
Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage for Individuals and Small Employers?

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I. Executive Summary

Health insurance purchasing arrangements — variously called connectors, exchanges, pools, and health insurance purchasing cooperatives (HIPCs) — are viewed by some policymakers as a key component of proposals to reduce costs and expand coverage. Proponents argue that allowing small employers and/or individuals to purchase health insurance through these arrangements will achieve several objectives, including: 1) reducing health insurance premiums by increasing pooling; 2) increasing choice of plans; 3) simplifying shopping; and 4) increasing competition.

This report evaluates whether health insurance purchasing arrangements can meet the objectives noted above, drawing on experience with previous government-sponsored purchasing arrangements and our knowledge of the functions and limitations of pooling in insurance markets. We conclude that government-sponsored purchasing arrangements will not meet the objectives contemplated by legislators.

Specifically, we find that these purchasing arrangements:

- **Will Likely Increase Health Insurance Premiums:**

Contrary to the goal of these proposals, past experience has shown purchasing arrangements increase premiums by as much as 6 percent by:

Duplicating Administrative Functions Now Performed by Other Entities:

Health insurance purchasing arrangements duplicate functions performed either by the state insurance department, health plans, or insurance agents or brokers. Previous research has found that most purchasing agencies had higher administrative costs by adding, not substituting, administrative responsibilities. In some instances, costs were 2 to 4 percent higher because of added administrative costs alone. For example, when purchasing agencies take on enrollment functions, insurers must continue their own enrollment functions to assure appropriate services, claims payment, etc.

Turning the Group Market into an Individual Market: Most purchasing agency proposals envision creating a marketplace whereby individuals, not employers, select coverage from a menu of approved options. This effectively converts a group market into an individually purchased market. An individual market is more expensive to administer and causes premiums to increase because of adverse selection. In these purchasing arrangements, each person — instead of the group — is selecting a health plan based on their own expected need for benefits, which drives up costs.

Failing to Address the Root Causes of Rising Costs: Health insurance purchasing arrangements do not impact the key factors that have driven cost increases over the past decade, such as provider reimbursement rates, utilization, increases in chronic illnesses, cost shifting from public programs to private payers and new technology. Purchasing arrangements primarily focus on rearranging how individuals and small employers buy coverage — creating new methods for distributing coverage — without addressing the underlying cost trend issues.

- **Will Not Increase Pooling of Health Insurance Risk:**

One of the most common misperceptions about purchasing arrangements is that they will increase risk pooling. In reality, these arrangements will not increase pooling because:

States Already Require Insurers to Pool: Pooling already occurs in the small employer market as a result of state small group reform laws that require insurers to pool all small employers and limit the variation in premiums that can be charged. Insurers participating in purchasing arrangements retain all of the health insurance risk of the groups they enroll, and the purchasing entity itself typically assumes the role of a distributor of coverage. Thus, the pooling of risk actually occurs at the insurer level.

Purchasing Arrangements Will Not Lead to “Economies of Scale”: Proponents of these arrangements sometimes claim they will give small employers and individuals the same clout as large employers. In reality, pooling thousands of independent small employers or individuals together does not create the dynamics of a “single” large employer and costs will always be higher because of administrative differences and adverse selection. Moreover, most of the health care premium dollar goes directly to payments for health care providers. It is important to understand that when insurers negotiate payment rates with providers, they negotiate on behalf of all their members — individuals, small groups, large employers and federal and/or state employees. Thus small employers are already enjoying “economies of scale” by being able to take advantage of the favorable provider reimbursement levels insurers have negotiated for their entire product portfolios: large group, small group and nongroup members.

- **Will Provide Limited Choice of Plans:**

Past experience indicates that purchasing arrangements often provide little choice of plan type for two reasons:

First, under most proposals, a state or federal agency — and not the marketplace — would decide what coverage could be offered, thus limiting the diversity of products available to those specified.

Second, adverse selection within individual choice arrangements often limits plan choices to highly managed plans. For example, these entities may provide a choice of different HMOs, yet do not offer popular broad-access PPO products consumers have demanded over the last decade. When PPOs were offered through these arrangements, they were often forced to withdraw their products as they attracted a disproportionate population of high-cost members.

II. Introduction

Policymakers have proposed a wide variety of alternatives to expand health insurance coverage to small employers and individuals. One component of many of these proposals is the establishment of new purchasing arrangements to distribute coverage to individuals and small employers, commonly referred to as “purchasing pools,” “connectors,” “exchanges,” or Health Insurance Purchasing Cooperatives (HIPCs).

Despite the various terms assigned to these purchasing arrangements, their core functions are generally indistinguishable and include: 1) marketing and disseminating plan information; 2) distributing coverage and overseeing plan enrollment; and 3) collecting and managing money flow from employers or individuals to plans.¹ While there may be a tendency to view these entities as “new” arrangements, they share many functions with state purchasing cooperatives which have proved to be disappointing as they failed in their primary goal of lowering premiums.

Proponents of these arrangements argue they will help individuals and employers access health insurance coverage, reduce the cost of coverage, facilitate individual choice among competing plans offered by the arrangement, decrease the number of uninsured, control adverse selection, and reduce administrative costs. Some proponents view these arrangements as structures for implementing a system based on expanding the individual market, the downside of which is that this would result in replacement or “crowding out” of existing employer-sponsored coverage by coverage offered through the arrangement, particularly in the small group market.

The objective of this paper is to evaluate whether health insurance purchasing arrangements are likely to achieve the goals of proponents. We begin with a discussion of how employees of large employers, small employers, and individual purchasers are pooled today in the health insurance market. Importantly, we address common misperceptions attributed to the purchasing arrangements noted above and evaluate their potential impact, if any, on those seeking coverage in the small group and individual markets.

¹ Wicks, Elliot K. 2002. The Commonwealth Fund, Health Insurance Purchasing Cooperatives.

III. How Pooling Occurs in Today's Health Insurance Market

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Pooling of risk is fundamental to insurance and exists in all types of insurance offered today.
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Purpose of Pooling

Pooling of risk is fundamental to insurance and exists in all types of insurance offered today. Insurers combine, or “pool,” large numbers of groups/individuals to obtain a stable and measurable block of business for which expected future claims can be predicted with some degree of accuracy and to offer favorable rates. Without pooling, the pricing of insurance premiums would be nearly impossible to determine accurately, resulting in significant increases in some years followed by significant decreases in other years, based on individuals’ claims experience.

There are a number of key factors that generate dissimilar claims costs within different pools:

Market Segment: The nongroup versus the group market as well as the small, mid-size or large group markets;

Rating: Rules which vary in the degree to which they permit insurers to consider certain risk factors when setting premiums; and

Risk Differences: Within a market segment, carriers may segment experience based on variables including network differences, benefit design, and the state of the insured.

The key objective of pooling is to spread the risks of each individual among all members of the pool with the goal of establishing stable rates over time. A health plan must have a sufficiently large and balanced pool of risk to offset the costs of very high cost claims during the year. Healthier individuals with little or no expected health care costs subsidize the costs of the high-cost persons in the pool, generating more stable and affordable premiums for all in the pool.

To achieve this goal, the pool must attract enough relatively healthy people to offset health care costs incurred by sicker individuals. When this balanced cross-section of risks is lost, the insurance pool becomes increasingly skewed to those with higher claims, thereby increasing premiums. This phenomenon is commonly known as “adverse selection” and illustrates the point that a large pool does not necessarily translate into lower premiums. Pools created for reasons other than obtaining health insurance, such as employment, are typically less likely to experience adverse selection.

How Does Pooling Occur Today?

In this section, we review how pooling occurs today in the large employer, small employer, and individual health insurance markets. Pooling occurs in each of these markets, perhaps to a larger extent than many people realize, but in different ways. These differences are important to understand before we turn to the question of whether purchasing arrangements affect pooling of health insurance risk in such a manner that would benefit small employers and individuals while ultimately reducing the number of uninsured.

Large and Mid-Size Employer Groups

Large employer groups generally maintain a pool consisting solely of their own experience. Many large employers “self-fund” their insurance — that is, they assume the risk for their employees’ health claims, purchasing only stop-loss coverage to protect against individual catastrophic claims and/or much higher-than-expected overall claims. These groups tend to have more than 1,000 employees. In general, membership in such pools is automatic, with almost all eligible employees participating in the pool due to the large premium subsidies typically provided by the employer.

Because of the significant subsidy employees of these large employers receive, they are more likely to remain in the insurance pool, rendering the pool more cohesive. In addition, most members of these pools are actively working and are thus less likely to incur high health care costs. Therefore, the costs associated with any less healthy individuals in the pool are offset, or subsidized, by the significant number of healthy individuals in this particular type of pool.

This combination of large premium contributions offered by the large employer, the high degree of participation, the cohesiveness of the pool, and the significant number of relatively healthy individuals yields more affordable premiums than those found in other segments of the health insurance industry, such as the small employer or individual markets.

Small Employer Groups (Generally 2-50 Employees)

It is a common misperception that small employers do not currently enjoy the benefits of pooling. Even prior to the small group reforms that began about twenty years ago, there was a substantial amount of pooling in this market. The post-reform market requires even a greater amount of pooling. As a result of state small employer health insurance reforms, health plans are already required to pool all of their small employers together for rating purposes. While the magnitude of pooling varies by state, there are some general common themes: each insurance company must pool the experience of all small employer groups when developing premiums. Each small group’s rates are based on the overall experience of this pool, adjusted to reflect the composition of the group as allowed under state law.

State small employer health insurance reform laws limit the extent to which premiums for small employers can vary due to many factors. Some states limit rate variations due to demographic factors, such as age and gender, industry, group size, and area. Other states limit the amount of variation associated with the aggregate morbidity present in any specific group.² Under these rules, insurers are not allowed to charge premiums outside of

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Health plans are already required to pool all of their small employers together for rating purposes.

² According to the National Association of Health Underwriters, 37 states have enacted some version of the 1993 NAIC small group rate reform which provided for variation due to morbidity to be $\pm 25\%$ from a midpoint rate, with some additional variation provided for between classes of business. Thus, the widest range for the entire pool would be $\pm 35\%$. Another 10 states have adopted even more restrictive rate reforms by not allowing any variation attributable to morbidity. Hawaii and Virginia have not adopted any reforms, although Hawaii has an employer mandate for employers over a certain size, Pennsylvania has adopted rate regulations that apply only to HMOs and Blue Cross and Blue Shield Plans, and the District of Columbia reforms are limited to prohibiting differential premiums among members of a group based on health status. National Association of Health Underwriters, State-Level Individual and Small-Group Market Health Insurance Reforms February 2006. <http://www.nahu.org/legislative/market%5Freform/indsgmktreformschart.pdf>.

these ranges. Therefore, healthier groups, whose costs would fall below this range, are forced to provide an increased cross-subsidy to less healthy groups than may have been present prior to reforms. Conversely, groups whose costs would fall above the range are enjoying increased subsidies by healthier groups. Thus, these reforms spread the medical costs of all small groups more evenly to generate more affordable premiums for groups with unhealthy members. However, this resulted in higher premiums for the healthiest groups. In a voluntary market, it is the healthiest groups that are most critical to maintaining a sustainable pool; these same groups are the most price-sensitive and therefore most likely to leave the market.

While these reforms force cross-subsidization in the small employer market, they have not lowered overall premiums and may have had exactly the opposite result. The small employer market is more expensive than the large group market due to a combination of adverse selection and significant price sensitivities among very small firms. Combining these characteristics makes it difficult to maintain a stable and consistent pool of small employers since the many different groups comprising the pool are free to enter and leave their existing insurance pool for an alternative insurer.

It is also difficult to attract and maintain healthier groups and members required to realize stable premiums. Very small groups behave more like individual purchasers and may not offer coverage if the costs of coverage outweigh the perceived benefits. Moreover, small employers may not make coverage available because they do not believe their workers could afford to purchase coverage if offered or because the business cannot afford to offer coverage itself.³

Thus, in order to maintain a viable small group market, adequate premium variation must be permitted to encourage the healthiest groups to participate while cross-subsidizing costs incurred by less-healthy groups. States have tried to balance the need to attract healthier-than-average small groups with the need to protect firms with sicker-than-average workers from substantial rate increases. These rating limitations create an environment where significant pooling occurs already within the existing small employer market.

Individuals (Nongroup Market)

Individual coverage is also pooled. Individuals who join health insurance pools do so for the sole purpose of purchasing health insurance coverage and generally do not receive premium subsidies from a third party such as an employer and generally do not enjoy tax benefits to offset the cost of coverage unless they are self-employed. These individuals are not related in any other manner, such as employment. For this reason there is no natural cohesiveness holding the “group” together which can result in adverse selection which is a major concern in the nongroup market. Similar to the discussions in the previous sections, for any pool to be sustainable, there must be a sufficient number of healthy individuals to subsidize the unhealthy individuals. Also, since individuals are much more cognizant of their own health status than an employer would be for the aggregate status of all of their employees, individual insurance is much more susceptible to adverse selection. There is every incentive to employ a “just in time” principle for purchasing

insurance in the individual market if there are no disincentives precluding this. By “just in time” we mean waiting to purchase insurance until an individual has a known need for services, then purchasing the insurance and dropping it once the need has been satisfied. No pool can be sustained in the long run if this is allowed.

In the nongroup market, the primary tool available to insurers to preclude adverse selection and attract enough healthy individuals to subsidize the sicker individuals who have purchased insurance previously is maintaining relatively affordable premiums. Where allowed, insurers employ medical underwriting (the process of identifying and classifying the risk represented by an individual or group) with the goal of providing maximum coverage at the lowest premiums. However, as the effects of underwriting diminish, the overall cost of the pool is likely to increase. To maintain stable overall premiums within the pool, insurers must continue to enroll enough new, healthy individuals to subsidize premiums for remaining pool members.

As noted earlier, the claims experience of all individuals covered by an insurer are pooled. Each individual's rate is based on the overall experience of this pool, adjusted as permitted under state law; most states permit rating adjustments for health status at time of initial underwriting, though such adjustments may be limited. Most states permit insurers to reject high risk individuals to avoid adverse selection and keep premiums as affordable as possible.

In markets that permit medical underwriting, an individual's premium will generally not increase based on changes related to their own health status once they are accepted for coverage. This pooling creates cross-subsidies between the healthy and sick within the insurer's pool.

Some states prohibit underwriting and require insurers to community rate their products and therefore do not permit variation in premiums based on demographics or health status. While this form of pooling provides for increased cross-subsidies compared to pools where such variation is allowed, it can lead to higher overall premiums that discourage enrollment of young and healthy new individuals to subsidize older, sicker subscribers. This form of adverse selection can result in deterioration of a market over time to the point where premiums are out of reach for many consumers.

In order to avoid such deterioration of the market, 35 states have created high-risk pools as an alternative means of pooling coverage for individuals unable to obtain coverage in the individual market due to pre-existing health conditions. The medical costs associated with these pools are very high as the individuals who join these pools often suffer from chronic conditions that result in significantly higher-than-average claims. These pools typically limit premiums to 150 percent to 200 percent of the premiums for a standard risk individual. However, these premiums are insufficient to cover the medical and administrative expenses of this population and additional funding is usually required to cross-subsidize high-risk pools.⁴

This discussion demonstrates there is significant pooling in the current nongroup market.

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For any pool to be sustainable, there must be a sufficient number of healthy individuals to subsidize the unhealthy individuals.

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⁴ Comprehensive Health Insurance for High-Risk Individuals, Twentieth Edition, 2006/2007, published by National Association of State Comprehensive Health Insurance Plans. The combined premiums for all 33 high risk pools in operation in 2005 were \$951 million; total costs were \$1.576 billion, or a loss ratio of 166 percent. This means that for every premium dollar, the high risk pool incurred \$1.58 in claims and administrative costs.

IV. Purchasing Arrangements

Policymakers have attempted to make lower premiums available in the small group and individual markets by creating entities to facilitate the purchase of insurance coverage by small employers. This section of the paper examines these alternate purchasing mechanisms to determine their potential for delivering lower premiums to small employers.

HIPCs

More than a dozen states have enacted state-sponsored purchasing entities, generally referred to as Health Insurance Purchasing Cooperatives (HIPCs) during the 1990s. These HIPCs contracted with multiple insurers to offer benefit plans to employees of small employers. The HIPCs performed a number of administrative functions, such as contracting with insurers, marketing, and enrollment. They did not assume insurance risk; the risk remained with the insurers offering coverage through the purchasing arrangement.

Proponents argued these arrangements would provide lower-cost health insurance for a variety of reasons, including:

- Collective purchasing power would increase competition within the marketplace;
- Administrative costs would be reduced through savings from economies of scale with one entity (the HIPC) providing many of these services; and
- Allowing employees to choose from multiple health plans could stimulate competition by encouraging employees to make cost-conscious choices.

However, the state-sponsored HIPCs formed in the early 1990s were unable to attain these goals. It is well-established that HIPCs failed to offer premiums lower than premiums employers could obtain outside of the purchasing arrangement.⁵ Premiums were typically higher due to additional administrative functions, particularly in HIPCs that allowed employees to select among multiple health plans.

Most of these purchasing arrangements never achieved a significant market presence because they failed to offer better rates, the key factor influencing purchasing decisions in the price-sensitive small employer market. For example, one study found that among employers that offered coverage in three states, only 2-6 percent of eligible employers purchased coverage through a purchasing pool.⁶ Most government-sponsored purchasing cooperatives were disbanded because they failed to offer better value for small employers. This is illustrated in the chart below, which updates a table we prepared in 1999 when more state-sponsored purchasing cooperatives were in operation.

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Most government-sponsored purchasing cooperatives were disbanded because they failed to offer better value for small employers.
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⁵ Long and Marquis, 1999; Long and Marquis, 2001; Wicks et al., 2000; Yegian et al., 2000.

⁶ Long and Marquis, 2001.

State-sponsored Health Insurance Purchasing Cooperatives Failed to Attract Substantial Enrollment⁷

STATE	HIPCS ACTIVE AS OF SEPT 1999	ELIGIBLE EMPLOYERS	REGION	ENROLLMENT	MARKET SHARE	STATUS AS OF 12/31/2007
California	Health Insurance Plan of California (<i>renamed PacAdvantage</i>)	2–50 Employees	Statewide	8,200 employers; 144,000 people (1999) – 9,000 employers and 147,000 people (2002)	2% (1999)	Disbanded in 2006
Colorado	Colorado Health Care Purchasing Alliance	Any size	Statewide	1999: 1,350 employers, 18,000 members (<i>only 11,212 were from small employers</i>)	2% (1999)	Disbanded is 2002
Florida	Florida Community Health Purchasing Alliance	1–50	Statewide (<i>8 regional groups</i>)	Peak: 92,000 (1998)	5%	Disbanded in 2000
Montana	Community Health Options	2 or more	None listed	Not available	N/A	Disbanded (<i>date unknown</i>)
New Mexico	NM Health Insurance Alliance	2–50	Statewide	1,036 employers; 5,200 people (2002) 5,600 enrollees as of 1-08	2% (1997)	In operation
North Carolina	Caroliance	Fewer than 50	Statewide	Peak: 1,100 employers; 5,000 people	1.6% at peak	Disbanded in 2000
Texas	Texas Insurance Purchasing Alliance	2-50	Statewide	Peak: 1,000 employers; 13,000 people	1%	Disbanded in 1999
Utah	Care of Utah	2-50	None listed	Not available	N/A	Disbanded (<i>date unknown</i>)

Connector/Exchange Proposals

Policymakers have turned their attention towards the health connector or exchange model. The Commonwealth Health Insurance Connector enacted in Massachusetts in 2006 is the most publicized program. Similar proposals have been introduced in 15 states and Washington State adopted health insurance exchange legislation in 2007.

Although proposals vary somewhat from state to state, connectors and exchanges are similar in form and function to health insurance purchasing cooperatives. They negotiate with insurers to offer specified benefit packages to individuals and small groups. Individuals and employees would purchase coverage directly from the connector. The connector would market coverage, collect premiums, enroll individuals, and determine whether they would be eligible for subsidies when subsidies are made available through the connector.

Some advocates view connectors as a vehicle to de-link health insurance coverage from employment.⁸ Certain connector proposals could create incentives for employers to transition from providing coverage directly to employees to simply financing individual coverage.

⁷ Harrington, Timothy and Bender, Karen, Review of Health Insurance Purchasing Cooperatives, September 15, 1999; additional data from interviews with health plans; Wicks, Elliot, Health Insurance Purchasing Cooperatives, Commonwealth Fund Issue Brief, November 2002; Wicks, et. al., Barriers to Small Group Purchasing Cooperatives, Economic and Social Research Institute, March 2000 (market share percentages); January 2008 enrollment figures for the NM Health Insurance Alliance: New Mexico Human Services Department.

⁸ Heritage Foundation, 2007.

Employers play a critical role in organizing and paying for coverage in today's market. Any proposal that moves away from employment-based benefit pools, which tend to be the most stable risk pools, would have negative consequences.

In some proposals, subsidies would only be available through the connector, which might cause some employers to stop sponsoring coverage and move people into a connector where groups would be broken up and each individual would select their own coverage, resulting in fragmentation that could undermine the pooling that occurs in today's employer market.

Any proposal that moves away from employment-based benefit pools, which tend to be the most stable risk pools, would have substantial trade-offs. Employers play a critical role in organizing and paying for coverage in today's market. Employers contributed an average of 84 percent of the premium for single coverage and 72 percent of the premium for family coverage in 2007.⁹ If employers cease to provide benefits, it may be difficult to provide the same level of public subsidy to these individuals over the long-term. With lower subsidies, fewer people will likely purchase coverage. Moreover, moving people into an individual marketplace would actually increase the administrative costs of providing insurance, could undermine the pooling that occurs in the market today, and exacerbate adverse selection problems.

The basic functions of connectors are the same as HIPCs. A "primer" for state officials on insurance connectors and exchanges developed last year by AcademyHealth asserted that connectors are materially different from HIPCs because connectors/exchanges do not assume any risk for the products being offered.¹⁰ We dispute this particular assertion; we are not aware of any state-sponsored HIPC that assumed direct insurance risks for the products offered.

Connectors may be proposed along with a host of other initiatives to assist the uninsured that may make it difficult to assess the impact of the purchasing arrangement itself. For example, in Massachusetts, there are a number of factors that could alter the cost of insurance that will be difficult to separate from the core connector/exchange function of distributing health insurance. These additional factors include:

- Mandates to purchase coverage, which could force lower-cost individuals and firms who previously decided not to buy insurance to enter the insurance market;
- Subsidies available only through the Connector, which creates an incentive to purchase coverage through the Connector for those eligible for subsidies;
- Merger of the individual and small group markets, which would likely reduce premiums for individual purchasers while raising them for small employers; and
- Only allowing the sale of new products for young adults through the Connector and not on the open market, which would give the Connector a pricing advantage for this relatively low-cost population.

It may take years to assess whether the Massachusetts Connector, absent subsidies or other market changes, will reduce costs or increase them. Individuals have enrolled in the Connector only since July 2007. Assessing the impact on the small employer market will take even longer because access is not yet open to small employers.

⁹ Kaiser Family Foundation HRET, Employer Health Benefits: 2007 Annual Survey.

¹⁰ Lischko, Amy, Health Insurance Connectors & Exchanges: A Primer for State Officials, AcademyHealth, September 2007.

FEHBP Buy-In Proposals

Some have proposed to improve affordability of health coverage for small employers and individuals by creating a new program based on the Federal Employees Health Benefits Program (FEHBP) or state employee programs. As under FEHBP, the new program would likely have a uniform, national set of benefits and would be administered through the Office of Personnel Management (OPM) — or a similar entity — which would negotiate program rates and premiums.

Under these “buy-in” proposals, we expect small employers would form a separate pool under a federally or state-sponsored program. The average age and risk composition of the government employee workforce, generous benefits, and other factors will likely preclude a viable program under which small employers and individuals actually buy into government employee risk pools. Thus, we assume that when people talk about FEHBP or state employee “buy-in,” they are actually suggesting programs modeled after these government programs.

These “buy-in” proposals would function much more like a health insurance purchasing cooperative than a single employer health benefit program. The FEHBP is relatively stable because it is available only to federal workers and retirees who have a substantial reason to participate because the government subsidizes about three-quarters of their premiums. In contrast, these “buy-in” proposals would be voluntary arrangements that would be prone to adverse selection. In other words, more costly firms may see an economic benefit to switching from their current coverage to the FEHBP-like pool, driving up costs for the pool.

Government buy-in arrangements are unlikely to result in economies of scale precisely because they are not a single employer benefit plan, but would be open to thousands of independent small employers or individuals. As a result, these programs would tend to have much higher unit costs due to the additional administrative expense involved in marketing, enrolling and servicing all of these independent entities.

Moreover, some buy-in proposals would exempt health plans participating in the program from state laws regulating health insurance coverage and benefits. If enacted, such proposals could create two sets of rules for the same market. Consequently, when two sets of rules are in place for a given market, market segmentation and adverse selection are likely results.

Rating rules are one example of this phenomenon. States with strict rating laws such as New York or Maine, which prohibit small group rating adjustments for health status or age, would allow carriers participating in the new program to offer preferential rates to employers with the youngest, healthiest workers. Rates for state-regulated small group insurance would subsequently increase, a consequence that would be repeated and worsened over time, threatening the viability of the existing small group insurance market in those states.

The long-term impact of these proposals would depend on the rules included and other factors. As we explain in the next section, the core “pooling” function of these FEHBP buy-in proposals is unlikely to have much impact on costs for small employers and individuals.

Association Health Plans

Federal policymakers have also proposed legislation that would allow small employer groups to band together to form “association health plans” or “AHPs.” This legislation would encourage the formation of federally certified AHPs by exempting these plans from various state laws that govern health insurance now sold to small employers today. The goals of this proposal are to allow small groups to obtain the purchasing power of large groups, provide more choices to these groups and lower premiums.

One major difference between this proposal and most other forms of purchasing arrangements mentioned in this report is that most federal AHP proposals would exempt associations from state laws, including rating laws, consumer protection standards, and benefit mandates. Creating one set of rules for AHPs, while leaving the state-regulated market with more comprehensive rules, would create significant adverse selection issues. Under the AHP proposals, small firms could opt for AHPs when they do not need the protections of state law and then jump back to state-regulated coverage when workers become ill to obtain lower rates.

In 2003, National Small Business United (NSBU) engaged us to analyze the “Small Business Health Fairness Act of 2003” (H.R. 660 and S. 545).¹¹ Our analysis concluded that AHP legislation would have a detrimental impact on small employer premiums, especially for firms with high-cost workers, and would cause more small employers to drop coverage, thereby increasing the nation’s uninsured population.

We found that once federal AHP legislation was fully implemented, health insurance costs would increase by 23 percent for small businesses in the state-regulated insurance market. This increase would result from AHPs’ ability to attract healthier-than-average firms out of the insured state-regulated market. AHPs’ exemption from mandated benefits would allow them to tailor products attractive to healthier populations. Moreover, AHPs’ exemption from rating limitations and marketing standards would allow them to enroll healthier-than-average groups and encourage firms with high cost workers to switch back to the state-regulated market.

As AHPs attract small employers whose perceived health status is good, firms with greater expected health care utilization would remain in the regulated market, where they have the protection of mandated benefits and other regulations. The resulting outflow of low-cost groups from the state-regulated market and the remaining concentration of high-cost groups would start an adverse selection spiral that would accelerate premium increases for employers in the state-regulated market.

Another difference is that most AHP proposals would allow the association plan to self-fund or assume risk. Thus, AHPs would act much like insurance companies, offering health benefit plans to thousands of independent small employers. The American Academy of Actuaries commented that self-funded AHPs would pose a risk for insolvency due to inadequate AHP solvency requirements that did not increase with the size of the

¹¹ Karen Bender and Beth Fritchen, *Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers*, Mercer Risk, Finance and Insurance for National Small Business United, 2003.

plan unlike the solvency standards currently required by the states.¹² Historically, there have been many examples of AHP-like organizations becoming insolvent. The other purchasing arrangements mentioned in this report avoid this problem by contracting only state-licensed health insurers to assume all risk for coverage offered.

V. Realities of Pooling

While pooling of risks is an essential function of insurance, assembling many small groups or individuals into a purchasing arrangement pool does not automatically reduce costs. While it may be tempting to think that health insurance costs can be lowered if purchased in bulk, like commodities or consumer goods, the economic and actuarial realities affecting the cost of health insurance are fundamentally different.

The underlying purpose of pooling is to combine members together in order to obtain a more stable and predictable block of experience so that future expected costs can be more accurately predicted. Pooling will not generally lower premiums, unless the risk of those individuals pooled together is lower than average. Moreover, the purchasing arrangements we discuss in this paper do not pool risk — this is the function of health plans — but rather focus on how health insurance coverage is distributed and therefore focus primarily on the relatively small and stable administrative component of premiums.

This section of the paper discusses some of the common misconceptions regarding health insurance risk pooling and alternative purchasing arrangements, drawing on the history of previous state-sponsored arrangements and our knowledge and experience regarding the functions and limitations of pooling.

Purchasing Arrangements Will Not Reduce Premiums for Small Employers and Individuals

The theory behind pooling arrangements is that members of small employer groups will be able to collectively leverage their purchasing power in the health insurance market and negotiate lower premiums. Lower premiums can only result from two major sources — lower average claims and/or lower per-person administrative costs.

Numerous studies have found that state purchasing arrangements were not able to offer lower premiums to small employers:

- An analysis of the five largest plans in the California HIPC found that their costs were 6 percent more expensive than coverage outside the HIPC when comparing benefit-adjusted or “equivalent” coverage.¹³ This is the only analysis we know of that has evaluated costs on a benefit-adjusted basis inside and outside of a HIPC.

¹² American Academy of Actuaries, Letter to The Honorable John A. Boehner, April 28, 2003.

¹³ To Pool or Not to Pool: Analysis of Small Group Health Insurance Rates in California, Shore KK, Yegian JM; Abstr Acad Health Serv Res Health Policy Meeting, 2000.

- Our 1999 review of HIPCs in eight states concluded that premium rates for plans offered through HIPCs “were not significantly different from premium rates outside the HIPC,” and there “[did] not appear to be any consistent and significant cost savings attributable to [HIPCs];”¹⁴
- A 1999 study by RAND researchers published in *Health Affairs* concluded that HIPCs “appear to have little effect on health insurance costs for their participants.” Specifically, the study surveyed over 21,000 employers nationally and found that monthly single premiums for small employers participating in HIPCs averaged \$180 in 1997, compared to \$172 for non-participants;¹⁵ and
- A March 2000 report by the U.S. Government Accountability Office (GAO) found that purchasing cooperatives typically offer plans at market prices comparable to plans with similar benefits offered to small employers outside the cooperative.”¹⁶

Why are purchasing arrangements unable to lower premiums? To answer this question it is important to evaluate whether purchasing arrangements can reduce the drivers of health insurance costs.

Various approaches purchasers may employ to lower claims costs include: 1) negotiating lower provider reimbursement rates; 2) reducing the utilization of services; 3) attracting healthy individuals; and 4) reducing administrative costs. The following sections describe why purchasing arrangements are unlikely to positively impact these factors in any meaningful way.

Provider Reimbursement Rates

Provider reimbursement is a major determinant of health insurance costs. The cost of care administered by health care providers typically accounts for 80-90 percent of the health care premium dollar. As a result, the largest insurance companies have devoted significant resources to the goal of obtaining the most favorable provider reimbursement rates. These insurance companies are able to negotiate significant discounts from providers in exchange for the insurers’ ability to direct a significant number of members to these providers by including them on a preferred provider list. This in turn gives providers access to a larger base of insured patients.

Insurers negotiate these reimbursement arrangements on behalf of all of their commercial business — individual, small employer, and large employer. The magnitude of the discount is largely driven by the number of members an insurance company has in a given geographic area. Because discounts are volume dependent, it would make no sense for an insurer to negotiate separate payment rates for one company (or market segment) versus another and thus reduce its negotiating leverage with local doctors and hospitals. *Thus, small employers and individuals currently enjoy the benefits of these provider contracting and maintenance efforts.*

¹⁴ Harrington and Bender, 1999.

¹⁵ Long & Marquis, “Pooled Purchasing: Who Are the Players?” *Health Affairs*, Vol. 18, No. 4, (July/August 1999). <http://content.healthaffairs.org/cgi/reprint/18/4/105?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=%22Pooled+Purchasing%3A+Who+Are+the+Players%3F%22+&andexactfulltext=&andsearchid=1&FIRSTINDEX=0&resourcetype=HWCIT>

¹⁶ Cooperatives Offer Small Employers Plan Choices and Market Prices, GAO, March 2000. <http://www.gao.gov/archive/2000/he00049.pdf>

Small employer purchasing arrangements do not affect provider payment rates; health plans negotiate payment rates with providers for all of their products and markets. Moreover, purchasing arrangements are likely to represent a very small portion of a health plan's total membership — the small group market is about one-fifth of the total private market today — so small employers tend to benefit from being pooled with other employers when health plans negotiate with providers. The individual market is even smaller, representing about 5 percent of total members. This market, too, is enjoying the preferable provider reimbursement levels negotiated by insurers for all of their members.

Any proposal permitting purchasing arrangements to negotiate their own rates would likely be ineffective because these entities would not have the critical mass of membership required in specific geographic areas from only small employers and/or nongroup members to be able to more effectively negotiate lower rates than those currently offered in the market.

Utilization of Services

Reduced utilization or demand for services is another key method for lowering average anticipated claims costs, and thus lowering health insurance premiums. *There are no features in past or current purchasing proposals that would change or reduce the utilization of or demand for health care services.*

In the marketplace today, insurers are experimenting with various methods to reduce unnecessary utilization and demand, including: 1) implementing health management strategies (wellness plans, disease management); 2) educating consumers to become better health care purchasers; 3) providing access to on-line support tools containing information on health conditions, health care provider qualifications, cost, and quality; 4) offering high-deductible consumer-driven health plans, coupled with health savings accounts; 5) adopting transparency initiatives that enable consumers to select providers based on efficiency; and 6) introducing value-based benefit products. As an example, the number of employers offering consumer driven health plans has risen from 5 percent of all large employers in 2005 to 14 percent in 2007 with 18 percent indicating they are very likely to offer such plans in 2008.¹⁷

Past and current HIPCs and purchasing arrangements do not specifically address how demand for services will be lowered. In fact, it may be likely that more innovative products and approaches might not be included among the choices offered within these proposed purchasing arrangements. These arrangements control the benefit options offered, and may seek less diversity of product design in order to promote comparability of products across participating carriers. This conclusion is supported by the limited product offerings of past HIPCs.

¹⁷ Mercer, 2007. National Survey of Employer-Sponsored Health Plans, released 2008.

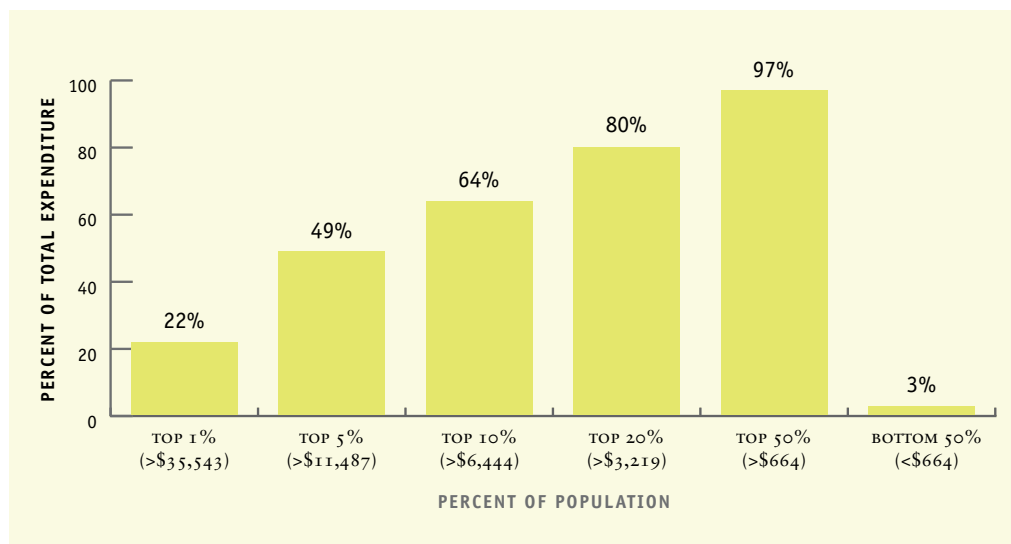
Risk Selection

Risk selection is another method to achieve lower health insurance premiums for a specific segment of the population. However, providing coverage only to the portion of the population with better risks will not address the affordability issue for the entire population. In fact, HIPCs or other purchasing arrangements that benefit from risk selection do so to the detriment of the rest of the market, which is then comprised of higher-risk or less healthy members.

Much of the small group reform legislation states enacted in the 1990s focused on preventing market segmentation through risk selection, by limiting the variation of premium rates and forcing cross-subsidization between high- and low-risk small employer groups. As noted earlier, state small group market reforms limit the extent to which health insurers can vary rates for small employer groups based on health status or expected claims costs.

Under various purchasing arrangement approaches, employees of a group are sometimes free to choose from all of the insurance companies and plans offered in the purchasing arrangement. Since the group is no longer with one insurance company, it is not clear how rates would be determined and the extent to which health status or claims experience would be reflected in an individual’s rates.

As the following chart demonstrates, a small percentage of the population (5 percent) accounts for almost half of all health care spending in this country. Therefore, in the majority of states that permit premiums to vary by claims experience or health status, insurers who enroll relatively healthy individuals in their plans will ultimately collect excess premiums. Conversely, insurers who enroll less-healthy members will realize deficient premiums in the short-term unless premiums are increased to fully compensate the insurer which, over time, may price sicker individuals out of this market as premiums become unsustainable.



Source: Conwell LJ, Cohen JW. Characteristics of people with high medical expenses in the U.S civilian noninstitutionalized population, 2002. Statistical Brief #73. March 2005. Agency for Healthcare Research and Quality. Rockville, MD. Web-site: <http://www.meps.ahrq.gov/PrintProducts/PrintProdLookup.asp?ProductType=StatisticalBrief>. Accessed April 7, 2006.

Note: Figures in parenthesis are expenses per person.

The purchasing arrangement in California (PacAdvantage) attempted to address the potential for adverse selection by incorporating a risk adjuster. The purpose of the risk adjuster was to redistribute premium income between insurers enrolling healthier-than-average and sicker-than-average individuals. However, the risk adjuster lacked sufficient accuracy to fully compensate insurers, especially PPOs, for the cumulated anti-selection. Over time, program rates became unsustainable, forcing PPOs to leave the program and ultimately for the HIPC to disband.

Administrative Costs

Advocates of HIPCs also argued that they could generate administrative cost savings. However, numerous studies have shown HIPCs did not realize the administrative savings anticipated:

- Detailed case studies of HIPCs conducted by Mark Hall and Elliott Wicks revealed “much less opportunity for administrative cost reductions than first appear[ed] possible.”¹⁸ In some instances, the HIPC actually resulted in another layer of administrative expenses that accounted for an additional 2-3 percent of the premium, according to the Hall/Wicks study. This lack of demonstrated savings is one of the major reasons for their lack of success;
- A review of the literature shows that the administrative costs for HIPCs were equivalent to or greater than the administrative costs for non-HIPCs;¹⁹ and
- A 2000 GAO study found that “anticipated administrative savings never materialized...” According to some cooperative officials, administrative savings are inherently limited because cooperatives can relieve insurers of only a fraction of their costs. Moreover, when assuming responsibility for an administrative task such as marketing, a cooperative generates its own costs that must be covered, typically by a fee to members.”²⁰

In retrospect, this lack of administrative savings was not surprising. Insurance companies still needed to enroll members, add new members, delete terminated members, generate bills, complete premium reconciliation, administer claims, submit rate filings (if required), develop products, maintain provider networks, ensure compliance with state and federal regulations, and submit required financial reports. The presence of a purchasing pool may actually increase costs since the pool may require special reporting, system modifications on behalf of insurers to meet the pool’s administrative requirements, etc.

¹⁸ Hall, Mark, et.al. HealthMarts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed, Health Affairs, Vol. 20 No. 1, January/February 2001.

¹⁹ Long & Marquis, 2001; Trude & Ginsburg, 2001; and Wicks et al., 2000.

²⁰ Cooperatives Offer Small Employers Plan Choices and Market Prices, GAO, March 2000 <http://www.gao.gov/archive/2000/he00049.pdf>.

As the following chart illustrates, purchasing arrangements do not eliminate any of these functions.

Typical Purchasing Arrangements Would Duplicate Existing Functions of Other Entities

FUNCTION	CURRENT RESPONSIBILITIES			PURCHASING ARRANGEMENT
	STATE	INSURERS	BROKERS	
Approval of Benefits	X			X
Approval of Premiums	X			X
Advertising/sales		X	X	X
Enrollment		X	X	X
Education	X	X	X	X
Billing		X	X	X
Claims Processing		X		
Complaints/appeals	X	X	X	X

Most purchasing agency proposals envision creating a marketplace whereby individuals, not employers, select coverage from a menu of approved options. This effectively converts a group market into an individually purchased market. An individual marketplace is more expensive to administer because each administrative function must be performed separately for each employee rather than at the group level. Moreover, in these purchasing arrangements, each person — instead of the group — is selecting a health plan based on their own expected need for benefits, which drives up costs.

One of the areas that initial supporters of HIPCs thought could be a source of administrative savings was minimization of marketing costs and/or elimination of agents’ commissions. While some programs initially eliminated agents, they generally had to reverse course. A recent study by AcademyHealth reaffirmed the critical role of marketing/agents in the success of these programs.²¹ The article cited agent and broker involvement as one of four major components critical to the success of any state insurance coverage program, which would include HIPCs as well as connectors/exchanges. Agents play an important role in programs aimed at the individual and small group markets. Agents shepherd entities through the maze of insurance delivery systems, describe various insurance products, advise what may be best for their clients, assist in the enrollment process, and may even intervene with claim issues.

Critics of the insurance industry often point out that the total administrative costs for individuals and small groups are significantly higher than the corresponding administrative loads for large groups. While this is true, these are not apples-to-apples comparisons. Large employers have human resource departments responsible for a significant portion of the administration of health benefits. These costs are not borne by the insurance

²¹ Marketing State Insurance Coverage Programs: Experiences from Four States, Vopel, et. al, AcademyHealth, November 2007.

company. Therefore, they are not part of the administrative costs reflected in the statistics. Consultant fees are also not included in these data. The costs for agents are explicitly reflected in the premiums for small employers and nongroup policies where at least part of these costs is not reflected in the premiums for large groups.

Pooling Small Employers Together Will Not Create Economies of Scale Similar to Those Experienced by Large Employers

One of the underlying assumptions behind various purchasing arrangements is that bringing many small groups together to purchase health insurance will increase their purchasing power, giving them the same ability to negotiate lower health insurance premiums that large employer groups enjoy. *However, there are significant differences between a pool of many small employer groups and a large employer pool.*

The American Academy of Actuaries stated this principle well: “A single employer with 999 employees is not the same as 333 groups with 3 employees each.”²² The NAIC used the following analogy: grouping many small employers does not create the equivalent of a large employer any more than grouping three twelve year-olds creates a thirty six year old.²³ The large employer acts as the “glue” that holds the group together.

Small employer groups are some of the most price-sensitive purchasers of health insurance. As such, these groups tend to move in and out of small group pools by either switching carriers or dropping insurance on a regular basis. This ability to enter and exit the insurance market makes the pool less cohesive than large group pools, which makes the small group market one of the most volatile health insurance markets.

Generally, the smaller the group, the higher the claims per member, because smaller groups tend to behave more like individuals. That is, among the smallest groups, those who have a greater need for health insurance (because of a known health risk) are more likely to purchase coverage while those with the lowest expected need for health insurance are less likely to obtain coverage. This point is illustrated in the following chart, which shows that very small groups have expected claims that can be 33 percent higher than employees in groups with 6 to 50 beneficiaries:

The Smallest Employers Have Much Higher Claims Costs

EMPLOYER SIZE	CLAIMS (PER MEMBER PER MONTH)
2	\$289.00
3–5	\$220.00
6–50	\$200.00

Source: Adapted from “Wading Through the Basics of Health Care Risk Pooling,” American Academy of Actuaries Luncheon Briefing, July 22, 2005.

*The information provided above is for illustrative purposes only. While the magnitude of the numbers is indicative of real experience, the actual numbers would vary.

²² Bender, Karen, et.al., Wading Through Medical Insurance Pools: A Primer, American Academy of Actuaries Issue Brief, American Academy of Actuaries, September 2006.

²³ Testimony of Joel Ario, Acting Commissioner of Insurance, Commonwealth of Pennsylvania, representing the National Association of Insurance Commissioners before the U.S. Senate Committee on Finance on Small Business Health Insurance: Building a Gateway to Coverage, October 25, 2007.

In general, the small employer group market tends to pay higher premiums than the large employer group market for similar benefits.²⁴ One key reason for this is adverse selection. A number of characteristics of the small group market contribute to the potential for adverse selection. First, small employers are not required to offer health insurance and offer coverage at much lower rates than large employers, where nearly all employers offer coverage.²⁵ Therefore, employers with employees/dependents with medical conditions requiring higher-than-average health care services are more cognizant of the value of health insurance and more likely to purchase it. For “micro groups” (2-4 employees), the decision maker is most likely the business owner, and his/her decision is most likely based upon knowledge of his/her family’s and employees’ needs as well as costs. In contrast, the decision maker for large employers is more removed from the health conditions of employees/ dependents.

Since states require pooling of risk in this market, higher-risk or less healthy groups enjoy some level of premium subsidies from groups with lower-than-average health care costs. However, healthier groups with lower-than-average risks may not perceive an economic value in health insurance because they are required to provide subsidies to these higher-risk groups. The more restrictive the rating rules, the greater the subsidies required from the healthier groups, and the less attractive health insurance is for the exact market segment critical to creating a viable pool, the healthy groups.

Also, small employers generally do not have as stringent employment rules as large employers. Because such rules seek to ensure employees meet the physical requirements of the job or do not use illicit drugs, their absence among small employers may mean the pool for small employers is riskier.

In order for any pool to be viable in the long run it must be self-supporting. Therefore, there must be enough healthy individuals to subsidize the medical costs associated with less-healthy individuals. This is generally not a problem for the large employer since the “glue” holding the pool together is independent of health insurance decisions. However, this is not the case for the 333 independent small groups in our previous example. Therefore, it is critical to have rating flexibility to ensure there are sufficient numbers of healthy groups to provide subsidies for the sicker groups. Under HIPC or connector-like proposals where employees are allowed to choose from all of the benefit plans, it is difficult to incorporate this rating flexibility for reasons cited previously.

Another factor exerting upward pressure on rates is that administrative costs are generally higher for small employers than for large employers. In the example of 333 groups with 3 employees above, the administrative costs for selling, enrolling, and administering the products they select will be substantially higher than administering the product(s) offered to the single large employer with 999 employees. Thus, whether the health plan or the purchasing arrangement performs these administrative functions, the costs will always be higher in the small employer than in the large employer market.

²⁴ Wicks, Elliot K., November 2002.

²⁵ Kaiser Family Foundation website, Health Insurance Premium Growth Moderates Slightly in 2006, But Still Increases Twice as Fast as Wages and Inflation, <http://www.kff.org/insurance/ehbs092606nr.cfm>.

Purchasing Arrangements Do Not Offer More Choice of Plan Types

One goal of purchasing arrangements is to offer more choice of coverage. However, the very structure of these arrangements may actually inhibit the introduction of new, innovative products that provide individuals and consumers with their preferred choice of product. Past experience indicates that purchasing arrangements often provide little choice of plan type for two reasons: 1) under most proposals, a state or federal agency would decide which plans and products could be offered, and 2) adverse selection within individual choice arrangements often limits plan choices to highly managed plans.

Purchasing arrangements may fail to provide the choices that consumers want at an affordable rate because a state or federal agency — and not the marketplace — would decide what coverage could be offered. Decisions about what coverage to offer are made by purchasing arrangement boards, and the process can become very political in nature, resulting in various special interest groups lobbying for inclusion of specific coverage that can ultimately make the products offered less affordable. According to the NAIC, “one of the most difficult issues in health insurance reform is how to define a basic benefit package that is both “adequate” to meet health needs and “affordable.”²⁶

In state-regulated markets, the balance between benefit design and affordability is market-driven. Benefit design is continually changing to reflect rising costs, changes in the practice of medicine, and/or consumer demands. For example, Medicare did not include drug benefits when first passed during the 1960s; it took about 40 years to modify the program to include these benefits. In the commercial health insurance market, drug benefits were added much faster as employers and employees demanded these benefits.

The marketplace drives various innovative designs that have emerged over the years. In the 1990s the market saw the aggressive managed care movement evolve with the promise of lowering costs by providing preventive care services for early detection and by eliminating what health plans believed to be unnecessary costs. However, as the managed care approach began to be perceived as overbearing, the market was faced with a backlash and PPO products grew in popularity. In the market today, innovative products such as consumer-driven health plans have emerged with the promise of curbing increasing health care costs. These solutions may be difficult to incorporate in purchasing arrangements.

A second reason is that adverse selection within individual choice arrangements often limits plan choices to highly managed plans. These arrangements typically allow the individual employees of small employers to select among all plans offered by the purchasing arrangement. However, they have often offered a much more limited choice of product types than the choices available to employers in the open market, typically just HMOs or HMOs with a point-of-service option. PPO plans that have become the most popular option over the past decade were typically not offered due to adverse selection.²⁷ Purchasing arrangements that did offer PPO options often found these products were magnets for less-healthy individuals who placed a higher value on broad choice of providers with few restrictions on use of services, thus undermining the stability of the purchasing arrangement.

²⁶ Joel Ario testimony.

²⁷ Wicks, et al., 2000

Our review of HIPCs in eight states in 1999 found that HIPCs offered limited product choices.²⁸ Indemnity plans and PPOs had a very difficult time competing in HIPCs, demonstrated by the fact that none of the HIPCs studied were providing such benefit options. More specifically, the study found the following:

- **CA: PacAdvantage.** (Active from 1993-2006) Began with 20 health plans. PPOs were available from three carriers during the first three years, but the last one withdrew in July 1998, citing adverse selection. At the end, PacAdvantage offered a choice of HMOs only, two of which offered POS plans. PacAdvantage attempted to offer PPOs again by implementing a risk adjustment system among plans, but this ultimately was not successful. PacAdvantage cited the inability to keep PPOs in its plan as one of the factors leading to its demise;²⁹
- **CO: Cooperative for Health Insurance Purchasing (CHIP).** (Active from 1995-2002) From the beginning, CHIP offered only managed care entities and elected to limit the number of participating carriers. Four HMOs were selected at the start. Initially, employees had a choice of HMO or POS coverage, but insurers stopped offering this dual option because of adverse selection. CHIP wanted to offer a PPO, but no carrier was willing to offer one due to adverse selection concerns;
- **FL: Community Health Purchasing Alliances (CHPAs).** (Active from 1994-2000) Initially, approximately 45 insurers participated in one or more CHPA districts. Product choices originally included HMO and PPO products as well as indemnity plans, but the indemnity plans soon withdrew due to adverse selection. By 2000, this number diminished to five carriers. Toward the end, CHPAs eliminated employee choice, allowing health plans to enroll all members of a group to limit adverse selection;
- **NC: Caroliance.** (Active from 1995-2001) Initially only six carriers participated in Caroliance. By 1999, only BCBS of North Carolina was selling statewide with just two other carriers, both HMOs, participating; and
- **TX: Texas Insurance Purchasing Alliance (TIPA).** (Active from 1994-1999) TIPA ceased in 1999 when its last remaining carrier, BCBS of Texas, dropped out of the program. More than 20 plans, including HMO, PPO, and indemnity plans, participated at one time or another, but by 1996 carriers were beginning to drop out because of adverse selection concerns. HMOs made up the majority of participating plans.

Typically, small group purchasing arrangements standardize benefit packages offered to facilitate comparison shopping by employees. Generally, several different levels of benefit packages are offered and employees can decide which level of benefits provides the most economic value. For example, in the Massachusetts Connector there are three different levels of benefit plans (Bronze, Silver and Gold) and one additional plan for young adults

²⁸ Harrington, Timothy, and Bender, Karen, Review of Health Insurance Purchasing Cooperatives (HIPCs), William M. Mercer, Inc. September 15, 1999.

²⁹ Chan, Gilbert. Insurance-Pool Plug Pulled: Small-business Health Partnership Not Profitable. Sacramento Bee; August 12, 2006.

aged 18 to 26. In addition, the number of health plans allowed to offer coverage is also limited. Other state-sponsored HIPC's have had the same type of structure with standardized benefits and limited health plan participation.

One of the goals of purchasing arrangements is to improve consumer choice of benefits to employees of small employers. However, decisions about what coverage will actually be offered can run counter to that goal.

Purchasing Arrangements Do Not Enhance Competition

Some proponents of purchasing arrangements have argued they would stimulate competition among participating health insurance plans by encouraging cost-conscious choices among employees, thus reducing premiums and expanding coverage. This type of managed competition, it is argued, would spill over into the larger health insurance market.

Purchasing arrangements to date have failed to stimulate competition or deliver lower premiums. Indeed, it is unlikely purchasing arrangements can stimulate competition beyond that which exists today in the small employer market. If these entities adopt a highly regulatory approach, they may actually reduce competition and product innovation.

In a market-driven environment, competition helps contain costs. As stated earlier, the small employer market is one of the most cost sensitive purchasers of health insurance. These groups tend to move from carrier to carrier for small changes in premium rates.

While this price sensitivity fosters a competitive market for small employer health insurance, the competitiveness of the market varies by geographic region. Much of the competitiveness in the small employer health insurance market is directly related to the regulatory environment of the region (i.e., strictness of rating rules) and market size. Generally, those markets with more flexible rating rules and/or very large populations have more competition.

It is difficult to hypothesize how an insurance carrier that does not have any presence whatsoever in a given state will be able to negotiate provider contracts competitive with health plans able to deliver a large number of members. It is theoretically possible that some carriers that are currently in the large group market in a given area may elect to enter the small group. However, history has shown that once carriers have elected to exit the small group market, they do not re-enter voluntarily for several reasons: 1) they no longer have the infrastructure necessary to support the complicated regulatory requirements of the small group market; and 2) they no longer have the sales delivery force that serves this market.

If the rules of the purchasing arrangement are too burdensome, there is not adequate protection from potential adverse selection, or the potential market share is very low, carriers may not be willing to enter this market. In addition, if the number of health insurance carriers participating in the purchasing arrangement is limited, the competitiveness of the market may not increase in the long term.

It is unlikely purchasing arrangements can stimulate competition beyond that which exists today in the small employer market.

Purchasing Arrangements May Lead to Adverse Selection

One misconception associated with pooling is that combining groups will generate lower premiums for everyone in the pool. This is simply not true. The underlying purpose of pooling is to combine members together in order to obtain a more stable and predictable block of experience so that future expected costs can be more accurately predicted. As discussed earlier, pooling spreads the risks among all members with the goal of establishing a fair and equitable health insurance premium for each person in the pool.

Larger pools will not necessarily lead to lower premiums; both the size of the pool and its composition must be considered.

In order for the pool to be able to offer low premiums, there must be enough low cost or healthy members/groups in the pool to offset the costs of the unhealthy members/groups enrolled. In other words, the pool is dependent upon cross-subsidization of risks.

Therefore, some members will pay more than their fair share and others will pay less. If a pool enrolls a disproportionate number of unhealthy members, the premiums in this case will be higher. Thus, larger pools will not necessarily lead to lower premiums; both the size of the pool and its composition must be considered.

Other examples of pools with higher-than-expected claims can be found in the experience of some of the state-sponsored HIPCs. Several HIPCs, most notably those in Texas and Iowa, experienced adverse selection because they were required to community rate by class within the HIPC while insurers in the outside market were allowed to vary rates significantly due to health status. When two different sets of rules are in place, market segmentation and risk selection follow. Groups representing higher-than-average risks had an economic reason to join the HIPC while groups with lower-than-average risks had an economic reason not to join.

The American Academy of Actuaries (AAA) has expressed concern regarding market segmentation in many public forums. In its February 1996 Public Policy Monograph entitled *Providing Universal Access in a Voluntary Private-Sector Market*, the AAA states reforming market segments independently, without any restrictions over which market individuals are allowed to select when they purchase guaranteed-issue insurance, could lead to cost increases within a single market segment (the entire small group market constitutes a single market segment in this report).³⁰ This concern was reinforced in an October 1998 letter to U.S. Representative Harris Fawell discussing the market segmentation that could result from proposed legislation involving association health plans (AHPs).³¹

While one conclusion that could be drawn from the experience of the state-sponsored HIPCs is to ban health status as a rating factor, this might not actually further the goal of reducing health care costs. A study by the U.S. General Accounting Office (now called the Government Accountability Office) indicated that states that use some version of community rating had average premiums that were about 6 percent higher than the average premiums in states that employ health status rating bands.³² Therefore, elimination of rating bands would result in upward pressure on premiums, the exact opposite of the intended reasons for introducing HIPCs.

³⁰ American Academy of Actuaries, Public Policy Monograph, *Providing Universal Access in a Voluntary Private-Sector Market*, February 1996.

³¹ AAA Association Health Plan Work Group letter to U.S. Representative Harris W. Fawell, October 5, 1998.

³² United States General Accounting Office, *Private Health Insurance Small Employers Continue to Face Challenges in Providing Coverage*, United States General Accounting Office, October 2001. <http://www.gao.gov/new.items/d028.pdf>

Some proponents of purchasing arrangements hoped these arrangements would be able to attract new employers who had previously been uninsured. However, for the reasons cited previously, purchasing arrangements generally have not been able to obtain premiums lower than those available in the current market. Without a significant decrease in premiums, many of these employers would not be interested in purchasing insurance.³³

VI. Conclusion

Proponents of purchasing arrangements argue that allowing small employers to join together for the purpose of purchasing health care coverage will reduce premiums, expand choice and improve the stability of coverage for small employers. As described in this paper, purchasing arrangements are unlikely to meet many of the stated goals of their proponents.

Purchasing arrangements will have little ability to reduce health insurance costs for small employers or individuals. These proposals will tend to increase costs by duplicating administrative functions performed by others in the market today and converting group coverage into less efficient individually purchased coverage. Indeed, the history of state-sponsored purchasing cooperatives demonstrates that purchasing cooperatives have failed because they did not provide enhanced value for small employers.

Proponents claim that these arrangements will give small employers and individuals the same clout or economies of scale as large employers in negotiating lower rates. In reality, pooling thousands of independent small employers or individuals together does not create the dynamics of a single large employer and costs will be higher because of administrative differences and adverse selection. Alternative purchasing arrangements have little potential to reduce costs because they simply rearrange how people purchase coverage, while doing nothing to impact the cost of care, which is the major component of the health insurance premium, and will tend to increase administrative costs.

While some policymakers also claim that these arrangements will increase choice, history has shown that these purchasing arrangements provide little choice of plan type. Adverse selection within individual choice arrangements often limits plan choices to highly managed plans. For example, these entities may provide a choice of different HMOs, yet do not offer popular broad-access PPO products consumers have demanded over the last decade. When PPOs were offered through these arrangements, they were often forced to withdraw their products as they attracted a disproportionate population of high-cost members.

While pooling is an essential function of insurance, the alternative purchasing arrangements described in this report will not increase the pooling of risk in the individual or small employer market. States already require significant pooling of risk in the small employer market as a result of small employer health insurance market reforms.

³³ Wicks, Elliot K., Health Insurance Purchasing Cooperatives , The Commonwealth Fund, Issue Brief, November 2002.

Moreover, because the insurers participating in these arrangements would retain all risk, these arrangements will not create larger or more stable risk pools for small employers or individuals.

While purchasing arrangements can serve as an alternative method for distributing coverage, simply forming a purchasing arrangement will not increase coverage choices, transform groups of small employers into large employers, or confer small groups or individuals the same purchasing and price advantages currently enjoyed by large employers.

