted practices that made agents hostile.

- The potential for administrative savings was probably overestimated.

*Changes in the environment may have made HPCs less viable.*

- Small-group reforms legislated by states and by the federal government have helped to make coverage more available on a fair basis. This has probably reduced demand for HPCs somewhat, since they had similar objectives.
- Smaller increases in premiums in the last five years or so have made employers less receptive to changing to a new, unfamiliar product. So it has been hard to interest employers in HPCs when they are not dissatisfied with what they have.
- The level of competition in the small-group market has increased appreciably, so some cost reductions have already been realized—for example, lower agent commissions. There is less administrative “fat” to be trimmed, making HPCs’ efforts to lower administrative costs even more difficult.
- Widely overlapping provider networks allow greater choice of doctors, so the employee-choice provision is not as much of an advantage as it would have been if HMOs had non-overlapping provider networks.

*The idea may have been poorly implemented in some cases.*

- The people who start and run HPCs have traditionally been motivated by a commitment to a social mission—a desire to make coverage as widely available as possible, including to higher-risk populations, such as groups of 1 to 5 employees. This perspective has sometimes led HPCs to adopt policies that put them in the position of being victims of adverse selection.
- HPCs’ consumer orientation may have made them see health plans as adversaries rather than partners, and that may have made them less receptive to understanding plans’ concerns and somewhat slow in accommodating their needs.
- Restrictions in law sometimes put HPCs at a competitive disadvantage. Some states required HPCs to be more permissive in accepting higher-risk groups than was required of health plans selling outside the HPCs. A substantial number of HPCs, unlike large employers, were prevented from negotiating prices with health plans except for the administrative cost portion of the premium. In Florida, HPCs could not contract with health plans at all, so they could not negotiate over anything and did not even pay agents.

- Some states established excessive numbers of HPCs, which caused some inefficiencies and made it harder to form coherent, consistent policies. Moreover, marketing efforts were dissipated rather than being concentrated on markets with the greatest potential.
- There were not major problems in leadership and staffing, though sometimes staff and boards were not fully familiar with the health industry and thus crafted policies that were not a good fit with health plans' standard practices. When problems arose, leaders and staff were sometimes slow to understand the nature of the problem and to make needed corrections.
- Generally, the contractors who administered enrollment, premium collection, eligibility determination, etc., did a good job, though there were some glitches.

*Resistance or opposition from interest groups, particularly health plans and insurance agents, was a source of major problems.*

HPCs need the participation of a number of high visibility, prestigious health plans to offer meaningful choice. Lack of vigorous support from health plans has hurt HPCs in a number of ways:

- Initial participation rates were generally adequate in most states. Plans were under political pressure to participate and anticipated that HPCs would be part of national health reform. They participated because they thought HPCs would be a major source of business.
- Health plans generally do not like being put into this kind of direct head-to-head competition for standardized products. They do not like serving very small groups: profit rates are low because there are few economies of scale, risks are higher than for larger groups, and turnover is high. Health plans particularly do not like HPCs' employee-choice feature; because they do not get the whole group, with its range of high- and low-risk individuals, they fear they will get just the less healthy individuals.
- Health plans say that they realize little, if any, administrative savings, even though HPCs perform administrative functions. Plans say it is not worthwhile to change their administrative apparatus to make it mesh most effectively with the HPC's administrative approach because the volume of business is too small. Moreover, they still must retain the own administrative apparatus to serve their non-HPC small-group business.
- Most of the reasons which led health plans to participate initially have disappeared: There is little direct political pressure to participate. HPCs are not a major source of revenue. And the market is much more competitive;

this had led many plans to focus on their most profitable areas of business, which is not HPCs.

- The consequence is that many plans have pulled out. Withdrawal of plans in Texas resulted in the failure of the HPC. In Florida, the number of participating plans has fallen from the original 35 to only 5. At one point, North Carolina was down to only one plan that served more than a very limited region. Some recent efforts to start HPCs (New York City, Kansas) have not attracted all the plans they wanted.
- The fundamental problem is market share: HPCs cannot attract and retain prestigious health plans, achieve significant economies of scale, and negotiate lower premiums without market share. Yet HPCs cannot achieve large market share without attracting and retaining the best insurers, offering lower premiums, and achieving economies of scale.

Lack of support and, often, outright hostility from agents has also seriously hindered HPCs' marketing success. A number of HPC creators thought agent commissions were excessive and a major source of cost excesses for small-group insurance, so they sought to reduce or eliminate the role of agents. Some HPCs gave employers the option to buy directly from the HPC without going through an agent or paying the agent fee. Others paid lower commissions to agents than they were used to getting. These policies, along with some others that irritated agents, turned many agents against HPCs and made them unwilling to promote HPC products. HPCs have concluded that they cannot sell in volume to small employers except through agents, so they have changed course and tried to recruit agents and adopt agent-friendly practices. This has had a positive effect, but many agents remain indifferent or hostile, and few agents sell HPC products in any volume.

In the future, some health plans and some agents will continue to participate *if they find it profitable to do so*. Right now, HPCs need them more than they need HPCs.

## **Future Prospects and Supportive Policies**

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HPCs' capacity to achieve their social objectives depends on achieving some "critical mass" size. If they were larger, they could achieve economies of scale, attract large and prestigious plans, perhaps negotiate effectively with health plans, and have enough visibility to be seen as an attractive option for employers. Policy makers could support policies that would help HPCs reach that critical mass size, but many would be controversial because they involve a degree of compulsion:

- Small-group market reform laws could be amended to allow health plans to opt to sell their small-group products only through HPCs (this is now prohibited under guaranteed-issue requirements). Some health plans would choose to do this and would thereby save on administrative costs.
- Insurers and health plans could be required to participate in HPCs as a condition of offering coverage in the small-group market.
- Health plans could be required to sell their small-group products *only* through a HPC.
- Government could temporarily subsidize employers for buying coverage from a HPC—for example, by giving them temporary tax credits.
- Government could mandate that all small employers allow individual employees to choose from several health plans. The HPC would be the most attractive vehicle for meeting this requirement in an economical and “has-sle-free” way.

Although the experience with HPCs has been somewhat disappointing, it underscores the fact that there is no quick fix for the problems of small employers and the uninsured generally, at least none that does not require more extensive interventions than we as a society have yet been willing to make. Short of mandating coverage or giving large subsidies to employees or employers, nothing is likely to *solve* the problem of the uninsured. If we are unwilling to take such dramatic steps, a case can still be made for incremental reforms, including public efforts to promote HPCs.

# Introduction

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**B**eginning in the late 1970s with the emergence of managed competition theory and peaking during the years of the Clinton reform effort, purchasing cooperatives have frequently been touted as a means of addressing a variety of problems in health care purchasing, especially for small employers. This has been true of proposals offered by reform proponents of widely differing political perspectives.

To date, however, the promise of small-group purchasing arrangements remains largely unfulfilled. While some large-employer coalitions have achieved what appears to be striking success, the growth of effective collective purchasing among smaller employers—where analysts believed the need to be greatest—has been modest. Of course, the measure of success depends in part on the definition of pooled purchasing.

If pooled purchasing is defined broadly—to include purchasing cooperatives or alliances, business coalitions, multiple-employer trusts (METs) or multiple-employer welfare associations (MEWAs), and trade, professional, or other membership organizations—then 33 percent of employers with fewer than 10 workers and 28 percent of firms with 10 to 49 workers say that they participate in pooled purchasing.<sup>1</sup> But if a more restrictive definition is used—one that conforms more closely to the concept that many reformers had in mind when the idea of pooled purchasing gained prominence (and the one we use in this study)—then the numbers are much smaller. Today there are probably fewer than 20 small-group cooperatives or alliances that fit this definition, and they provide coverage for probably no more than a million employees and de-

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<sup>1</sup> Stephen H. Long and M. Susan Marquis, “Pooled Purchasing: Who Are the Players?,” *Health Affairs*, Vol. 18, July/August 1999, pp. 105-111.

pendents.<sup>2</sup> Only a handful of these have more than 50,000 individuals enrolled. Yet the idea of pooled purchasing for small employers continues to have much appeal. Several new efforts have been initiated very recently—during 1999 in New York City and Michigan, for example—and the collective purchasing concept is the fundamental structural foundation for current Congressional proposals for Health Marts and Association Plans.

The continuing appeal of pooled purchasing and its apparent advantages for small employers and their workers stands in stark contrast with the very modest success of the concept in practice. Why have health purchasing cooperatives or coalitions (HPCs) not been more successful? That is the fundamental question that our research attempts to answer. There are, of course, several possible explanations: (1) The small-group purchasing construct may simply not be as good in reality as it appears on paper; thus the liabilities or limitations of the construct may outweigh the potential gains. (2) The concept may have been sensible when the idea was broached, but changes in the health care environment and economy may have made the idea less viable. (3) The concept may be basically sound but has been poorly implemented. (4) There may be a number of barriers, particularly various forms of political opposition from interest groups, that inhibit the growth of the small-employer purchasing cooperative movement.

In undertaking this research, we were prepared to accept any or all of these hypotheses to explain why some cooperative efforts have been more successful than others. But we wanted to be especially sensitive to the fourth factor above—the *political* element. We knew that it was possible that the concept could be economically sound and would, if implemented, benefit consumers and small employers but still not succeed because of insufficient awareness and support from consumers and employers and/or lack of cooperation or outright opposition from affected interest groups such as agents and insurers.

The purpose of the study, then, was to understand why HPCs have not assumed a more prominent position in the market for health coverage for small employers. What hurdles do small-group purchasing cooperatives encounter and what is their relative importance in limiting success? In addition, we sought to determine how the hurdles might be overcome. That is, what would it take to make HPCs more successful?

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<sup>2</sup> Institute for Health Policy Solutions, personal communication and web site, [www.ihps.org](http://www.ihps.org). The estimates are for organizations that conform to the criteria used to determine the entities that would be included in this study, as explained in the methodology section of this chapter.

# Methodology

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We chose to study these issues by doing detailed case studies of prominent purchasing cooperative efforts. Since there are many kinds of organizations that assist small businesses in purchasing health care, our first task was to define the kinds of purchasing entities to include in the study. With the assistance of our Advisory Group, we decided to include only entities that meet the following criteria:

- *Employer size.* Entities must offer coverage to small businesses, which we define as those with 50 or fewer employees (although we include entities that exclude groups of one and those that also offer coverage to larger groups).
- *Eligibility.* Coverage must be open to all small businesses. (Thus we exclude association plans.)
- *Competing plans.* Employers must have a choice of at least two independent, competing health plans.
- *Employee choice.* The purchasing entity must at least permit (if not require) employers to allow *individual employees* to choose different health plans.

We also decided to study a variety of different kinds of HPCs, both those that were generally viewed as being successful and those that were considered less successful, some that started as a result of government initiative and others that had no government endorsement. We settled on six HPCs as the prime sites for our investigation—the Health Insurance Plan of California, the Colorado Alliance, the Texas Insurance Purchasing Alliance, the Florida Community Health Purchasing Alliances, Caroliance, and Cleveland’s Council of Smaller Enterprises. During late 1998 and through the autumn of 1999, we made site visits to California, Texas, North Carolina, and Cleveland, and we did extensive telephone interviews in Colorado and Florida. At these sites, our approach was to conduct structured interviews with HPC staff and board members, state politicians, insurance agents, and state insurance regulators. We also did more limited telephone interviews in several other sites, including the newly started HPC in New York City, a Long Island HPC, and the HPC of the Connecticut Business and Industry Association.

In an important sense, this project builds on work that two of the authors have done in other studies sponsored by the Robert Wood Johnson Foundation. In 1997 and 1998, Mark Hall and Elliot Wicks conducted a study of small-group

insurance market reform based on site visits in seven states,<sup>3</sup> and part of that effort involved a review and analysis of the role that HPCs played in small-group reform in those states. Dr. Wicks and another colleague in December 1997 conducted detailed interviews with insurance agents in California who had sold coverage through the California purchasing cooperative. The authors brought knowledge from this previous work to this project, and some of the conclusions are informed by this earlier research.

The results of the case studies are presented in Chapter 2 through 7.

## **The Promise — Better Coverage for Small Employers**

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The idea that small employers could benefit by collectively purchasing health insurance has been around for a long time. For many years, existing trade or business associations, formed primarily for other purposes, offered health coverage to their members. But the idea of pooling the purchasing power of small employers really began to excite reformers when large employers, beginning in the 1980s, showed that they could use their purchasing muscle to extract savings from the health system, primarily by getting health plans to give them “volume discounts” and by shifting to managed care structures designed to improve the efficiency of medical service delivery. Reformers concluded that by pooling their purchasing power, small employers could realize similar benefits.

Bringing coverage premiums down for small employers had particularly high priority. Then, as now, many of the uninsured were employed by small firms, and many of these firms did not offer coverage. The cost of coverage was a major barrier, particularly since many small firms are low-wage, marginal businesses just managing to stay afloat. Yet the cost of coverage for small firms was substantially greater than for large firms.

Collective purchasing—in the form of health purchasing cooperatives or health purchasing coalitions (HPCs)—seemed like a good solution to a number of problems plaguing small businesses. Small employers cannot afford to hire specialized staff or spend much time themselves to make wise choices in selecting health plans. They certainly cannot individually bargain with health plans to get a better deal. They could benefit by being able to turn to an entity like a HPC that would represent their interests and that could offer purchasing expertise and market leverage in negotiating with health plans.

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<sup>3</sup> All of the reports based on this study, of which Mark A. Hall was principal investigator, can be found at the following web site: [www.phs.wfubmc.edu/insure](http://www.phs.wfubmc.edu/insure).

Supporters believed that HPCs could reduce costs in several ways. They noted that as much as 25 percent of the premium that small employers pay was attributable to insurers' administrative costs, compared to perhaps 8 percent or 9 percent for large groups. They observed that the agent commission component of administrative costs was much higher for small groups, partly because marketing to and servicing small firms is expensive. It is less costly to sell coverage, collect premiums, and provide administrative and support services for a single firm that has 1,000 employees than for 100 firms that have an average of 10 employees each. By centralizing the administrative functions in a single agency that served many small employers through the same mechanism, the HPC was expected to achieve economies of scale. The HPC could have one administrative apparatus to replace the many administrative structures of health plans serving small employers. The savings that plans would realize could be passed on in lower premiums.

In addition, HPC proponents believed that by pooling their purchasing power, small employers could influence both the price they pay for coverage and the way in which health care is organized and delivered. Together, small employers could command sufficient market share that health plans would be eager to compete for and maintain a share of the HPC's business, just as they do for large businesses. Plans might also be responsive to pressure from HPCs to make other changes to improve efficiency or quality—for example, by making managed care products readily available to small employers, by focusing more on quality improvement, or by providing performance “report cards” for consumers. Such competition among plans for small firms' business could perhaps have equally important long-term effects on efficiency, cost, and quality: employees would be drawn to health plans that offered the best combination of cost and quality, and this would put pressure on health plans to continually improve. Because HPCs require health plans to offer standardized benefit packages, consumers have a much easier task in comparing prices and assessing the relative value of competing plans.

Such competition for individual consumer's loyalty is a by-product of another key feature of HPCs: employee choice. The HPC construct makes it feasible for even the smallest employers to allow individual employees to choose from a variety of health plans, something few small employers could afford to do on their own because of the administrative complexities of offering more than one plan. Employee choice was seen as a particular advantage for consumers as managed care began to account for an ever larger share of the market. Without employee choice, each time a small employer switched health plans or an employee changed jobs, workers and their families would typically be forced to sever relationships with their current doctors and other providers as they moved to a different managed care plan. Such switching was seen as a par-

ticular problem for workers in small firms, because small firms are often short-lived and because workers in this part of the economy change jobs frequently.

The potential benefits of HPCs made them a popular idea among lawmakers, particularly since they seemed like a solution that required little in the way of new government funds. The success of the Cleveland Council of Smaller Enterprises (COSE) made it the focus of much attention, and there was regular discussion and debate among analysts and lawmakers about how HPCs should be structured. A number of states passed legislation that either established HPC-like entities or enabled them to operate—among them, California, Florida, Iowa, North Carolina, Texas, Kentucky, and Colorado. Some HPCs started without government sanction, perhaps the most notable being the Connecticut Business and Industry Association. The culmination of this interest was President Clinton’s national health reform proposal, which made HPC-like entities, called “Alliances,” the vehicle for health coverage purchasing for all but the very largest employers.

Before leaving the issue of how HPCs can benefit small employers, it is important to correct one common misperception. HPC-like arrangements are often referred to as pooled purchasing arrangements, which, of course, they are in the sense that employers purchase coverage collectively. But some people incorrectly deduce from this terminology that HPCs can realize savings by pooling *risks*—for example, by accepting higher-risk groups, combining them with average-risk and below-average-risk groups, and then charging them all essentially the same rate.<sup>4</sup> This has sometimes been proposed as a way a HPC could reduce premiums for high-risk groups. But the fact is that, if, in rating each group in the pool, a HPC voluntarily decides or is required to apply rules that are significantly more permissive than those used by insurers offering coverage outside the HPC, the HPC will become a victim of adverse selection.

To illustrate, assume that the HPC decides not to vary rates based on age while the rest of the market does. Employers with older employees will find it cheaper to buy coverage through the HPC than elsewhere (presumably, the desired outcome). But the HPC will then attract a preponderance of employers with older workers, which will increase medical claims. To cover the increased costs, the health plans offering coverage through the HPC will either have to raise the premium (if state law permits), or they will decline to participate any longer with the HPC. If premiums rise, the younger, lower-risk employers will be able to find coverage less expensively outside the HPC. As the lower-risk

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<sup>4</sup> In reality, most risk pooling does not go this far, which is pure community rating. Instead, most pooling uses modified community rating, which allows rate differentials based on factors such as age and geography but excludes rating based on health status or claims experience.

employers leave, the problem gets progressively worse in a spiral of adverse selection.

A HPC that adopts significantly more permissive rating rules will become a high-risk pool, if it survives at all. The only way a HPC can offer lower prices by pooling risks is by excluding higher-risk applicants, as some association plans do by the nature of their membership requirements. But such exclusion is inconsistent with the feature of making the HPC open to all small employers.

The lesson is that a HPC has to use essentially the same rating rules and selection restrictions as health plans use outside the HPC. The pooling that produces lower costs for higher-risk employers and individuals has to come through the rating reform laws *that apply to all health plans offering coverage in the small-group market, whether inside or outside the HPC.*

## **Measuring Success**

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As part of the case studies in the immediately following chapters, we assess the success of the various HPC efforts before turning to a detailed explanation for the reasons for the degree of success or failure. Here, we lay out the criteria we use to measure success. If HPCs were a typical business, success would be measured in terms of profits (return on investment) and market share. But HPCs are not typical businesses. Most are non-profit entities designed and operated to serve other businesses and to achieve certain social purposes. So it is appropriate to consider a broader range of measures of success, as outlined below.

### ***Establishing market share***

Early enthusiasts almost certainly envisioned that HPCs would command a significant market share. The ultimate proof of usefulness is a HPC's ability to attract employers; if the HPC enrolls many employers and employees, that is proof that they think it provides something of value that is not as readily or cheaply available otherwise.

### ***Making available a previously unavailable product***

If the HPC offers a health insurance product that has characteristics that were previously unavailable and people buy the product, the HPC has created added value. If other competitors respond by offering similar products, that response could be considered a success even if the HPC itself does not capture a large market share.

### ***Offering coverage at a price lower than the “outside” market***

If coverage through the HPC is less expensive than what insurers charge for comparable coverage sold through other channels (other things being equal), the HPC has achieved an important objective.

### ***Having a positive competitive effect on the market as a whole***

Even if a HPC does not capture a substantial market share, it is certainly possible that its presence could alter competitive conditions in a desirable way. If, for example, its presence encourages price competition, perhaps by getting outside insurers to lower their prices in anticipation of competition from the HPC, buyers benefit even if HPC prices are no lower than outside prices. Or the HPC might serve as an easy point for new competitors to enter the market, thereby increasing competition generally.

### ***Contributing to a reduction in the number of uninsured workers and their families***

If the HPC helps to decrease the number of uninsured, that achievement certainly has positive social value.

## **Impediments to Success**

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Having assessed the extent of the HPC success, the next step in each case study is to determine why the HPC was not more successful. The following is a list of possible impediments that a HPC might face that could hamper its success. We consider the extent to which these apply in each case study.

- Inability to get the right numbers and types of health plans to participate.
- Unwillingness or failure of agents to adequately promote sales.
- Inability to communicate effectively with, market to, and capture the attention of employers.
- Flawed conception of role.
- Structural and organizational impediments.
- Inhospitable insurance market rules.
- Leadership and staffing inadequacies.
- Poor implementation of administrative functions.
- HPC products are not unique or do not match employers' needs.

# Florida Community Health Purchasing Alliances

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## Brief History

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Florida's Community Health Purchasing Alliances (CHPAs) were established as part of 1993 legislation that reformed the small-group market in the state. The proposal to form the purchasing alliances was strongly supported by Governor Lawton Chiles, and his administration vigorously promoted and encouraged the CHPAs during his years in office.

Each of the 11 initial CHPAs was a state-chartered, private non-profit organization, governed by a state-approved board representing consumers, business and industry, and state and local government. Initial funding was provided by state grants totaling more than \$8 million, and the state's Agency for Health Care Administration was charged with overseeing CHPA activities and providing technical assistance.

Participation is open to employers and self-employed persons with between 1 and 50 employees. Employers were to give employees the option of choosing from a minimum of two health plans offered through the CHPAs, and employers must contribute at least 50 percent of the premium of the least expensive plan. Any health plan that meets conditions required for certification as an "Accountable Health Partner" can offer services to participating employers. CHPAs do not negotiate with health plans with respect to premium prices, and they do not contract with the plans; the contract is between the health plan

and the employer. Administration of enrollment, eligibility, premium collection, etc., is done by a third-party administrator. Initially, the CHPAs offered just two standardized benefit plans—the “standard” and “basic” plans that all health plans were required to sell both inside and outside the CHPAs.

Over the years, some changes occurred. The number of CHPAs was reduced several times, so that now seven consolidated CHPAs divide up the state. The benefit options available to employers were increased, first by adding a more comprehensive “Plus” plan and later allowing each carrier to offer a plan similar to their best-selling “street” plan as well. The CHPAs no longer receive a subsidy from the state but must finance their operations entirely from fees they add to the premium and pass on to employers.

The future of the Florida CHPAs now (February 2000) looks rather bleak. In the last few months the number of participating plans has been halved from 10 to 5. Humana, the only national health plan that remains, now offers products in only 5 of the original 11 CHPA districts. The other 4 remaining plans are local. (Blue Cross and Blue Shield had pulled out in 1999.) A number of counties are no longer served by any plan. Enrollment is down to about 45,000. The CHPA districts with very low enrollment will probably not be able to survive because they will not generate enough revenue from administrative fees to support their staffs.

## **Measuring Success in Florida**

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### ***Establishing market share***

Enrollment in the CHPAs grew rather quickly until 1997, when it reached about 75,000. It peaked at approximately 92,000 in 1998 but fell thereafter to about 70,000 in the autumn of 1999, after the number of participating health plans fell from 20 to 10. As noted earlier, by the beginning of February 2000, the number of health plans had fallen to 5, and enrollment was down to about 45,000. At the peak, the CHPAs accounted for about a 5 percent market share. Although this is a larger share than that captured by HPCs in most other states, the 5 percent still fell far below what many, including the original administrator, Health Plan Services, had expected. Staff of the first administrator noted that the *number* of firms enrolled was not far from what they anticipated, but the average *size* of the enrolled groups (just over two lives) was much smaller than expected.

### ***Making available a previously unavailable product***

The CHPAs gave employers the option of letting their employees individually choose among a number of health plans, without the employers themselves having to deal with each individual plan. That advantage has been greatly diminished now that the number of participating plans has decreased, and none are offered statewide. And even when the number of plans was larger, choice was largely restricted to HMO and PPO plans, since the indemnity plans that participated in the early days withdrew, citing adverse selection.

The CHPAs believe that their special contribution has been to be advocates for a segment of the small-group market that previously had very few products readily available. They say that the smallest businesses—the one- to five-life groups, which make up most of the CHPA customers—were not being well served by anybody prior to the establishment of CHPAs.

### ***Offering coverage at a price lower than the “outside” market***

Initially, prices inside the CHPAs were lower than outside for the standard and basic plans, perhaps by as much as 6 percent.<sup>5</sup> But the price advantage essentially disappeared and in fact, may have reversed. It is important to remember that CHPAs do not negotiate premiums; the plans set their own premiums, and the CHPAs’ administrative percentage and fee is added on top of the plan premium. Moreover, state law requires insurers to pool together all small groups inside and outside the CHPAs for purposes of setting rates unless the insurer has approximately 2,000 lives inside the CHPAs, in which case the CHPA pool can be separately rated. Only Blue Cross met the requirement and did rate separately.

Thus, for most plans, the rate inside the CHPAs can be lower than outside only if the plan believes that it saves on administrative costs because of the administrative functions performed by the CHPAs. Alliances were initiated with the thought that they could bring economies of scale to the small group market by centralizing and taking over from the insurance carriers the tasks of enrollment, premium collection (and distribution), enforcing premium contribution and employee participation requirements, and some aspects of marketing. The expectation was that the carriers would experience lower administrative costs as a result, and thus premiums would be lower. This expectation was not met in Florida, however, largely because the alliances’ market share was too small.

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<sup>5</sup> Mark A. Hall and Elliot K. Wicks, citing Lazarus and Associates study in *An Evaluation of Florida’s Small-Group Health Insurance Reform Laws*, Wake Forest University School of Medicine, December 1998 p. 40, [www.phs.wfubmc.edu/insure](http://www.phs.wfubmc.edu/insure).

Carriers generally continued to duplicate the administrative functions that the TPA did for the alliance business. They said that the level of enrollment was too small to justify making the effort and expense to alter their administrative processes to interface most effectively with the administrator's systems. More importantly, they said that they would still have to maintain their administrative structure and personnel to handle their non-alliance small-group business. (Carriers cannot meet the guaranteed-issue requirement by offering coverage through just the alliances.) Much of the administrative cost is a fixed cost, so having the CHPAs' administrator do some of the administrative functions produces little, if any savings, the carriers contend. The carriers also seemed not to trust the TPA to do the job well, even though there seems to be no documentation that performance was deficient. So they felt compelled to duplicate various processes to assure themselves that the administrator did the job right.

Finally, health plans argued that there are additional administrative costs to selling through the CHPAs: they must do separate rate filings with the Department of Insurance, often under tight deadlines, and the rates are due at separate times.

### ***Having a positive competitive effect on the market as a whole***

Most interview subjects agreed that the combination of small-group reform and the establishment of CHPAs encouraged more vigorous price competition: small-group reform requires all health plans to offer products with standardized benefits in the form of the basic and standard plans, so that like products can be compared; and for plans participating in the CHPAs, comparative premiums for the standard and basic plans are available within 24 hours of request from the CHPAs' administrator. Some health plans acknowledged that they studied this information in setting their own rates, and agents mentioned that they too used the information as a way of comparing the costs of various health plans' products even when they did not finally sell a CHPA product to a customer. The comparison of CHPA products was probably a reasonably good indicator of relative prices for non-CHPA products as well, since the benefits levels in the CHPAs standard or Plus plans are not far different from those of the "street plans" that are the health plans' biggest sellers outside the CHPAs.

The effect of comparative price information on competition was strongest when up to 35 health plans, including many of the large national plans, were offering products through the CHPAs. Now that the number has fallen to 5 plans, none of which serves the entire state, the competitive effect is, of course, nil.

### ***Contributing to a reduction in the number of uninsured workers and their families***

Small-group reform, by itself, can be expected to reduce the number of uninsured to a degree if, by enlarging the rating pool, it brings down premium rates for higher-risk groups that would otherwise be deterred from purchasing coverage. CHPAs might have enhanced this effect if they could have achieved economies that brought premiums down even further and thereby made coverage more affordable. But after the first few years, CHPA prices were not lower than outside prices, so there was no price advantage for buying from a CHPA.

On the other hand, the CHPAs argue that if they did not focus on serving very small employers (those with five or fewer employees), these small employers might not get coverage at all. There is wide agreement and substantial evidence to support the conclusion that health plans would like to avoid selling to these “micro-groups.” Health plans have discouraged agents from serving these groups by paying very low commissions—as low as 0.5 percent, according to several sources—and plans acknowledge that they generally see these small groups as probable money-losers in a community-rated market and would certainly not make any deliberate efforts to seek their business. But the CHPAs have served this market; in fact, the average group size is just over two lives.

## **Impediments to Success in Florida**

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### ***Inability to get the right numbers and types of health plans to participate***

Initial participation by health plans was extensive. More than 45 plans sought and were awarded certification during the early years, including the major carriers operating in the state. (The CHPAs did not select plans; they were required to offer all health plans that met the state certification requirements.) About 35 plans actually sold products through the CHPAs. Some observers attributed the high level of interest to political factors. National health reform was seen as being just over the horizon, and CHPA-like entities were expected to be part of the Clinton administration plan. Some health plans undoubtedly participated willingly, wanting to be in on the ground floor if purchasing alliances became a major purchasing outlet for employers. Others may have participated with less enthusiasm. Governor Chiles was a strong supporter of the CHPAs and made it known that he wanted health plans to participate. Some of the people we interviewed reported that the governor’s staff “twisted the arms” of health plans, making it clear that if they wanted the governor to look favorably on the health plans’ legislative concerns (such as opposition to “any willing

provider” laws), they would participate. One observer said that plans were pulled in “kicking and screaming,” and another commented that Blue Cross “threw up a ton of barriers” to thwart the process.

The legislation establishing the CHPAs also held out a carrot for participation: the law included the option that both Medicaid and state employees might ultimately purchase coverage through CHPAs, and only plans participating with the CHPAs would have access to these important blocks of business. Although the implied promise to include Medicaid and/or state employees was never fulfilled,<sup>6</sup> many observers thought the prospect induced a number of health plans to seek certification to sell through the CHPAs.

While Governor Chiles was still in office, several of our interview subjects predicted that health plan participation would decline once he left office. That prophecy was fulfilled. While Governor Bush is not opposed to CHPAs, he has not been vigorous in supporting them either. Since he came into office, the number of participating health plans has fallen from about 20 to 5, and several observers felt that there was some cause-and-effect relationship. Whether that is true is difficult to establish, since the number had fallen already from 35 to 20; but there clearly is no longer a political disadvantage to non-participation. Some plans might have participated initially even without the political pressure just because they wanted to be good corporate citizens and support a promising experiment for serving a neglected part of the market. But since the experiment proved only modestly successful, participation for this reason may have also declined.

Some health plans that willingly participated in the CHPAs did so because they did not have a significant presence in the small-group market and saw participation as an opportunity to develop market share. Some new HMOs, which had no agent force or other channels of distribution, saw the CHPAs as a promising, ready-made distribution channel. One national insurer, Humana, was said to have participated in part because they needed more private-pay enrollees in order to meet federal requirements regarding the ratio of Medicare patients to private-pay patients in the Humana HMO. (Humana has continued to participate up to the present.)

On balance, it appears that a number of important health plans were never enthusiastic about the CHPA concept. Those, like Blue Cross, that already had a significant market share, saw few advantages to participation. They had al-

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<sup>6</sup> Observers cited several reasons to explain why state employees were not included. The state already had considerable bargaining power in negotiating rates for state employees, and the employee unions opposed being included, in part because they had reservations about being part of a system that included Medicaid recipients and in part because the unions wanted to continue to point to their success in getting good benefits for employees as a way of retaining workers’ loyalty to the union.

ready developed the administrative structures and distribution networks to reach the small-group market. Then the CHPAs came along and made it possible for new entrants to move into this market without developing such an administrative structure and incurring these costs because the CHPAs and the TPA perform many of them. Blue Cross was especially upset that any agent would now be permitted to sell their products. That provision made it more difficult for them to keep their own agent force happy and created the possibility that agents with no investment in maintaining a good relationship with Blue Cross would steer bad risks their way.

Even some health plans that did participate say that they saw the CHPAs as competitors for their business. What they apparently mean is that, under the employee-choice provision, when an employer buys through the CHPAs, a participating health plan may get only a few of the employees, whereas if the plan signs up the business directly, that plan gets all of the employees. While, of course, it is not mathematically possible for all health plans to have fewer enrollees as a result of the CHPAs presence (unless *total* enrollment falls as a result, which is unlikely), plans fear that *they* will be the plan that ends up with fewer enrollees on net. The fear is probably most valid for the health plans, like Blue Cross, that started with a large agent force that was effective in promoting their products to small employers.

Another reason health plans cited for not liking the CHPAs is the danger of adverse selection. Plans note that when they enroll an entire group, they enroll the healthy along with the not-so-healthy, thereby averaging out good risks and bad risks. But with the employee-choice provisions of the CHPA plan and no underwriting, they fear that they will get a disproportionate share of the bad risks. The fact that any agent can be certified to sell CHPA products makes health plans especially wary; they have no control over these agents and fear that they might pass the bad risks to particular health plans. The fear of adverse selection may of course be valid for some plans, but again it cannot be true for all plans: if some get a disproportionate share of bad risks, others must get more than their share of the good risks. But no plans seem to think they will be a winner; they all expect to be losers. For most plans, the negative value of being a possible loser seems to be weighted much more heavily than the positive value of being a possible winner.

Health plans also look with disfavor on the CHPA business because the average group size is so small (just above two lives) and includes a number of one-life groups. For these micro-groups, the selling and servicing costs tend to be high relative to the premium, and the average time of coverage with the plan tends to be shorter, so the fixed costs of selling to them are not spread over any appreciable time during which premiums can be collected. But the health

plans are most concerned about what they see as the high risks associated with covering these groups. Plans contend that the micro-groups, especially the one-life groups, have substantially higher loss ratios than larger small groups. A major reason, they say, is that such groups tend to buy health insurance when they know that someone in the group needs expensive care and then drop it once the care is delivered. (They believe this to be true despite the 24 month exclusion for prior conditions that applies to one-life groups, compared to only a 12 month exclusion for larger groups).<sup>7</sup> Again this reason for a negative attitude about CHPA business is based on questionable logic: if these employers were not buying through the CHPAs, they would either be buying directly from the health plans—so the health plans would have to absorb these higher-risk groups anyway—or they would not be covered at all—a result which health plans presumably would not be willing to publicly espouse.

A number of observers argue that the health plans intentionally channeled the micro-groups through the CHPAs by encouraging agents to enroll them there, presumably with the hope that some of the high-risk individuals would enroll with some other insurer, or perhaps, as some observers claim, because insurers want to “kill” the CHPAs by making them a dumping ground for high-risk groups. If plans are allowed to rate the CHPA pool separately—which is permissible only if the insurers’ total CHPA enrollment is large enough to be “credible”—the rates could go so high as to make the CHPAs not viable as a source of coverage.<sup>8</sup>

As noted, the number of health plans has now fallen to only 5, and none is available statewide. While 45 plans may have been too many, the present offerings are so few as to place the future of the CHPAs in doubt.

Several factors probably explain why plan participation dropped off. As alluded to earlier, lack of political pressure to continue is seen by a number of people as an important factor. Some plans apparently saw the change of governors as an opportunity to do what they had always wanted to do but previously felt constrained from doing. Some health plans have withdrawn not necessarily because of unhappiness with CHPAs but because they are facing financial pressures and are responding by concentrating their efforts on their most profitable

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<sup>7</sup> A differential policy between the CHPAs and health plans selling to micro-group outside the CHPAs has also probably contributed to the problem: the CHPAs require micro-group to be in business for only 30 days before they are eligible to buy coverage, whereas health plans generally require that a group be in business for at least a year. The shorter eligibility time increases the likelihood that a person in need of costly care might form a business primarily for purpose of being eligible for group coverage with the CHPAs.

<sup>8</sup> Blue Cross did rate the CHPA business separately and then requested the Department of Insurance approve a large rate increase. The request was denied, and. Blue Cross then declined to continue participating.

lines of business. In fact, across the country, a number of health plans have left the small-group business entirely, for this reason. Some of the plans probably decided that the CHPA business is not worth the effort it takes. In the case of national plans, the decision makers are frequently not in Florida and thus may not be sensitive to the Florida situation.

The CHPAs have responded to this crisis with a number of ideas. For groups of one to four (which make up by far the majority of their enrolled employers), the CHPAs have decided to eliminate the employee-choice provision, though employees can choose among several benefit options offered by the single plan the employer chooses (which technically meets the law's requirement for choice). Thus a health plan will now enroll everybody in the group. The HPCs hope this change will relieve health plans' concerns about getting just the one or two high-risk people in the group. And by getting the whole group, the plan has a larger premium over which to spread the fixed costs of selling and administering the group. The change raises the question, however, about what value the CHPAs add if they no longer permit plan choice and do not have lower prices than the outside market. Their response is that they provide better service to and serve as advocates for these small employers and that they still provide one source for a variety of products. They say that agents have a hard time getting these small groups enrolled directly because of various barriers the carriers place in their way. The CHPAs do not put up such barriers.

In a further effort to make the smallest groups more acceptable to insurers, the CHPAs are apparently even considering supporting a legislative change that would allow health plans to separately pool CHPA business for rating purposes. They seem to think that the change would make the smaller groups more acceptable to health plans (presumably because the insurers could charge higher rates to reflect their belief that these groups are higher risks). Perhaps the insurers would then agree to have the CHPAs be the sole source through which the smaller small groups buy coverage, since the plans themselves have not been eager to market to or serve this group of employers. On the other hand, if the health plans are correct in believing that these groups are higher risk, putting them in a separate rating pool would raise their rates compared to what they have to pay now.

Thoughtful observers among the CHPA leaders suggest that such efforts to accommodate the concerns of health plans are appropriate but belated. According to this view, CHPAs were remiss in not being more willing to treat health plans as partners rather than adversaries from the beginning. For example, they should have been more accommodating in trying to adapt to the health plans' concerns about administrative hassles.

### *Unwillingness or failure of agents to adequately promote sales*

Although Florida law mandated that all CHPA sales be conducted through agents, agent hostility was still an initial problem. During the time the CHPA structure was being planned, some proponents supported eliminating the agents' role by having CHPAs market directly to small employers. Though this approach was rejected by the legislature, the initial threat to their livelihood turned many agents against the concept. The mood of agents at an initial information meeting was characterized by one observer as extreme hostility. The fact that government funds were used to subsidize the CHPAs added to the problem; many agents interpreted the government support as unwarranted government interference in a private market.

One reason many agents have not had favorable views toward CHPAs is that "general agents" have been very hostile because they are cut out of the process. Their function is to recruit and train agents for the carriers they represent; this was often the only way an agent could get access to a carrier. The general agents would then get part of the commission in return for providing certain services to the agents as a kind of middle-man. For CHPA sales, the agent no longer needs to go through the general agent because the law requires that carriers allow agents to sell directly if they go through the CHPAs and because the CHPAs and their administrator perform many of the functions that the general agent might have previously performed. The general agents thus lose income and are extremely hostile to CHPAs. This hostility has probably filtered down to all agents, particularly since the agents must continue to deal with the general agents for non-CHPA business.

Once established, the CHPAs worked hard to generate agent support and educate agents about the possible advantages of participation. The CHPAs refer potential customers to agents, and the agents that are most successful in selling the CHPAs' product are favored with a larger number of referrals. To some degree, these efforts to win over agents have dissipated much of the original hostility, but it is still a small minority of agents—perhaps 50 to 80 out of 2,300 in the state—that sell any significant number of CHPA plans. Sales through the CHPAs have proved especially attractive to agents who previously sold primarily property and casualty insurance but now find the CHPAs to be an easy entrée into the health insurance market.

It is clear that agents have been especially ready to put very small groups into the CHPAs. While this is a segment of the small-employer market the CHPAs are eager to serve, the preponderance of micro-groups has made the CHPAs'

business less attractive to health plans.<sup>9</sup> One reason that agents use the CHPAs for the smallest employers is that it is now much easier for agents to provide micro-groups with a range of prices that might include a plan that is affordable. Within 24 hours of a request for a premium quotation, the administrator provides a spreadsheet array of plans and prices, whereas a typical agent might be familiar with only two or three carriers outside the CHPAs. Getting quotations from a variety of companies outside the CHPAs would be substantial work for the agent for a very small return, especially since carriers typically pay low commissions for micro-groups. On the other hand, for larger groups, selling through the CHPAs may be *more* work, not less, because the agent might have to individually counsel employees about a range of plans that are now available to them. If agents sell coverage outside the CHPAs, all employees are in the same plan, so no counseling is required.

***Inability to communicate effectively with, market to, and capture the attention of employers***

The proof of any marketing effort is the number of sales made. No one suggests that the CHPAs' market share has been what was expected or hoped for when the CHPAs were formed. Both the CHPAs and the private-sector administrator (until just recently, Health Plans Services) had allocated funds for marketing, and eventually the health plans responded to heavy pressure from Governor Chiles and also contributed to marketing efforts. The administrator got paid on the basis of the number of individuals enrolled, and because enrollment was far below expectations, the administrator lost money on the CHPA business. This put a damper on its enthusiasm for spending more money for marketing.

The CHPAs' marketing budget was also probably not allocated in the way that would have maximized enrollment. Because there were initially 11 state-subsidized CHPAs, each with more-or-less equal status, they each had their own (state-subsidized) marketing budgets and developed separate marketing plans. The division into so many districts produced duplication of effort and inconsistent strategies and, perhaps most importantly, meant that money for marketing could not be concentrated in the areas with the most population, where the potential for enrollment was greatest.

One observer noted that the lack of a business coalition or other employer group lending a strong voice in support of the CHPAs was a real disadvantage, given the groups who did not support the concept.

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<sup>9</sup> Another explanation for the preponderance of very small groups may be that these are the groups that were least likely to be insured before reform; the larger small groups were more likely to already have had coverage.

### ***Flawed conception of role***

As is true in a number of other states, many of the people involved in the implementation of the purchasing cooperative approach to serving the small-employer market saw their activities as a kind of mission to meet an important social need. As one of the more successful CHPA executive directors noted, he began his job thinking he would be a reformer, dealing with issues like quality, measuring health outcomes, and so forth. But he discovered that his real job is to *sell insurance*. A number of those implementing the CHPA concept, including some at the state oversight level, may not have been sufficiently focused on the business aspects of their effort and may not have had sufficient appreciation for the complexities of marketing and administering a new insurance product.

Some of the people we interviewed argued that the CHPAs' biggest mistake was not seeing the health plans as partners but as adversaries. In hindsight it is clear that without the plans' support, it is difficult to make a purchasing cooperative a success. These observers believe that had the CHPAs been more willing to listen to the plans' concerns and to accommodate their needs, the plans would likely have made a greater commitment to selling the CHPAs' products because it would have been more profitable to do so.

### ***Structural and organizational impediments***

According to most observers, the CHPAs in Florida started with some significant structural disadvantages because of limitations built into the enabling legislation. First, CHPAs were required to accept all health plans that met certification requirements and accept whatever prices the carriers set. Some observers believe that if the CHPAs had been able to limit participation to a relatively small number, the health plans with the winning bids might have reasonably expected to get a larger market share, making it more likely that they would have made a serious commitment to selling through the CHPAs. Under these circumstances, carriers might have been more willing to negotiate good prices to get access to this market.

Second, the CHPAs do not have master contracts with health plans. Instead, the contract is between the employer and each of the health plans in which one or more employees is enrolled. While the employer does not deal with each health plan—since that is done by the administrator—the CHPAs believe that health plans' administrative costs would be reduced if the CHPAs were the master contract holders. (In the 1999 legislative session, the CHPAs sought, without success, to get this authority.) This feature of the structure also means that agents' commissions are controlled entirely by the individual health plans, and each health plan that enrolls someone in a group pays a separate commis-

sion to the agent. From a psychological standpoint, this division of agent commission payments probably creates the impression that the reward is not very great for selling a CHPA product. The health plans' practice (now prohibited) of paying very low commissions for sales to very small groups (as low as 0.5 percent) made the situation worse: even if the CHPA group was made up of ten employees in total, if only one or two employees signed up with a particular health plan, the health plan would often pay the agent the commission rate that applied to a one- or two-life group. The financial reward for selling the CHPA product was thus significantly less than for selling the same group a single insurer's plan—perhaps another explanation for the fact that the average group size for the CHPAs is just over two.

Third, when the system was first established, the state was divided into 11 districts, each with its own CHPA, staff, and board. This structure created some problems. Some of the directors, staff, and boards were less familiar than others with the unique problems and characteristics of the insurance market and thus less prepared to make the new ventures successful. Each CHPA felt the need to operate somewhat independently, and it was often hard to get them all to do business the same way, even though such uniformity was important to the carriers. Eventually a state board was established to help resolve differences and promote uniformity. Scarce resources from state subsidies were spread across 11 CHPAs, each supporting its own staff structure, facilities, and so forth. The opportunity to realize economies of scale was lost.

Eventually, CHPAs combined so that there are now just seven. Although the consensus seems to be that 11 was too many, several observers defended the idea of locally based CHPAs. They said that the 187 board members—local people willing to give their time and effort—acted as “ambassadors” for the CHPAs. They brought knowledge of, passion for, and commitment to the local areas that a single state board would have lacked.

Fourth, the CHPAs were also hampered initially by being confined to selling just the standard and basic plans, when employers generally wanted more options. Few people were interested in the “bare bones” basic plan, but the standard plan, though not dramatically less comprehensive than the health plans' “street plans,” was also perceived as being inferior. This deficiency was corrected when the CHPAs added their Plus plan—which became their best seller—and later when the health plans were allowed to offer another plan that was essentially the same as their street plan.

Fifth, the association with government probably handicapped the alliances. Although technically not government agencies, they were for several years subsidized by government, and they had to fight the perception that they are an arm of government. Small business people, in particular, seem wary of getting

involved with government programs, and their natural caution is exacerbated by many agents' hostility to the concept. Moreover, flexibility is limited by the fact that many kinds of decisions to alter operational and structural features require legislative approval. Because of the highly political nature of the environment, it is difficult and time-consuming to make changes—a significant disadvantage in a rapidly changing market.

Several observers argued that some of these negative structural features were not just the result of bad judgment by the architects of the system but were intentionally put in place by those who did not want the CHPAs to succeed.

### ***Inhospitable insurance market rules***

Florida's small-group insurance market rules are in most respects ideal for a purchasing cooperative. In addition to the usual requirements regarding portability, pre-existing conditions, and so forth, Florida required guaranteed issue of all small-group products from 1994 on. Moreover, the rating rules were relatively restrictive, allowing rating variations for only age, gender, family status, geographic location, and use or non-use of tobacco. No adjustment is permitted for health status or claims experience.

In many states, the community rating rules prohibit insurers from offering discounts to HPCs for anything other than administrative costs. At least theoretically, the Florida rules were somewhat more permissive: a plan that had a large enough CHPA enrollment is permitted to rate that business separately from the rest of its business. Only Blue Cross actually did this, but they used it to seek *higher* rates for their CHPA business.

Florida applies the reform rules to one-life groups. While this has allowed the CHPAs to serve a group of employers that might have otherwise been neglected, the disproportionate share of one-life groups that make up CHPA enrollment have clearly been a cause for concern by health plans. They view one-life groups as relatively high-risk groups; indeed, they believe they should not be included in the small-group market. Naturally, therefore, CHPAs' proclivity to attract large numbers of these groups does not make the CHPA business attractive to health plans.

### ***Leadership and staffing inadequacies***

As noted earlier, because there were originally 11 different CHPAs, it was almost inevitable that the leadership would vary in quality and effectiveness. One person charged with working with all of the CHPAs characterized dealing with the multitude of CHPAs as an "awful" experience, and another person noted that all of the CHPAs' directors wanted to have their "thumbprint" on the

decisions, even though some of them did not really understand insurance. Involving so many people when decisions had to be made for all of the CHPAs—11 districts, each with an executive director and a 17-member board—was not efficient and slowed down the process.

Most observers pointed to two or three CHPAs as being especially well led. But even one of these executive directors acknowledged that, once he began operating, he had to revise his understanding of what his role was by recognizing the primacy of finding effective ways to market and sell the CHPA products.

People in state government seemed to be effective in some important respects. The staff responsible for oversight were committed to the purchasing alliance idea and worked vigorously to provide technical assistance and monitor the activities of the CHPAs. Some observers suggested, however, that they were sometimes less flexible than desirable, viewing health plans' questions about their decisions with hostility, which created hostility in turn. One state official close to the governor was very aggressive in promoting CHPAs and in urging health plans to support the effort. While not always eager to comply with what was asked of them, the health plans knew that they had to take his demands seriously. The influence of key staff with the governor seemed to play an important part in the health plans' cooperation, even if sometimes not freely given. The consensus seems to be that Governor Bush has not shown the same commitment to the purchasing alliance concept and that this has had a negative effect.

### ***Poor implementation of administrative functions***

Although there were some start-up problems related to administration, they were probably no more severe than might be expected. As previously noted, partly because the CHPAs accounted for such a small proportion of their business, the health plans generally did not revise their own administrative processes to take advantage of some of the functions performed by the administrator. Although the administrator tried to do electronic data interchange, many of the health plans, including some large ones, lacked the capacity to accept data in this form and thus had to re-enter it all by hand. The health plans also were not willing to trust the accuracy of the work done by the administrator and thus insisted on re-doing some of the functions to reassure themselves, even though less expensive ways to provide such assurance—namely, audits—were available.

The original administrator acknowledged that the company had entered the business of serving alliances because they thought this purchasing approach was the wave of the future. They were very disappointed with the actual experience in Florida and elsewhere, finding that enrollment fell far below expecta-

tions and that it was not a profitable line of work for them. They also vastly underestimated the demand for coverage from one- and two-life groups, which meant their per-member costs were higher than expected. They have essentially pulled out of the business of administering HPC-like operations, and beginning in December 1999, a new administrator (which also serves the California HIPC) took over the Florida CHPA business.

The fact that the administrator had access to so much proprietary health plan information created anxiety among some of the participating plans. They feared that the administrator could use the information, such as the list of groups enrolled, to compete with them outside of CHPA. The administrator recognized this potential conflict of interest and created a “firewall” between its functions for the CHPAs and the other parts of its business.

### ***HPC products are not unique or do not match employers’ needs***

The CHPA products seem to meet a substantial number of employers’ needs, especially the smallest employers and particularly since the CHPAs have broadened the choice of benefit plans to include more than the standard and basic plans. Before the CHPAs began serving the small-group market, the employee-choice option clearly was not available, and some small groups value having this option. On the other hand, it is reasonable to ask how important the employee-choice provision is to the many very small groups that the CHPAs serve. When there is only one employee, choice obviously is not an issue, and it may not be much of an issue when there are only two employees enrolled. That is apparently the view of the CHPAs, since they are proposing to eliminate employee choice for groups of fewer than five employees. They say they will still provide the easiest way for small employers to choose among multiple plans and products; the difference will be that *employees* will not have a choice of several health plans after the employer makes the choice.

The CHPAs say they have a special niche in the market—serving and advocating for the very small employers. Without the CHPAs, this market segment would not be well served, they contend. Agents acting without the CHPAs’ assistance just do not find it profitable to give much attention to the micro-groups. The CHPAs point out that their presence prevents carriers from inappropriately turning down applicants or prolonging the application process to such a degree that the employer gives up. Of course, by serving this function, the CHPAs are probably ensuring that they will suffer from adverse selection.

Not having a PPO product was cited by the staff of one of the largest CHPAs as a real disadvantage in being able to attract larger small groups. Even having a POS option would make the CHPAs more attractive to these larger employers.

These employers are even more difficult to attract now than in the past because the CHPAs offer few “name brand” health plans.



# The Health Insurance Plan of California

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## Brief History

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The Health Insurance Plan of California (HIPC) was a product of the period of reform in the early 1990s that culminated with the debate over President Clinton's Health Security Act. It was begun at a time when many people believed that comprehensive national reform was on the near horizon. Small employers were a particular concern of policymakers because they often had difficulty in getting health coverage and because a high proportion of uninsured people work for small firms.<sup>10</sup> The small-employer purchasing cooperative concept was being widely discussed at the time, and the debate focused on issues like whether there should be only one purchasing alliance in a state, whether all small employers that purchase coverage should be required to purchase through the purchasing cooperative, and whether the purchasing entity should be private or public.

It was in this policy climate that the legislation establishing the government-sponsored Health Insurance Plan of California was passed, along with other small-group insurance market reforms. The HIPC, the first entity of its kind, was financed initially by a government loan of \$5.5 million. It was governed by the Managed Risk Medical Insurance Board (MRMIB), a government agency in the Health and Welfare Agency that also managed several other government

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<sup>10</sup> Jill M. Yegian et al., *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience*, The California HealthCare Foundation, May 1998. This manuscript is a detailed description of the HIPC experience in its first five years.

health insurance programs, and the staff of MRMIB also served as staff for the HIPC. The Board had substantial latitude in deciding on the features of the HIPC. What emerged was a purchasing alliance that was offered to all small employers with 2 to 50 employees, with employee choice, two relatively comprehensive standardized benefit plans (that differ primarily with respect to the level of cost sharing), and a requirement that employers contribute at least 50 percent of the least costly plan available to their employees and that at least 70 percent of employees participate. (Initially the HIPC also offered a PPO plan from several carriers. Eventually all PPOs left the HIPC because of adverse selection.) The HIPC had the power to negotiate premium prices with potential health plans, and it could choose to exclude plans that offered unsatisfactory prices or failed to meet other minimum standards. Market rules in the state were quite tight, initially allowing rate variation of  $\pm 20$  percent for health status and then only  $\pm 10$  percent. The HIPC choose to use only age and geography (along with family size) as rating factors. The HIPC hired an outside firm to administer enrollment, premium collection, health plan payment, and marketing.

The HIPC began offering coverage statewide in July 1993 with a complement of 20 health plans. It grew rapidly initially, and attracted firms with an average group size of about 10. The state law stipulated that the HIPC be privatized by July 1996. The HIPC issued an RFP for bidders in 1996 but got no response, and again a year later when a bid was accepted but was then overturned on appeal. Finally, in 1998, the Pacific Business Group on Health, a large-employer coalition, won the bid to operate the HIPC. They took over control on July 1, 1999.

## **Measuring Success in California**

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We begin by seeing how the California HIPC fares when assessed by the standards for success identified earlier.

### ***Establishing market share***

By June 1999 the HPC was providing coverage for about 8,200 employer groups, nearly 84,000 employees, and more than 144,000 enrollees. Those numbers are large in absolute terms and show that the HPC has appeal for many employers and employees. But as a share of the potential small-group market, it is just about 2 percent. The HIPC had a spurt of initial growth after its launch in 1993, a period of relatively slow growth, and then reached relative

stability by 1999. Certainly, relative to the entire small-group market, such enrollment has to be considered only a modest success.

### ***Making available a previously unavailable product***

The HIPC's major innovation was to make it practical for small employers to allow their employees to choose from multiple health plans. Prior to the establishment of the HIPC, employee choice was not a viable option because small employers, with their limited resources, cannot deal with the administrative complexities of having contracts with multiple health plans. There is universal agreement that the ability to offer choice was a major selling point for the HIPC. For example, it allowed employers to enjoy the savings of offering an HMO rather than more expensive fee-for-service or PPO coverage without forcing employees into any particular health plan or set of providers. If employees found they were dissatisfied with a particular plan, an employer wishing to be responsive to employee complaints did not have to negotiate anew with a different health plan; the employee could simply choose a different plan within the HIPC offering. Moreover, the multiple-choice feature permitted the employer/owner to choose a more expensive plan for himself or herself (often a PPO when the HIPC offered a PPO), while still having to pay only for less expensive coverage for employees (as when the employer contributes to the premium an amount equal to a fixed percentage of the least costly plan available in the area through the HIPC).

### ***Offering coverage at a price lower than the "outside" market***

It is always difficult to compare prices inside and outside HPCs. Benefits are usually not identical, and it is also difficult to control for other factors to ensure the comparison is valid. What we can report is the general consensus of the people interviewed during the course of this research.

Certainly the initial expectation was that the HIPC would be able to offer more economical coverage. The HIPC hoped to reduce *administrative costs* in several ways: by paying agents lower commissions than was customary in the small-group market; by offering employers the option of avoiding a commission fee altogether through allowing direct purchase from the HIPC; and by realizing economies of scale through centralization of enrollment, collection of premiums, and marketing functions. The HIPC also expected to be able to use the promise of a large customer base to negotiate *lower premiums* with health plans. That is, the HIPC expected to get "volume discounts," just as large employers were able to do.

Not all of the expectations for administrative savings were realized. The HIPC did pay lower commissions initially, but this was one of several innovations that created great hostility toward the HIPC among agents. To try to improve relations with agents in order to promote more sales, the HIPC ultimately raised its commission rate to be comparable to (and according to some reports, higher than) the commission insurers generally pay in the small-group market. (In the meantime, however, the commission rate in the small-group market as a whole had declined considerably.)

The decision to allow direct purchase through the HIPC also proved to be less successful than hoped. About 70 percent to 75 percent of employers used agents from the very beginning and thus paid the commission. The HIPC also found that its costs for administering direct enrollment were higher than anticipated, so that the costs were comparable to the commission rate. To remove this thorn in the side of agents and create greater incentives for them to promote the HIPC product, the HIPC changed its policy. Direct sales are still an option, but the employer pays a fee equal to the agents' commission; so a sale made by an agent costs the employer no more than a direct purchase.

The verdict about the success of centralized administration of enrollment, premium collection, and marketing is less clear-cut. Health plans we interviewed were unanimous in praising the administrator for doing a good job. A representative of one large insurer reported that his company did reap administrative savings, which were passed on to HIPC customers. He noted that the company treated the HIPC business as if it were a large group with different divisions across the state. However, at least at present, if the participating plans are realizing administrative savings, they are not passing them down to the extent that they cause the price of the HIPC's products to be below those of the market in general, since HIPC prices are essentially comparable to outside-market prices.<sup>11</sup>

In terms of negotiating favorable premiums with health plans, the HIPC administrators believe that their initial negotiating efforts bore fruit. During the negotiating process they were able to persuade health plans to lower their rates below their initial bids, and HIPC staff says that their prices were below the prices for comparable coverage in the outside market in the first few years of the HIPC's history. Many plans reported that the HIPC price was the pricing point around which their outside plan prices were established. In recent years,

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<sup>11</sup> One provision for charging employers for administrative expenses created a significant problem for very small employers. In addition, to adding an administrative percentage fee to the premium, the HIPC charged a fixed-fee for each group regardless of size. For very small groups, the amount of this fee was sufficient to raise the per-employee premium to a point that the HIPC price was less competitive than it should have been. The HIPC eventually abandoned this pricing arrangement.

the HIPC prices have been like those of the rest of the market. The HIPC is generally not the price leader any longer. One group of analysts drew this conclusion about the HIPC's influence on market prices: "While the MRMIB's initial negotiations with plans in 1993 did have an effect on premiums, in subsequent years the HIPC has responded to the market rather than vice versa."<sup>12</sup>

### ***Having a positive competitive effect on the market as a whole***

HIPC officials believe that the fact that HIPC prices are like those of the small-group market in general should not be interpreted as lack of success. They argue that the introduction of the HIPC into the small-group market had an important competitive effect, inducing plans to bring down their prices generally. The HIPC's marketing materials display prices for all health plans in a side-by-side, easily compared format; so a high-priced plan is obvious. The public visibility may encourage plans to offer competitive prices so that they will not seem out of line with their competitors. But the HIPC staff notes that there is an incentive for plans to keep their outside prices in line with their HIPC prices. If a plan is offering a lower price through the HIPC than it does in the outside market, the plan is "competing against itself" with the advantage going to the HIPC. But plans do not want to do that: they would rather make a sale outside the HIPC than inside it because they are then ensured of getting the *whole group* rather than sharing the group with other plans offered through the HIPC.

One HIPC staff person expressed some reservations about the appropriateness of a price differential between the HIPC and the outside market. If the HIPC price is significantly lower, this suggests that the HIPC is either getting a discount—which means it is cost-shifting to somebody with less market power—or it is enrolling a below-average-risk population. It is questionable whether either of these is consistent with serving the social good. There is, of course, the possibility that a lower HIPC price is due to greater efficiency, for example, lower administrative costs—which no one would criticize as an inappropriate source of savings. But most observers seem to think that the savings potential from this source currently are rather small.

While it is true that HIPC prices were initially lower than outside prices, it is very difficult to know whether this has put downward pressure on prices generally. The small-group market has become much more competitive all over the country during the period since the California HIPC began. The California experience of stability in small-group premiums in the last several years may

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<sup>12</sup> Yegian et al.

simply be a reflection of market forces that have influenced the small-group market in many areas across the nation and have little to do with the HIPC.

The HIPC's employee-choice feature has also prompted another market reaction from health plans, according to one agent source. Apparently, some health plans are loosening up on their participation requirements (which require that a minimum proportion of employees enroll with the plan) so that small employers can offer several different health plans without going through the HIPC. For very small employers, however, the administrative complications may still make this impractical.

It is difficult to know for certain how many employers that buy coverage from the HIPC would otherwise be uninsured. The HIPC collects information from employers to determine which of them were previously uninsured. The proportion has usually been about 20 percent, but substantial numbers of these may be relatively new companies that would have bought insurance elsewhere if the HIPC were not an option. Moreover, the HIPC's beginning coincides with the point when California's small-group market reforms took effect. These changes may have been at least as important as the HIPC in making health coverage more accessible to small employers. But even if all of the newly insured firms buying coverage through the HIPC would have otherwise been uninsured, the total impact on the uninsured is small: even 20 percent of the 144,400 people enrolled amounts to only 29,000 people, a small fraction of the total uninsured population in California.

## **Impediments to Success in California**

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Having assessed the extent of the HIPC's success, the next step is to determine why the HIPC was not more successful, using our usual criteria.

### ***Inability to get the right numbers and types of health plans to participate***

The number of plans participating in the HIPC has always been around 20, though not all plans offered coverage statewide. Although this seems sufficient to offer substantial choice, problems arose with plan participation from the beginning. The HIPC had the authority to choose any number of plans it wished from those responding to the initial RFP. Some within the HIPC leadership had hoped to limit participation to a relatively small number of large, powerful plans, perhaps five or six. Their reasoning was that this number would give employers real choice but would be small enough to create the reasonable expectation that each plan could capture a large share of the HIPC's market,

thereby creating strong incentives for plans to market aggressively to potential HIPC customers.

A major barrier to implementing this strategy arose immediately when Blue Cross declined to participate and, in fact, took aggressive action to counter the potential threat that they saw the HIPC as presenting. Blue Cross accounted for a significant share of the small-group market, and this block of business represented a major part of its total business. In addition to declining to participate—which a number of interview subjects considered a serious blow to the HIPC—Blue Cross went on the offensive. In March 1993, they sent a letter to agents telling them that Blue Cross was not going to participate in the “government run” HIPC because “[agents] are a necessary component of health care coverage, education and implementation, [and] any action that would curtail this vital link to employers and employees . . . would be a disservice to all concerned.” (The reference to the HIPC as “government run” appears seven times in one-and-a-quarter page letter.) The letter went on to praise Blue Cross’ own “small group purchasing pool, capitalizing on agents.” As this letter notes, Blue Cross took steps to change its product line to offset the HIPC’s attractive choice of multiple health plans by allowing individual employees within a group to choose from several plan types, including HMO and PPO coverage.

Subsequent to the letter from Blue Cross, Blue Shield also declined to participate. In April 1993, they also sent a letter to brokers saying that they “cannot support a pool which does not acknowledge the value of the agent and brokers community to small employers. . . .” According to a Blue Shield representative, they were worried that participation would threaten their relationship with agents and brokers, who were their exclusive source of sales. (Two years later, after a change of leadership, Blue Shield did become a participating health plan.)

Given these limitations, the HIPC leadership decided to sign contracts with all of the plans that sought to participate and continued that practice through the years.

Another significant problem for the HIPC was difficulty in getting and maintaining participation of PPO plans. According to consistent reports from agents, the availability of a PPO plan is important to selling the HIPC to small employers, even though the PPOs typically accounted for only about 3 percent to 4 percent of enrollment. In small businesses, the owner is normally covered under the HIPC plan along with the employees, and while owners may be willing to channel employees into HMOs, they very often want to have PPO coverage for themselves. The HIPC offered as many as three PPOs during its first three years of operation. But the last PPO, Employers’ Health Insurance, withdrew in July 1998. The reason given was that they were losing money because of ad-

verse selection. HIPC administrators acknowledge plans' concerns regarding adverse selection in an employee-choice environment but also contend that the PPO model's relative inefficiency with regard to unit price and utilization management may have placed the PPOs at a untenable competitive disadvantage in the HIPC model.

Three years after beginning operations, the HIPC developed a risk-adjustment mechanism. The intent was to offset losses plans might experience as a result of adverse selection, thereby reducing incentives for plans to avoid higher-risk groups and focusing competition on price and quality. The PPOs did receive substantial transfers under this risk adjustment mechanism, but they said there were not sufficient to permit them to operate their HIPC business at a profit. Blue Shield, which offered its PPO only in counties where it did not have an HMO product, found that it was ineligible for participation in the risk-adjustment mechanism because in many of these counties the enrollment was below 1,000, which was the minimum to make a plan eligible. Thus by 1998, all PPOs had withdrawn from participation.

A point-of-service HMO option provides some of the same flexibility in choosing providers as a PPO. Currently, two participating HMOs offer POS options, Kaiser and Blue Shield. But Blue Shield reports that, while the POS is still profitable, its cost experience is worsening. This calls into question their continued ability to provide this option. Relatively few people sign up for Kaiser's POS; apparently, people who are attracted to the unique features of Kaiser do not find the POS particularly appealing.

The consensus is that the lack of a PPO plan has been an important factor in limiting the HIPC's appeal to small employers, particularly to Silicon Valley entrepreneurial start-up firms, which generally want to offer generous benefits to their hard-to-retain technical workers.

### ***Unwillingness or failure of agents to adequately promote sales***

There is unanimous agreement that agents' lack of enthusiasm for and even outright hostility toward the HIPC has been a major problem. In hindsight, virtually everyone agrees that, under current market conditions, it is very difficult to sell the HIPC product without the enthusiastic support of a substantial number of agents and brokers. Most small employers, lacking a benefits manager, depend upon agents to inform them of health coverage options and to give them advice about what to buy. The agent has to plant the HIPC idea as a viable option; otherwise, the HIPC is unlikely to be considered by most small employers.

Several decisions the HIPC made initially made agents hostile: commissions were lower than those prevailing in the small-group market; the amount agents were paid in commission was prominently displayed in the invoice provided to employers; and employers could buy HIPC products without going through an agent and without paying the commission fee at all. Agents interpreted these features as an attempt by the HIPC to reduce or eliminate their role, and they were right. HIPC leaders wanted to reduce the costs of coverage, and saw the costs related to sales and marketing as a potential source of significant savings. Agents and brokers viewed these efforts as a threat to their livelihood and reacted accordingly.

Even though the HIPC has changed all of the features that agents found most egregious and has taken other steps to woo agents, even today many remain indifferent or hostile to the HIPC. As one agent who is *not* hostile said, agents have a very long memory. Of course, some agents have recognized that the HIPC offers an opportunity for them to make money. (One knowledgeable agent guessed that perhaps only 2 percent of the 189,000 licensed agents in California regularly sell a HIPC product.) The agents who were successful in selling the HIPC product were not enamored with the HIPC, but they were able to see beyond the “agent-unfriendly” features and to recognize the *business opportunity* that the HIPC presented to them. They had generally carefully thought through how to present the HIPC option in a way that would make it attractive to employers. They found ways to turn to their advantage elements of HIPC requirements that other agents found to be barriers to selling the HIPC.

HIPC leaders are quick to acknowledge that their initial attempt to minimize the role of agents was a critical error. But in their defense, it is important to remember that the HIPC was being designed in 1992 when there was a strong expectation of national reform, reform that was thought likely to include either employer mandates, perhaps with subsidies for some small employers, and/or a requirement that small businesses purchasing coverage do so through an organization like the HIPC. Had those expectations been realized, the decision to try to minimize agents role might have seemed less mistaken than it does now.

### ***Inability to communicate effectively with, market to, and capture the attention of employers***

The California HIPC was one of the first efforts of its kind. Because the concept seemed so sensible and seemed to meet such an obvious need, many proponents may have expected that simply making the product available would ensure substantial demand. That did not prove to be the case, although the HIPC did experience a substantial initial surge in enrollment. According to two 1996

surveys, fewer than one-third of small employers had heard of the HIPC.<sup>13</sup> As just noted, strained relationships with agents clearly hurt HIPC sales because most employers buy health insurance through agents.

Primary responsibility for marketing fell on the administrator, which had a fixed budget for marketing as part of its contract. Among other things, the administrator did a direct mailing to eligible businesses twice a year, and also followed up with telemarketing. Any lead developed through this process was followed up by a one of 17 sales representatives, and if the employer was interested, the employer was referred to an agent. The HIPC also used radio advertising effectively. However, the HIPC staff believe that these efforts fall short of what is needed. They estimate that to do an effective job of marketing, it would take at least three times the \$400,000 that was budgeted for that purpose in FY 1997-98.<sup>14</sup>

In sum, reaching employers, persuading them to recognize the HIPC as an option, and selling them on the product is not an easy task. As one HIPC staff noted, selling the HIPC is somewhat like starting a new insurance company and attempting to capture a large market share. It may be unrealistic to expect dramatic sales early in the process.

### *Flawed conception of role*

Proponents of the HPC concept believed that sales and administrative costs could be reduced substantially by centralizing some of the administrative functions in the HPC and by reducing the role of the agent and paying lower commissions. In addition, the hope was that the HPC could exploit the prospect of representing a large share of the small-business market to negotiate favorable prices from health plans, similar to the way that large employers were able to do. The leadership of the California HIPC gave high priority to offering a more favorably priced product than was otherwise available in the small-group market.

In hindsight these expectation were probably unrealistic, at least in a market where the purchase of insurance is voluntary. As already emphasized, attempts to diminish the role of agents and to lower commission costs proved highly damaging to the HIPC. The expectation of substantially savings through centralization of administration was probably not realized either. One prominent staff member of the HIPC suggested that administrative costs may even be slightly higher. (For instance, the HIPC has had to develop and administrator a risk-adjustment process.) Finally, the HIPC's ability to negotiate favorable

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<sup>13</sup> Yegian et al.

<sup>14</sup> Yegian et al.

rates was reduced for two reasons: first, the market share it captured was ultimately not large enough to allow the HIPC to exert much leverage with health plans, and, second, market conditions in the small-group market in general became substantially more competitive so that there was less room to extract savings. Perhaps the HIPC presence may have contributed to the increased competition, though the same phenomenon appears in other markets as well.

One observer noted that the HIPC has always displayed some internal ambivalence about its role. It was originally conceived—and supported by the legislature—because it was seen as giving promise of solving some pressing social problems, namely, the needs of small employers seeking reasonably priced health coverage. That social mission played a part in the way the HIPC was structured and operated. But the HIPC has to operate and succeed in a competitive market; it has to be a business, and business objectives may conflict with the concept of the HIPC as a social service enterprise. To use one example, the HIPC did not medically underwrite, instead using community rating and adjusting rates based only on age; whereas the rating laws permit a plus-or-minus 10 percent in rates for health risk, and health plans use this flexibility in pricing their products outside the HIPC. Several observers said that the consequence was the HIPC suffered from adverse selection: higher-risk groups found they could save (presumably, about 10 percent) by going through the HIPC; lower-risk groups could realize similar savings by buying outside the HIPC.

Most observers seem to agree that choice, not price, is the main attraction the HIPC offers to employers. By tying their premium contribution to the premium of a low-cost HIPC plan, employers can sometimes save while still not forcing their employees into a particular health plan. While giving employees a choice among several plan options is surely beneficial, it is probably not the reason that the legislature initially supported the HIPC option.

### ***Structural and organizational impediments***

The HIPC seems not to have suffered from significant structural or organizational impediments. It is generally given high marks for having been able to start up quickly and operate smoothly.

The fact that it was an arm of government seems to have had both advantages and disadvantages. One observer argues that it would have been impossible to organize such an entity and to get all of the players to trust the process and participate without government's imprimatur. Locating the entity within MRMIB also gave the entity a degree of flexibility it would not have had had it been located within a typical bureaucracy. It did not have to follow all of the procedures regarding purchasing and competitive bidding that is typical within

normal government agencies. And its board was already experienced in dealing with insurance issues because of the other programs for which the board was responsible. But all of its plans were made and its activities carried out in an open forum, visible to all, including health plans, and had to pass the test of “fairness.” A private entity would not have to operate with these restraints and would thus have more flexibility. Association with government undoubtedly made some agents even more suspicious of the HIPC than they otherwise would have been, but that association may have helped to ensure some businesses that this was a legitimate operation.

### ***Inhospitable insurance market rules***

The small-group insurance market rules have generally been compatible with the HIPC’s needs. The exception is the provision which allows insurers to adjust premiums  $\pm 10$  percent for health status. As already noted, a number of observers reported that the HIPC experienced some adverse selection because it does not adjust its rates for health status. If the rate variation permitted for health status were reduced to zero (as in Colorado), the HIPC would benefit.

### ***Leadership and staffing inadequacies***

With very few exceptions, the people we interviewed spoke highly of the leadership and staff of the HIPC, both past and present. No one attributed any shortcomings of the HIPC to the staff or its leadership. One insurance agent suggested that the board’s unfamiliarity with small employers may have led it to support some decisions regarding agents that proved to be costly mistakes in hindsight.

### ***Poor implementation of administrative functions***

The HIPC appears to have had no significant problems in carrying out its administrative functions. In fact, the administrator was generally praised for performing in an efficient and timely manner.

### ***HPC products are not unique or do not match employers’ needs***

The original expectation was that a major attraction that the HIPC would offer was a lower price. It is generally agreed that small employers tend to be price-sensitive, and the expectation was that a lower price would create substantial demand. In the first several years, the HIPC’s prices were lower than those available in the outside market, but in subsequent years, the HIPC was seldom the price leader. So the HIPC cannot attract new customers solely on the basis of price and particularly not large numbers of uninsured small businesses that

are deterred from buy coverage because they cannot afford normally price coverage.

The capacity to make it practical for small employers to offer employees a choice of plans was initially a unique feature of the HIPC. But as single health plans began to offer small employers a multiple-choice option (that is, perhaps HMO, PPO, and POS coverage but from a single health plan), even this advantage may have become less telling than it once was. The availability of POS plans and PPOs provides enrollees with a choice of providers, so even if they do not have a choice of plans, enrollees offer have broad choice of providers, which to many enrollees may be the most important form of choice. This is particularly true in California, where health plans have sought to sign up as many providers as they can, which results in broad overlap of providers from plan to plan. The relative advantage of the HIPC's employee-choice feature is somewhat reduced as a result. In fact, unlike multiple-choice option which some health plans offer, the HIPC cannot offer a PPO. On the other hand, only the HIPC offers customers the option of Kaiser along with other health plans,<sup>15</sup> and that is often an important advantage in a state where Kaiser is such an important player.

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<sup>15</sup> Yegian et al.



# The Alliance in Colorado

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## Brief History

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The Alliance is a health purchasing coalition that was established by large self-insured employers in Colorado in 1988. As part of an emphasis on value purchasing and quality measurement, their initial efforts were directed to developing a PPO that these large employers could offer on a self-insured basis. That PPO now provides coverage for 130 employers and about 55,000 individuals. But these large employers recognized that small business is a vital part of the Colorado economy and that small employers also needed to have a good source from which to buy cost-effective coverage. As part of their efforts to serve smaller employers, The Alliance supported the small-group reform legislation, including provisions to certify purchasing cooperatives that would serve the small-group market. Using \$750,000 from The Alliance reserves and from a grant from The Hartford Foundation, The Alliance established the Cooperative for Health Insurance Purchasing in 1995. CHIP is a non-profit arm of The Alliance and was established without any state subsidies. The law permits other cooperatives, and one was actually certified, though it has not accounted for any significant market share.

CHIP offers coverage to employers of all sizes (with one enrolled group having more than 200 employees). This inclusion of larger groups makes the Colorado cooperative different from virtually all other coalitions that serve small employers. Colorado's small-group reform laws apply to groups having from 1 to 50 employees, and CHIP serves one-life groups as well as groups of over 50 em-

ployees. CHIP is an employee-choice model; employers must offer their employees the option of selecting coverage from any of the four health plans that participate, and they must contribute at least 50 percent of the employee-only premium for the least costly plan.

## Measuring Success in Colorado

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### *Establishing market share*

During its first year, CHIP grew rather quickly. In December 1996 approximately 738 groups accounted for a total enrollment of 13,066. Membership continued to grow through about mid-1997, to just over 17,000 members and about 1,000 groups. Since that time, however, membership has fluctuated between 17,000 and 18,000 members; it was 17,967 as of September 30, 1999. However, the number of groups has increased to about 1,350, reflecting participation by more smaller groups. Average group size is 6.8 employees. In assessing the CHIP's share of the small-group market, it is important to remember that CHIP enrolls groups with more than 50 employees. Of the total membership, 11,212 members (62 percent) and 1,309 groups (97 percent) represent groups with 50 or fewer employees.<sup>16</sup> This represents about 2 percent of the small-group market in the state. The proportion of one-life groups in CHIP is high, 37 percent. The average group size for the groups with 50 or fewer employees is 4.4. (The Table below shows details for enrollment as of September 30, 1999.)

Number of Employees	Members	Subscribers	Groups	Average Group Size
Up to 50	11,212	5,816	1,309	4.4
51-200	6,284	3,172	42	75.5
201 +	471	186	1	186.0
Total	17,967	9,174	1,352	6.8

### *Making available a previously unavailable product*

CHIP gives employers the opportunity to offer their employees individual choice of four HMOs. These are major managed care plans, including Kaiser Permanente, which together have provider networks that probably include 90 percent

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<sup>16</sup> One employer with more than 200 employees buys coverage through CHIP, and 42 employers participate who employ between 51 and 200 people.

of the physicians in the state. The employee-choice model was not available to small groups before CHIP entered the market, and that feature is thought by many to be a major selling point that attracts CHIP customers (though it is presumably not influential in attracting the many one-life groups).

CHIP also offers employers a choice of plan types: they can choose to offer employees either the standard HMO plans (both IPA and group models) or a POS plan. At one time individual employees could choose either a standard HMO or a POS plan, but the insurers declined to continue offering this “dual option” choice because they feared the POS plan was becoming the victim of adverse selection. (The loss of this option caused CHIP to lose several larger employers.) Although CHIP would like to offer a PPO, no health plan has been willing to offer this plan type under the employee-choice model, fearing that the healthy people would choose the HMO option and that the less healthy would choose the PPO. Several benefit options are also available: the state-defined basic and standard plan benefits must be offered by all insurers operating in the small-group market and is thus offered through CHIP, but CHIP also offer a “Plus” plan that has lower consumer cost-sharing. The best seller is the standard plan, which, in Colorado, unlike most states, has a benefit structure that is essentially the same as that which the HMOs offered as their “street” plan before small-group reform and which is therefore not viewed as inferior coverage.

Another unique feature of the CHIP offering is its emphasis on what large employers refer to as “value purchasing.” CHIP has taken the lead in issuing report cards on the performance of participating health plans so that employees have the information to assess aspects of care quality as they select a health plan. CHIP has also sought to build specific performance standards into its contracts with health plans. Originally, the performance guarantees were enforced by a set of financial rewards and penalties, with a certain percentage of premiums at risk and with money transfers to be made from plans that did not meet targets to those with better performance. The health plans particularly did not like the plan-to-plan transfer provision of this feature and have gradually chipped away at the program, first by demanding elimination of the transfer provisions and then by negotiating elimination of any monetary penalties. All that remains is the performance standards but without any penalties for not meeting specified goals.

Originally CHIP also tried to introduce a form of cost controls that were unique in the small-group market, though not uncommon for large employers in Colorado: CHIP negotiated three-year contracts with participating health plans that imposed caps on rate increases during the life of the contract. These cost controls were negated, however, when state officials interpreted the small-group reform law in a way that effectively prohibited health insurers from offering a

different price to employers enrolling through CHIP than to employers buying coverage from the same plan outside of CHIP. The law requires carriers to treat CHIP as they treat other small-group buyers; that is, health plans cannot offer discounts from the adjusted community rate. (Variation is permitted for differences in administrative costs, but the medical component of the premium cannot vary.)

### ***Offering coverage at a price lower than the “outside” market***

As just noted, originally the small-group reform law was interpreted by CHIP as allowing them to negotiate premiums, creating at least the possibility of lower premiums for CHIP customers. (The health plans had vigorously opposed giving negotiating power to purchasing cooperatives.) But that interpretation was overturned, so that carriers can now charge lower rates to CHIP customers only because of lower administrative costs.<sup>17</sup> In general, the carriers do not believe that they save much in administrative costs by selling through CHIP. The participating health plans do offer some discount off the administrative cost component, but when CHIP adds on the costs of its own administration plus the commission it pays to agents, the total is somewhat higher than the price an employer could get by buying directly from the health plan.

CHIP staff complain that the health plans are not giving full credit for the expenses they do not incur because of CHIP’s administration, but the health plans deny there is any additional savings. They point out that insurers have been subsidizing the costs of administering their small-group business by spreading those costs over all their lines of business. The premium price for small groups does not include the full costs of administration; for example, administrative costs might be 10 percent, but the premium reflects perhaps only 2 percent. Thus the health plan cannot give CHIP a 10 percent discount because the carrier does not have its costs reduced by 10 percent when CHIP takes over administrative functions. In addition, health plans say that the scale of business with CHIP is not large enough to permit them to realize many administrative cost reductions, since many of these costs are more-or-less fixed and thus do not decline significantly when plans are relieved of perform-

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<sup>17</sup> In general, state insurance officials have been reluctant to support legislation that would allow HPCs to negotiate discounts from the adjusted community rate that plans charge other small groups, that is, to be pooled separately from the rest of the small-group market. They fear that the HPC might draw off more favorable risks and dilute the rest of the risk pool. But advocates of letting HPCs negotiate rates argue that so long as the HPC is required to accept all small groups regardless of risk, this fear is unfounded. If by chance the HPC drew a population with a more favorable risk profile, any employer could take advantage of the resulting lower premium by joining the HPC, and the problem would be self-correcting. Moreover, those who hold this view say that it is appropriate to let the HPC negotiate on behalf of its large number of members just as large employers negotiate on behalf of their employees.

ing some administrative functions for just the CHIP business. They admit, however, that the lack of success of some CHIP efforts to reduce administrative costs, such as by introducing electronic transfers, can be blamed at least partly on the health plans.

### ***Having a positive competitive effect on the market as a whole***

If CHIP has had an effect on the nature of competition apart from the general effect of small-group market reform, it has not been large. CHIP staff believe that the health plans have modified their direct offerings to make them more attractive than what employers can buy through CHIP.

### ***Contributing to a reduction in the number of uninsured workers and their families***

CHIP reported that in the first several years of operation, between 17 percent and 20 percent of enrolled employers did not previously have health coverage. This is slightly lower than the 26 percent of newly insured employers reported for the small-group market as a whole following small-group reform.<sup>18</sup> It is difficult to know, however, whether either figure represents people that would not have been insured without reforms or the availability of CHIP products, partly because so many other factors affect employers' decisions to buy coverage and partly because they data does not necessarily reflect people who had no form of recent coverage.

## **Impediments to Success in Colorado**

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Having assessed the extent of the HPC's success, the next step is to determine why the HPC was not more successful. We will consider which of our standard list of impediments apply to the Colorado HPC.

### ***Inability to get the right numbers and types of health plans to participate***

CHIP has been successful in maintaining support from health plans. The four that now participate have done so since CHIP began operations, and they are four of the five largest plans in the state. CHIP has sought to persuade the fifth plan to offer CHIP products but without success. Historically, the lowest-cost plan (which has changed over time) has tended to get more than 50 percent of

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<sup>18</sup> Mark A. Hall and Elliot K. Wicks, *An Evaluation of Colorado's Small-Group Health Insurance Reform Laws*, p. 12, web site: [www.phs.wfubmc.edu/insure](http://www.phs.wfubmc.edu/insure)

the CHIP business, with the remainder being divided more-or-less equally among the remaining three plans.

CHIP staff believe that one reason they were able to get cooperation from the major health plans was that as the CHIP was being planned, they took deliberate steps to seek the advice and counsel of the health plans and to involve them in the process. For example, planning meetings were held at each of the health plans' offices. The hope was that the health plans would feel a sense of investment in the final outcome.

Although the health plans continue to sell coverage through CHIP, it would be a mistake to conclude that they are enthusiastic supporters. Representatives from several insurers questioned whether it made good business sense to participate, noting that profit margins are small. (These observers were not employees of the plan that has the largest share of the business.) They were not seeking to increase enrollment through CHIP. In fact, they thought that many of the enrollees that they get through CHIP would have enrolled with them anyway. This observation is reflective of the common tendency among health plans to see CHIP as something of a competitor; that is, they think that without the CHIP, they might have enrolled the whole group rather than the one or two individuals that might choose to sign up with their health plan. This feeling may be somewhat less strong in Colorado than elsewhere, however, since two of the companies never required that they be the exclusive carrier for a group. Finally, some plans indicate that dealing with the CHIP business is administratively difficult, in part because CHIP staff have not always been "insurance-savvy" and have not thoroughly understood how health plans administer their programs. One plan that referred to CHIP as their "most difficult account" said that the calls they field from brokers and employers related to CHIP problems are more time-consuming than for their other business.

Given some of the health plans' perspectives about the low profit potential and the burdens and frustrations associated with CHIP participation, the obvious question is why they continue to participate. One reason appears to be that they feel some obligation to support the community and that participation in this effort is an element of community support. Undoubtedly, a decision to withdraw would not be viewed favorably by some influential people in the state. A second reason seems to be that as long as they are not *losing* money on this business—given that profit margins are low for small-group business in general—continued participation is probably desirable from a competitive standpoint. It is a way of hedging their bets by not closing off a line of business. But, feeling that the CHIP needs them more than they need the CHIP, they demanded and got certain concessions from the CHIP during the latest round of

contract negotiations, such as elimination of financial penalties for not meeting performance targets.

Health plans began their participation in a spirit of partnership, but the pressures of competition have forced them to be increasingly concerned about “the bottom line.” Ultimately, what counts is sales. Plans want whole groups, and they have reservations about exposing employees to other plans every time the employer renews coverage or on a daily basis when fellow employees are enrolled in a different health plan, as happens when a group has CHIP coverage.

Unlike in some other states, however, our informants did not suggest that health plan participation was a response to explicit political pressure from high-level state officials. Nevertheless, several observers noted that the health plans often tempered their reactions to Department of Insurance actions that they found objectionable because they did not want to incur the ire of Department officials. These top officials were also very strong supporters of small-group insurance reform, including CHIP. So to be seen as cooperating with the CHIP effort may have seemed like a prudent strategy. However, these Insurance Department officials have now left, and the health plans are not talking about declining to participate.

### ***Unwillingness or failure of agents to adequately promote sales***

Despite the fact that CHIP does allow employers to buy directly from CHIP without going through an agent, Colorado has not experienced the level of agent hostility which has been common elsewhere and which has been a real impediment to success for other HPCs. CHIP staff attribute the more friendly response to their vigorous efforts to cultivate agent support and educate agents about the CHIP from the beginning. CHIP officials always thought it was crucial to persuade agents to actively promote CHIP products, and most of their marketing efforts have been directed to agents. They report that agents find it easier to work with CHIP than with the carriers, a reflection of CHIP’s deliberate efforts to provide good service to agents.

As noted, direct sales are permitted, and the inclusion of that feature may have produced some agent hostility by creating the impression that the CHIP might operate without agents. But the initial hostility seems to have been largely overcome by CHIP policies. Buyers get no price advantage by not using agents, and CHIP encourages people who inquire about CHIP products to seek the help of an agent; in fact, CHIP will refer potential customers to specific agents. Commissions for CHIP sales are comparable to what agents receive for direct sales to insurers. CHIP is increasing the commission rate for sales to employers with workforces of 20 to 40 employees in the hope of capturing a higher proportion of the larger small groups.

The fact that CHIP was initiated by an existing business coalition rather than government may also have played a part in the more congenial relationship between CHIP and agents.

Despite the fact that relationships between agents and CHIP seem to be reasonably good, the number of agents who vigorously promote the CHIP seems to be fairly small. At least, their support has not been sufficient to produce a large market share for CHIP.

### ***Inability to communicate effectively with, market to, and capture the attention of employers***

Although CHIP has aimed some marketing directly to employers using various kinds of advertising, they really see agents as the most important target for their marketing efforts. They believe that winning over agents is the key to winning over employers. They do not believe that their marketing success would be dramatically better if they had a larger budget for advertising.

If measured in terms of market share alone, CHIP's marketing strategy has to be judged as being only modestly successful.

### ***Flawed conception of role***

For the most part, it is hard to fault The Alliance for its view of the role it could play in the Colorado market. It took on the ambitious task of offering the CHIP products to groups of all sizes and managed to do so successfully. It does not appear to have been a victim of adverse selection, probably because it did not attempt to offer coverage on a more liberal basis than the rest of the market. Fortunately, the market rules in Colorado are among the more stringent in the country, making it easier for the CHIP to pursue its social mission of spreading risk broadly and limiting rate variation without becoming a dumping ground for high-risk groups.

### ***Structural and organizational impediments***

The CHIP started with an organizational advantage not present in many such efforts: it was formed by a respected, well-established business coalition. That undoubtedly gave it some initial credibility. Although the CHIP architects sought the sanction of state legislation and played a part in structuring that legislation, The Alliance received no state monies to fund the new entity, and CHIP was not seen as having any government connection. Since small employers and agents often have a negative view of government, the separation from government may have helped to make employers and agents less wary about participating.

### ***Inhospitable market rules***

For the most part, the market rules governing sale of coverage to small employers has been favorable to the development of the CHIP effort. The laws have increasingly restricted the factors that health plans can use in determining rates, so that now, insurers are entirely prohibited from using health status or claims experience in determining rates. Allowable rating factors are age, location, family size, and plan benefits. As a result, CHIP is able to meet one of its social objectives of making coverage available to higher-risk as well as lower-risk groups without becoming the victim of adverse selection and without doing medical underwriting. This contrasts with HPCs in some other states, which have tried to be more liberal in their rating policies than the rest of the market and subsequently found themselves getting a disproportionate share of higher-risk groups.

CHIP staff generally believe that their inability to negotiate over anything but the administrative component of the premium has been an impediment to getting more favorable rates. They say that if a plan did not offer CHIP a good rate, they could take their business to another carrier. The health plans discount this argument, saying that margins are already very thin on this business and thus there is not much room for negotiation, particularly given the small market share that CHIP represents for several of the plans. On the other hand, the insurers strenuously opposed efforts to give CHIP legislative authority to negotiate, which suggests the plans thought they had something to lose. One plan also noted that if CHIP had such authority, it might work to its disfavor, since health plans would be less likely to participate under those circumstances.

### ***Leadership and staffing inadequacies***

Although few observers expressed any strong criticism of CHIP leadership, some said that some staff's lack of familiarity with health insurance and insurer practices created problems for health plans that might have been avoided. At least one health plan indicated that they were required to spend considerable time educating CHIP staff on certain important insurance matters, even to the extent of providing legal advice. HPC staff responded that they sought such advice only when it was unclear how legislation should be interpreted and they wanted to interpret it in a way that would be viewed favorably by carriers.

Leaders in the Department of Insurance, who were active and outspoken supporters of both small-group reform and the CHIP concept, appear to have been important in helping the CHIP fulfill its objectives. In general, the Department was given high marks for trying to educate agents and insurers about small-

group reform and in vigorously enforcing the laws in a way that, incidentally, helped the CHIP. For example, unlike in Florida, the Department prohibited insurers from paying very low commissions for the smallest groups. In Florida, that practice was not curbed by the Insurance Department, at least not initially, and it was one of the factors that probably contributed to the very high concentration of “micro-groups” in the Florida HPCs, since the HPCs paid more generous commissions.

### ***Poor implementation of administrative functions***

While complaints about administration are relatively mild, at least one health plan said that they felt compelled to re-do some of the administrative tasks because they had found the administrator to be inaccurate. They also believed that the underwriting that CHIP does for the business for employers with more than 50 employees has not always been done correctly; so they are auditing that function as well.

CHIP staff believe that ultimately there may be ways to improve administration and reduce costs by making greater use of electronic media and data exchange.

### ***HPC products are not unique or do not match employers' needs***

Observers agree that employee choice of health plans is an important selling point for CHIP, and that a substantial number of small employers are willing to pay a bit extra to have that feature. Offering choice may even prove less expensive to the employer in the long run: the employer can tie the employer contribution to the least expensive plan and thus move toward a defined contribution approach to paying for health coverage, which gives employers an easier way to limit their premium contribution. But the employer can accomplish this objective while still giving employees choice in two ways—a choice of health plans and a financial choice of how much they want to spend above the cost of the least expensive plan. Obviously, however, this feature has not been so overwhelmingly attractive as to ensure the CHIP of a large customer base.

Paradoxically, the CHIP products seem to fill a need for one-life groups, given the high-proportion of one-life groups in CHIP. But this may really reflect the fact that the CHIP makes it easier for agents to serve one-life groups: the agent can easily and at little expenditure of time get a premium quotations from four health plans. Without the CHIP, it would not be cost-effective for the agent to seek multiple quotations.

CHIP staff acknowledge that their inability to persuade plans to continue offering the “dual option” choice of an HMO and a POS plan has caused them to

lose customers. And their inability to offer a PPO has also limited their potential market.



# The Texas Insurance Purchasing Alliance

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## Brief History

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The Texas Insurance Purchasing Alliance (TIPA) grew out of Ann Richards' support for major insurance reform during her campaign for governor. When she was elected, she took vigorous action to overhaul the insurance system, and small-group reform, including TIPA, was a part of the health insurance reform package. The act was passed in 1993 during the period when comprehensive health reform was high on the national agenda, and TIPA was seen as fitting in with the general direction of change. Key legislative supporters saw it as a way for small employers to exert purchasing clout to get better prices and also as a way to help reduce the number of uninsured workers in a state where two-thirds of the 300,000 firms with fewer than 50 employees did not offer health coverage.

Though modeled after the California HIPC in many respects, TIPA differed in being organized as a non-profit corporation, rather than a governmental entity. Initially it offered health coverage to small employers with 3 to 50 employees, and then in 1997, when HIPAA took effect, to those with 2 to 50 employees. It was an employee-choice model, with standardized benefits, and (as was the case in the entire small-employer market) participating employers were required to pay at least 75 percent of the premium of the least costly plan (later changed to 50 percent). Because guaranteed issue was not initially part of small-group reform, TIPA did medical underwriting for purposes of determining whether to accept or reject employers until September of 1995, when guaran-

teed issue went into effect. Although state rating rules allowed considerable rate variation for health status, TIPA used modified community rating (using sex and age) in anticipation of a change in state law requiring modified community rating. After the guaranteed-issue provision took effect and community rating was not adopted by the legislation, TIPA began using tiers for health status in 1997 and then group size and industry factors in 1998.

The administrator for the program was Blue Cross and Blue Shield of Texas, also a participating health plan.

TIPA began offering coverage on a pilot basis in Houston in May of 1994, and then extended coverage statewide in January 1995. More than 20 health plans participated at one time or another, and at its peak, TIPA enrolled about 1,000 firms and covered nearly 13,000 people. But health plans began to withdraw as early as 1995, and the exodus continued so that by mid-1999 only one health plan, Blue Cross and Blue Shield of Texas (BCBS), was still participating. As plans withdrew, enrollment fell also, declining to 8,300 lives in 1998. When BCBS decided to withdraw also, the TIPA board voted to disband. TIPA closed its doors in July 1999.

## **Measuring Success in Texas**

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### ***Establishing market share***

At its peak, TIPA enrolled about 1,000 of the approximately 300,000 small employers eligible to participate, about three-tenths of a percent. The 13,000 people covered at the time also represented about three-tenths of a percent of potential lives. In terms of market share—the percent of insured employers buying through TIPA—the staff estimates the proportion was about 1 percent at the enrollment peak, which made TIPA the twentieth largest source of health insurance coverage for small employers in Texas.

### ***Making available a previously unavailable product***

TIPA clearly brought an option to small employers that was not available before: a benefit plan that allowed individual employees in each group to choose from several different health plans. Our respondents did not always agree about the extent to which employers found this to be an attractive feature. Some employers found it confusing, with too many options, and saw it as adding unwanted complications, though others clearly saw it as an important benefit. Initially, TIPA also offered a community-rated product, which was not available elsewhere.

### ***Offering coverage at a price lower than the “outside” market***

At its roll-out in Houston, TIPA accepted all plans that bid. Upon reflection, TIPA concluded that the prices it was getting were higher than what plans were offering outside TIPA. When they went statewide, instead of accepting all applicant plans regardless of price, TIPA decided to be selective in choosing health plans. They concluded that following this strategy yielded prices that were more like those of the general market, though no direct comparison was possible because the benefits differed. Initially, BCBS, a major plan, offered lower prices inside than outside TIPA. But this policy was strongly opposed by marketing people within BC, and subsequently, prices were equalized. TIPA officials, as well as an agent that had a good deal of TIPA business, report that in the later years TIPA prices were only slightly higher than prices the plans offered outside TIPA. TIPA officials say, however, that per-member per-month premiums increased at a rapid rate, averaging increases in excess of 30 percent per year during TIPA’s life despite the fact that benefits were somewhat reduced during this time.

### ***Having a positive competitive effect on the market as a whole***

We heard few reports that TIPA influenced the nature of competition in the Texas market. TIPA staff suggest that insurers recognized that TIPA’s ability to offer a choice of plans and benefit levels was attractive to employers and that in Texas and elsewhere they responded by remodeling their own offerings to include more choice.

### ***Contributing to a reduction in the number of uninsured workers and their families***

TIPA reports that about 50 percent of the firms enrolling were not previously offering coverage, compared to only 17 percent for other insurers. Whether these firms would have gotten coverage elsewhere in the absence of TIPA is unknown. (The consensus is that the high proportion of uninsured firms was a source of adverse selection against TIPA, since previously uninsured individuals are seen as a source of pent-up demand.) Initially, TIPA was community rating its products when the rest of the market was not, which undoubtedly made coverage more affordable for some higher-risk firms that otherwise might have remained uninsured (but which would also produce some adverse selection against TIPA). Unlike in some states, most notably Florida, the Texas HPC was not getting a preponderance of very small groups: average group size was between six and seven employees.

## Impediments to Success in Texas

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Having assessed the extent of the TIPA's success, the next step is to determine why TIPA ultimately failed. We consider our standard list of possible impediments that a HPC might face.

### *Inability to get the right numbers and types of health plans to participate*

Initially, TIPA had no trouble getting health plans to participate. More than 20 plans, including HMOs, PPOs, and indemnity plans, contracted with TIPA at one time or another. Informants indicate that initially health plans felt they had no choice but to participate. Given the apparent support for major reform at both the state and federal levels, companies felt political pressure to contract with TIPA. Moreover, the consensus was that HPC-like structures would be a major part of national reform, and the health plans did not want to be left behind by failing to enter at the beginning. Some newer plans and those with little presence in the small-group market saw participation as a way to gain a foothold in a market that might otherwise have been difficult to enter. One health plan representative said a common view among health plans was "Let's give this a try."

On the other hand, many plans were not eager to see TIPA succeed. They did not welcome the possibility of small employers having purchasing clout, and they saw TIPA as a competitor, in the sense that they might lose a group to TIPA and have only a few or even none of the individual employees sign up with their company. There were important exceptions, most notably BCBS. The BCBS leadership was strongly supportive, partly because of BC's traditional commitment as a non-profit to serving social ends as well as for long-term business reasons: the small-group market needed reform, and the BCBS president believed that that its failure would create a "domino effect" that would lead to national health insurance. Prior to the start of TIPA, BCBS was the third largest seller in the small-group market, and they probably hoped that they could capture a larger share of this market.

BCBS was not only an enthusiastic supporter of and participant in TIPA; they also won the competition to serve as the administrator. As part of this agreement, they committed \$2.3 million over five years for marketing and advertising. They anticipated that they would recover this money and make a profit over time from per-member fees, expecting perhaps 30,000 or 40,000 people would be enrolled after a year or two, as happened in California. Of course, enrollment never approached these numbers, and the BCBS fee was subsequently tripled. (BCBS also had to assume additional functions not originally

anticipated, most notably hiring an out-of-office sales force to recruit agents to sell the TIPA products).

Once national reform fizzled and Governor Richards lost her re-election campaign, both the political and economic pressures on health plans to remain in TIPA dissipated. Since enrollment was small, many health plans, already unenthusiastic about TIPA, concluded that they were not in danger of losing substantial business by leaving. In addition, the consensus is that plans were experiencing rather high loss ratios, probably because TIPA was the victim of some adverse selection. Some plans also believed that the employee-choice feature of TIPA fore-ordained that some plans would be selected against. According to this thinking, healthy individuals in a group, who expect to have little need for health services, choose a plan largely on the basis of price. Individuals with health problems who anticipate a need for health services are more concerned about service quality, network size and quality, and the way the plans define medical necessity. They would choose the more generous—though somewhat more costly—plans. With limited ability to underwrite, especially when TIPA was using community rating, the more generous plans would get a disproportionate share of high-risk, high-cost individuals. They would either lose money or be forced to raise rates to the point where they were not competitive.

Health plans also found that it was costly to administer the TIPA business, for several reasons. The benefits were different from their standard offerings. They had to set up a different claims processing system (since the TIPA business generally did not fit well with either their existing group or individual business), write and print new contracts, and get approval from the Department of Insurance for a new product. Plans generally insisted on checking, that is, re-doing, the calculations they got from the TIPA administrator, thus duplicating this function. Plans insisted on doing their own computations, according to one health plan representative, because BCBS was, *by reputation*, not a good administrator (even though they may have actually administered this program well). All of this effort was required for a very few enrollees. In essence, there was little reason for health plans to continue to participate, and they did not. By 1996, carriers were starting to drop out. Lacking either a carrot or stick, TIPA could do little, and the hemorrhaging continued until TIPA was forced to close its doors.

TIPA officials note that at least one other practice of health plans hurt TIPA. For previously uninsured firms, a number of insurers were delaying returning rate quotations for a month or two, rather than providing a quotation within 10 days as required by insurance regulation. They saw newly insuring firms as bringing pent-up demand and wanted to avoid them. TIPA, which met the 10-

day deadline, thus became the path of least resistance for businesses newly seeking coverage, which TIPA officials believe resulted in adverse selection against TIPA.

### ***Unwillingness or failure of agents to adequately promote sales***

As in California, which was used as a model, TIPA hoped to reduce administrative and sales costs by limiting the role of agents. Employers could purchase coverage directly from TIPA without paying a commission at all, and when an agent did make the sale, the commission structure was much lower than the rest of the market. The flat-fee arrangement was supposed to yield a commission of about 5 percent, but because premiums were higher than expected, it was closer to 3.5 percent compared to 8 percent to 10 percent outside. Agents saw these decisions as a direct attack on them, and the result was that many were alienated and hostile. Virtually all of our informants acknowledge that the decision to minimize the role of agents was a major mistake and that it had very serious negative consequences for enrollment. Those actively involved in administering TIPA admit that they vastly underestimated the importance of the agent distribution system, mistakenly thinking that if they built an attractive product, employers would come.

Even though TIPA made several changes to please agents—including raising commissions in 1995 so that they were as good as or better than those outside and eliminating direct sales without commission—these steps were not sufficient to offset the initial TIPA actions that alienated agents. Between 400 and 500 agents were certified to sell TIPA, but only 30 or so were significant producers. A very few agents sold TIPA to a large number of employers; one agent enrolled 100 employers of the 400 that made up his small-group business. TIPA officials believe that the agents who sold only one or two TIPA contracts tended to use the TIPA as a place to dump high-risk groups that they did not want to send to their favored insurers. According to a number of our sources, it is understood and sometimes made explicit that health plans do not look favorably on agents that send them many high-risk groups. As one informant said, the health plans send out “invisible rays” to let agents know they do not want the bad risks; “health plans don’t need a manual” to get the point across.

Other factors contributed to agents’ lack of enthusiasm. According to some respondents, within BCBS and perhaps among other insurers, middle managers “went out on the street and bad-mouthed TIPA” to agents, saying that TIPA business was coming at the cost of the company’s existing business. The motivation for this hostility was money: the middle managers get a percentage of the premium when agents sell the company’s products, but not when the sale is a TIPA product. Given their dislike for TIPA, middle managers were recalci-

trant about making administrative changes that would have helped to overcome some of the problems plans were experiencing. They had no incentive to help TIPA succeed. The same is true for “general agents,” who help recruit and provide important services to agents and who tend to be influential leaders in the profession; they were cut out of the distribution channel for TIPA products.

Originally, agents also had some difficulty getting certified to sell TIPA products, since state law requires separate certification to sell HMO products, and many agents lacked that certification. (At the time TIPA started, HMO market penetration in the state was very low.) In 1997, the legislature amended the relevant law so there was only one form of licensure for agents who wished to be licensed to sell in this market. Another early issue was whether agents selling the TIPA products had to be individually appointed by every carrier participating in TIPA. TIPA reached an agreement with the Department of Insurance that individual appointments were not required, and that agreement was codified in 1997. Another factor was the complexity of the rate structure: originally using age-sex rating, TIPA had 56 rating cells for each geographic area, and the agents hated the complexity. This problem was lessened when TIPA prepared a computer program to ease the rating task.

Some aspects of TIPA sales were appealing to agents that sold the product, in particular the retention rate, which was 92 percent. Thus agents could continue to earn commission without having to resell the product.

### ***Inability to communicate effectively with, market to, and capture the attention of employers***

TIPA found that it was much more difficult to capture the attention of employers than anticipated. Producing a product that offered advantages for small employers was not by itself sufficient to attract business. Two years after TIPA’s start up, 20 percent of employers surveyed had heard of TIPA, but few knew much about it or understood its unique features. According to a board member who is also a small employer, employers could not quite figure out what TIPA was; they tended to want to fit it into one of the known categories, as either an insurer or a broker.

The legislature provided only \$250,000 in start-up costs for the HPC, and this was completely inadequate to advertise TIPA effectively. TIPA’s ability to get BCBS to commit \$2.3 million over five years for marketing certainly helped, but several informants, including two key legislators, argued that TIPA was severely undercapitalized and that it would have taken a budget of \$2 million per year to adequately market this new form of coverage. The legislature, though remaining supportive of TIPA, was not willing to allocate funds of this magnitude for advertising, particularly to advertise on behalf of a state-run entity

that could be viewed as competing with the private sector. And, of course, the supporters of TIPA vastly underestimated the crucial part agents played in the marketing process.

### ***Flawed conception of role***

In a number of respects, the TIPA promoters probably overestimated the role that the new entity could play. Some of their decisions likely reflected the expectation that TIPA could influence the market by capturing a large market share. Although these expectations seem naïve now, at the time, they seemed more reasonable. National reform was expected, and TIPA-like structures seemed likely to play an important role in the reformed system. Many supporters of reform assumed that all employers would be required to provide coverage, and some TIPA proponents may have assumed that also. A number of people anticipated that the Texas legislature would tighten rate bands to move toward adjusted community rating. Of course, none of these expectations was realized.

It is difficult to determine how serious an error was the decision to adopt modified community rating for TIPA. At the time, the HMOs, who made up the majority of TIPA health plans, were already doing community rating and, in fact, were prohibited from rating on any other basis. Our informants did not agree about the extent to which community rating caused serious adverse selection problems for TIPA. Some felt it was a serious problem, but others noted that TIPA's adverse selection problems really emerged when guaranteed-issue provisions became law in September 1995; and shortly thereafter, TIPA moved to rating on the basis of health status. In any case, the extent of the problem was not precisely documented.

### ***Structural and organizational impediments***

Nothing clearly emerges as a major structural or organizational feature that could explain much of TIPA's difficulties. In a relatively conservative state like Texas, the fact that TIPA was seen as somehow linked with the government might be thought to be a source of some suspicion and hostility. When questioned about this possibility, various observers speculated that the government link might have been a disadvantage with employers in some parts of the state and might have exacerbated the unfriendly response from agents, but no one pointed to this feature as being a significant contributor to TIPA's lack of success. One observer suggested that many employers did not really know that TIPA was, in a sense, an arm of government.

### ***Inhospitable insurance market rules***

The reform rules in Texas were patterned after the first NAIC model, which means the rating limits are quite broad, so that health plans are able to vary rates by large margins based on health status and experience, as well as age and gender. An insurer that varied rates by as much as the law would allow could have premiums that differed by a ratio perhaps as high as 30:1, but in reality the maximum premium variation was probably on the order of 10:1, according to TIPA staff. TIPA clearly would have benefited from tighter rating rules, particularly because it chose to use modified community rating when it began. Although it did reject high-risk groups (until guaranteed issue took effect in 1995), the consensus is that TIPA suffered from some adverse selection because its prices were lower for the higher-risk groups that were acceptable risks and higher for the lower-risk groups. When TIPA adopted a rating system that included more factors, the rating became complicated and confusing. Several informants concluded that TIPA would have worked better in a (modified) community-rating environment.

On the other hand, the ability to vary rates for different blocks of business gave TIPA the potential to offer lower prices than the outside market if it could capitalize on administrative efficiencies and bargaining power. In community-rating states, it is often difficult for HPCs to get approval for health plans to offer different rates inside and outside the HPC.

The original legislation establishing TIPA required that the employer contribute a minimum of 75 percent of the premium of the least costly plan (for employees only), and at least 90 percent of employees were required to enroll in a plan if the employer was to be eligible. These requirements proved to be too limiting, and in 1995 the law was changed to make the minimum employer contribution 50 percent and the minimum employee participation rate 75 percent.

The lack of a risk-adjustment mechanism was not a serious flaw because once TIPA abandoned community rating, premiums were adjusted to reflect risk differences. The ability to negotiate premiums, a power denied some HPCs, was initially an advantage. When it was employed subsequent to TIPA's initial roll-out in Houston, it allowed TIPA to contract selectively to get more favorable prices. But the power to negotiate was ultimately not a compelling advantage, since TIPA lacked sufficient market share to be able to negotiate. As one observer noted, without sufficient volume, "the ability to negotiate is a complete fiction."

### ***Leadership and staffing inadequacies***

Some observers, including some on the TIPA board, suggested that the board members' inexperience with insurance issues made them a bit naïve about what could be accomplished, a bit late in recognizing emerging problems, and less receptive to some suggestions for change that might have helped to improve the situation as things began to deteriorate. One observer thought that a board that was more experienced in insurance matters would have been more successful in persuading health plans to accept the TIPA concept. One or two informants also thought that the change of executive directors at the early stages of TIPA's development may have created some difficulties, though the nature of the difficulties was not specified. The staff of TIPA was limited to only two people, certainly small compared to efforts in some other states, but no one specifically mentioned staff size as a source of problems.

Several observers were convinced that the loss of Governor Richards' support as a consequence of her reelection defeat was a severe blow, making it much easier for health plans to exit without fear of political disadvantage and dooming the prospects for passage of community rating, which would have improved TIPA's position. Others, however, saw this as less important, arguing that the expectation of community rating was totally unwarranted even with Governor Richards' support and that few plans participated simply to gain her favor.

### ***Poor implementation of administrative functions***

The administrator for TIPA was BCBS. The company leadership was institutionally and philosophically committed to doing this job and doing it well, and, for the most part, administration seemed reasonably efficient. BCBS administrators wanted TIPA to succeed, and they expected to make money from administering the program. Some informants suggested that BCBS was not as flexible and timely as they might have been, yet they were able to begin operations in May 1994, only four months after getting the contract in February of that year.

One problem for TIPA, however, was clearly related to the BCBS administration of the program. Competing health plans believed, falsely, that BCBS was taking advantage of their administration to "skim off" the good business for themselves. The structure of the system made this impossible, and those who are in a position to know said the idea was "ludicrous" but admitted that the perception was there. In part, this reflects lack of understanding on the part of some insurers. Some were even under the false impression that groups were *assigned* to particular carriers, which of course is impossible under the actual practice of employee choice.

What does seem true is that health plans did not experience significant if any administrative savings on their TIPA business. Partly because they did not trust BC, they duplicated many of the functions that the administrator performed. They did not trust the underwriting, billing, and collection processes, even though TIPA officials offered to pay for after-the-fact audits, and many insurers had to take the administrator's data and re-enter it by hand onto PC-based spreadsheets because their large computer systems were not set up to handle this unique business. One knowledgeable BCBS administrator for TIPA observed that the best such small-group purchasing alliances can hope for is to offer employee choice without *raising* administrative costs, but it is not feasible to offer employee choice *and* cut costs. Another BCBS administrator observed that HPC supporters tend to be victims of the "false theory of homogeneity:" they think that administering 30,000 lives made up of 5,000 groups is like administering a single group of 30,000 lives, but it is not.

### ***HPC products are not unique or do not match employers' needs***

A HPC's products are likely to be successful only if they offer something that employers cannot get from others in the small-group market and if that something is needed or wanted. Clearly, if TIPA had been able to offer a benefit plan like that generally selected by small employers *at a lower price*, that might have been a selling point. In fact, one agent with a large number of TIPA sales noted that other agents would sell the product if the price were attractive. But TIPA prices were not lower than the rest of the market. Initially, the rates were high in part because the benefit package was very generous, a reflection of the Governor's desire to respond to small employers' complaints that they could not get coverage equivalent to that available to large employers. (The benefit package was subsequently modified to make benefits less comprehensive but more affordable.)

One observer suggested that premiums were high because insurers, expecting the worst, tended to bid high; that is, with individual employee choice, they feared they would get the high-risk individuals (a hemophiliac, for example) in a group and some other insurer would get the more favorable risks. Several observers suggested that TIPA had become a high-risk pool. However, this observation conflicts with the view that TIPA prices are about the same as or slightly higher than the rest of the market. It appears that no one made a serious effort to document the extent of adverse selection. Although there is general agreement that TIPA got higher-than-average risks, the evidence is anecdotal and impressionistic and thus hard to assess as a cause for TIPA's failure. One health plan informant argued that to offer a lower price, TIPA would have had to have lower costs, and it did not. Even a large volume would not have

brought a lower price unless health plans could reduce costs by participating in TIPA.

The feature that TIPA offered that was not available elsewhere was *plan choice* for employees. Although plan choice clearly had an appeal for some employers, several observers noted that small employers in Texas are very price sensitive, and they are not willing to pay much extra for plan choice. One health plan observer put it more strongly, arguing that small employers in Texas do not care about choice, only price: "It's a rate-only driven market, and employers will move an account for only a couple of bucks a month."

Perhaps one reason for the limited appeal of plan choice is that when TIPA started, HMO penetration was limited in Texas, accounting for perhaps only about 10 percent to 20 percent in the small-group market. Since most people were not in HMOs, they could still choose to go to their normal providers; they were not being channeled into closed-panel plans. So the employee-choice feature offered few advantages to those people. Perhaps that is why some employers saw the employee-choice option as adding unnecessary complexity rather than increased flexibility.

On the other hand, the employee-choice feature enabled savvy employers to save on premium payments even when average TIPA prices were not below the general market. Since an employer could peg the employer contribution to the *lowest cost plan* in the area and pay as little as 50 percent of that premium, an employer might save substantially in geographic areas with one low-cost plan, even though no employees chose that plan. (When it was still participating, Kaiser, for example, offered a rate that was about 30 percent below competitors' rates.)

Two legislators noted that small businesses and insurers had been clamoring for the option of a benefits package that was free of state mandates. In effect, TIPA offered that in the form of the standard plan; all health plans were supposed to offer it by law, but, in fact, most agents did not present it as an option except through TIPA. But this reduced-benefits plan did not sell. Both of the legislators independently reported that they were "confounded" and frustrated by the inconsistency between the employers' and insurers' demands for mandate-free benefits and the abysmal sales of the standard plan.

# Caroliance: North Carolina's Purchasing Alliance

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## Brief History

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North Carolina's purchasing cooperative, known as Caroliance, arose out of legislative debates in 1992 and 1993 over comprehensive health care reform. Proposals for more sweeping reforms failed, but the market-based proposal of Lt. Governor Dennis Wicker succeeded. Meeting with industry representatives and other interest groups, the lieutenant governor crafted a bill, modeled on Florida's, that allowed for the creation of a statewide system of regional purchasing alliances that small groups could use on a voluntary basis to purchase health insurance. North Carolina had enacted small-group market reforms about two years earlier.

The legislation provided \$6 million in start-up seed money but intended for the alliances to be self-supporting. To oversee development of the alliance system, an 11-member board was appointed by the North Carolina General Assembly in late 1993. Board members include the lieutenant governor, the state insurance commissioner, and nine public appointments, six of whom are required to represent small business. An executive director was hired in January 1994, and three other staff members were hired over the next year. The State Board was charged with setting up from 4 to 12 noncompeting regional purchasing alliances. Six alliances were incorporated initially, mostly based on proposals from local chambers of commerce. Each alliance has its own governing board

of local small-business owners and its own executive director and support staff. A third-party administrator (TPA), HealthPlan Services in Tampa, Florida, was hired to assist the regions with marketing to small groups, enrollment, premium billing and collections, payment of agent commissions, and database maintenance.

Caroliance began selling its products in late 1995. Initially, six carriers participated in various regions, with Blue Cross and Nationwide selling in all regions. Enrollment at the end of the first year was fewer than 500 groups with about 1,600 lives. Enrollment peaked in 1997 at about 1,100 groups and 4,300 lives. In 1998, some carriers withdrew (notably, Nationwide) and enrollment dipped somewhat to 900 groups and 4,000 lives. In 1999, more carriers withdrew, leaving only one available statewide, and enrollment dropped sharply to approximately 700 groups in February. It had climbed to 913 groups and 2,500 lives in August 1999. Four of the original regions closed and consolidated into two, and subsequently these two consolidated into a single statewide alliance. The original TPA declined to renew its contract, and the only one willing to bid was a brand new TPA for whom Caroliance was its first customer. Caroliance has used most of its start-up funding, and the alliance system is still far from being self-sufficient. Without any additional infusion of state support, which presently does not appear likely, it is not clear how Caroliance will continue past 2000. However, Caroliance has survived previous predictions of demise.

## **Measuring Success in North Carolina**

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### ***Establishing market share***

At its peak, Caroliance enrolled about 1,100 of the approximately 68,000 small groups (1.6 percent) purchasing in the small-group market. However, because the average group size was only about four lives, this accounted for only 0.8 percent of small-group enrollment. Although Caroliance built enrollment back up to 900 groups following its low point of 700 groups, average group size dropped to below three, so its mid-1999 enrollment was only about 0.5 percent of the total small-group market enrollment.

### ***Making available a previously unavailable product***

The primary way in which Caroliance increased market options is that, prior to HIPAA, it offered groups that included members with health problems access to more comprehensive benefit packages than were available to them in the outside market. When Caroliance was started, only state-mandated basic and

standard plans were required to be guaranteed-issue (until HIPAA took effect in 1997). However, all Caroliance products were sold on a guaranteed-issue basis, and Caroliance offered a “Select” plan with more generous coverage alongside the state-mandated plans. The Select plans were medically underwritten, based on a group’s health status, but were sold on guaranteed-issue basis. Thus, high-risk groups could obtain more generous benefits through Caroliance. These select plans were popular with high-risk groups. Sixty-three percent of the guaranteed-issue lives in Caroliance in 1997 were in the select plans. Now, since HIPAA, high-risk groups can choose any product in the market, and so this marketing advantage has dissipated. (As we note later, this marketing advantage made Caroliance the victim of adverse selection.)

Following HIPAA, Caroliance continues to offer better options for the self-employed (defined as groups of one). It is the only place other than Blue Cross where the self-employed can obtain, on a guaranteed-issue basis, plans other than the state-mandated plans. In other words, the system that existed for all small groups prior to HIPAA still exists for groups of one. Also, Caroliance actively markets to groups under five, whereas many insurers try to avoid this end of the market because of higher per-unit administrative and sales costs and greater adverse selection concerns.

Another improvement introduced by Caroliance is its use of standardized products. All products sold through the alliances were standardized at each benefit level to allow easier comparison by purchasers. This feature was generally viewed positively by insurance agents. Caroliance also offered a simplified underwriting/rating process in order to give agents and their clients a quicker response. Agents can receive premium quotations virtually instantaneously via fax, whereas in the outside market a quotation reportedly can be delayed for several weeks. However, this advantage has been reduced now that Caroliance has implemented a five-tier rating system. This makes quoting more complicated and means that it is more difficult to estimate the exact price until applicants undergo medical underwriting.

Another advantage Caroliance offered over the outside market was that group insurance could be purchased without any employer premium contribution, as long as 100 percent of eligible employees participate. In the outside market, “list-billing” rules prevent the sale of group policies unless the employer contributes at least 50 percent of the premium. However, this option for employee purchase attracted but a few groups, presumably because of the high cost of insurance premiums without an employer contribution and because 100 percent participation is difficult to achieve within a group.

Caroliance also intended to offer employees of small groups something most had not had before: a choice of health plans. Employers purchasing through

Caroliance are required to offer employees a choice of at least two health plans, which could be with the same or different carriers, and pay at least 50 percent of the cost of the lowest-cost plan (unless 100 percent of employees participate). However, if an employer pays at least 70 percent of the premium for the lowest-cost plan, employees may be offered only one plan. Fewer than 5 percent of employer groups ended up enrolling with more than one carrier. This was primarily due to the limited number of participating carriers. The mean number of carriers per region was only three in 1995 and two in 1998. In mid-1999, there was only one statewide carrier, and a second carrier existed only in two metropolitan areas. Also, some employers think the choice feature is complicated and time-consuming when claims problems arise. Therefore, some employers reportedly pressure all employees to purchase the same plan even if they nominally offer more than one.

#### ***Offering coverage at a price lower than the “outside” market***

Insurance agents reported that, in general, Caroliance prices are higher than those in the outside market. This was confirmed by an internal study by Caroliance. Although Caroliance officials believe they offer “competitive” prices in some markets for some age and family groupings, it is clear that Caroliance does not offer better prices.

#### ***Having a positive competitive effect on the market as a whole***

We heard no direct reports that Caroliance has influenced the nature of competition in the North Carolina market. There was no indication that, as a result of competition from Caroliance, the market has become more efficient. The main impact is that Caroliance has attracted riskier business and is often viewed as “the carrier of last resort.”

One possible positive impact is that Caroliance assisted an out-of-state insurer’s entry into the market. Rather than hire a sales manager to recruit field agents and advertise to employers, the new insurer worked with Caroliance to train its independent agents and to create a new product for Caroliance. Facilitating market entry or expansion would generally be considered a positive market benefit. However, Caroliance feels that it was used unfairly by this insurer since, after only nine months, once the insurer’s agent network was developed, the carrier promptly withdrew from Caroliance, took away some of its enrollment, and became a competitor to Caroliance, using about 20 of its agents.

### ***Contributing to a reduction in the number of uninsured workers and their families***

More than 50 percent of the groups purchasing through Caroliance in both 1996 and 1997 were reported to be previously without coverage, compared to approximately 20 percent in the outside market who had no previous coverage. Whether these groups would have gotten coverage without Caroliance is unknown. The definition of “previously uninsured” used by the state of North Carolina is that a firm has not had group coverage in the preceding 30 days. Thus, these percentages may represent more than the chronically uninsured (for instance, new businesses, groups switching coverage after a relatively short lapse, and groups with employees switching from individual to group coverage). A Caroliance representative suggested that the alliance is serving as an entry point into the health insurance system for new businesses since Caroliance has more lenient rules regarding how long a business must be in operation to qualify for coverage.

The fact that 70 percent of covered lives in Caroliance have guaranteed-issue rates, versus only 2 percent in the outside market in 1997, lends credence to the notion that Caroliance is providing a valuable service to sicker groups. Also, only through Caroliance are the state-mandated benefit plans actively marketed. Prior to 1997, only these plans were guaranteed issue, and it was difficult to obtain information about these plans other than through Caroliance.

## **Impediments to Success in North Carolina**

### ***Inability to get the right numbers and types of health plans to participate***

Caroliance officials expressed frustration at the lack of carrier participation. Also, in our interview with carriers, we noted a lack of enthusiasm on the part of those carriers who do (or did) participate. Greater enthusiasm was expected because, at the time of the legislation, insurers were strongly in favor of market-based reforms as an alternative to more sweeping government involvement. Several major, national carriers were involved in early discussions about the design of the legislation, which they strongly supported, but none ultimately were strong participants. In 1995 when carriers were invited to sign up with Caroliance, 14 requested application packets but only 6 insurers completed the enrollment process, and just 2 of these sold statewide. Since then, carrier participation has dwindled so that, by mid-1999, only Blue Cross was selling statewide and only two carriers (both HMOs) were selling in limited regions.

Blue Cross continues to be an active participant and has no present plans to alter its course.

Various explanations have been given for the low participation rate by carriers. On the political front, the national push for comprehensive health care reform lost steam by the mid-1990s with the failure of President Clinton's reform plan. Carriers no longer felt compelled to support the alliance model as an alternative to government dominance of the insurance system. Blue Cross has continued to participate, observers speculate, because of its special ties to state government and its history as an institution with a broader social mission. Also, the fact that Caroliance is seen as the "pet project" of the lieutenant governor, who aspires to become governor, makes participation politically advantageous, especially for an insurer headquartered in the state. Some interview subjects questioned whether, without this impetus, even Blue Cross would still be participating.

On the business front, the alliance system has been viewed by insurers as primarily a source for high-risk business. In addition to the fact that it has focused on the state-mandated, guaranteed-issue plans, insurers observed that Caroliance discourages the lowest-risk business since the underwriting system does not offer the discounts allowed by the rating bands. Thus, until 1999, only standard and substandard rates were available through Caroliance; there were no preferred rates. Moreover, carriers see the employee-choice feature as an invitation for adverse selection, since in theory a carrier could be left with only the sicker members of a group if the healthier members chose a competing carrier. Also, Caroliance's marketing and publicity during its start-up phase may have scared away some insurers and created the impression, which quickly turned to reality, of its being a high risk pool. We observed examples of news articles based on press releases that trumpeted the fact that Caroliance was available for employers who had difficulty finding coverage elsewhere. This says very openly that Caroliance is targeted directly to high-risk groups.

Some carriers reportedly left Caroliance as a result of amended business strategies unrelated to the alliance system. Others, namely managed care plans, cited the lack of physician networks in rural North Carolina as a reason for their nonparticipation. Some carriers did not trust the system of delegating underwriting decisions to the Caroliance TPA. Others complained of the lack of a risk-adjustment mechanism for alliance business.

### ***Unwillingness or failure of agents to adequately promote sales***

Caroliance has had a mixed reception from the agent community. Its relationship with agents got off to a rocky start because it was modeled after Florida, which initially intended to allow sales without agents. Even after Caroliance

made it clear that it welcomed rank-and-file agents and that it would sell only through agents and would pay commissions, attitudes remained negative due to the vocal opposition of managing general agents, who are influential professional leaders. Managing general agents have a strong reason to oppose Caroliance since it does not pay them “override” commissions for recruiting and supervising field agents. Agents complain that Caroliance, with its state funding, is unfairly competing with the private sector and that it is an unnecessary intermediary between insurers and purchasers that makes the system more complicated and expensive. By the time Caroliance began selling, the decision had been made to use agents as the distribution system for Caroliance products (although override commissions would not be paid). However, some agents feared that, if Caroliance ever became too successful, they might be cut from the sales loop since nothing in the legislation requires their participation.

Other agents, however, have found Caroliance to be useful in their work. Many agents hesitate to bring high-risk business to their favored insurers, so they like the fact that Caroliance is an easy route for coverage for these groups. Since HIPAA, agents also have found Caroliance to be one of only a few places to purchase group coverage for the self-employed. Other beneficial aspects include fast premium quotations, easy comparison of products, and the availability of more comprehensive, “Select” products for higher risk groups. Because of these features, Caroliance is reportedly more successful with agents who sell health coverage only on an occasional basis and so are less knowledgeable about all of the offerings in the market. Also, Caroliance allows agents who are not otherwise registered with an insurer to sell its products. Referring to the low commissions (discussed below), one observer noted that selling Caroliance business requires a different operational philosophy from what most agents are used to: money can be made by Alliance sales, but it is “fast nickels, rather than slow dimes.”

On the other hand, agents have observed that Caroliance premiums are too high and commission levels are too low for the better risks. To expedite the process of providing quotations to agents, the Caroliance TPA (until recently) used a pricing framework that offered only two rating tiers (standard rates and substandard rates) and no discounts to the lowest-risk groups. Some informed observers speculate that even with the recent implementation of a five-tier rating system (spanning 80 percent to 120 percent of standard rates), Caroliance will never be able to offer prime, low-risk groups prices that are as low as the outside market; insurers are so leery of receiving adverse selection through Caroliance that they inflate their Caroliance rates, even for the healthiest groups, to account for the expected increase in loss ratios. One source also noted that, even where Caroliance prices are generally competitive with outside premiums, employers have been swayed by added “perks” in the outside mar-

ket, such as a small amount of term life insurance thrown in for free. By law, Caroliance is not allowed to add such incentives to its products or to sell anything other than health insurance.

Another deterrent to agents is that, for several years, commissions paid by Caroliance for underwritten business were only about 5 percent, compared with the 8 percent to 10 percent range available elsewhere. Carriers have commented that they view Caroliance business, in general, as guaranteed-issue business (even though a portion of it does pass underwriting), and so they set their Caroliance commissions at the 5 percent level that they use for guaranteed-issue groups, to reflect the lower expected profitability. Carriers also justify the lower commissions with the observation that there is less work for agents in selling through Caroliance. Although Caroliance encourages its carriers to set consistent commissions for comparable business sold in and out of the alliance, it appears that the alliance has given carriers mixed messages in this regard. Blue Cross, the largest carrier, continues to pay only a flat 5 percent commission, which is lower than what it pays outside Caroliance.

An additional complaint by agents is that Caroliance has not reduced their workload. Some observed that they still have to play a significant role in helping to resolve enrollees' claims disputes, even though that function was to be the responsibility of Caroliance.

### ***Inability to communicate effectively with, market to, and capture the attention of employers***

Caroliance has struggled to get its message to employers. Most of Caroliance's start-up funding has gone to support the regional offices and the State Board office in Raleigh. Therefore, the resources available for marketing have been inadequate. Initial plans called for the TPA to create a statewide marketing program without any state subsidy, encouraged through a per-member administrative fee. However, with disappointing early enrollment levels, the TPA was reluctant to invest heavily in a marketing program. Therefore, marketing has been carried out by the regions in a fairly decentralized manner that engendered duplication and a lack of coherence in the sales effort. This is one reason Caroliance officials concluded that dividing the state into six regions was counterproductive and inefficient and thus recently merged all regions into one.

### ***Flawed conception of role***

Caroliance began as a well-intentioned effort to reform the health insurance purchasing environment for small groups. However, proponents of the alliance

idea in North Carolina appear to have had unrealistic expectations about what Caroliance could accomplish in a competitive, profit-driven marketplace. Caroliance saw its role as setting an example for the rest of the market. Offering innovations such as standardized products, choice for employees, comprehensive benefits for guaranteed-issue business, and streamlined underwriting have appeal from a social standpoint. But, in the words of one knowledgeable observer, trying to “fit a square peg in a round hole” is challenging and may require some heavy-duty carpentry work.

Ultimately, what happened is that the peg (Caroliance) was reshaped to fit the market. In order to address the concerns of insurers and agents, Caroliance has systematically had to eliminate most of its distinctive features and become almost indistinguishable from the market. One informed commentator described this experience as having been a “colossal wrestling match” with the industry in which Caroliance was “pinned” and so had to “give up,” “yield to the market,” and “do what the rest of the market does.” No longer does Caroliance offer only standardized plans. It now allows insurers to offer their own benefit structure, as long it fits within a prescribed range. It has adopted a five-tier rating system (spanning 80 percent to 120 percent of standard rates) in order to give discounts to the healthiest groups, even though this sacrifices some of the streamlined aspects that appeal to agents. Similarly, it has moved from only a single category for family coverage to one that distinguishes among four family sizes. And it seems willing to make additional compromises if necessary to appease market participants.

### ***Structural and organizational impediments***

Two features of the health insurance market structure affected the success of Caroliance. First, managed care penetration remains relatively low in North Carolina, particularly in the rural regions. Thus Caroliance has had a difficult time in some regions offering managed care products, which are generally less expensive for purchasers. Only two HMOs have participated in Caroliance and neither across the whole state.

Second, Caroliance has been hampered somewhat by market consolidation, which has contributed in part to the decline in the number of carriers participating in the alliance. In several instances, carriers that participated or that had expressed an interest in participating merged with other insurers or withdrew entirely from North Carolina.

Two organizational features of the alliance were also identified as problematic. As mentioned earlier, some agents were unhappy with Caroliance’s ties to state government, even though the government role was only intended to be temporary. This attitude clouded their enthusiasm and willingness to participate.

Other observers characterized the design of the program around the concept of multiple regions as inefficient.

The requirement that Caroliance take all willing insurers and its inability to engage in competitive bidding were not structural impediments, since it never had sufficient interest from insurers for selectivity to be feasible.

### ***Inhospitable insurance market rules***

Market rules impeded Caroliance's ability to compete. First, the flexibility in North Carolina's  $\pm 20$  percent rating rules allowed carriers to sell through Caroliance at rates higher than those offered outside. Second, carriers were allowed to pay lower commissions in Caroliance. Third, guaranteed-issue rules differed for Caroliance business, at least prior to HIPAA's effective date in 1997. In its first months of operation, Caroliance was allowed to sell only the guaranteed-issue basic and standard products, which were not very appealing to consumers. As a result, groups whose risk status allowed them to qualify for more comprehensive coverage did not buy Caroliance coverage, which meant that only higher-risk groups used Caroliance. Although Caroliance was allowed in 1996 to add the more comprehensive Select plans, it was required<sup>19</sup> to sell the Select plans on a guaranteed-issue (though medically underwritten) basis, whereas in the outside market carriers could reject higher-risk groups for these favored plans. As a result, Caroliance was more attractive to high-risk groups in the pre-HIPAA environment. Although HIPAA was expected to level the playing field for Caroliance because outside carriers would be required to guarantee-issue all of their products, Caroliance still is attracting a disproportionate amount of this business, in part because it has been slow to adopt the more aggressive risk-rating techniques used elsewhere in the market in response to HIPAA.

The point has also been made that market rules have kept Caroliance from offering "perks" to a purchaser to "sweeten" a health insurance sale. Because Caroliance is restricted to selling health insurance, it cannot, for instance, offer a small term-life insurance policy for free or a discount on dental insurance as an add-on to a health insurance sale.

### ***Leadership and staffing inadequacies***

By all accounts, the Caroliance executive director has been a tireless and enthusiastic promoter and an effective administrator. Because he had no prior professional experience in health insurance, however, he has had to learn

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<sup>19</sup>It is not entirely clear to us whether this was required by law or by policy of the Alliance Board.

about the industry on the job. The political leverage created by his friendship with Lt. Governor Wicker has probably been an asset in encouraging participation or more favorable terms from insurers.

The leadership of the regional alliances has been restricted to representatives of the small-business community. However well motivated this community might be, they do not have the necessary time, interest or expertise. Some sources thought the conflict-of-interest rules that prohibited insurers or agents from serving on these boards may have hampered Caroliance in gaining ready access to expertise and practical insight into the complexities of insurance markets. Also, insurer membership on the boards might have produced more “clout” with the industry or given it a stake that would have helped recruit more insurer participation.

One observer also noted the need for renewed leadership at the highest levels of state government to set the alliance concept back on course in North Carolina. A recharged political climate for health care reform, initiated by a gubernatorial run by the original advocate for the Caroliance legislation, was viewed as perhaps the only hope for reviving Caroliance.

### ***Poor implementation of administrative functions***

HealthPlan Services of Tampa, Florida, a nationally recognized administrator of health insurance purchasing cooperatives, was chosen as the TPA for the Caroliance program at its outset. No complaints were identified regarding the timeliness or overall quality of its work. However, several features of the administrative system were identified by observers as problematic. Several carriers complained that, contrary to the prediction that Caroliance would streamline the process of enrolling and administering small groups and thus reduce administrative costs, signing up business through the alliances actually is more work since the Caroliance products do not mesh well with their existing administrative systems. Caroliance’s volume of business is too small for carriers to justify changing their procedures significantly.

Some carriers were uncomfortable with delegating the underwriting process to the TPA, which caused some insurers to resist participating in Caroliance. One carrier that did participate pointed out that the two-tier rating system (100 percent and 120 percent of standard rates) used by the TPA eliminated discounts for the healthiest groups.

In late 1998, HealthPlan Services decided not to renew its contract with Caroliance. The TPA role has been assumed by Workable Solutions, an Orlando, Florida, firm headed by the executive director of a Florida HPC. No other TPA firms answered an invitation to bid on the contract. The transition to the new

TPA reportedly has been smooth, and relations with Blue Cross, the remaining statewide carrier in Caroliance, are comfortable. Operationally, Workable Solutions has made minor adjustments to the Caroliance system so it will be more compatible with Blue Cross.

***HPC products are not unique or do not match employers' needs***

Agents report that, above all, price is the chief factor that small groups consider when shopping for health insurance. Caroliance has never been able to realize its goal of offering lower prices. Thus it has had a difficult time attracting what it desperately needs: healthy groups to stabilize its risk pool and to interest more carriers in participating at competitive rates. Multiple factors, discussed earlier, have contributed to this result. Moreover, Caroliance has not offered unique alternatives of sufficient importance to purchasers. Employee choice has been limited by low carrier participation and is not widely favored by employers or agents. Agents reported that smaller groups without human resource (personnel) managers are hesitant to offer a choice of plans because having multiple carriers makes it even more difficult to help employees resolve claims disputes. The affirmative marketing of guaranteed-issue products and a wider selection among these products is an advantage to higher-risk groups, but it is an advantage that does not help Caroliance succeed. And standardized products and a streamlined system for providing premium quotations appeal to agents, but these are not significant advantages to employers. Moreover, several of Caroliance's unique attributes have diminished as it has adapted to requests by participating carriers and the realities of the market.

# COSE: The Council of Smaller Enterprises of Cleveland, Ohio

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The Council of Smaller Enterprises, known as COSE (“COH-see”), is a private purchasing cooperative that has operated in Cleveland, Ohio, since 1973. In a number of respects, it does not fit the model of a HPC that is used elsewhere in this study. It is a completely private organization that was founded and operated without any special legislative authorization or public funding. It is dominated by a single insurer, and its territory is restricted to a single metropolitan area. Nevertheless, COSE is included in this study because of its prominence in the development of the HPC concept and because of its notable successes.

## Brief History

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COSE is the division of the Greater Cleveland Growth Association (a Chamber of Commerce) that is addressed to the needs of smaller businesses, which COSE defines as 150 or fewer workers. In 1973, COSE responded to difficulties its members were experiencing in finding good, affordable health insurance coverage equivalent to what was available for large employers. COSE negotiated an agreement with the largest insurer in the market (then called Blue Cross and Blue Shield of Ohio, now called Medical Mutual of Ohio) to give a 10 percent discount to COSE members on its standard health insurance plan. Thus COSE began offering health insurance as so many other business associations have, simply by serving as a marketing vehicle for a single insurer, which generated a modest price break for its members, but nothing more. In

the first decade, health insurance enrollment through COSE grew rapidly, to reach 8,500 employees by 1978, 15,000 by 1983, and 21,000 by 1985.

In the early 1980s, COSE's role changed significantly. Concerned that its rates had been increasing too steeply and that it had lost most of its price advantage over the outside market, COSE began to negotiate more aggressively with Blue Cross, and in 1983 it took charge of the administrative aspects of billing, collection, and enrollment. It was at this point that COSE moved from simply offering a health insurance discount to assuming the role of a collective purchasing agent. COSE insisted that it be given the same information about its membership that large employers are given about their employees, such as total enrollment, premiums, and claims. Using this information, COSE negotiated for rates that reflected the risk characteristics of its membership as a whole, requiring Blue Cross to treat it as a separate, large customer rather than as part of its small-group block of business. COSE also began to more actively manage the benefits and plan choices it offered—for instance, by adding Kaiser as an option when Blue Cross was slow to create an HMO product and by asking Blue Cross to add other innovative plan types, such as multiple-option point-of-service plans and medical savings accounts. Finally, COSE created a subsidiary to take on the administrative functions of billing, collection, and changes in enrollment. COSE's role and structure as a purchasing cooperative has remained essentially the same since the early 1980s, although it continues to make important refinements in its operations, as discussed in detail below.

## **Measuring COSE's Success**

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### *Establishing market share*

Precise, or even approximate, market share figures are not available for COSE, since its market is limited to the Cleveland area, and market share data is not collected on a metropolitan or county basis in Ohio. However, from all indications, COSE dominates the small-group market in Cleveland. It has an enrollment of approximately 200,000 people, composed of 13,000 employers, with 80,000 employees and 120,000 additional family members. (A few of these groups are employers larger than 50, but the vast majority are small firms, most of whom have fewer than 10 workers.) COSE's enrollment continues to increase steadily, at about 2 percent to 3 percent a year. Medical Mutual of Ohio, COSE's primary insurer, is the largest small-group insurer in Cleveland, and almost all of its small-group business is through COSE, which is by far its

largest account. By rough estimate, COSE probably accounts for anywhere from 60 percent to 80 percent of small-group enrollment in Cleveland.

### ***Product Innovations and Employee Choice***

Unlike classic HPC's, COSE offers only limited choice among insurers, either to employer groups or to individual employees. Throughout its history, the dominant insurer has been Medical Mutual of Ohio (formerly Blue Cross and Blue Shield of Ohio). In the later 1970s, COSE offered plans from several other insurers, but in the early 1980s, it decided that it could achieve a significant price advantage only by concentrating its enrollment with primarily a single insurer. Although COSE has included Kaiser as an alternative to Medical Mutual since the early 1980s, Kaiser has had only about 10 percent of COSE's enrollment, and it is regarded as somewhat of a "step-child" within COSE.

Another limitation in choice is that COSE employers exercise the primary authority in choosing which plan to offer, rather than choice being exercised by individual employees. During its early years, employers were allowed to offer only one COSE plan, but that was during a time that COSE offered only traditional indemnity insurance, so the primary decision was over the level of benefits. Since the 1980s, employers have been able to offer employees a choice among plans and insurers, but they are not required to do so, and the range of choice is limited. Employers may offer only three or four plan types (HMO, PPO, POS, etc.), depending on the group size and the options selected, and only one version or benefit level for each plan type.

COSE would like to move toward a broader range of employee choice, but it is hesitant for two reasons. First, this would complicate enrollment, billing, and collections. Second, Medical Mutual is concerned that too much plan choice at the level of individual employees will lead to increased adverse selection among plans, with sicker employees opting for higher benefits, as has happened within very large employer groups such as the federal employees' plan. This selection phenomenon is diluted if the benefit level and plan type is chosen by the employer on behalf of the group as a whole.

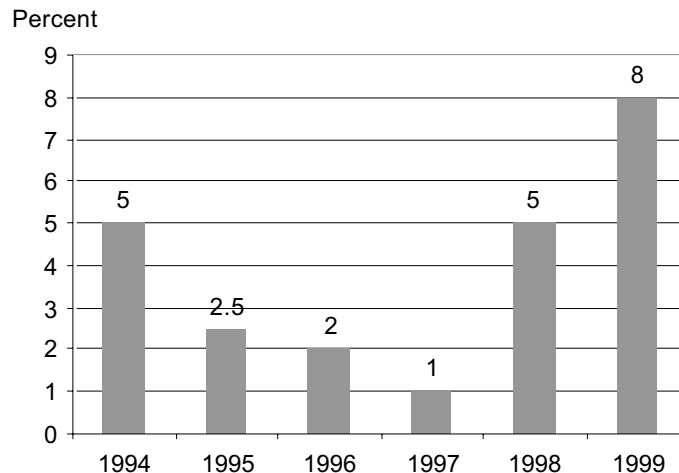
COSE officials and insurers do not see these limitations in choice as a significant disadvantage. They note that Medical Mutual sells five plan types (indemnity, PPO, point of service multi-option, HMO, and medical savings account), and most of these come with several benefit levels. These options, plus the two benefit levels for Kaiser's HMO product, result in a total of 18 plan types and benefit levels from which employers can choose. Most employers offer two plan types, although many choose only one.

Also, as can be seen, COSE has been proactive in adding innovative plan structures such as multi-option point-of-service and medical savings accounts. COSE sees as one of its primary functions offering the types of plans and benefits that its members want. It is notable, however, that only about 20 percent of COSE enrollment is in HMO plans. Half the enrollment is in PPO and POS plans, and about one-fourth is still in traditional indemnity, although this is shrinking. (MSA enrollment is minuscule.) COSE has lower HMO enrollment than in other small-group markets because of employer preference and because the HMO plans are not substantially lower priced than the PPO plans. Moreover, COSE's stable prices have avoided the price shocks that, in other markets, have caused employers to seek out cheaper, tightly managed alternative plans.

**Lower Prices**

There are several indications that COSE has achieved significant savings. This is suggested by the very fact of its success, since if other insurers were able to offer better value, there would be more competition from the outside market; but COSE has dominated the Cleveland small-group market for many years. COSE's price increases have been low or moderate over the past five years, similar to price increases in the larger group market and in the more competitive small-group markets elsewhere. COSE's rate increases for Medical Mutual plans have been approximately the following:

**Percent Change in Premiums for COSE, 1994-1999**



We were told, but did not confirm, that Medical Mutual's rates are 12 percent to 14 percent lower in COSE than in the outside market. Kaiser estimated that

its COSE prices are 2 percent to 3 percent lower than in neighboring small-group markets.

***Contributing to a reduction in the number of uninsured workers and their families***

The most notable respect in which COSE has increased opportunities for employers who have traditionally had difficulty finding coverage is that it offers enrollment down to one-life groups, that is, including the self-employed. HIPAA and small-group laws in most states cover only down to groups of two, and prior to these laws many group insurers did not offer coverage to groups of fewer than five. Insurers generally are reluctant to enroll the smallest groups due to greater per-unit expenses in sales and administration and due to greater adverse selection. For instance, prior to HIPAA, Kaiser did not sell group coverage to employers with five or fewer workers, and now it sells to sole proprietors only through COSE. More significantly, only COSE offers guaranteed-issue products to sole proprietors, whereas other Ohio insurers who sell to them do so only if they pass medical underwriting.

In other respects, however, COSE has not increased opportunities for those who otherwise have difficulty finding coverage (other than by offering a lower price). First, COSE discourages enrollment by smaller groups by requiring that groups with fewer than five members enroll 100 percent of eligible employees that do not have coverage elsewhere. This is a more demanding participation standard than the 50 percent to 75 percent participation requirements that are common elsewhere in the industry. Also, because COSE purchasers must pay a flat enrollment fee of \$450 per year, membership is less attractive to the smallest groups. As a consequence, average group size at COSE is about 6, which is considerably larger than at most HPCs. On the other hand, about two-thirds of its groups have fewer than 10 members, and most of its new enrollment is from groups under 10, which is where COSE officials believe they have their strongest market position.

A second indication of COSE's lack of impact on the uninsured is the fact that the portion of its new enrollees who previously had no insurance (about 25 percent) is not noticeably different than elsewhere in the state or in other states. Although 25 percent appears to be a high proportion of previously uninsured, this is typical in the small-group market generally since many small employers are start-up companies, or they have dropped insurance for a time thinking they do not need it or cannot afford it. Informants at COSE did not believe this 25 percent figure was significantly better than the small-group market as a whole.

If, in fact, COSE had an unusually high proportion of people who have difficulty finding insurance, one would expect it to have a higher-risk subscriber pool than the rest of the market, but most interview subjects viewed the COSE risk pool as equivalent to or slightly better than the rest of the market. This is because the underwriting practices within COSE are no different than in the rest of the market. Prior to HIPAA's requirement of guaranteed issue, COSE's leading insurer refused coverage for approximately 10 percent to 15 percent of applicants judged to be higher risks based on standard underwriting criteria, which is similar to the denial rate we heard of elsewhere in the state. Following HIPAA, both COSE insurers changed from modified (age/gender-adjusted) community rating and adopted rating tiers that use the full rating flexibility of  $\pm 35$  percent allowed by Ohio law. For Kaiser, this departure from community rating is a "very un-Kaiser like" policy that it adopted out of necessity, in order to avoid becoming the "carrier of last resort" in COSE. However, both Kaiser and Medical Mutual now use risk rating in the non-COSE market, so their underwriting practices in COSE are no more stringent than outside, and as noted above, only in COSE do they offer guaranteed-issue products to sole proprietors.

## **Explanations for and Impediments to COSE's Success**

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It is clear that COSE has been quite a bit more successful than most other purchasing cooperatives throughout the country. We inquired extensively into the reasons for this success, and we explored limitations or unique aspects of COSE that may prevent or counsel against its replication elsewhere. The following discussion employs a modified version of the organization in other sections of this report.

### ***Limiting the number of participating plans***

We inquired why COSE does not include more insurers as a means to offer employers more options or to create more price competition. We were told that COSE follows a "sole-source" philosophy, with the exception of Kaiser. COSE prefers this arrangement because it fears that adding more insurers will increase concerns about adverse selection, which will cause more problems in administration and policing. According to one interview subject, insurers would "eat each other's lunch chasing after the good accounts." This is telling commentary, since, even though COSE has only two insurers, for years Kaiser has complained (and Medical Mutual essentially agrees) that Kaiser was re-

ceiving a disproportionate share of bad risks. There is a long and complicated debate about why, and the extent to which, this is so. For a time, Kaiser seriously considered withdrawing, but several changes were made in both Kaiser's underwriting procedures and in COSE's participation rules which Kaiser hopes will "level the playing field." Although this controversy has been resolved for now, its length and intensity illustrate COSE's point that increased competition comes at the cost of increased administrative burden and potential for increased focus on risk selection concerns.

We also inquired why COSE does not engage in competitive bidding. Even though it limits the number of insurers, conceivably it could periodically put out for bid which insurer gets the contract, thereby increasing its bargaining leverage. This has never been done. The only time COSE seriously looked at other insurers was in the mid-1990s when Medical Mutual's future was uncertain, due to its failed merger with Columbia/HCA and changes or uncertainty in its leadership. Rather than competitive bidding, COSE renegotiates rate increases each year with Medical Mutual and Kaiser without considering other alternatives.

From the surface, it may appear this is due to the intimate connections between Medical Mutual and COSE, since Medical Mutual has a very close and special (one is tempted to say "cozy") relationship with COSE. For instance, Medical Mutual's CEO has frequently been on the board of COSE's parent organization, and senior managers at Medical Mutual frequently serve on COSE committees. There is no doubt that a close and long-term business relationship exists. Both parties describe the relationship as a quasi-partnership, and it was frequently difficult in our interviews to determine whether particular policies and procedures were those of COSE or of Medical Mutual, since the two so often seem to act with a single mind. Nevertheless, it is also clear that these two negotiate at arms length, and the connections that exist do not constitute a serious conflict of interest. Rather, the close relationship serves legitimate interests of COSE in maintaining long-term stability in prices. The results speak for themselves. If this business strategy were not successful, COSE would not manage to maintain its high level of enrollment in an intensely price-sensitive market.

One of the strongest reasons we heard for maintaining this long-term stability is that frequent changes in insurers would lead to fragmentation of the risk pool. Since many COSE members join primarily to obtain the insurance benefits, a change in insurers would likely result in a large disruption in membership, as some members left COSE in order to stay with a preferred insurer. Moreover, one actuary explained that the departing insurers would most likely receive the better of these risks, since COSE is not as skilled at targeting and

attracting good risks. Elsewhere, we have observed this phenomenon of an association risk pool deteriorating following a change in insurers. Associations seek to be treated like a large employer pool, but unlike a large employer, they lack the glue that keeps the risk pool intact. Since insurance serves as the glue that holds the COSE risk pool together, changes in the insurer are likely to undermine the stability of the risk pool. Maintaining this stability, in turn, gives Medical Mutual a more credible actuarial basis on which to establish rates, which in turn helps COSE to maintain its price advantage, and this price advantage is what keeps existing members from leaving for other insurers. There is an aspect of self-fulfilling prophecy, then, in COSE's insistence that its members' interests are best served by a long-term relationship with Medical Mutual. The assertion works because Medical Mutual is sufficiently convinced to give the price discounts necessary to keep the membership on board.

### ***Direct marketing and sales, without the use of agents***

Purchasing cooperatives seek to lower prices in part through administrative efficiencies. The greatest potential for administrative savings is from agent commissions, which elsewhere range from 5 to 10 percent for small-group business. Most cooperatives, however, have found it impossible to establish a foothold in the market without working through agents, and it is frequently said that agents are the key to reaching small employers, who do not have the time or inclination to shop for their insurance on their own. COSE, however, is the most prominent example of a successful cooperative that has operated, for the most part, entirely without agents. The main reason it has been able to do so is historical. When COSE began offering health insurance, the former Blue Cross sold only directly, through its internal sales force, and did not use independent, commissioned brokers. Similarly, until 1996 Kaiser sold only directly. When Blue Cross began to use independent agents in the mid-1980s, COSE was functioning well without agents and so did not see the need to include them. COSE has a sales staff of five who are paid on commission to sell memberships, with health insurance being one of the primary benefits; and Medical Mutual has an internal staff of about 10 devoted to selling and servicing COSE business.

More recently, however, in 1999 COSE has begun to allow independent, commissioned agents to sell its policies to larger groups (sized 10 and up). COSE began this as an experiment, which it is still evaluating, to see if this will increase sales in the portion of the market where it faces the most competition. This strategy was proposed by Medical Mutual. Previously, Medical Mutual had faced the dilemma of keeping its agents happy while having to close off a sig-

nificant part of its market to agents, which had created some degree of tension or rivalry within Medical Mutual. COSE allows Medical Mutual and Kaiser to pay agents a 6 percent commission for new sales, which is built into the premium for all COSE members (both new and renewing). COSE does not feel the need to extend commissions for sales to groups under 10 since it is already strong in this portion of its market. Both decisions are subject to evaluation and revision. COSE will determine whether agents bring in significant business, how risky that business is, and how much premiums have to increase due to agent commissions. So far, agent sales are still a very small portion of new enrollment, and agents have not caused adverse selection. COSE estimates that using agents added only approximately 0.5 percent to 1 percent to the 1999 rates because this cost is spread over the entire block of existing (non-agent) business.

### ***Attractiveness to employers***

The primary reason businesses join COSE is to obtain health insurance benefits, although by doing so they enjoy the other benefits of a business association membership. Membership costs \$450 a year, and COSE charges an administrative fee of \$12 per group and \$1 per employee each month for employers that purchase its health insurance. Cost is the prime consideration in employers' choice of insurance. COSE's price advantage is sufficiently strong that even with the membership and administrative fees, it captures most of the small-group market in Cleveland. It is surprising that COSE is so successful even for the smallest groups, since the membership fee has a proportionately larger per-person impact on smaller businesses.

Employer satisfaction is reflected by COSE's low turnover in membership, which averages less than 20 percent a year. (This is low for small businesses since so many fail each year or encounter financial difficulties or a change in circumstances that cause them to drop insurance altogether.) COSE believes its members are less likely to switch insurers because of a momentary or slight price advantage elsewhere. COSE believes this is due to its convincing its membership that it aggressively negotiates on their behalf and does better than they could do on their own. Also, COSE's success in avoiding any sudden, large rate increases has kept its members from shopping around. Agents say that most employers will accept single-digit increases without shopping elsewhere, but double-digit increases are a sufficient shock to cause much more price shopping. As noted above, this stability in membership is itself the key to COSE's price advantage. Medical Mutual officials explained that a stable risk pool forms a much more credible basis for actuarial projections and is a more desirable block of business because there are fewer service and administrative

demands. This is another respect in which COSE has been able to replicate a large employer group.

### *Conception of role*

Early in its history, COSE had virtually no underwriting restrictions. It accepted all applicants and used pure community rating. It did so not so much from social philosophy but rather from a sense of what its membership wanted, and consistent with the former Blue Cross' practices at the time. Therefore, COSE was free to change its operations to respond to changing circumstances and false assumptions. With respect to community rating and open enrollment COSE, quickly found that the inevitable adverse selection was eroding its price advantage over the market. From 1978 to 1982, its prices increased 130 percent. COSE instituted medical underwriting in phases, in response to changing market conditions and regulatory rules. In the early 1980s, it began to reject higher risks, and it adopted modified (age-adjusted) community rating. Gender and family size adjustments were subsequently added. In 1997, COSE began again to guarantee issue coverage, as required by HIPAA, but it also adopted risk-adjusted rating, using the allowable rate bands of  $\pm 35$  percent to reflect individual health status. Another change was made in 1999, when COSE extended guaranteed issue to sole proprietors. It did so in order to comply with regulatory requirements for status as a "bona fide association," but it is evaluating whether this will result in significant adverse selection. If so, it may be forced to close off membership to these firms.

Unlike more public purchasing cooperatives, COSE does not see its role as being primarily addressed to the public policy problem of reducing the number of uninsured. COSE arose from the desire of private employers to find more value (lower costs or better benefits) in the health insurance they were purchasing. Accordingly, COSE has instituted underwriting requirements and made other changes designed to serve the interests of those who are currently purchasing insurance rather than to increase risk pooling or create options for the previously uninsured. On the other hand, COSE instituted aspects of small-group reforms—such as whole group coverage, guaranteed renewability, and waiver of pre-existing condition exclusions—prior to the reform law because these features were desired by its members. To the extent that lower prices or better coverage help the previously uninsured, that result is certainly welcomed by COSE, but it is not its primary purpose. This can be seen, for instance, in the fact that COSE was not involved in the open enrollment mechanism in Ohio that pre-dated HIPAA.

Prior to HIPAA, Ohio law required small-group insurers to offer open enrollment to higher risks, up to a quota based on each insurers' market share.

Since COSE is not an insurer, it did not itself have to offer open enrollment, although insurers that sold through COSE were subject to this requirement for uninsurable applicants who contact them directly. Moreover, small-group insurance sold through COSE did not count toward the market share calculation used to set insurers' open enrollment quotas. Association business was treated as if it were large group business for purposes of calculating small-group market share. Moreover, COSE did not view itself as having the responsibility of referring declined applicants to open enrolling insurers. Indeed, representatives from COSE knew almost nothing about the pre-HIPAA open-enrollment requirement. Since COSE operated without insurance agents, there was no one with either an economic, a legal, or a social obligation to assist rejected applicants in learning about open-enrollment options elsewhere. Now that guaranteed issue applies to all small-group products, both inside and outside of associations, these problems have been resolved.

In summary, although COSE's primary purpose is not to reduce the number of uninsured, its ability to focus on creating better value for its members allows it to avoid some of the mixed and sometimes irreconcilable goals of more public purchasing cooperatives. By offering attractive products at favorable rates, COSE may well help to bring previously uninsured employers into the market, although this is not conclusively established. Certainly, COSE has helped to keep employers from leaving the market.

### ***Structural and organizational features***

The fact that COSE was implemented through private initiative rather than under government auspices appears to have contributed to its success. Most insurers and many employers reflexively react with hostility, or at least suspicion, to any government intervention in their market. Private cooperatives begin without having to fight these ideological battles. Moreover, government-sponsored cooperatives usually implement a uniform, state-wide system under a fairly rigid set of operating rules. COSE has been able to choose its own operating territory and to develop its operating rules in its own way, through trial and error by adapting operating procedures to changing conditions. As one interview subject explained, health care delivery markets are local, employers are local, and so should be insurance purchasing arrangements.

Competing against these concerns is the problem of start-up costs. One advantage of government sponsorship is that it provides essential start-up capital. A number of business associations have failed or have not flourished because they believed they could simply endorse an insurance product, receive a price break, and allow everything else to happen on its own. Purchasing cooperatives are more successful when they operate like benefits departments at

very large employers. This requires someone with expertise to shop carefully among insurance offerings, bargain aggressively, and then manage enrollment and billing. At COSE, these lessons were learned the hard way, over a number of years, an insight captured in the observation that COSE is a “20-year overnight success.” Like other, more recent, cooperatives, COSE in its development phase also struggled with the need for sufficient professional staff and expertise. COSE met these needs through two sources: The former Blue Cross provided the necessary expertise, and COSE relied heavily on volunteer service from its members for manpower. Now, COSE has a professional staff of ten who are paid through the administrative fees collected from employers. COSE stresses the importance that the spirit of voluntarism among its membership played, and still plays, in its success.

Nevertheless, the COSE combination would be hard to achieve without the large base of enrollment that it has. In large part, this is due to the market conditions that prevailed when it originated, and to its special relationship with the former Blue Cross. When COSE was formed in 1973, Blue Cross was the dominant insurer in the Cleveland market. Blue Cross gave COSE major price concessions, so that very quickly, COSE was able to secure a large enrollment base. Since then, Kaiser has been added as an additional insurer, but in many ways it appears that COSE has been run in cooperation with Blue Cross, now Medical Mutual. Some would say they are virtual partners, and in our interviews we detected that COSE representatives tended to speak of Blue Cross/Medical Mutual policies and practices as if they were COSE’s. We do not mean to suggest a bias against Kaiser or inappropriate favoritism for Medical Mutual, only to report that the size and closeness of Blue Cross/Medical Mutual to COSE is a unique factor that helps to explain its success, especially in the early years.

Here again, there is a contrast with government-sponsored cooperatives, which by virtue of their public endorsement find it politically very difficult to limit themselves to a single or dominant insurer because this would appear to constitute an unfair exclusion of competitors. This “sole-source” arrangement is perfectly legitimate, however, when arrived at through private decision making.

Finally, it was impressed on us that COSE’s success is due in part to the absence of conflicts of interest among its membership and governing body. We were told, and we have observed elsewhere, that many business associations are permeated by various conflicts of interest in which “everyone is always looking for a buck” and in which there are various hidden costs. Some associations are formed by general (or managing) agents who want to earn “override” commissions on a large block of business that someone else sells. Others are formed in cooperation with insurers who, in lieu of general agents, pay an

override commission to the association, which it uses to support its other activities. None of these legitimate, but non-essential, motivations appear to be at the core of COSE's existence. It appears to function under a more pure, member-service ethic. Although its insurance sales are obviously a major draw for association membership, the costs of membership are clearly stated, and we detected no hidden kickbacks or other incentives from insurers.

### ***Market rules and legal support***

For most of its history, COSE has offered health insurance without any special legislative assistance or permission. Since 1993, however, Ohio's reform law has attempted to facilitate replication of the COSE model elsewhere in the state by clarifying the regulatory auspices under which private purchasing cooperatives function, and by providing some minor facilitation, primarily by waiving the 2 percent premium tax that is imposed on indemnity health insurance for alliances with enrollment of at least 2,500 lives. We asked interview subjects how important this legislative endorsement is to the success of COSE. Most said that the law is largely irrelevant: it neither helps nor hinders COSE's operation, although avoiding hindrance is an important achievement. One way in which the law avoids hindrance is by not imposing more demanding rating and underwriting restrictions on COSE than exist in the regular small-group market.

Apart from avoiding any disabling requirements, the reform law has had only marginal relevance to COSE's success. This can be seen in the fact that COSE was formed and achieved its success many years before the market reforms took effect in 1993. Following the reform law, other private cooperatives have been formed in Ohio, in part through the law's encouragement, but their total enrollment (30,000 in 1995) pales in comparison to COSE's 200,000. The major way in which the law encourages cooperatives is through the waiver of premium tax, but this helps only if the cooperative offers indemnity insurance, whereas most cooperatives other than COSE offer primarily HMO insurance, which is not subject to premium tax. So the reform law has helped to publicize the COSE model and to facilitate its replication, but it does not appear to play an essential role. Indeed, a number of other business associations exist in Ohio that have not sought official legal status as purchasing cooperatives. We lack enrollment figures for them, but examples we were given indicate that some have more enrollment than the official cooperatives, although none have anywhere near the size of COSE.

Another important aspect of COSE's legal treatment is its status as a "bona fide association." Under HIPAA, this allows COSE to cancel health insurance when its members leave the association. These employers are still eligible,

however, to purchase insurance elsewhere, even from the same insurers, without undergoing new exclusion periods. If termination of COSE coverage were not allowed, then COSE could not enforce the requirement that purchasers remain COSE members and pay their association dues.

Another aspect of bona fide association status is that COSE can offer rates different from the rates its insurers use for other small groups. In effect, Medical Mutual and Kaiser are allowed to rate their COSE business based on the claims experience of the COSE block, as they do for larger employers, rather than in relation to their other small-group business. However, *within* COSE, rate variations *among* different employers must follow the normal small-group rating rules. In other words, COSE insurers maintain two separate small-group rate bands, one for COSE and the other for the rest of their Ohio small groups. This ability to rate COSE business separately is important to these insurers' ability to treat COSE like a large employer group and therefore to COSE's ability to negotiate lower rates. Otherwise, if COSE business had to be priced within these insurers' regular small-group rating bands, they would be reluctant to give lower rates since this would constrain the extent to which they could increase rates for higher risks outside of COSE.

### ***Leadership and staffing***

COSE's long-term and close relationship with Medical Mutual has been noted above. This has provided critical expertise, and Medical Mutual's senior managers who work with COSE have held these positions for 15 years. Also, COSE hires a consulting actuary, and it has a senior manager who has been with the program for 14 years. The level of expertise, dedication, and long-term commitment of these senior staff has been important to COSE's success. COSE also has about eight other staff positions devoted to administrative functions, and it has five staff members who work on sales.

### ***Administrative functions***

COSE claims that it achieves remarkable savings in administrative costs by centralizing billing, collection, and enrollment functions. Its administrative fees amount to only 1 percent of premiums, and Medical Mutual's medical loss ratio is about 88 percent, meaning only 12 percent of its premium goes to administrative overhead. These are admirable figures compared with the rest of the small-group market. It is questionable, however, how much of this is due to administrative efficiencies rather than bargaining power or avoiding agent commissions. Under any arrangement, the billing, collection, and enrollment functions would be efficient since COSE offers insurance primarily only through one insurer. Only employers that offer both Kaiser and Medical Mu-

tual, or that also purchase dental or life insurance, would have a modest benefit in consolidated billing.

Most of the administrative functions performed by COSE are contracted back to a Medical Mutual Subsidiary. Obviously, Medical Mutual cannot do these functions cheaper as a contractor than on its own account. What this arrangement has achieved, however, is more bargaining leverage for COSE through increased information about component costs. Prior to taking on these administrative functions, COSE was unable to identify the administrative costs and so could not effectively negotiate over this component of the premium. Transferring these functions to COSE and then contracting them back to Medical Mutual isolates and identifies this component of costs. Also, this arrangement creates sufficient control and independence that COSE is able to persuade its dental and life insurance carriers to allow Medical Mutual to handle the billing and collection for these products as well. This arrangement has not been entirely free of controversy, however. Kaiser is uncomfortable with having its enrollment and billing handled by its competitor and so maintains duplicate accounting systems, which reduces the extent to which it can capitalize on administrative savings.



# Assessing the Success of HPCs

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If measured in terms of market prominence, small-employer purchasing arrangements have been both less common and less successful than many of the early proponents hoped. But there are a variety of measures that can be used to judge success. We consider these below.

## *Market share*

If actual market shares are measured against expectations, it is hard to come to any conclusion other than that HPCs' performance has been disappointing. The ability to achieve some of the important objectives that supporters held out for HPCs—bargaining clout with health plans and reduced administrative costs, for example—is directly related to enrollment size and market share. Surely, proponents of HPCs hoped that they would account for at least 10 percent or 20 percent of the small-group market at some point, but typical market shares are far below that. California and Florida HPCs, the two HPCs that have had the largest total enrollments, still account for less than five percent of their states' small-group markets. There are exceptions, however: COSE dominates the small-group market in Cleveland (though precise market-share figures are not available).

Of course, market share is not the only measure of market power. The California HIPC's enrollment of approximately 150,000 people is only about 2 percent to 3 percent of the total small-group market, but that number still represents an enrollment larger than all but the very largest large groups. In a competitive market, health plans are still likely to see a "group" of that size and even smaller as business worth competing for.

It may also be premature to judge HPCs' ability to attract enrollment. The market-building process may take longer than expected. It is important to remember that for the most part, HPCs grow by "taking business away" from health plans' direct sales. (The proportion of newly insured customers tends to be similar for HPCs as for the market generally.) It is perhaps not inaccurate to view a new HPC's marketing challenge as analogous to the task that a new insurer would face in trying to penetrate an existing market. Success is unlikely to occur quickly, and it will not be automatic even if the HPC offers a superior product.

Some HPCs continue to grow at steady rates (though some others have lost enrollment and even disappeared). Moreover, everyone concedes that early HPC initiatives were hindered by mistakes in conception, structure, and strategy. New HPCs may be able to avoid some of these problems and grow more quickly, and existing HPCs may find that they can correct the mistakes and thereby attract more enrollment.

### ***A new, previously unavailable product***

HPCs have clearly been successful in offering a new product that meets a need for many small employers—a choice of several health plans with the requirement, or at least the option, that individual employees can choose among all the plans offered. Prior to the establishment of HPCs, employee choice was not a viable option for small businesses because of the administrative burdens a small employer would have had to bear in offering multiple plans (assuming any plans would be willing to sell coverage under conditions of multiple choice, given their minimum participation requirements).

This unique feature of HPC coverage is generally acknowledged as being most important in attracting small employers to HPCs. It clearly benefits employees. Further, it allows employers to gain the cost advantages of moving to managed care plans without alienating employees by forcing them all into one plan. Agents report that the employee-choice feature is important in very small firms when the employer has a close relationship to employees and especially cares about their reaction to the coverage decisions. Employee choice can also be compelling for larger small firms because it is very difficult to choose one plan that will please 15 or 20 employees.<sup>20</sup>

Employers can offer multiple-plan choice while still limiting their financial liability: they can tie their premium contribution to the least costly plan, while letting employees choose more expensive plans if they wish. And adopting the

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<sup>20</sup> Elliot K. Wicks and Trisha Kurtz, "The Role of Insurance Agents in Selling Products of the California HIPC," unpublished manuscript, Institute for Health Policy Solutions, 1998.

strategy of a fixed-dollar contribution probably makes it easier for employers to ask employees to absorb the cost of premium increases that plans might impose.

A product that HPCs do *not* offer for which there is a demand is PPO coverage. HPCs acknowledge that they would very much like to offer PPOs because it would help them draw in more employers; small-firm owners often want the flexibility of PPOs for themselves. But health plans are generally unwilling to make PPO coverage available through HPCs because they fear that they will become victims of adverse selection. For the most part, the health plans that once offered PPO coverage through HPCs are no longer willing to do so.

### ***A lower price than the “outside” market***

Initially, several HPCs were able to offer premiums that appeared to be somewhat lower than what small employers would have had to pay for comparable coverage if bought directly from health plans. With few exceptions, however, the price advantage of HPC products has disappeared.

Several factors may explain the lack of a price differential. It may be that health plans believed initially that HPCs might account for a large market share, and that they had to offer very good prices to avoid losing a major share of business to competitors. Once they saw that HPCs were not going to be major sources of coverage, they may have decided to keep HPC prices in line with their “outside” prices to avoid “competing with themselves.” It is likely also that the small-group market has gotten more competitive in general, with downward pressure on prices, so that there is less room to give discounts to HPCs. Finally, health plans may have offered lower initial prices to HPCs in anticipation of realizing administrative savings, which did not materialize.

It is also true that in a number of states the law prohibits health plans from giving discounts to HPCs for anything but savings in administrative costs. Plans cannot discount the medical claims component of the premium.

### ***A positive competitive effect on the market as a whole***

It is difficult to establish whether the existence of HPCs has altered the competitive environment because so many other changes were occurring at the same time HPCs were entering the market. No health plan we interviewed pointed to any particular changes that they had made in response to HPCs, but other observers did suggest that some policy changes could well be a reaction to HPC products.

Some HPC staff believe that when it became clear that the employee-choice model was attractive to employers, health plans responded by developing their

own multiple-choice products—for example, allowing individual employees to choose from HMO, PPO, and POS coverage options.

Some people associated with HPCs suggest that the ready availability through the HPC of price quotations for standardized products helps to promote vigorous price competition, since consumers can quickly and easily compare prices for essentially identical products. The comparison is probably relevant for health plans' non-HPC products as well, because plans are likely to keep the premiums for products sold outside the HPC reasonably in line with those for HPC products. They may be required to do so by rating laws, but even if not, they will probably want to do so because otherwise the HPC products will appear more attractive. Most health plans want to avoid that unfavorable comparison with their direct-sale products because they would prefer to sell the products outside the HPC, where they get the whole group rather than inside where they may get just some members of the group.

### ***A reduction in the number of uninsured workers and their families***

There is no compelling evidence that HPCs have had a major impact on the number of uninsured. Although quantitative evidence is difficult to find, the consensus seems to be that typically, though not always, HPCs attract about the same proportion of previously uninsured people as the small-group market as a whole. Although many of the legislators who supported HPCs hoped that they would substantially reduce the number of uninsured, that hope was probably unrealistic. In fact, the expectation would probably not have been realized even if HPCs had been more successful in lowering the costs of coverage. Most people who have studied the problem of the uninsured agree that large numbers will remain uninsured until the cost of coverage is reduced by much more than is possible through the kinds of reform represented by pooled purchasing arrangements and small-group insurance market reforms. For example, a recent research study concludes that for workers with incomes between the poverty level and 300 percent of that level—which is the income group that includes a disproportionate share of the uninsured—subsidies would have to equal between one-third to one-half of the premium in order to produce a substantial reduction in the number of uninsured. Even larger subsidies would be required to induce people at the bottom of this income group to purchase coverage.<sup>21</sup>

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<sup>21</sup> Mark Pauly and Bradley Herring, “Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance,” prepared for the Council on the Economic Impact of Health System Change conference, *Using Tax Policy to Reduce the Number of Uninsured*, December 17, 1999, p. 26.

Some HPCs contend that they serve a segment of the market that would otherwise likely be uninsured. A number of HPCs attract disproportionate shares of very small groups, those with five or fewer employees, including one-life groups. HPCs believe that without their presence, many of these firms might remain without insurance because health plans generally view them as high risk and would make little effort to insure them.

### *The context for measuring success*

HPCs have not captured a major share of the small-group market. The price of health coverage purchased through HPCs is generally not lower than the price offered elsewhere. The presence of HPCs may have had a modest effect in promoting greater competition among health plans in some areas, but HPCs have not transformed the nature of competition in any fundamental way. HPCs have not had much impact in reducing the number of uninsured people.

In view of this modest record, it would be easy to say that the HPC model is fatally flawed and that the creators of the concept were just in error when they thought it would work. But such a judgment would be too harsh.

The more sophisticated proponents of the HPC model never believed that HPCs, by themselves, were the solution to providing affordable health coverage for small employers. They understood that even under ideal circumstances, HPCs could not produce sufficient premium reductions to attract large numbers of uninsured people. They knew that economies of scale in administration and the ability to negotiate favorable rates required large scale. They recognized that risk pooling that would make premiums more affordable for higher-risk firms could not be done by HPCs on their own, but had to be created by insurance reform laws that applied to *all* small-group insurers.

These proponents were advocating for the HPC model at a time when comprehensive national health reform seemed likely. HPCs were seen as part of a larger reform package that would include key ingredients to make HPCs viable and to make the objectives set out for them realistic. In addition to changes in laws regulating the small-group insurance market, reformers were expecting mandates to ensure that everyone had health coverage and were anticipating that the federal government would provide subsidies to make coverage affordable for all Americans. The common assumption was that all employers would be required to pay for some portion of coverage (often in the form of a “pay or play” mandate) and that at least all small employers would be required to purchase coverage through something like a HPC. These ingredients were key parts of the Clinton administration’s health reform proposal and were commonly included in other proposals as well. In such a system, HPCs seemed to make real sense. If they became the vehicle for coverage for large numbers of

small employers—all of whom would now be required to provide insurance—they would be large enough to realize economies of scale in administration and to negotiate lower premiums. As a result, if small firms purchased through HPCs, the government funds used to finance subsidies would go farther because more of the money would be spent for medical expenses and less for administration and marketing.

These expectations regarding comprehensive health reform were, of course, not realized. Employers were not mandated to provide coverage. No subsidies were available for low-wage workers or marginally profitable businesses. Not even the smallest businesses were required to purchase coverage through HPCs if they decided to offer coverage at all. The results should not have been a surprise. As one of the founders of a successful HPC said, it was like having a recipe for a gourmet dish and then leaving out a high proportion of the ingredients. The resulting product was not very successful.

Although HPCs have not been as successful as hoped, it is important to recognize that they have also not been the failure that some critics, especially health insurers, claimed they would be. They have proved that it is possible to offer individual employees a choice of health plans without running up prohibitively high administrative costs. They have demonstrated that employee choice does not inevitably lead to major adverse selection problems among the health plans offering coverage through the HPC. They have shown that even in a market where participation is voluntary and no subsidies are available to small employers, HPCs can meet the health coverage needs of a significant number of small employers and their employees.

# Identifying Impediments to Success

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**W**hen we began our research we considered four broad categories of explanations for the limited success of HPCs, and when we actually looked at each HPC's experience, we tested the validity of a number of specific hypotheses. In the analysis that follows, we summarize our findings by grouping the specific hypotheses, along with some other findings, under the four broad categories.

*1. The small-group purchasing construct may simply not be as good in reality as it appears on paper; thus the liabilities or limitations of the construct may outweigh the potential gains.*

The present experience is probably not sufficient to fully test this proposition, yet it appears to contain elements of truth. Some of the expectations of the original proponents of the HPC concept have not been fully realized:

*1. Gaining market share has proved more difficult than many people anticipated.*

Small employers are not automatically drawn to HPCs just because they offer what proponents see as advantages over coverage purchased through normal channels. Devising effective marketing efforts is not easy and requires a major financial commitment. Health plans have not made vigorous efforts to promote products sold through HPCs, and only a few agents have tried to heavily promote HPC-based coverage.

2. *The potential for administrative savings is probably less than originally thought.*

This issue is discussed in more detail in the next section of the paper, but the basic point is that achieving substantial administrative savings requires that the HPC operate at a scale substantially larger than any of them have been able to do. In addition, some of the larger costs of serving small firms do not go away just because the administrative functions are centralized within the HPC.

- II. *The HPC concept may have been sensible when the idea was broached, but changes in the health care environment and economy may have made the idea less viable.*

Again, there is some evidence to support this proposition:

3. *Small-group insurance reform has made the market operate better and more fairly, accomplishing some of what reformers thought HPCs would do.*

In the eyes of many political supporters, HPCs and small group insurance reform had similar objectives—making coverage more affordable and making it possible for more small employers to get access to reasonably priced health care. Small-group reform has helped to achieve those objectives—by requiring health plans to offer coverage to all small groups, by ensuring portability of coverage, by eliminating excessive waiting times for coverage of pre-existing conditions, and by limiting the extent to which health plans could vary rates between low-risk and high-risk groups. Those reform efforts have been at least modestly successful in improving access and ensuring equitable treatment, though they have been less successful in bringing down the average costs of coverage.<sup>22</sup> These successes have probably reduced the pressure to develop HPC-like structures, though only HPCs can provide choice of health plans to individual employees.

4. *Premium increases have been much smaller than in earlier years, so employers are probably less likely to move away from the status quo, that is, to switch from their regular coverage to HPC coverage.*

Small employers are price-sensitive, but their sensitivity is reduced when price increases are small, as they were in the mid-1990s. If price is relatively stable and employers like their current health plan, they are not likely to be especially receptive to switching to something un-

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<sup>22</sup> See studies by Mark A. Hall, *Evaluations of Small-Group Health Insurance Reform Laws*, Wake Forest University School of Medicine, 1998, [www.phs.wfubmc.edu/insure](http://www.phs.wfubmc.edu/insure).

known like a HPC. If, however, premiums start to rise rapidly, as many observers think they will, the situation could change. (Between Spring of 1998 and Spring of 1999, premiums for smaller firms [3 to 199 workers] rose by 6.9 percent, compared to 5.2 percent the year before and 4.8 percent for all firms.<sup>23</sup>)

5. *Insurers now compete more vigorously in the small-group market, so some of the cost reductions HPCs hoped to promote have been realized without HPCs.*

Health plans have cut administrative costs (including lowering agent commission rates) and have tried to improve efficiency of medical delivery. These were changes HPCs hoped to accomplish, and to a considerable degree market forces have already produced that result, even in markets where HPCs are not a force.

6. *The attraction of the employee-choice feature may be diminished because managed care plans have overlapping networks of providers.*

When the HPC idea was first proposed, observers of the health system generally believed that the managed care market would be characterized by competition among a number of health plans, each offering its own network of carefully selected providers under exclusive contract and with unique plan philosophies and levels of utilization control. Had that vision become reality, HPCs' capacity to allow individual employees choice of plans would have been a real advantage: employees and their families would not have to change health plans and establish new relationships with providers every time they changed jobs or their employer changed health plans. But the market evolved differently. Health plans have generally sought to have very broad overlapping provider networks, which means that when people change health plans they may be able to retain their relationships with providers. And plans are probably less different in terms of philosophy, control of utilization, and so forth than many analysts expected.

On the other hand, having a choice of plans probably makes consumers more tolerant of some of the features of managed care. The intensity of the "managed care backlash" might be reduced if people felt that they had chosen the plan in which they are enrolled rather than being forced into it because their employer offered no options.

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<sup>23</sup> Jon R. Gabel et al., *Employer Health Benefits, 1999, Annual Survey, Executive Summary*, The Kaiser Family Foundation and Health Research and Education Trust, 1999, p. 3.

*III. The concept may be basically sound but has been poorly implemented.*

There can be no doubt that some of the problems HPCs have experienced are attributable to design flaws and mistakes in implementation.

*7. Flawed conception of role.*

For the most part, HPCs have been started not by entrepreneurs with a typical business orientation but by people with a social mission—the desire to improve coverage options for small employers. They have generally sought to make coverage as widely available as possible and have been committed to broad risk-sharing and the inclusion of high-risk groups in the risk pool. They hoped to encourage health plans to focus on improving both efficiency of delivery and quality of care. In some instances, this dedication to achieving desirable social ends appears to have contributed to policy decisions that hurt HPCs' ability to compete with the “outside” market. In particular, several HPCs were damaged by policies which made them victims of adverse selection.

The California rating law, for example, permits health plans to vary rates by  $\pm 10$  percent for health status, but the HIPC chose not to use health status as a rating factor. Several observers suggested that this contributed to some adverse selection for the HIPC, although the effects were not severe. Initially in Texas, the state law did not require guaranteed issue of any products, so TIPA did medical underwriting to accept or reject applicants. But TIPA used modified community rating to establish rates, whereas in the outside market, greater rate variation was the rule. TIPA experienced some adverse selection as a result, although our informants did not agree about how severe the problem was. In North Carolina, the HPC offered higher-risk groups fairly comprehensive coverage on a guaranteed-issue basis (though medically underwritten) when no outside insurer did so. As a result, higher-risk groups seeking comprehensive coverage flocked to the HPC. Several HPCs we studied were more willing to accept newly formed businesses than were insurers operating outside the HPC, thus making them more vulnerable to selling coverage to firms that may have been formed partly for the purpose of being eligible for HPC coverage.

The lesson to be drawn from this experience is that HPC designers and managers have to reconcile their commitment to a social mission with the realities of the marketplace. It is hard to succeed if the HPC's criteria for selecting and rating applicants are more liberal than those used by insurers in the outside market; the result will be adverse selection and consequent high medical claims costs. Health plans are likely to

respond in one of two ways: Where the law permits, they may raise the premiums for the HPC business to offset the higher claims costs, thereby making the HPC non-competitive for average- or low-risk business. Or if the law requires uniform rating inside and outside the HPC, health plans may withdraw from the HPC rather than take a loss on HPC business.

Another example of a conflict between achieving social goals and business success is the inclination of HPCs to seek out the business of very small groups, which are often shunned by insurers. For example, in both Florida and North Carolina, the HPCs made special efforts to serve these micro-groups, and they have drawn in a disproportionate number of employers in this size category. The problem is that the insurers believe (with some apparent justification) that these are higher-risk groups, with higher claims experience. Where permitted, health plans will respond by raising rates for the HPC; where not, health plans may withdraw from participation.

Finally, the sense of mission which many HPC leaders brought to their job often made them think of health plans as adversaries: as the purchaser for small employers, the HPC was to be on one side of the bargaining table and the health plans were on the other side as sellers. Although this is a valid role for the HPC, hindsight suggests that some HPCs could have been more sensitive to the concerns and needs of health plans. Sometimes because of lack of understanding about the way insurers operate, HPCs brought expectations or made demands that health plans were unable or unwilling to meet. HPCs sometimes also over-estimated their bargaining clout with health plans.

8. *Inhospitable insurance market reform rules.*

In some instances, HPCs were placed at competitive disadvantages, not by a misplaced sense of social mission, but by restrictions in the law. In North Carolina, for example, the small-group reform law required that only the basic and standard benefit plans be sold on a guaranteed-issue basis. This meant that these less comprehensive plans were the only option for high-risk groups. Since the HPC initially offered only the basic and standard plans, they attracted primarily higher-risk groups; the groups with better risk profiles bought more comprehensive coverage, which was not available from the HPC. Some agents told us the situation was exacerbated by practices of health plans: they did not actively market the basic and standard plans and discouraged agents from bringing that business to them; in effect, they channeled high-risk groups to the HPC. When the HPCs later got the authority to sell more

comprehensive “Select” plans, they had already established a reputation as “insurers of last resort.” Moreover, even though these HPC Select plans were medically underwritten, they were still the only comprehensive plans available on a guaranteed-issue basis. Thus, once again, the HPC drew a disproportionate number of higher-risk groups.

A different kind of reform rule has limited HPCs’ ability to negotiate prices. In most states (California is an exception) the rating rules prohibit health plans from giving HPCs a rate that is different from the rate established for non-HPC business except for differences in administrative costs. This restriction is designed to discourage HPCs from selecting good risks to keep premiums down, but it also gives them little bargaining room. They generally do not, for example, have the opportunity a large single employer has to try to get a “volume discount” even though they may represent a larger enrollment than most big single employers. This limitation created a problem for the Colorado HPC, which originally negotiated a multiple-year cap on premium rates as a cost-control measure. The HPC’s cost containment provision was voided when the law was interpreted to allow price negotiations over only the administrative component of premiums. In Florida, the situation is even more extreme: HPCs do not hold the contract with the health plans—employers do. Florida HPCs must also allow any willing health plan to participate. Thus Florida HPCs have nothing to bargain about; they have no influence on price at all, and they cannot exclude health plans. A corollary of this provision is that HPCs in Florida have no control over the commission agents receive for HPC sales. Commissions are determined entirely by the health plans, and they pay the commissions. This distances the agents from the HPCs and reduces HPCs’ opportunities to establish good relationships and create loyalties with agents.

Some of our informants questioned whether prohibitions or limitations on ability to negotiate prices with health plans was really a disadvantage. They observed that when HPCs have a small market share they just do not have much leverage to be effective bargainers. Moreover, even in California, where the HPC has flexibility to bargain and an enrollment of about 150,000, prices are currently not significantly different from the outside market—which suggests that bargaining is not very effective, though it may have been initially.

#### 9. *Structural and organizational impediments.*

The problems HPCs have experienced are not primarily structural or organizational, but some structural features exacerbate other problems. All the HPCs we examined in detail except COSE were initiated by gov-

ernment, being either an agency of government or a non-profit organization receiving the imprimatur of and/or start-up subsidies from government. While this link with government gave the HPCs some initial credibility and, in most cases, some start-up funding, our informants generally agreed that, on balance, the association with government hurt more than it helped because small businesses, and especially insurance agents, tend to be suspicious of government. Having an official role assigned by state law also produces a degree of inflexibility that makes it hard for HPCs to adapt quickly to changing circumstances. Frequently, they cannot change policies, once such a change is deemed desirable, without getting the law changed. That is difficult just in terms of the steps that have to be taken and the time required. But, in addition, because any such change is likely to be viewed adversely by some interest groups, there is almost always political opposition that slows down or thwarts the process. A wholly private organization that does not depend upon state law to define its role—as with COSE and the HPC of the Connecticut Business and Industry Association—can more easily change policies and redefine itself.

Two other HPCs—those in Florida and North Carolina—experienced another structural problem: there were too many HPCs established in the state (11 in Florida and 6 in North Carolina). Some knowledgeable people in Florida defended multiple HPCs, each with a local board, as helping to create local awareness and responsiveness. But the consensus was that the large number of HPCs caused difficulty in getting agreement on policies, duplication of functions, rivalries among HPC leaders, extra complications for health plans, and wasteful dissipation of resources that could have been better targeted to maximize enrollment. The validity of these arguments is demonstrated by the substantial consolidation that has occurred in both states. None of the states that had only one structure—including geographical large and diverse California—seemed to be at a disadvantage for having a single centralized entity.

*10. Inability to communicate effectively with, market to, and capture the attention of employers.*

Most HPCs acknowledge that HPC coverage is not an option that most small employers readily think of when they are contemplating purchasing coverage for the first time or renewing their coverage. Since the most effective communication with employers is through insurance agents, the problems between HPCs and agents (discussed in detail below) have hindered HPC marketing efforts. Some HPCs—the Texas

TIPA, for example—said their marketing budget was woefully inadequate; they did not have enough marketing money to become a viable competitor. Other HPCs (Colorado, for example) report that they did not think that difficulties in attracting enrollment were attributable to inadequate money for advertising and marketing.

One reason that employers may be a bit slow in recognizing the advantages of HPC-based coverage is that they are not the primary beneficiaries of HPCs' key feature—individual employee choice of health plans. *Employees* benefit from this choice feature, but *employers* make the decision about where to buy coverage. Small employer/owners can choose the plan they want for themselves without giving their employees choice.

*11. Leadership and staffing inadequacies.*

Leadership and staffing difficulties were evident in some HPCs, but they do not seem to have been a major cause of problems. HPC leaders and boards were sometimes inexperienced in the ways of health insurance and thus had unrealistic expectations or were not quick enough to pick up on emerging problems. These criticisms were expressed to one degree or another in Texas, Florida, and North Carolina, for example. But overall, the criticisms of HPC leaders were relatively mild, and in some instances, notably California, the leadership was praised as being forceful, effective, and far-sighted.

*12. Poor implementation of administrative functions.*

In general, administration of HPC functions did not seem to be a severe—certainly not a fatal—problem. There were initial administrative rough spots for some plan administrators, but they were generally ironed out relatively quickly. In Texas, the decision to have one of the participating health plans, Blue Cross, also serve as the plan administrator made competitor plans suspicious. They thought Blue Cross might gain some advantage as a result of its position as administrator.

*13. HPC products are not unique or do not match employers' needs.*

HPCs do offer a unique product: a structure that allows employers to offer employee choice of competing plans. This feature is not matched by any construct available through other sources, and virtually all our informants indicate that this feature is what attracts most employers to HPCs. On the other hand, one could argue that the fact that the proportion of employers choosing HPCs is small is an indication that employee choice is not compellingly attractive to many employers.

For the most part, HPCs offer only HMO coverage. The difficulties they have faced in getting health plans to offer PPO or POS options has hindered their ability to attract some employers. Health plans have been unwilling to offer these types of plans because they fear that when individual employees can choose among any health plan, the higher-risk individuals will choose the PPO or POS service benefit options because of the greater flexibility they offer, while the healthier employees will select the HMO benefit. Thus the health plans that offered PPO or POS coverage would become victims of adverse selection.

The effects of adverse selection could be offset by implementing a risk-adjustment system that would adequately compensate health plans that enrolled a disproportionate number of higher-risk individuals. Only the California HPC has a risk-adjustment mechanism in place, but it has proved inadequate to induce health plans to continue offering PPO coverage. When a PPO was an option, the health plan offering the PPO coverage was the recipient of risk-adjustment transfers, but they were insufficient to prevent the plan from withdrawing. Since the market trend seems to be moving away from closed-network plans toward plans offering more flexibility in provider choice, the inability to offer that choice may continue to hamper HPC enrollment growth. Whether this disadvantage can be overcome by development of an adequate risk-adjustment mechanism is uncertain.

We also heard some complaints that HPCs offered too few benefit options, particularly when they first began operations. Some HPCs reported that their initial offerings did not provide sufficient choice or that benefits were too limited or too generous to appeal to sufficient numbers of employers. This is something of a dilemma for HPCs: to make it easy for consumers to compare plans' relative value and to avoid unmanageable administrative complexities, the number of benefit options probably should be relatively small; but plans selling coverage outside the HPC will virtually always offer a larger number of benefit options and thus seem to provide greater flexibility. Health plans also like to be able to distinguish themselves by offering benefit packages that are slightly different from those available from competitors. So they are not enthusiastic about being forced to compete without the flexibility to tailor benefits to particular employers' needs.

*IV. Various forms of opposition and resistance from interest groups inhibit the growth of the small-employer purchasing cooperative movement.*

*14. Inability to get the right numbers and types of health plans to participate.*

15. *Unwillingness or failure of agents to adequately promote sales.*

As noted earlier, in devising the idea for doing this research, one of our major hypotheses was that HPCs were having difficulties because their mission conflicted with the interests of influential interest groups that did not want to see them prosper, especially health plans and insurance agents. Because we think the role of these two groups is so important, we give this detailed attention in the following two sections.

## **The Crucial Role of Health Plans**

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**H**ealth plans have a critical influence on the success of HPCs. Unless sufficient numbers of quality, “name brand” health plans are willing to participate initially and stay as partners with the HPC, success is unlikely. Given their inability to offer lower prices, the characteristic of HPCs that is most important in attracting small employers is their capacity to offer employees a choice of health plans. If the choice is very limited or does not include at least some of the largest and most prestigious health plans, the HPC will not be an attractive option to most small employers. Under such circumstances, an employer who chooses HPC coverage would, in effect, be forcing employees into plans that most do not prefer, as well as requiring many to change physicians and other providers. That would likely strongly displease employees, since the ability to retain their relationship with existing providers is the most important factor in consumers’ choice of health plans. If health plans that participate initially later pull out, the problems are similar: employers who chose to remain with the HPC could force some of their employees to sign up with new plans and new doctors. Such instability would deter many employers from staying with the HPC.

HPCs that opened their doors in the late 1980s and earlier 1990s were generally encouraged by the health plans’ response. Most HPCs found that major health plans were willing to participate. In Florida, 45 plans signed on as “accountable health partners.” The California HPC was able to persuade more than 20 plans to participate. The Alliance’s HPC in Denver offered a choice of 4 of the 5 major health plans in Colorado. HPCs in North Carolina, Texas, Connecticut, and most other states found sufficient numbers of willing health plan participants initially so that they were able to offer employers a meaningful selection.

In assessing this early experience, it is important to recall the political context of the times. The idea of pooled purchasing for small employers had real political currency. Influential and visible policy analysts like Alain Enthoven and

the “Jackson Hole Group” were articulate in their support of the concept as part of the theory of managed competition, and the idea was the subject of much debate and analysis. Politicians were attracted to it, since it seemed like a way to lower costs and improve choice without spending significant additional tax monies. The expectation that HPC-like entities would be part of President Clinton’s national health reform structure made state politicians receptive to the idea of “getting there first.” Several Governors—most notably Lawton Chiles in Florida and Ann Richards in Texas—were strong supporters of the HPC concept.

In addition, health plans were under attack for not serving small employers well. They were being criticized for practicing risk selection—for jacking up prices or doing whatever they could to avoid selling coverage to small businesses that might employ one or two high-risk workers or otherwise pose higher-than-average risk.

Being on the political defensive and under pressure to help small employers buy affordable coverage, many health plans were willing to participate, even if sometimes reluctantly or without enthusiasm (see discussion of Florida). The expectation that HPC-like entities might be a major, if not the exclusive, source through which smaller employers would buy coverage led other health plans to participate; they wanted to make sure that they would be in at the start and not have to try to catch up later after other plans had already captured a share of the market through this new vehicle for acquiring coverage. Still other health plans—particularly newly formed HMOs that were just entering a market and lacked an existing marketing structure and agent force—saw the HPC as a convenient entrée. Finally, some health plans (see discussion of Texas), felt that they had a social responsibility to participate in an experiment that offered the prospect of offering better service, more affordable prices, and enhanced choice for small employers and their workers. Even under these circumstances, some prominent health plans refused to participate (see discussion of California).

The conditions which led health plans to participate changed over the decade of the 1990s. President Clinton’s national health reform effort failed. Small-group insurance market reforms—which limited rate variation, required insurers to sell to all applicants, and increased portability—made the market work better for small employers. Some of the most supportive governors were replaced by successors who, while not opposed to HPCs, assigned no special priority to the HPC concept (as in Florida and Texas). These changes reduced the political pressures to participate. Other changes reduced the economic incentives. The prospect that HPCs would account for a large portion of the small-group market was not realized anywhere; so plans concluded that they could

market effectively to small groups without being part of the HPC. Perhaps most importantly, the competition among health plans became so fierce that margins eroded and health plans become intensely concerned with the bottom line. As a result, health plans began to focus on the most profitable portions of their business and drop those lines that were less profitable or had less potential to add to net revenues. The rapid consolidation occurring among health plans exacerbated these trends.

The consequences are what would be expected. Health plans that never liked HPCs pulled out. Those that were lukewarm supporters or participated only for defensive reasons left as well. Some plans that expected HPCs to be a major source of business for themselves were disappointed and left, and others realized that they could compete effectively without being in the HPC because it did not account for a large market share. Those that remained sometimes became more resistant to innovations that were supported by HPCs but were not viewed with enthusiasm by health plans (as in Colorado).

Of course, not all health plans responded negatively, since a number of HPCs continue to offer coverage from some of the best-known plans in their area. But the departure of health plans has hurt a number of HPCs—for example, in Texas, Florida, and North Carolina. Texas went from having as many as 20 to only one in a period of five years. The number of participating plans in Florida fell from about 35 initially to only 5 today, and none of these serves the whole state (although some of the reduction is due to mergers of health plans). North Carolina lost all but one of its original statewide carriers.

It is obvious that HPCs cannot operate without health plans, but it is hard to distinguish cause from effect: Do some HPCs fail to get and keep adequate enrollment because they do not have enough participating plans, or are they unable to attract sufficient numbers of desirable plans because they lack the enrollment to make health plan participation attractive or a competitive necessity? The answer is that both factors are at work. When health plans withdraw, for whatever reason, there are fewer health plan options from which to choose, so HPCs have a harder time attracting employers. But when enrollment falls off, health plans have less incentive to continue participating. Once the cycle begins, it is hard to stop, as the experience in Texas illustrates.

### ***Health plans' reservations about HPC business***

Although health plans' attitudes toward HPCs run the gamut from outright hostility to real support, most have some reservations about participating. Some plans that were initially hostile to the concept saw HPCs as a threat because, by pooling the purchasing power of many employers, HPCs give small employers the potential to have the kind of bargaining clout that large employ-

ers bring to the negotiating table when they buy health coverage. HPCs also force health plans to engage in head-to-head competition: in virtually all cases, participating plans have to offer standardized, identical benefit packages, so consumers can easily and accurately compare prices to determine relative value. Additionally, where HPCs have the authority to negotiate prices and select a limited number of plans (as in California), plans were initially under strong competitive pressures to lower prices.

Health plans, like most other kinds of businesses, prefer not to be forced into direct price competition (as is shown by the fact that health plans in Florida successfully opposed giving HPCs the authority to negotiate prices). One health plan representative illustrated this antipathy to competition very clearly in noting that he did not like the fact that the employee-choice provision of HPCs gives every employee the option of easily enrolling in a different health plan at each open enrollment period, as well as continually exposing each employee to co-workers who are enrolled in other plans. Those “disadvantages” are not present when a health plan enrolls a group outside the HPC.

Even some health plans that originally may not have been hostile to HPCs have been disappointed with aspects of their experience. Marketing to and servicing the small-group market is difficult and expensive for health plans because of the diseconomies of small scale. By centralizing many of the administrative functions, HPCs promised to reduce those diseconomies and lower the costs health plans incur in that market. But most health plans and HPCs agree that the promise has not been fulfilled. Most plans still perform many, if not all, of the administrative functions they always performed, for several reasons. First, plans often do not find it worthwhile to change their administrative structures—which can be a costly process—just to accommodate the small amount of business the HPC produces. Second, since much of their small-group business is sold outside the HPC, plans still must retain an administrative apparatus to serve those customers. Third, plans do not always trust the HPC’s administrator and so duplicate some functions to verify their accuracy. The fact that in several states the administrator was an organization that other health plans viewed as either a direct competitor (as in Texas) or a potential competitor (as in Florida) reinforced their conviction that they needed to duplicate some of the accounting functions.

In the end, many health plans seem to believe that participation with the HPC actually adds to their administrative burdens. It requires negotiation with the HPC, sometimes with staff who have not always been fully knowledgeable about the health insurance business or who have treated health plans as adversaries rather than partners. And it involves conforming to another set of insurance department regulations and exposing the plan to the possibility of

violating yet another set of rules, which differ from state to state (a concern of national companies).

Health plans often view participation in HPCs as exposing themselves to risks they would prefer to avoid. They complain about the employee-choice provision of HPCs partly for that reason. They say that if they enroll a whole group in the non-HPC market, they get the good risks along with the bad, thereby evening out their risk exposure. But employee choice creates the possibility that a plan will attract primarily the higher-risk employees. Plans such as PPOs, which are likely to appeal to less healthy people, have good reason to harbor such fears. But the fact is that virtually all health plans seem to think that *they* will be the victims of adverse selection (even though if one plan gets a disproportionate share of bad risks other plans necessarily get a disproportionate share of good risks). For most health plans, the fear of being the victim of adverse selection seems to outweigh the prospect of being the beneficiary of favorable selection.

In some states, health plans acted in ways that almost ensured that HPCs would get a disproportionate share of high-risk groups. Informants told us that some health plans attempted to channel high-risk business to the HPCs, often by conveying the message to agents that they would not look favorably on agents who sent the health plan “bad” risks. One interpretation of such actions is that health plans saw this as a way of ensuring that they could share the risk with other health plans, since with employee choice in HPCs, the individuals in higher-risk groups might choose coverage from several different plans. Another interpretation is that health plans sought to cause the HPC to fail as a competitor by, in effect, making it a high risk-pool.

In pursuing their social mission to serve employers who would otherwise have had difficulty getting access to insurance, HPCs have sometimes reinforced the health plans’ fears. HPCs have occasionally used marketing tactics (as in HPC newspaper advertisements in North Carolina) that conveyed the message that employers who have not been able to find coverage anywhere else should come to the HPC. This kind of appeal really scared health plans, especially before the days of laws requiring that all small-group products be provided on a guaranteed-issue basis.

Health plans complain most bitterly about the higher-risk profiles of the very small “micro groups” that a number of HPCs (Florida and Colorado, for example) have attracted in large numbers. Health plans say that these groups of one, two, and three employees incur substantially higher medical claims per capita than larger groups. They view these groups as behaving similarly to people in the individual insurance market: plans think that micro-groups often buy coverage when someone in the group needs expensive medical care and that they then drop it after the care is delivered. Turnover among such groups

tends to be very high also, which exacerbates the marketing and administrative diseconomies of serving them.

The requirement that health plans serve micro groups is normally a consequence of a state's small-group reform laws rather than a specific requirement related to HPCs; so plans would legally have to serve such firms even if there were no HPC. But because these micro groups are often disproportionately concentrated in the HPC portion of the market, health plans tend to associate the problem with HPCs. Some HPCs, as in Florida, have seen it as part of their social mission to reach these very small employers because they have not been well served by the traditional market. Health plans generally would not make efforts to serve these micro groups, and many plans probably believe that they could avoid attracting many of them, especially since agents have minimal incentives to sell to such firms because the commission (in absolute terms) is so low relative to the cost of serving the firm. The HPCs' willingness to serve these tiny groups and to give them good service counts as a measure of success for HPCs, but it counts against them in terms of health plans' worries about adverse selection.

Concerns about adverse selection have deterred health plans from continuing to offer PPO coverage through HPCs. Several HPCs offered PPOs initially, but they have all withdrawn (except in the case of COSE), presumably because they were the victims of or feared becoming victims of adverse selection. (The strong consensus is that people who anticipate needing medical services find especially attractive the flexibility of provider choice that PPOs offer.) In California, even the presence of a risk-adjustment feature was not sufficient to keep PPOs as participants. The lack of PPO offerings has limited HPC enrollment: among small firms, the owner is typically the person who decides on the type of coverage, and owners often want PPO coverage for themselves; if the HPC does not offer a PPO, an owner with this view will not select the HPC.

Because health plans are very concerned about the exposure to risk that participation in HPCs creates, one would expect health plans to urge HPCs to develop an effective risk-adjustment mechanism. But health plans seldom even mention risk-adjustment as a possible solution to their concerns. Perhaps they have little faith in HPCs' ability to develop a system that will accurately adjust for risk differences among plans. But it is also important to note that plans generally do not look with enthusiasm on mechanisms that involve plan-to-plan transfers. In part that may be because administering the system may require that an outside agency scrutinize health plans' internal accounting and strategically sensitive business information. In any case, only the California HPC had a risk-adjustment mechanism in place, and it did not provide large enough transfers to keep PPOs in the system.

### ***Future health plan participation***

What are the prospects for future participation of health plans with HPCs? Recent experience is not especially encouraging. Efforts to start a HPC in Kansas in 1999 were set back because only one plan responded to an invitation to participate. New York City's successful effort to initiate a HPC in 1999 produced four willing health plan partners, but some of the prestigious plans whose participation the HPC sought declined.

Given the very intense competition in the current market, health plans, even non-profit plans, are likely to continue to participate only if participation makes good business sense. Decisions are less likely to reflect some philosophical position or views about social responsibility and are more likely to be based strictly on business considerations. In the absence of strong political pressures, plans are likely to participate only if it is more profitable in the long run to stay in than to get out. If they do not ultimately get substantial enrollment that *they would otherwise not get*, or make higher profit margins on the HPC business, plans are likely to opt out. The fact is that many plans view the HPC as a competitor. They suspect that they would have gotten the same amount or even a larger amount of business if they did not deal with the HPC. Without the HPC, for example, they might have enrolled the whole group rather than the one or two individuals who might choose to sign up with their health plan.

This skeptical attitude toward HPC participation is likely to be especially strong among investor-owned insurers, but even the non-profit health plans know that they have to be businesslike. Concern for social mission has to be balanced with the need to be competitive in a fiercely competitive market.

The real issue here is market share: if HPCs accounted for a significant share of the small-group market, health plans would feel compelled to participate. But that raises a dilemma: HPCs cannot attract and retain the best insurers, achieve significant economies of scale, and negotiate lower premiums without market share. Yet HPCs cannot achieve large market share without attracting and retaining the best insurers, offering lower premiums, and achieving economies of scale.

## **Agent Hostility to HPCs**

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**O**ne of the original objectives of HPCs was to make coverage more affordable by reducing administrative costs. Agent commissions, as a major component of administrative costs, were a particular target because they represented a significantly higher proportion of per-enrollee premi-

ums for small businesses than for large businesses. Many HPC proponents held the view that the size of agent commissions was out of proportion to the services agents provided. Many also believed that it was possible to eliminate agents from the process by having employers buy directly from the HPC. They concluded that, by centralizing marketing, sales, and services activities and by exploiting up-to-date technologies, HPCs could perform the same functions at lower cost.

This view found its way into the structure of several HPCs. Both in Texas and California, for example, employers were given an option: they could use an agent and pay an agent commission (at a rate lower than what agents typically received for sales in the small-group market), or they could buy coverage directly from the HPC without a commission fee or the use of the services of an agent. Not surprisingly, most agents reacted with great hostility to this reform, seeing it as a threat to their livelihood. Even where agents retained their role as the sole distribution source for HPC coverage—as required by law in Florida and as implemented in Colorado, for example—they reacted with hostility. They were aware that many HPC proponents would have preferred to build a system that eliminated agents from the distribution process. The agents' fears about the threat posed by HPCs were reinforced by the provisions of the Clinton Administration's national health reform proposal, which was widely interpreted as a takeover of the industry that would entirely eliminate the role of agents.

Agent hostility has been fueled by a policy which virtually all HPCs have adopted: the elimination of the role of "general agents." These general agents traditionally received "override" commissions for recruiting, training, and managing agents. Because they are influential in the agent community, their antagonism toward HPCs has had an influence out of proportion to their numbers.

It is interesting to note that several efforts to market HPC-type products without the use of agents seemed to have created less backlash than in the instances just noted. The Long Island HPC and COSE both started their activities without using agents, and there seemed to be little negative response from the agent community. The COSE example may be anomalous because of the close relationship with Blue Cross, which did not use agents. Yet it is perhaps noteworthy that neither of these entities had any connection to government; they were entirely private efforts. In contrast, where the agents responded most negatively to HPCs, the HPCs all had some level of endorsement from government. It is probably harder for agents to attack efforts that threaten their incomes when the initiative is taken by a totally private-sector entity: that is likely to be viewed as "fair" competition and the consequence of "impartial"

market forces. There is no one that can be identified to which blame can be assigned.

HPCs quickly discovered that they could not successfully market their products without agents and brokers.<sup>24</sup> Even in California where employers could save by foregoing the services of an agent, only about 30 percent bought coverage directly from the HPC. The remaining 70 percent or so chose to use the services of an agent and to pay the extra cost of the agent's commission. Most small employers depend heavily upon agents for advice and recommendations about health insurance coverage. (In many cases, these agents already sell other kinds of insurance to the business.) Without a benefits staff and lacking the time, resources, or inclination to research such a complicated area on their own, small employers rationally look to agents for help in making coverage decisions. And they also like the idea of having the agent on call to help resolve coverage and claims disputes, which are likely to be more important and more frequent under managed care. Agents report that when they do sell HPC coverage, they, not the employers, normally suggest the HPC as an option.

The lessons from the early HPC experiences were clear: HPCs cannot do without agents. HPCs involved in direct sales also discovered that the cost of performing functions that agents previously performed was higher than expected. Savings were not large.

HPCs now universally recognize that they must cultivate agents if they are to be successful in penetrating the small-group market. Offering a superior product is not sufficient to bring in employers in any volume. A number of HPCs target much of their advertising and marketing to agents rather than to employers. They know that they have to depend upon agents as the vehicle for attracting business, and they have changed policies to make the HPC more attractive to agents. The California HPC, for example, eliminated the cost advantage employers could realize by buying directly from the HPC: employers now pay the equivalent of the agent commission whether they buy directly or through an agent. In addition, the agent fee no longer appears as a separate item on the employer's premium invoice. Other changes have also been made to placate agents.

Almost all HPCs have made vigorous efforts to educate and recruit agents and to make it more attractive for them to sell HPC products. Many, for example, have raised the commission that they pay so that it is equal to or even higher than what insurers typically pay, especially for the very small employers. (It is

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<sup>24</sup> Only COSE was able to market products without the assistance of agents, but that was largely due to the fact that the dominant health plan had always operated without agents and even now uses agents only for groups with 10 or more employees.

important to note that most insurers now pay lower commissions in the small-group market than was the case when HPCs first came on the scene.)

These efforts to appeal to agents have been successful in overcoming some of the hostility, but not all. The proportion of agents who sell more than just a few HPC contracts is quite small everywhere. Some agents, however, have overcome their reservations about HPCs and recognize that HPCs represent an opportunity for them to distinguish themselves from other agents and to make money by promoting the HPC's products. Most HPCs identify a handful of agents that sell the HPC product in large volume and are enthusiastic about the income they generate by promoting the HPC. Their enthusiasm is reinforced when the HPCs reward them by directing queries from potential customers to the successful agents. Such agents note that the retention rate for HPC sales tends to be higher than for other kinds of coverage, which makes it possible for the agent to derive income without having to do as much work. Agents also report that employees with HPC coverage complain less than those with other forms of coverage, because they themselves chose the health plan in which they are enrolled. As a result, the agent has to do less work to service the account.<sup>25</sup>

Although a few agents are enthusiastic supporters of HPCs, a vastly larger group of agents remain hostile or at least indifferent to the HPC and do not sell HPC products in any volume. It remains to be seen whether HPCs can bring more agents over to their side. The more astute agents may be concerned that if the HPC begins to account for a substantial share of the market and thus becomes widely known in the employer community as a good source of coverage, the temptation to cut out the agents could reappear. On the other hand, agents with such foresight may foresee that innovations like the Internet and electronic commerce are likely to bring changes in their role that could be even more profound.

In any case, it seems clear that at least for the foreseeable future, HPCs will face a real challenge in trying to persuade agents to vigorously promote the HPC among their small business customers. If HPCs do not succeed in that effort, they will not be able to capture a large share of the small-group market. Agent indifference may be as damaging as agent hostility.

### ***Summary***

Implicit in some of our original hypotheses about the lack of success of HPCs was the view that some opponents were “out to get” HPCs—that they actively sought to cause HPCs to fail. That may have once been the case, for some

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<sup>25</sup> Wicks and Kurtz, 1998.

health plans and insurance agents in particular. But although agents and health plans play a crucial role in explaining the lack of HPC success when measured in terms of market share, this result now seems less the consequence of malevolence than just lack of motivation to actively support HPCs. With some important exceptions, neither agents nor health plans anticipate any large benefits from participating with HPCs. They do not need to oppose them. They just do not need them.

# Future Prospects

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Interest in HPC-like entities remains high. State legislators seek ideas about how to make them work effectively, and Congressional proposals for Health Marts and Association Plans are still on the table. Is this wishful thinking, or is there unrealized potential in the collective approach to purchasing coverage for small employers and perhaps individuals as well? This is the issue we now explore.

## Can HPCs Offer Lower Premiums than the Outside Market?

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One of the promises initially made for HPCs was that they could make coverage more affordable for small employers. This expectation was based on the observation that small employers, on average, paid much more for coverage than large employers. Proponents believed that HPCs could help to bring small-group prices more in line with large-group prices. In light of the limited success that HPCs have had in delivering on this promise, it is important to examine the validity of the original notion. What is the reasoning that would support the view that HPCs can lower costs? If they have the power to negotiate, what can they do with this capacity?

We noted earlier that the savings cannot come from having the HPC pool risks on its own. Unless the HPC excludes high-risk groups, which is inconsistent with basic design principles, the pooling that produces lower costs for higher-risk employers and individuals has to be a product of small-group reforms that require *all* insurers and health plans to pool risk. If a HPC tries to accept all applicants (putting them into one risk pool), while health plans operating outside the HPC do not, the HPC will become a high-risk pool and not be viable.

One possible source of savings is that HPCs might have lower administrative costs. Early proponents of HPCs noted that the administrative component of premiums was much higher for small groups than for large groups. One reason was that agent commissions were higher. Moreover, there were diseconomies of scale associated with the fact that each insurer had its own apparatus for marketing, selling to, and servicing small employers. The argument was that if these administrative functions could be centralized in the HPC, the administrative component of the savings could be reduced significantly.

The reality has been somewhat different from the expectations. The proportion of the premium that goes for administration has not generally been much different for coverage sold through the HPCs than for products sold directly by health plans. In part, this reflects a change in the small-group market. As it has become more competitive, insurers have sought to reduce administrative costs by streamlining their administrative apparatus in general and by paying lower commissions to agents. So there is not as much “fat” for HPCs to cut.

The relatively low enrollment that HPCs have attracted has also prevented the realization of some expected administrative savings. Insurers have often not found it cost-effective to modify their administrative apparatus for the low volume of sales they get from the HPC. So they continue to perform the same administrative functions for this business as they do for their other small-group business, often duplicating what the centralized HPC administrator does. They also duplicate the functions because they often do not trust the administrator to give them timely or accurate data—for example, to match eligibility with premiums to make sure that someone who has not paid premiums is immediately made ineligible for coverage, which is especially important when providers are capitated and paid per enrollee. If HPC sales accounted for a large part of a health plan’s business, health plans might find it worthwhile to change their administrative functions, and with time, they might learn to trust an effective administrator. But so far, that has not been the case. Thus, because health plans’ administrative costs are not reduced appreciably, the premium they offer to the HPC is higher than might have been expected.

HPCs have also found that centralizing administrative functions has not provided the economies of scale expected, which again is partly a reflection of volume but partly a reflection of the fact that it will always be more expensive to serve 1,000 firms with five employees each than to serve one firm employing 5,000 workers. In addition, a firm of 5,000 employees will assign staff people to manage benefits. They perform some of the functions that an agent (or the HPC itself) does for small employers, so the cost is internalized rather than being built into the premium. HPCs have found that centralizing the functions that

agents and brokers perform is not always less expensive than paying the level of commissions that are now typical in the small-group market.

If HPCs' scale of business were large enough, the centralized administrator could replace some of the marketing and administrative functions now done by each individual insurer. But even then, so long as the health plans still have a substantial portion of the small-group business outside the HPC, they cannot completely eliminate the fixed costs associated with the administrative functions for this part of their business.

Finally, HPCs have sometimes taken on administrative functions that did not exist before—for example, running a risk-adjustment mechanism. While not expensive, there is some addition to administrative costs associated with the new tasks.

Thus, with respect to reduced administrative costs as a source for lower premiums for HPC, the reality is likely to continue to be that savings, if any, will be small so long as HPCs account for a relatively small share of the small-group market.

Proponents of HPCs also believed that high-volume HPCs could persuade health plans to provide medical services more efficiently—for example, to offer more managed-care products to small employers or otherwise reorganize delivery to improve efficiency. But the potential here again seems limited. In the highly competitive market that exists in most places today, health plans already have strong incentives to improve efficiency to reduce costs for both the small-group and large-group market, and they have probably done most of the relatively easy things to further that objective. Managed care plans, for example, are now readily available to most small groups (which was not the case when the HPC idea first attracted the interest of analysts and policymakers). It seems unlikely that HPCs could identify many new sources of efficiency that health plans have not already considered, let alone persuade health plans to undertake them.

A third cost-saving possibility is that HPCs might get “volume discounts,” as large employers have done in the past. They could use their negotiating clout to bargain for more favorable rates. There are several troubling aspects to this argument. In the first place, HPCs have not had sufficient volume to give them much bargaining power. But even if they did, the reason for giving discounts is not clear. It assumes one of four things:

1. Health plans are making “pure profits” (profits beyond a reasonable return on investment) that the HPC could capture. Pure profits are present only when a market is not highly competitive; but that does not seem to be the case in the small-group market, at least not any longer.

2. If there is sufficient volume, health plans will feel compelled to sacrifice profits—perhaps selling at a price that is below average costs but covers marginal costs—to avoid losing the business entirely to a competitor. That may be valid reasoning for the short-run, but in the long-run, a health plan cannot offer a discount that is not ultimately reflected in lower costs. One possibility is that with a larger share of the market, a health plan might be able to negotiate larger discounts with *providers*. But health plans in many markets seem to believe that they have largely exhausted their capacity for squeezing provider prices further. (Most analysts believe that there are further provider inefficiencies still to be eliminated, but it may be that these inefficiencies are so grounded in prevailing medical practice patterns that they are difficult to eliminate merely through pressure on provider prices.) Another possibility is that if the volume is large enough, the business can still be profitable with lower profit margins. And it is also possible that if the average cost is lower because the fixed costs are spread over a substantially larger volume of business, prices can be lower without reducing profit margins. But it is doubtful that HPCs can promise that level of volume in the near future.
3. HPCs could receive a better price because the enrolled groups represent employers of below-average risk. At least to this point, this has not been the case—generally the contrary has been true. But even if it were true, it would almost certainly be a consequence of practices that deter higher-risk groups from joining the HPC. Such practices, however, are contrary to the spirit of HPCs and the intent of small-group reform laws.
4. A health plan might give a discount to a large HPC buyer if the plan could shift the losses to some other payers by charging them more. Whether such cost-shifting is still a possibility in a market where most buyers are now negotiating premiums and are generally unwilling to pay other than “their own” costs is questionable. But even if it were possible to cost-shift, would this be justifiable from the standpoint of good social policy? Probably not.

In sum, it seems that there is not much likelihood that HPCs will be able to offer significantly lower prices than are available outside the HPC. In part this is because the small-group market has become competitive, and in some states, the presence of a HPC may have helped to speed up the evolution to a more competitive market. This picture could be changed, however, if HPCs were to account for a large share of the total small-group market, as discussed below.

# What Might Be Done to Make HPCs More Successful?

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## *The justification for promoting HPCs*

Before discussing how to make HPCs more successful, it is important to consider whether there is justification for promoting them. We have already suggested that HPCs are not likely to lower premium costs dramatically, and that means that they are not the solution to the problem of the uninsured. Any cost reductions they achieve will, of course, help at the margin, but for many of the uninsured, coverage will become affordable only if the net cost they pay is reduced by much more than any savings HPCs might hope to achieve.

A major benefit that HPCs provide to small firms and their workers is choice of health plans. Giving small-firm workers a choice among competing health plans is feasible only through some entity like a HPC. About two-thirds of workers now have choices of health plans,<sup>26</sup> but choice is least common among smaller firms. Americans value having options, for good reasons: increased choice leads to better matching of individual preferences with the various characteristics of insurance (benefits, price, style, etc.) and to greater consumer satisfaction. The prevalence of managed care reinforces the value of choice. Even though managed care plans have overlapping networks of providers in many areas, the overlap is not complete. So, without HPCs, some small-firm employees will be forced to change providers when they change jobs or their employer changes health plans—not a desirable outcome in the minds of most consumers. Moreover, as noted earlier, the employee-choice feature, which allows individuals to compare prices and value among competing plans, can help encourage competition and, ultimately, improve health plan performance.

There is another set of circumstances which might justify promoting HPCs. A number of people who are seeking ways to remedy the problem of the uninsured are considering public policies that would either provide incentives for or require consumers and employees to buy *individual* health coverage. In addition, some large employers, most notably Xerox,<sup>27</sup> are considering alterations in their health benefits policy that would move in the direction of giving employees fixed-value vouchers and letting them choose to buy coverage either

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<sup>26</sup> Jon R. Gabel, "Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny," *Health Affairs*, Vol. 18, November/December, 1999, pp. 62-74.

<sup>27</sup> Based on a talk by Patricia M. I. Nazemetz, Vice President, Human Resources, Xerox Corporation, at the Robert Wood Johnson Foundation conference "The Employer-Based Health Insurance System: Repair it or Replace it," Washington, D.C., November 22-23, 1999.

from the company plan or elsewhere. If this trend to replace defined benefits with defined contributions caught on, the result could be that many more people would be buying coverage in the individual market. The inefficiencies of marketing, servicing, and administration that are characteristic of the small-group market are magnified in the individual market. Moreover, the potential for individuals to be confused by the complexity of choices and misled by questionable marketing practices is very great. A strong case could be made for having individuals use HPCs as their source of coverage. The HPC could provide reliable, understandable information about quality, benefits, and costs, thereby simplifying and making manageable the decision-making task. Moreover, some administrative savings would almost surely be realized by centralizing some of the sales and servicing functions.

In considering the possible role of HPCs in serving people purchasing individual coverage, it is worth reiterating the point made earlier about the small-group market: the terms under which the HPC accepts people seeking insurance cannot be any more liberal than those that are used by insurers generally if the HPC is to avoid becoming a victim of adverse selection. To be more specific, a HPC cannot accept individuals on a guaranteed-issue basis unless all insurers must do so.

### *Options for promoting HPCs*

If HPCs deserve to be encouraged, what can be done?

There is nothing much wrong with HPCs that having larger market share would not cure. Their biggest barrier to success is not being big. This may seem like a tautology—the equivalent to saying that HPCs could be successful if they were just successful. But it is not quite the same. It is more an issue of critical mass. If HPCs commanded a significant market share—say, 15 percent or more of the relevant market—they might accomplish the following things, each of which would help to attract more small employers:

- They would be better able to get prestigious, high-visibility health plans to participate.
- They would have more leverage in negotiating with health plans, which might have a favorable effect on coverage costs, as well as giving small employers influence on issues related to quality of care, customer service, and so forth.
- They would achieve greater economies of scale in their own administration, and health plans would realize greater internal administrative savings, both of which should reduce costs of coverage.

- They would be more visible and thus more likely to be seen as an attractive option for small employers, and they could better afford to develop effective marketing efforts.

### **Actions HPCs might take**

The challenge, then, is to identify ways for HPCs to increase market share to some critical mass that brings them to the level where they realize these advantages. The lesson from current experience is that HPCs can do some things better to attract more customers. They can vigorously court, educate, and reward insurance agents, since small employers depend very heavily upon agents for advice about coverage and plan selection. They can focus their marketing efforts in areas where the payoff in terms of increased enrollment is likely to be greatest. They can attempt to do more to accommodate the needs and preferences of health plans. They could consider including insurance agents or health plans on an advisory panel or even on their boards to draw on their knowledge and help create a sense of partnership (this feature is part of the proposal for Health Marts).<sup>28</sup> To accommodate the insurers' concerns about micro-groups, they might (as is being done in Florida) consider eliminating the employee-choice feature for these very small groups.

To one degree or another, these steps would have the HPCs succeed by having them operate more like the outside market. One of the lessons learned from the experience of existing HPCs is that they cannot succeed if they depart dramatically from the practices of health plans generally with respect to rating practices, willingness to accept high-risk groups, relationships with agents, product design, design of administrative apparatus, and so forth. COSE provides a good example of an organization that has been successful by being much like the outside market. But this poses a fundamental dilemma for HPCs: if, in order to succeed, they have to become essentially like the outside market so that they offer little that is unique, how can they justify their existence? To use the Florida example, if micro-groups are no longer to have the option of employee choice, what is unique about buying coverage from a HPC?<sup>29</sup> Or if insurers and agents, who are sellers, are to be part of HPC governance, how can the HPC any longer claim to be representing the interests of purchasers, that is, the small employers and their employees? Why, for exam-

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<sup>28</sup> For a discussion of this idea for governance as well as a more thorough discussion of Health Marts and other collective purchasing arrangements for small groups, see Elliot K. Wicks and Jack A. Meyer, *Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?*, National Coalition on Health Care, Washington, D.C., May 1999.

<sup>29</sup> Some defenders of this policy argue that providing good service to these very small employers—who are generally not well served by agents and insurers in a non-HPC market—is a valuable role that no one else except HPCs will fill.

ple, would agents or health plans support aggressive HPC efforts to negotiate a lower premium, since the result would be lower revenues for them? There may be certain features of HPCs—such as, employee choice and arms-length relationships with health plans—that are so fundamental that they cannot be compromised without jeopardizing HPCs’ reason for being.

It is worth reiterating that many of the problems HPCs face would go away if they could reach critical-mass enrollment levels. Some of the compromises they are tempted to make to woo agents or placate health plans would not be necessary if they were larger. The dilemma, of course, is to achieve that size without making excessive compromises. This leads to consideration of possible public policies that might help HPCs reach that objective.

### **Public policy options**

If policymakers were to decide that HPCs should be promoted, they have several options, which involve increasing degrees of political difficulty.

One option would be to permit health plans to sell small-group coverage *only* through a HPC. Currently, plans cannot follow this strategy because doing so would violate guaranteed-issue provisions of HIPAA and various state laws. If a health plan could satisfy its obligation to offer its products on a guaranteed-issue basis by marketing exclusively through a HPC, the health plan could avoid much of the administrative cost of serving this market. It would not have to duplicate any of the HPC functions. This provision would make the HPC especially attractive to health plans that do not yet offer small-group products but which would like to enter that market or to those that are willing to offer coverage but do not want to invest many resources in this market.

A second option would be for state lawmakers to mandate that as a condition of offering coverage in the small-group market, insurers and health plans must agree to participate in a HPC in that state. They could be permitted to sell coverage outside the HPC, but they would be required also to sell through the HPC. This would ensure that HPCs could offer coverage from the most prestigious plans and would guarantee that people would have a real choice of plans. The cost to the government of such a reform would be minimal compared, for example, to an approach that subsidizes coverage purchased through a HPC.

A requirement that plans participate might not accomplish the desired objectives in states without fairly restrictive rating rules because a recalcitrant insurer could offer HPC coverage but at a price sufficiently above its “outside” price as to deter any HPC buyers. Imposing this requirement might also induce some health plans that are on the margin about staying in a state to withdraw entirely. Finally, political reality suggests that if all plans have to participate, the HPC will be required to offer all health plans. But in that case, the admin-

istrative burden could be high, and consumers could be confused by too much choice. To solve this problem, the requirement could be that the mandate to participate would apply only to health plans that account for more than some percentage of the small-group market or perhaps the 15 or 20 health plans with the largest market share. (There are precedents for this kind of mandate: in New Jersey, health plans that sell health insurance in the state must either also participate in the individual insurance market or absorb a portion of the losses incurred by insurers that do serve this market.)

A third, more far reaching, approach would be to require that *all* coverage for small groups be sold through a HPC. To make this more manageable, it might be sensible to define small groups in less encompassing terms—perhaps all firms with 25 or fewer employees. In addition to the advantages of the previous approach, this reform would almost certainly reduce health plans’ administrative costs substantially because plans would not need to have a separate administrative apparatus to serve “outside” customers of the same size.

Again, this option poses the problem that a HPC could be forced to deal with a large number of insurers, which would add appreciably to administrative costs. Moreover, unless there was considerable standardization of benefit packages—which would meet with resistance from some insurers and consumers—the number and complexity of choices facing consumers could be daunting. (Again, New Jersey provides a precedent for this kind of limitation: only six benefit plans are available in the small-group market.) There is one further problem with this approach—and to some degree, with the previous approach: the requirement that plans participate takes away one of the tools HPCs sometimes use to negotiate more favorable deals with health plans—the ability to exclude health plans and thus deny them access to a portion of the market.

A fourth option is a policy that is aimed at achieving a different social purpose but which would indirectly benefit HPCs: a requirement that all employers that offer coverage give employees a choice of health plans. Support for such a policy could be expected from people who have been critical of some of the cost-control practices of managed care plans and who believe that a way to protect people from abuses is to give them a choice of health plans. Mandating that employers offer a choice of plans would make HPCs very attractive to small employers, since other approaches to offering multiple choice are likely to be burdensome and expensive for small firms. A less intrusive policy that would have a similar but smaller effect would be for the federal government to give

preferential tax treatment to employers that offered employees a choice of health plans.<sup>30</sup>

Although such approaches will be seen by some as undue government intrusion into the market, it is important to understand that insurers would still compete with one another for business as they do now. They would just have to compete by appealing to individual employees rather than to employers and insurance agents. This would still be very much a market approach—different from the present primarily because the competition would take place exclusively within the HPC. Our research suggests that competition could be even more effective in such a system because the HPC structure makes accurate plan-to-plan performance comparisons easier for consumers.

The benefit of mandating plan participation is that it ensures the HPC can offer a variety of plans and, with the second approach, virtually guarantees enrollment. Such guarantees pose a problem, however: a HPC may become complacent without competition and may not provide adequate levels of service. This argument points toward allowing more than one HPC to operate in a market, since competition encourages good performance. But most HPCs are not-for-profit organizations; sometimes the law requires that structure. It is not clear that there are strong incentives to establish competing non-profit HPCs. This might be an argument for letting for-profit entities operate as HPCs. However, few entrepreneurs have shown much interest in starting HPCs, probably because the profit-making potential seems uncertain. But the incentives might be different if the HPC were assured of getting plan participation and a significant number of employers.

In any case, it is clear that states would need to define carefully what kinds of organizations could qualify as a HPC and how they could operate. Probably the greatest danger is that HPC-like organizations will find ways to risk-select—that is, to draw off the better risks and to exclude the higher-risk groups. Because the financial incentives to avoid high-risk groups and individuals are very strong, especially if HPCs are allowed to be for-profit institutions, policymakers need to focus on ensuring that this does not happen. Such a result would set back a variety of reforms that have been designed to prevent risk segmentation.

A fifth policy option would be to temporarily subsidize employers for buying coverage through a HPC—for example, by giving temporary tax credits sufficient to make HPC-based coverage noticeably less costly than coverage bought directly from health plans. The justification would be to get the HPC to the

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<sup>30</sup> The authors are indebted to Sara Singer of Stanford University for suggesting these two policy options.

critical mass size so that it could attract desirable health plans, achieve administrative savings and other economies of scale, and sell coverage at reduced prices. Experience shows that once employers choose HPC coverage, they are likely to retain it, so “getting them in the door” appreciably enhances the prospects of success. However, any system of subsidies would have to be carefully crafted. Subsidies would have to be phased out in a way that would not cause employers to experience sudden large coverage cost increases. And there are the usual difficult problems of balancing the need to treat employers equitably with the need to avoid wasting money subsidizing employers that would have bought HPC coverage without the subsidy.

A sixth option for helping HPCs attract health plan participants is available to states or even larger municipalities: they could stipulate that health plans will not be considered as potential contractors to cover public employees unless they participate in the HPC.<sup>31</sup> Florida included a provision similar to this in HPC legislation, and Kentucky went even further and pooled small employers with state and municipal employees, although this provision was later overturned by the legislature.

## Lessons for Collective Purchasing Arrangements — HPCs and Others

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The interest in HPC-like structures continues. As noted earlier, proposals for Health Marts and Association Plans continue to get attention in Congress, and state legislators periodically show interest in promoting something like HPCs as a way to address problems that remain in the small-group market. Although these other forms of collective purchasing may differ in some important respects from HPCs, they are likely to be sufficiently similar to make the experience with HPCs relevant. As they contemplate these options, policy makers can benefit by reviewing the lessons learned from the HPC experiments already underway. Some of these lessons about collective purchasing arrangements for small employers are summarized below:

- Collective purchasing arrangements (CPAs) cannot attract significant numbers of the uninsured unless the net cost of coverage to the uninsured is substantially below the current market price. Without substantial subsidies to the uninsured, net cost reductions will almost surely not be achieved.

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<sup>31</sup> For elaboration on this idea, see Linda Blumberg and Len Nichols, *Health Insurance Purchasing Cooperatives: Design Choice, Success Criteria, and Early Performance in Four States*, Urban Institute Working Paper 06571-006, April 1999.

- CPAs' potential for lowering the cost of coverage relative to the outside market is limited because (1) the outside market has become quite price competitive, so there is less room than there once was for price reductions based on volume discounts; (2) most components of administrative costs cannot be eliminated or substantially reduced in the current market structure; and (3) savings that might be realized by pooling only lower-risk groups conflict with the widely accepted social objective of spreading risk broadly.
- If CPAs are to achieve their potential for reducing costs, they must attract a substantial market share and reach the "critical mass" that allows them to realize economies of scale, attract major health plans, and achieve high visibility.
- CPAs offer advantages unrelated to price: (1) choice of health plans for individual workers of small employers, which may be important in helping relieve the "managed care backlash;" and (2) a willing and readily available source of coverage for employers sometimes not well served by the outside market, particularly "micro" groups. These features, however, may create adverse selection problems for CPAs, making it more difficult for them to remain price competitive.
- In the long run, CPAs cannot remain viable if they choose to or are required by law to follow premium rating rules or rules for accepting applicants that are significantly more permissive than those that apply in the outside market. If they follow such a course, they will attract higher-risk groups and incur higher claims costs, and the result will be either that health plans will decline to participate or that premiums will be forced higher, and then lower-risk groups will leave.
- CPAs' potential for success depends to a high degree on being able to attract and maintain participation of at least several well-known and well-regarded health plans. Thus, CPAs need to be as accommodating as possible—without sacrificing fundamental principles—in addressing the concerns and meeting the needs of health plan participants.
- It is very difficult to successfully market CPAs to small employers without the support of insurance agents. Small employers rely heavily on agents in selecting health insurance. Agents are quick to view CPAs as a threat and to use their potent political strength and persuasive powers to oppose CPAs.
- In a voluntary market, where employers are not required to offer coverage and no one is required to use CPAs, there is a tension between achieving success in terms of gaining market share and achieving social objectives.

CPAs that make the most effort to accommodate the needs and preferences of agents and health plans are most likely to gain market share. But these efforts may so compromise the distinctive features of CPAs that they become little different from the rest of the market and serve no unique social purpose.

- Even if major health plans participate in a CPA, it is difficult for the CPA to achieve substantial market share so long as the health plans also sell outside the CPA. Health plans view this situation as competing against themselves, and they always prefer to sell outside the HPC since they then get the whole group rather than just some of the individuals in the group. This reduces risk and increases revenue.
- CPAs sponsored by private organizations already known and respected by the business community are more likely to succeed. CPAs sponsored by or affiliated with government may gain some initial credibility and political force by having the imprimatur of government. But that advantage has to be weighed against the disadvantages: less flexibility to change, the distrust of government common among many small employers and agents, and vulnerability to the charge of interfering with market forces.
- CPAs may be an appropriate vehicle for providing coverage for people who need subsidies to make coverage affordable, especially if the subsidy approach encourages people to seek coverage in the individual market. However, the approach must be structured to ensure that CPAs do not become victims of adverse selection.
- Even if CPAs remain small, they can serve an important function by developing innovations that serve as examples for the rest of the market and by providing information that makes the market more competitive and makes it work more smoothly.

## Summary

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HPCs have not succeeded in achieving the objectives that many policymakers had in mind when they supported the laws that initiated them. They have not brought prices down appreciably for small employers, and they have not by themselves done much to reduce the number of uninsured people. It would be easy to jump to the conclusion that HPCs have failed and do not deserve further support. But that conclusion would be unwarranted.

What the experience with HPCs, small-group market reforms, and other incremental policies underscores is that there is no quick fix for the problems of

small employers and the uninsured generally—at least none that does not require more extensive interventions than we as a society have yet been willing to make. HPCs have not caused prices for small employers to fall noticeably, but they have given individual small-firm employees what they did not have before—the opportunity to select a health plan that matches their needs. Even if HPCs had been as successful at bringing down premiums as the most optimistic supporters hoped, that would not have been sufficient to bring all or even most small-firm employees under the insurance umbrella. Short of mandating coverage or giving large subsidies to employees or employers, nothing is likely to *solve* the problem of the uninsured. In the meantime, if we are unwilling to take these more dramatic steps, a case can still be made for incremental reforms, including public efforts to promote the growth of HPCs. Doing so could help them achieve objectives that meet real social needs, including realizing savings that would help in a marginal way to reduce the numbers of uninsured.