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Right to Life, Inc.**

*State Affiliate of the National
Right to Life Committee, Inc.
Washington, DC 20004-2293*

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MAR 17 1999

March 17, 1999

To: Senator Rod Moen
From: Mary Klaver
Re: Senate Bill 1 -- Public Hearing Today

Please distribute a copy of the attached memorandum to the members of the Senate Committee on Health, Utilities, Veterans and Military Affairs when you conduct the public hearing on Senate Bill 1 today.

Thank you.

Dedicated successfully since 1968 to advocating for and protecting precious human life.

Please remember the Wisconsin Right to Life Education Fund 501(c)(3) charity and its lifesaving programs in your estate plan. By doing so, you may be able to achieve significant income, gift or estate tax benefits. Please call our development department today for confidential help in successfully implementing the gift plan most suitable for you.



March 17, 1999

To: Members of the Senate Committee on Health, Utilities, Veterans and Military Affairs
 From: Mary Klaver, Legislative Legal Counsel
 Re: Senate Bill 1 -- Abortion Rider Amendment

As you consider Senate Bill 1, which requires the department of employee trust funds to design, establish and administer a health care coverage plan for employers in the private sector, we would appreciate your consideration of the concerns and requests made in this memorandum.

Wisconsin Right to Life has had a long-standing concern with health care coverage plans that would either mandate or permit abortion coverage. SB 1 is silent on abortion and would, therefore, *permit* abortion on demand coverage. Unless SB 1 is amended, it is quite possible that the final health care coverage plan that is designed by the department and approved by the private employer health care coverage board could cover abortion on demand as a basic benefit. Pro-life employers, such as Wisconsin Right to Life, who might otherwise be inclined to purchase this health plan due to the anticipated cost savings would then be faced with an *ethical dilemma* because their premiums would become part of a commingled pool of money which would be used to pay claims for abortions.

An **abortion rider requirement** would solve this ethical dilemma. Under this approach, the main plan could only cover an abortion that is directly and medically necessary to prevent the death of the woman. Coverage for "nontherapeutic abortions" can only be obtained by an optional rider (or supplemental coverage provision) that is offered and provided on an *individual* basis and for which an additional, separate premium is paid by the individual. Only the funds attributable to the abortion rider premiums can be used to pay for nontherapeutic abortions. The abortion rider is also optional for an insurer which does not have to offer the rider if it so chooses. This approach solves the commingling problem and still permits abortion coverage for those individuals who want the coverage.

Last session, Wisconsin Right to Life supported the abortion rider requirement that was set forth in Assembly Amendment 1 to the Assembly Substitute Amendment 1 to Senate Bill 332 (copy attached, with one technical change). This amendment was adopted by the Assembly Committee on Small Business and Economic Development. Wisconsin Right to Life urges your committee to adopt this abortion rider requirement when you have an executive session on SB 1.

Thank you for your consideration of our request.

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1997 - 1998 LEGISLATURELRBa1843/3
PJK&RAC;jlg:km**ASSEMBLY AMENDMENT 1,
TO ASSEMBLY SUBSTITUTE AMENDMENT 1,
TO 1997 SENATE BILL 332**

March 5, 1998 -- Offered by COMMITTEE ON SMALL BUSINESS AND ECONOMIC DEVELOPMENT.

1 At the locations indicated, amend the substitute amendment as follows:

2 1. Page 1, line 8: before "creating" insert "coverage of nontherapeutic
3 abortions,".

4 2. Page 6, line 5: before that line insert:

5 "(ag) "Abortion" means the use of an instrument, medicine, drug or other
6 substance or device with intent to terminate the pregnancy of a woman known to be
7 pregnant or for whom there is reason to believe that she may be pregnant and with
8 intent other than to increase the probability of a live birth, to preserve the life or
9 health of the infant after live birth or to remove a dead fetus."

10 3. Page 6, line 5: delete "(a)" and substitute "(ar)".

11 4. Page 7, line 6: after that line insert:

HEALTH INSURANCE PURCHASING ALLIANCES
FOR SMALL FIRMS:
LESSONS FROM THE CALIFORNIA EXPERIENCE

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May, 1998

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The California HealthCare Foundation is a nonprofit, philanthropic organization whose mission is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of the people of California. Additional copies of this publication may be obtained by calling the Foundation's publications line at 510-587-3199.

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HEALTH INSURANCE PURCHASING ALLIANCES FOR SMALL FIRMS

EXECUTIVE SUMMARY

The Health Insurance Plan of California (HIPC) is a purchasing alliance for firms with between two and 50 employees. The HIPC, formed in 1993, serves as an intermediary between 19 participating health plans and 137,000 workers and dependents. Based on the managed competition model, the HIPC offers standard benefit packages, annual open enrollment, and premiums that vary with age but not with health status. This report reviews the first five years of the HIPC's existence, drawing four broad lessons for practitioners and policymakers.

✓ First, voluntary purchasing alliances are not the solution to the large and growing problem of the uninsured. The vast majority of firms enrolled in the HIPC were already insured, indicating that neither premiums nor other features that the HIPC offers are significantly more appealing to small firms that do not offer insurance than are other market options.

✓ Second, insurance brokers play a major role in the distribution system for small firms that purchase health insurance, and careful consideration must be given to the role that they should play in purchasing alliances. Initially, the HIPC's structure and compensation policy alienated brokers, creating animosity and adversely affecting growth. Changes in those policies have improved the situation, but have not completely resolved it.

✓ Third, on two key aspects of choice, the HIPC performs differently: choice of plan and choice of physician. The HIPC offers employees of participating firms a wide selection of health plans, such that each employee in a firm of 10 workers can select a different plan. But plans that allow extensive freedom of choice of providers are few: The HIPC currently offers 19 health maintenance organizations (HMOs) and two point-of-service plans (POSs); ~~preferred provider organizations (PPOs) are no longer offered.~~ In addition, the benefit of choice among HMOs might be achieved with fewer plans; offering such a large number of HMOs may create confusion and administrative costs that outweigh the value of a wide array of choices, particularly when the provider networks of the various HMOs overlap.

risk selection against PPOs

✓ Last, the implementation of risk-adjustment in the HIPC has been successful in the sense that plans have been willing to participate in the data collection and transfer of funds, and that the process has gone through multiple rounds with little disruption of the HIPC's normal operations. It appears, however, that even a sophisticated and well-designed risk-adjustment mechanism may not be sufficient to completely counter the effects of biased risk selection that results when PPOs and HMOs are offered side-by-side in an employee choice environment. The transfer of funds triggered by the risk adjustment process was not sufficient to prevent the PPOs that experienced adverse selection from exiting the HIPC.

As required by legislation, the HIPC will be soliciting bids for takeover by a private nonprofit entity in a competitive process. If the HIPC is privatized, the new management would have significant flexibility to change the current policies and operational rules. Perspectives on the potential for privatization vary.

Not the least valuable lesson from the HIPC is the experience that the Managed Risk Medical Insurance Board (MRMIB), the responsible state agency, has gained during the five years it has run

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the program. The Board has applied that experience to the creation of the Healthy Families program, an alliance which both offers choice to qualifying low-income children and provides a mechanism for subsidizing their coverage.



HEALTH INSURANCE PURCHASING ALLIANCES FOR SMALL FIRMS

I. INTRODUCTION

The Health Insurance Plan of California (HIPC) is the nation's first and largest state-run purchasing alliance for small firms. Through the HIPC, employees in small private companies gain access to an array of benefits, health plans, and prices similar to those once limited to employees in large corporations and public agencies. Indeed, small firms and their employees enjoy more choices than those available in many mid-sized and large firms, which increasingly contract with just one or two health plans.

In the five years since its creation, the HIPC has grown substantially, with 7,400 firms and 137,000 enrollees participating as of April, 1998, and has established itself as a stable and-experienced player in the competitive market for small group insurance. Despite this success, however, the HIPC has fallen short of the enthusiastic predictions made at the time of its creation. Receiving no public subsidy monies, the HIPC has not been able to reduce premium rates and thereby increase the percentage of small firms that offer insurance to their employees. Today, as when the HIPC was created five years ago, the majority of Californians without health insurance are workers in small firms and their families.

The limited market share achieved by the HIPC highlights the influence of insurance brokers and the innovativeness of the health plans in the small group market. Major insurers now offer multiple benefit designs and multiple network products to small firms, thereby achieving some of the choice offered by the HIPC, but in a simpler and more easily understandable fashion. To the extent that health plans include preferred provider organization (PPO) and managed indemnity products in their offerings, they can offer broader choice than the HIPC, which is limited to health maintenance organization (HMO) and point-of-service (POS) options. As more HMOs have entered the small group market, competition has increased and premium rates for comparable benefits now are similar between the HIPC and non-HIPC products.

The experiences of the California small group alliance have stimulated a vigorous policy debate concerning the future of the HIPC specifically and of health insurance purchasing alliances generally. The State of California has sought actively to transfer ownership and control of the HIPC from the public Managed Risk Medical Insurance Board (MRMIB), a state agency within the Department of Health, to a private nonprofit organization, thereby reducing the size of the public sector and freeing the HIPC from administrative rules and regulations that might have limited its growth. It has legislated a regulatory framework for the certification of new alliances in the hopes of facilitating competition among alliances for the allegiance of small firms and their employees. Most importantly, perhaps, the state has decided to use the purchasing alliance framework and the MRMIB's administrative oversight as the structure for its Healthy Families program (California's version of the Children's Health Insurance Program (CHIP)). Healthy Families differs significantly from the HIPC in being a subsidized program and in using federal and state monies to subsidize premiums and increase insurance coverage for children in low-income families, but will be managed using many of the principles (standard benefits, choice of health plans, and contracts with independent HMOs) that were pioneered by the small firm purchasing alliance. Indeed, some

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observers claim that the best reason for privatizing the HIPC at this time is to free up the directors and staff of the MRMIB so that they may focus their attention on what will potentially be a choice-based template for even broader subsidies and coverage expansions in the future.

Purchasing alliances for small firms continue to be of national interest, as well. President Clinton's budget for 1998-99 includes \$100 million—\$20 million a year for five years—to aid states in developing purchasing cooperatives for firms with one to 50 employees. Regardless of whether this proposed program eventually becomes law, it demonstrates the interest of policymakers at the federal level.

This report examines the structure and experience of the HIPC in its first five years and the lessons that can be drawn for purchasing alliances within other contexts and constituencies. In Section II, we describe the statutory and regulatory structure of the HIPC and how it fits within the context of rules governing health plan behavior in the small firm market. In Section III, key aspects of the HIPC's evolution are examined, including enrollment and premium trends. Section IV offers four lessons that can be drawn from the HIPC's early years. Those lessons pertain to the potential for purchasing alliances to increase insurance coverage, the role of insurance brokers, the nature of choice in the small group market, and the process of risk-adjusting payments to health plans. Section V considers key issues that are likely to affect the future of the HIPC and group purchasing in general in California.

II. BACKGROUND ON THE HIPC

Health Insurance Reform and Market Rules

In 1992, California passed Assembly Bill 1672 (AB1672), establishing a set of market rules for insurers of small firms (two to 50 employees). The market rules include guaranteed issue, guaranteed renewal, limits on pre-existing condition exclusions, and rating restrictions. The rating rules require plans to define a standard rate for all products that they sell. The standard rate can vary by age (according to seven categories), family status, and broad geographic areas; gender is not allowed as a rating factor. A ten-percent rate band allows insurers a small degree of flexibility in adjusting rates up or down for other factors believed to contribute to medical costs. The rules restrict the amount that insurers are allowed to raise or lower premiums from one year to the next.

The reform legislation also established the HIPC as a purchasing alliance for small firms within this sector. The HIPC functions as an intermediary between small employers and health plans, collecting premiums from the firms and distributing them to the plans. The MRMIB is responsible for the HIPC and performs the core functions of the health insurance sponsor under managed competition: designing the benefit package, negotiating with health plans, overseeing an annual open enrollment period, and risk-adjusting payments to plans. Daily operations, such as enrollment, marketing, and data collection, are contracted out to the private firm of Benefit Partners, Inc.

HEALTH INSURANCE PURCHASING ALLIANCES FOR SMALL FIRMS

Statutory and Regulatory Framework

The product of several years of debate, AB1672 represented a compromise among competing perspectives on health care reform.¹ As a result, the statutory and regulatory framework within which the HIPC is embedded reflects the divergent understandings of the role of health care purchasing alliances held by liberal and conservative political constituencies. The managed competition framework had been adopted in different ways by moderate Democrats, who viewed it as a cost-effective and politically viable mechanism for implementing universal coverage; and by moderate Republicans, who viewed it as a voluntary, private sector alternative to mandatory, public sector proposals. Managed competition, and by extension, purchasing alliances, were opposed on the left by "single payor" activists who wanted to eliminate private insurers altogether, and on the right by brokers and conservative activists who objected to further governmental involvement in health insurance.

In the early 1990s, when the political climate favored liberal proposals, many Democrats denounced the HIPC as unnecessarily timid while many Republican constituencies rallied around in support. Governor Wilson was a particularly strong advocate, without whose personal commitment the alliance would never have been created. After the resounding defeat of the Clinton Health Security Act, however, the political climate changed. Many Democrats supported the HIPC as an incremental step towards universal coverage while Republican constituencies pressed for privatization and the certification of competing alliances.

The statutory and administrative structure of the HIPC reflects the liberal perspective in creating a single, statewide, public alliance governed by a board of political appointees. It is subject to administrative rules typical of public entities, such as public hearings, disclosure of rates and other contract provisions, and civil service protections for employees. At the same time, the framework reflects the conservative perspective in that there is no mandate for small firms to purchase insurance for their employees, nor a mandate that those who voluntarily choose to purchase insurance participate in the HIPC. Although the state provided some initial start-up funds in the form of a loan, there are no subsidies for small firms that participate.

The sections of AB1672 concerning the HIPC are brief and non-prescriptive, thereby delegating considerable discretion to the entity that manages the alliance. The legislation mandates that the MRMIB establish a process for privatizing the HIPC within three years of its creation, although there is no requirement that it actually carry out the privatization. The legislation stipulates that if the HIPC is privatized, the entity assuming control be nonprofit and that its board of directors exclude individuals from the insurance or broker industries (a conflict of interest provision).

The HIPC is exempt from regulatory oversight by the Department of Corporations (DOC; which regulates HMOs and some PPOs) and by the Department of Insurance (DOI; which regulates indemnity carriers and some PPOs). This exemption from DOC and DOI regulatory oversight apparently would continue even after the HIPC is privatized. The statute makes no explicit mention of the legality, desirability, or regulatory framework for additional private alliances that would compete with the HIPC.

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How the HIPC Works

The employees of small firms that join the HIPC may choose from any health plan that the HIPC offers in their geographic region. For the 1998-99 enrollment year, the HIPC offers 19 HMOs and two POS plans² in some or all parts of the state. For each type of product (HMO or POS), benefits are standardized, but two levels of out-of-pocket cost-sharing at the time of service are available, designated as the "standard" and "preferred" options.³ Initially, the HIPC also offered several PPOs, but as of the 1998-99 benefit year, PPO options are no longer available. In addition to its managed care products, the HIPC offers optional dental coverage.

The same underwriting rules apply both inside and outside the HIPC, with one exception: within the HIPC, premiums for individual firms cannot be adjusted up or down 10 percent as in the general small group market. Inside the HIPC, premiums vary solely due to geography (six regions), family structure (four categories), and age (seven categories). The HIPC requires a minimum employer contribution of 50 percent of the lowest-cost, employee-only plan and participation from at least 70 percent of eligible employees (100 percent when the group has two or three eligible employees).⁴

AB1672 allowed for, but did not mandate, a formal process for adjusting payments to plans to account for risk differences across enrollees not captured by the HIPC's age-related premium schedule. Working in conjunction with actuaries from Coopers and Lybrand, the MRMIB staff developed such a process, which was put into use in 1996 and affected payments to plans for the 1996-97 contract year.

III. CURRENT STATUS OF THE HIPC

Enrollment Trends

During its first 30 months (July, 1993 to January, 1996), HIPC enrollment grew at a fairly steady, though decreasing, rate.⁵ More recent data, presented in Table 1, tell a similar story. For the last three calendar years (1995-97), the HIPC's growth rate, measured as an increase in the number of employer groups enrolled, was 29 percent, 18 percent, and 13 percent, respectively.

Table 1. HIPC Enrollment January, 1995 to January, 1998

	January 1995	January 1996	% Change 1/95-1/96	January 1997	% Change 1/96-1/97	January 1998	% Change 1/97-1/98
Total Groups	4,278	5,529	29%	6,500	18%	7,321	13%
Total Employees	5,170	56,930	26%	67,478	19%	75,873	12%
Total Enrollees	79,898	101,230	27%	120,999	20%	136,471	13%

Source: California Managed Risk Medical Insurance Board monthly reports.

HEALTH INSURANCE PURCHASING ALLIANCES FOR SMALL FIRMS

At the end of its first year of operation, the HIPC's enrollment represented roughly one percent of the small group market.* Since that time, there has been steady growth in small firm employment due to the strong recovery of the California economy. Table 2 combines HIPC enrollment data with information from the California Economic Development Department (EDD) to provide an updated estimate of the HIPC's market share. Differences in time period between the two data sources along with the fact that the EDD data do not distinguish between firms that do and do not offer insurance limit the precision of the calculation. Nonetheless, this "back of the envelope" estimate suggests that the growth in the number of firms choosing the HIPC has not outstripped the growth in the number of small firms created by the economic recovery. As a result, the HIPC's share of the small group market remains roughly one percent.

Table 2. HIPC Market Share by Group Size

Employee Size Category	All CA Firms ^a		All CA Firms with Insurance ^b		HIPC Firms ^c		HIPC Firms as a % of...	
	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(i) (ii)	(v) (vi)
2 to 10	659,289	80.4%	374,476	74.6%	3,697	71.2%	0.6%	1.0%
11 to 50	160,555	19.6%	127,596	25.4%	1,495	28.8%	0.9%	1.2%
Total	819,844	100.0%	502,072	100.0%	5,192	100.0%	0.6%	1.0%

Notes: ^a Figures for All CA firms are from the California Employment Development Department (EDD) and pertain to 3rd Quarter 1996 (the latest period for which data are available). The EDD reports data for firms with 0 to 9 employees. These figures have been adjusted based on the assumption that the number of firms with 2-10 employees = .9 x the number with 0 to 9.
^b The number of CA firms with insurance is calculated by multiplying EDD figures on the total number of firms by an estimate of the percentage of firms in each size category offering insurance. Offer rate estimates are from T. C. Buchmuller and G. A. Jensen, 1997, "Small Group Reform in a Competitive Managed Care Market: The Case of California, 1993 to 1995," *Inquiry* (Fall 1997): 249-263.
^c HIPC figures are from 11/96.

Characteristics of Groups Enrolled in the HIPC

Table 3 presents various measures that are collected and published by the MRMIB, including age of employees enrolling, percent of firms previously without coverage, and percent of employers utilizing brokers for enrollment services. Average firm size has held constant at approximately 10 employees since the HIPC began. The HIPC pool, initially younger than expected,⁷ has aged—the percentage of enrollees under age 40 has fallen from 62 percent to 56 percent since 1994—but does not appear to be older than the population in small firms providing coverage.⁸ The percentage of groups enrolling through a broker has always been fairly high, in the range of 70 percent, but it increased significantly after 1997, when the HIPC eliminated the financial incentive for employers to enroll directly without paying a broker commission. The percentage of the HIPC firms that were previously uninsured has held relatively constant at 20 percent.

HEALTH INSURANCE PURCHASING ALLIANCES FOR SMALL FIRMS**Table 3. Characteristics of Firms Enrolled in the HIPC and their Employees**

	January 1994	January 1995	January 1996	January 1997	January 1998
Groups					
% Using a Broker					
all groups	75.5%	68.5%	67.5%	71.9%	70.6%
groups enrolling since 7/97	—	—	—	—	94.5%
% Previously Uninsured ^a	21.8%	21.5%	20.4%	18.5%	— ^b
Employees					
Age Distribution					
Under 30	28.4%	27.5%	25.3%	26.2%	24.1%
30 to 39	33.5%	33.2%	33.3%	32.5%	31.8%
Under 40	61.9%	60.7%	58.6%	58.7%	55.9%
40 to 49	22.5%	23.7%	24.9%	25.1%	25.7%
50 to 59	11.7%	12.0%	12.6%	12.8%	14.4%
Over 60	3.8%	3.7%	3.7%	3.4%	4.0%
% Male	56.8%	55.8%	55.7%	56.5%	57.0%

Source: California Managed Risk Medical Insurance Board monthly reports.

Notes: ^a Figures refer to the percentage of groups previously uninsured, not the percentage of employees. Since previously uninsured groups tend to be smaller than average, the percentage of previously uninsured individuals is lower.

^b In late 1997, there was a change in the method used to calculate the percent previously uninsured. According to the MRMIB staff, the percent previously uninsured in January, 1998 is not materially different than in previous months.

A 1997 survey by the MRMIB provides some additional information about HIPC enrollees.⁹ Income is relatively high, with 48 percent of HIPC households earning over 400 percent of the federal poverty level and only 19 percent earning under 200 percent of the poverty level.¹⁰ The majority of HIPC households have no children. Only 38 percent of employers provide some contribution toward dependent coverage; most employees with children must pay in full for their children's coverage. Despite this, almost all employees (92 percent) with children choose to cover them. One-third of employees make no contribution to the cost of their HIPC coverage, one-third pay up to \$100 per month, and the remainder pay over \$100 per month.

Employer Awareness

The awareness of the HIPC's existence among small firms has been quite limited. A 1995 survey of California small employers found that only 24 percent were aware of the HIPC.¹¹ One might expect a low level of awareness during the early years of the HIPC, but two 1997 surveys showed only a slight increase in the percentage of small employer—30 and 32 percent—who had heard of

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HIPC has responded to the market rather than vice versa. This view is consistent with the recent upturn in premiums in both the HIPC and the market as a whole."

IV. LESSONS LEARNED

An understanding of the HIPC's structure, enrollment, premium trends, and other features is useful in evaluating the degree to which the alliance attracts small firms and is a viable option on the market. At least as interesting and useful, however, is a broad look at the experience to date with this social policy experiment. The next section discusses four lessons that have been learned from the HIPC in its first five years.

Lesson 1: The Effect of Voluntary Alliances on Insurance Coverage

AB1672 and similar small group reforms enacted in other states were motivated, in large part, by a desire to extend insurance coverage. The focus on the small group market reflects the fact that a disproportionate number of the uninsured are employees of small firms and their dependents, and that the small group market was rife with insurer practices that were objectionable on both efficiency and equity grounds. There is some evidence that insurance provision by very small employers in California increased in the two years following AB1672's enactment, though it is impossible to determine how much of this change was caused by the reforms and how much was due to other factors, including the state's recovery from a deep recession.²⁰ The HIPC's small share of the market, combined with the fact that roughly 80 percent of the firms enrolling in the program were previously insured, suggests that the HIPC itself has had essentially no impact on the number of Californians with health insurance.

The idea that voluntary purchasing alliances are not "the answer" to the problem of the uninsured should come as no surprise to anyone familiar with the economics of small firms and the small group insurance market. Nonetheless, given the ambitious rhetoric that often accompanies incremental insurance reforms, it is useful to note the limited potential of alliances for extending coverage.

Without providing explicit subsidies to small firms, the main way that a purchasing alliance might increase coverage is by offering lower premiums, due to an ability to negotiate better rates from plans and to achieve economies of scale in marketing and administration. However, in the case of the HIPC, the "power of the pool" does not appear to have materialized. Participating plans do not view the HIPC as a separate market, in the way that they do large groups such as CalPERS, but as one of several product lines they offer to small firms. The experience of the HIPC also appears to support the skepticism of some analysts as to the ability of alliances to generate economies of scale. One such skeptic, Mark Pauly, professor of Health Care Systems and Insurance at the University of Pennsylvania, writes:

"[t]he higher per-employee administrative cost in a set of ten, 25-employee firms, as compared to a single group of 250, arises because each firm must be sold

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the HIPC.¹² This limited awareness is not unique to the HIPC. California Choice—the other organization in California that offers a selection of health plans to small firms—registered even lower recognition scores, in part because it began operations in 1996. Similar results have been reported in other areas of the country with respect to employers' knowledge of purchasing alliances,¹³ programs providing premium subsidies,¹⁴ and small group reform legislation.¹⁵

Why don't more small employers know about the HIPC? One explanation is that health insurance is a relatively low priority for most small employers, who tend to rely on brokers for information. For reasons that will be discussed in the next section, the initial response of many brokers to the HIPC ranged from indifference to hostility; it appears that, at least initially, many brokers simply did not inform their small firm clients about the HIPC.¹⁶

Another explanation for the low level of awareness is the limited resources that have been available for marketing. Of the \$2.4 million in marketing funds that were budgeted for FY 1997-98, the HIPC's administrator, Benefit Partners Inc., spent \$2 million for staff members and other costs associated with providing service to brokers who sell the HIPC. This allocation is critical because the broker community is the main distribution channel for selling coverage to small firms. This outlay, however, leaves only \$400,000 for statewide marketing efforts, such as direct mail to employers. These funds fall far short of the amount required to establish and maintain brand name recognition of the HIPC for the 34 million people living in California. The HIPC's staff estimate that a reasonable budget would be at least three times the current allocation.

Premium Trends

A common argument for purchasing alliances in general, and one that has been made specifically in reference to the HIPC, is that group purchasing provides small employers greater leverage in negotiating premiums with plans. Indeed, HIPC brochures and much of the media coverage of the program make such claims. In order to understand the HIPC's place in California's small group market and, more generally, to assess the ability of purchasing alliances to deliver on the promise of lower premiums, it is useful to examine the premium trends for the HIPC plans and to determine whether they resulted from "the power of the pool" or simply from market-wide factors.

Each spring, the MRMIB negotiates premiums with all participating plans. The first round of negotiations (in the spring of 1993) produced rates that were reportedly 10 to 15 percent below those prevailing in the general small group market.¹⁷ Average premiums for the HIPC HMO premiums fell in each of the next two years. However, the first few years saw intense price competition in California's health insurance markets; during the mid-1990s, both large and small employers in the state experienced premium decreases.¹⁸

The question of whether the HIPC's size translates into greater bargaining power and hence lower rates can be rephrased as follows: Do health plans treat the HIPC as a distinct and separate market, or are their HIPC rates determined by market conditions pertaining to the small group market generally? Our interviews with representatives from a number of plans suggest the latter, which is not surprising given the HIPC's small size relative to the market as a whole. While the MRMIB's initial negotiations with plans in 1993 did have an effect on premiums, in subsequent years the

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insurance, each firm must receive a premium bill, and each firm must be serviced... But combining the ten firms into one HIPC does not change the number of sales, bills, or services required; you cannot make a giant just by rounding up a passel of midgets."²¹

Like the similarity of premiums inside and outside the HIPC, changes in the HIPC's approach to compensating brokers are consistent with Pauly's argument. In 1997, the HIPC increased brokers' commissions and began charging fees to groups enrolling in the program directly. While these changes were motivated in part by a desire to improve broker relations, they reflect recognition that the administrative costs associated with enrolling small firms previously had been underestimated.

In addition to providing further evidence on the limits of incremental reform, California's experience offers a somewhat more subtle lesson on the relationship between alliances like the HIPC and reforms affecting the entire market. Had the new rules, such as guaranteed issue and renewal, applied only to the HIPC, there likely would have been adverse risk selection against the alliance; high risk firms would have been drawn to the HIPC, while low risk firms would have found more favorable rates in the general market. Over time, this sorting would have caused the HIPC to evolve into a high-risk pool, or perhaps go out of business altogether. The fact that, with minor exceptions, the same rules apply inside and outside the HIPC has prevented this outcome. It is also possible, though somewhat ironic, that the inability of the HIPC to offer PPO products has prevented adverse selection, since PPOs tend to attract firms with sicker employees who want broader choice of specialty providers than are offered by HMOs.

While the congruence of rules inside and outside the HIPC may have ensured the alliance's viability, this situation may also have limited the HIPC's growth. A case can be made that the AB1672 reforms brought stability to the general small group market, and increased price competition by "leveling the playing field" and forcing the exit of insurers that had competed primarily on the basis of risk selection. To the extent that this occurred, the general market reforms may have reduced small employers' need for a program like the HIPC.

Lesson 2: The Role of Brokers in the Small Group Market

Policymakers and analysts are becoming increasingly aware of the important role that brokers play in the small group and individual health insurance markets.²² The HIPC's management and independent observers alike agree that the HIPC's relations with brokers got off to a rocky start. The attitude of the MRMIB, in keeping with the tone of the times, was that brokers added little value to the insurance transaction. Eliminating broker commissions, which amount to 8 to 10 percent of premium, would further the mission of the MRMIB by lowering premiums in the small group market, thereby increasing affordability and expanding access to small firms that previously had not been able to purchase coverage.

This perspective is hardly surprising, given its historical context. Decisions regarding broker compensation were made in late 1992 and early 1993. The managed competition model, on which both the ill-fated Clinton health plan and the HIPC were based, emphasized consumer choice

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among plans offering standardized benefit packages; there was no role for brokers. The assumption was that providing apples-to-apples comparisons would attract consumers by allowing them to choose easily among available options based on price, network, and quality.

Three features of the HIPC's initial enrollment structure and broker compensation system reflected the perspective that brokers add little value to the health insurance transaction. First, employers interested in joining the HIPC were allowed to bypass brokers and avoid their fees. Second, broker fees were itemized on the employer's HIPC bill, serving as a monthly reminder that the broker was receiving compensation regardless of services rendered during that month. Third, broker commissions were low relative to commissions offered outside the HIPC. In addition to creating significant animosity from brokers themselves, the MRMIB's early policies also contributed to the decision of two carriers with close ties to brokers, Blue Cross and Blue Shield, not to participate in the HIPC.

A number of factors contributed to a shift in the MRMIB's perspective. First, the Clinton health plan failed, eliminating the possibility that brokers would be made irrelevant by the reforms. Second, HIPC administrators found that employers who enrolled directly required more time and staff resources than those enrolling through brokers. But perhaps the most persuasive evidence of the value provided by brokers was that, despite the financial advantages of enrolling directly, 70 percent of firms joining the HIPC during its first three years came through a broker and voluntarily paid the commission.

The HIPC responded by altering its enrollment structure and compensation system. Commissions—both first-year and renewal—have increased since the HIPC began.²² The option to bypass brokers and avoid paying their fees has been eliminated; now, all employers who use brokers pay broker fees, and all other employers pay "in lieu of" broker fees of the same amount. The HIPC's management estimates that the elimination of the bypass option resulted in an increase of 10 percent in the number of brokers selling the HIPC. The HIPC has also initiated programs to offer additional rewards to brokers who enroll multiple employer groups and keep them updated on the HIPC's developments.

The changes in the compensation structure and these other initiatives appear to have been successful in improving broker relations. According to the HIPC's management, approximately 2,500 to 3,000 brokers currently sell the HIPC, a number that translates to about 15 to 20 percent of California brokers active in the small group market in California. The MRMIB is considering a policy of "burying" the broker's fee in the premium—converting the broker's fee to a percent of premium and including it in the HIPC's rates. This policy change would bring the HIPC in line with standard industry practices, and many believe it would improve broker relations and bolster the HIPC's sales and enrollment.

Lesson 3: Different Aspects of Choice

While there is evidence from a number of studies that health plan satisfaction is greater among employees who were given a choice of plans,²⁴ the vast majority of small firms that offer insurance to their workers offer only one plan.²⁵ In contrast, employees of firms choosing the HIPC enjoy a menu of between 11 and 15 HMOs and one or two POS options (depending on the region), each

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of which has two levels of cost-sharing. This wide choice of plans is perhaps the HIPC's defining feature.

Another aspect of choice important to consumers is the freedom to choose one's own physician, including the ability to self-refer to specialists. Because they provide some coverage for out-of-network care, PPO and POS products allow enrollees more provider choice than do HMOs. Although initially the HIPC menu included PPOs, dynamics of choice at the employee level led to adverse selection, which ultimately drove the PPOs from the program. Unable to attract new PPOs, HIPC policymakers added the POS design to the menu in July 1996. However, currently only two carriers offer POS plans, and those plans are substantially more costly than the least expensive HMOs. As Table 4 shows, only seven percent of HIPC enrollees had elected POS coverage as of April, 1998. One lesson that can be drawn from the HIPC's experience is that allowing employees greater freedom to choose their own plans may result in a reduction in other aspects of choice, such as the choice of type of plan.

Table 4. The Distribution of HIPC Enrollment by Health Plan, April, 1998

Health Plan ^a	Enrollment	% of Total Enrollment	No. of Regions Available
Kaiser North	29,754	21.8	3
Kaiser South	20,977	15.3	4
Aetna	15,146	11.1	6
PacificCare	13,103	9.6	6
Health Net	11,816	8.6	6
Blue Shield	11,246	8.2	6
Blue Shield POS	8,838	6.5	6
Lifeguard	7,995	5.9	3
CIGNA Healthcare	5,291	3.9	6
Metrahealth ^a	2,654	1.9	5
Universal Care	2,203	1.6	3
Omnii	1,675	1.2	3
Sharp Health Plan	1,625	1.2	1
CareAmerica	1,151	0.8	4
Kaiser North POS	781	0.6	3
National HMO	703	0.5	6
HMO California ^a	525	0.4	3
Blue Shield PPO ^{b,c}	505	0.4	3
CIGNA Select	185	0.1	3
Molina Medical Centers ^a	123	0.1	5
United Health Plan	109	0.1	3
Chinese Comm. Health Plan	107	0.1	2
SmartCare ^b	77	0.1	4
Contra Costa Health Plan	65	0.05	1
Total	136,658	100	6

Source: The California Managed Risk Medical Insurance Board: The HIPC.

Notes: ^a Unless otherwise noted, the product offered is an HMO.

^a Plan will be available during the 1998-99 contract year under a different name.

^b Plan will not be available during the 1998-99 contract year.

^c Available only in areas not covered by Blue Shield's HMO network.

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It is difficult to determine the extent to which the lack of a PPO option has limited the HIPC's growth. The fact that roughly one third of small California employers that offer insurance have chosen PPOs²⁴ suggests that many employers tend to prefer alternatives available outside the HIPC. While the HIPC's POS products may be an adequate substitute for some firms, those that strongly value choice of physician are likely to prefer PPO products. The POS product is based on the HMO model—essentially an HMO that allows the consumer to opt out at time of service—while the PPO product is built around the indemnity model and unlimited choice of physician. One alternative that offers strong competition to the HIPC is the "dual choice" option that many plans now offer. With dual choice, employees can choose from two or more products, frequently one HMO and one PPO, offered by a single health plan. This allows a situation that was initially possible within the HIPC: the owner and the high-wage employees of a small firm can choose PPO coverage, while the more price-sensitive employees can choose the HMO. Since both plans are insured by the same carrier, the costs associated with adverse selection are internalized.

When managed competition was being discussed as a model for national health care reform, there was some debate as to how many plans should be allowed to compete in a purchasing alliance's internal market. While some analysts claimed that more options could only improve consumer welfare, others argued that too many plans would essentially lead to information overload. In the case of the HIPC, there has been some discussion that 19 plans might be too many. The fact that the HIPC's internal market is quite concentrated—over 80 percent of enrollees are in five plans, while 12 other plans have market shares of less than two percent each—raises a question about the added value of offering many small plans with few enrollees. Negotiating rates and administering enrollment for these twelve plans is costly and time-consuming, and it is not obvious that these options make the pool more attractive. Anecdotal evidence suggests that the HIPC is unappealing to some small employers because it seems complex and confusing. Reducing the number of plans offered might make the HIPC appear simpler to this group, while not diminishing its appeal to employers attracted to the program by the choice of plans.

The argument for reducing the number of plans offered through the HIPC is strengthened by the degree to which provider panels overlap in California's current managed-care environment. While proponents of managed competition originally envisioned competition among plans with mutually exclusive provider networks, most of the plans in California are network model HMOs with overlapping provider panels. Thus, above a baseline number of plans, the incremental plan adds little provider choice. The clear exception is Kaiser Permanente. In fact, one way that the HIPC still offers an element of choice that is unique is that it allows employees to choose between Kaiser and other HMOs. This is generally not an option in the small group market because most other plans do not want to be offered side-by-side with Kaiser.

Lesson 4: The Reality of Risk-Adjustment

The fact that employee choice among plans led to adverse selection against the PPOs is not unique to the HIPC. Similar outcomes have been documented in other larger employer-sponsored groups organized on the managed competition model.²⁷ While proponents of managed competition have

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long acknowledged the importance of risk-adjusting payments to plans, however, very few employers have adopted risk-adjustment procedures. Therefore the HIPC's risk assessment/risk adjustment process (RARA) provides an opportunity for learning how risk adjustment can work in practice.

The risk-assessment component of the RARA process compares plans in terms of three risk factors: gender, family size, and medical diagnosis.²⁹ Risk-assessment values (RAVs) are calculated for each risk factor. The RAV for the medical diagnosis factor is based on a set of "marker diagnoses" that require an inpatient stay and are expected to have a high cost. Actuarial data from several carriers are used to calculate cost-based weights for these diagnoses. All plans submit data on the number of enrollees who had been hospitalized in the prior year for any of these diagnoses.²⁷ Plans that do not report any members with marker diagnoses are assumed not to have any. As a result, plans have a financial incentive to collect and report the diagnostic data. All information submitted by the plans is audited by the MRMIB staff.

An advantage of limiting the marker diagnoses to ones requiring hospitalization is that it reduces the discretion of health plans in designating "high risk" enrollees, and thereby reduces the potential for gaming the system. A disadvantage is that it fails to account for high cost diagnoses, such as HIV/AIDS, that are treated largely on an outpatient basis. With the tendency of managed-care plans to substitute outpatient care for inpatient care, this is a potentially important shortcoming. The exclusive use of inpatient data in the risk-assessment process is not due to resistance on the part of the MRMIB or Coopers and Lybrand to accounting for a broader range of diagnoses. Rather, the major stumbling block for incorporating additional diagnoses into the RAV formula is that many plans cannot provide the necessary outpatient data.

The three component RAVs are combined (with some additional adjustments for plans with very low enrollment) to create an overall RAV, which is normalized so that the value for the entire pool equals one. The distribution of RAVs across plans determines whether the risk-adjustment process is engaged—i.e., whether or not funds are transferred from lower risk to higher risk plans. If all plans have RAVs falling within the range of .95 to 1.05, no funds are transferred. If, however, any plans fall outside this range, an iterative procedure is used for transferring funds. The process starts by transferring funds from low outliers to high outliers. The ultimate goal is that these transfers will pull the outlier plans' RAVs within the .95-1.05 range. Plans that fall outside this range will always be affected by the risk-adjustment process. Since the total dollar amount required to bring low outliers to .95 need not equal the amount required to bring high outliers to 1.05, plans that were not outliers may also end up making or receiving transfer payments.

One lesson from the HIPC's experience is that risk assessment and risk adjustment do not require a large bureaucracy or a large increase in administrative costs. Another is that the transfer of funds necessary to counter imbalances in the distribution of risks need not be so large as to disrupt the workings of the market. Table 5, which summarizes the results for the RARA process, shows that in each of the three years the process was used, the majority of plans were unaffected—i.e., they neither made nor received transfer payments. When plans were affected, the amounts paid or received were generally small, although there were some exceptions. For example, in the first year of the process, the plan with the highest RAV received a transfer of \$46.04 per enrollee, per month. In the next two years, however, the maximum amount transferred was substantially

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lower. In the most recent year, the most received was \$9.07, and the highest amount paid into the RARA system was \$5.37 per enrollee, per month. That year, the total funds transferred represented 0.11 percent of the total premiums collected.

Table 5. HIPC Risk Assessment Risk Adjustment Results, 1996-97 to 1998-99

	Contract Year		
	1996-97	1997-98	1998-99
No. of plans participating	24	27	24
No. of plans affected	8	6	6
No. of low outliers (RAV < .95)			
- HMO	2	3	1
- PPO/POS	0	0	0
No. of plans making payments			
- HMO	7	3	4
- PPO/POS	0	0	0
Monthly risk adjustment (range)	\$0.69 - \$10.70	\$0.65-\$3.36	\$2.00 - \$5.37
No. of high outliers (RAV > 1.05)			
- HMO	0	0	1
- PPO/POS	1	0	1
No. of plans receiving payments			
- HMO	0	2	1
- PPO/POS	1	1	1
Monthly risk adjustment (range)	\$46.04	\$0.50 - \$2.11	\$2.73 - \$9.07
Transfers as a % of premium revenue	1.14%	0.04%	0.11%

The goal of risk adjustment is not to subsidize plans that have higher costs or to standardize premiums across competing plans. Rather, it is to minimize the incentives for plans to engage in cream-skimming, and to ensure that plans are not priced out of the market simply because they enroll a disproportionate share of persons who are costly to insure. The fact that PPOs were the victims of adverse selection and exited the HIPC despite receiving transfers via the RARA process might lead one to conclude that the process was unsuccessful in maintaining broad choice options for enrollees. This interpretation ignores some special circumstances pertaining to the HIPC. From the start, PPOs captured a very small share of the HIPC's internal market, which may have hastened the movement of these plans along the adverse selection "death spiral." It is possible that in a setting where the plan or plans receiving a disproportionate share of high-risk enrollees have a larger enrollment base, a process like the HIPC's RARA would be more successful in stabilizing the system and heading off a downward spiral.³⁰ It is fair to say, however, that even a sophisticated and well-designed risk-adjustment mechanism may not be sufficient to completely counter the corrosive effects of biased risk selection in a managed-competition environment. Dual (HMO/PPO) offerings by individual health plans appear to be successful in mitigating this form of adverse selection.

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V. PROSPECTS FOR THE FUTURE

The Privatization Initiatives

In 1996, as directed by the statute, the MRMIB issued a request for proposals (RFP) offering ownership and control of the HIPC to private nonprofit entities that had no conflict of interest (no insurer or broker membership on governing board) and who were able to pay off the balance of the loan that covered start-up expenses (about \$3 million). No bids were submitted. The following year the MRMIB issued a new RFP and received two bids. In both cases, the bidding entities were managed by individuals having extensive experience with purchasing alliances in the public sector (rather than, for example, experience with the brokerage or insurance business). The MRMIB accepted the bid from Provider Choice, a nonprofit entity led by John Ramey, the executive director of the MRMIB during the early years of the HIPC. The losing bidder was the Institute for Health Futures (IHf), whose senior management included Tom Elkin, former head of the public employees purchasing alliance (CalPERS) and Bruce Bronzan, former chair of the California Assembly Health Committee. The IHf appealed the criteria used by the MRMIB to award the HIPC to Provider Choice. Without addressing IHf's specific objection, the state's General Services Department invalidated the award on the basis that inadequate financial information had been provided to the bidders, and returned the HIPC to the MRMIB.

In 1998, the MRMIB issued a third RFP for the privatization of the HIPC. This RFP was more detailed than the previous versions, requesting specific information on how the bidding entities would improve the performance of the HIPC after assuming control. In particular, it requested explanations of which procedures and policies the private board would implement regarding use and reimbursement of brokers, employee choice of health plan (as distinct from employer choice), benefit designs, use of rate bands, open enrollment, marketing strategies, and risk adjustment. This seemed to reflect a desire on the part of the MRMIB to ensure that the private board would indeed improve performance and grow enrollment in the HIPC, rather than let it dwindle.

If the third attempt at privatizing the HIPC is successful, the MRMIB will repeal the regulations that govern the HIPC and the new entity will have wide latitude in changing the rules. Issues to be decided by the new management will include the number and identity of plan partners, operating procedures, benefit package design, participation requirements for small firms, and marketing and distribution strategy. Among other potential changes, a privatized HIPC might: offer fewer plans; replace annual open enrollment with rolling renewals; offer high-copay or high-deductible products with lower premiums; offer PPOs, and reduce the potential for adverse selection by switching from employee to employer choice of plan; and offer new products, such as life insurance and pension plans.

Participants and observers in the small group insurance sector express a range of views on the purposes and possibilities of privatization. These views include considerable speculation and are flavored by the individuals' political and business perspectives.

Nevertheless, they raise interesting and potentially important policy questions. A wide spectrum of opinion supports the privatization of the HIPC at this time. This support comes both from

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longtime critics of the MRMIB, such as brokers, but also from traditional supporters who feel that the HIPC would better grow and fulfill its mission if it were in the private sector. Conservative critics have always felt that public ownership and governance was at best a transitional mechanism, valuable perhaps for establishing credibility and stability, but now clearly unnecessary. Some liberal supporters of the MRMIB feel that there are continuing advantages to public governance but that these must be balanced against the disadvantages. Disadvantages of public governance include slow decision making, the ability of competitors to observe and participate in decision making, the cultural differences and occasional animosity between governmental administrators and the entrepreneurial broker community, and the shift in focus by the MRMIB from the small group market to the very different economic and political issues raised by the Healthy Families program for which it has been made responsible.

Other observers express skepticism that privatization offers significant advantages to the HIPC, especially given that for-profit and broker-affiliated entities are barred from bidding. The social entrepreneurs who have expressed the greatest interest in running the alliance share many of the social policy views that have guided the HIPC while under the MRMIB's authority. They may face continuing difficulties in overcoming skepticism and antipathy from brokers. Moreover, it is unclear that the slowdown in enrollment growth derived from the policies of the MRMIB rather than from, for example, a durable lack of interest in participation by small firms who can obtain equivalent coverage and rates directly from health plans.

Competing Purchasing Alliances

The legislation creating the HIPC neither envisaged multiple competing alliances nor proscribed them. Indirectly, however, it favored the single alliance concept by exempting the HIPC (and only the HIPC) from regulation by the DOC and the DOI. No criteria were established by statute to evaluate or regulate alternative alliances. The agencies have subsequently developed formal (DOI) and informal (DOC) criteria, but there has been no rush of applications. The paucity of entities interested in establishing competing purchasing or marketing alliances parallels the paucity of respondents to the RFPs for the HIPC privatization, raising serious questions about the future of alliances as a central feature of the private health insurance industry.

The passage of AB1672 stimulated speculation that associations of small businesses, brokerages, consulting firms, and other entities would strive to develop health insurance purchasing alliances. The only entity actually operating in the small group market in California, however, is Word and Brown, a general agency based in Orange County that developed an alliance under the name of California Choice. California Choice received authorization from the DOC to operate as a marketing alliance, rather than a purchasing alliance, under the condition that it not sign contracts with small firms and insurers (in which case it would need to be licensed as a health plan and abide by the regulatory framework governing these plans).

California Choice has developed several benefit designs and negotiates rates for these products with a range of health plans. Small firms that join California Choice contract directly with the health plans, using the benefit designs and rates established by California Choice, rather than con-

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tract with the alliance and have the alliance contract with the plans. (By way of contrast, the HIPC contracts with employers and insurers directly, and is exempted from DOC regulation by AB1672.) Individual employees can choose among all the plans covered by California Choice, but the employer must sign a contract with each individual health plan chosen by any employee. California Choice claims to have approximately 42,000 employees and dependents in the small group market.

The DOI expressed concerns over the manner in which California Choice received authorization from the DOC. It lent support to legislation, originally drafted by the broker community, that would create a regulatory mechanism for purchasing alliances under the oversight of the DOI. The proposed legislation was amended considerably based on input from the DOI, the MRMIB, and lobbyists; in its final version it prohibits brokers from owning purchasing alliances. The legislation, sponsored by Senator Peace (D-El Cajon) as SB1559, was passed in 1996. It authorizes the creation of purchasing alliances (i.e., entities that contract with both employers and insurers) and does not restrict its coverage to alliances focused on the small group market. SB1559 exempts marketing alliances which have obtained approval from the DOC, or are already in process with the DOC, from having to gain DOI certification. In particular, California Choice has been able to continue its activities as a marketing alliance without DOI regulation and oversight. Likewise, Benefits Alliance, which focuses on the mid-sized market of firms with 51 or more employees (and hence is not in competition with the HIPC), is exempt from DOI certification under SB1559. As a marketing alliance, it follows contracting procedures analogous to California Choice.

At this point, no firm has been certified as a purchasing alliance by the DOI and none are currently in the process of seeking certification. Several observers described the certification process established by SB1559 and the DOI as complex, time consuming, and expensive.

VI. CONCLUSION

Purchasing alliances for small firms already operate in a number of states, and federal policymakers have expressed interest in encouraging the creation and development of such alliances. The experience of the HIPC informs the outlook for these ventures both by establishing that purchasing alliances are viable market alternatives and by limiting expectations about what they can accomplish. Without subsidies, voluntary alliances will be unable to expand health insurance significantly among small firms. They can, however, provide an option that is distinct from others available in the market, which is attractive to numerous small firms.

One of the most valuable legacies of the HIPC may be the oversight and operational experience that the MRMIB has gained during the HIPC's first five years. Its pioneering efforts to shift governmental health programs from an indemnity to a purchasing framework have benefited participants in the state-subsidized Access for Infants and Mothers program and Major Risk Medical Insurance Program, as well as the small firms purchasing through the HIPC. Beginning in July, participants in Healthy Families, which will provide subsidized coverage for children in low-income households, will also benefit. In the long term, these purchasing strategies have the potential to expand insurance by subsidizing premiums within a multiple-choice framework.

HEALTH INSURANCE PURCHASING ALLIANCES FOR SMALL FIRMS**INTERVIEWS**

Cliff Allenby, Chair, Managed Risk Medical Insurance Board
Debbie Althouse, Director of Product Development for the Small Group Market, PacifiCare Health Systems
Skip Bishop, Chief Financial Officer, Benefit Partners, Inc.
Russell Clark, Director of Government Managed Care Programs, Blue Shield of California
Bob Crichlow, Executive Director, Benefits Alliance
Bill Dewey, Crawford & Crawford
Carl Dickerson, President, Dickerson Employee Benefits
David Duker, Vice President, Market Development, Word and Brown
Mitch Goodstein, Senior Vice President, Health Care Economics, PacifiCare Health Systems
Barb Hendricks, RFP Benefits
Alan Katz, Senior Vice President, Small Group and Individual Sales, Blue Cross of California
Richard Krolak, Ph.D., Controller/Assistant Treasurer, Provider Choice, Inc.
Steve Lindsay, Lindsay and Associates
Dave Ludwig, Senior Vice President, Sales and Marketing, Unicare
Jim Matura, Vice President, Sales and Marketing, PacifiCare Health Systems
Mary Melton, Strategic Accounts Manager, Small Business Unit, Kaiser Permanente
Leslie Peters, Senior Consultant, Coopers and Lybrand
John Ramey, Chief Executive Officer, Provider Choice, Inc.
Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board
Richard Spohn, Partner, Nossaman, Gunther, Knox & Elliott, LLP
Jack Steinbarth, Vice President of Business Development, Benefit Partners, Inc.
Patricia Steinbarth, Executive Director, Health Insurance Plan of California; President and Chief Executive Officer, Benefit Partners, Inc.
Glenn Terwilliger, Vice President, Corporate Underwriting, PacifiCare Health Systems
Donna Yates, Sales Manager, Health Insurance Plan of California/Benefit Partners, Inc.
Barbara Yonemura, Senior Corporations Counsel, State of California Department of Corporations
Amy Zajac, Legislative Advocate, Policy, Research, and Special Projects, Department of Insurance

All interviews took place between March and May, 1998.

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ENDNOTES

- ¹ T. R. Oliver and E.B. Dowell, "Interest Groups and Health Reform: Lessons from California," *Health Affairs* (Spring II 1994): 123-141.
- ² Point-of-service is a hybrid between the comprehensive coverage of HMOs and freedom of provider choice in conventional plans; in-network care is generally provided with minimal cost-sharing, while out-of-network care offers freedom of choice but entails substantially more cost-sharing.
- ³ Standard HMOs require a \$15 co-payment for outpatient visits and a \$100 deductible for inpatient care. Individuals choosing preferred HMO coverage face \$5 outpatient co-pays and no inpatient deductible. The in-network benefits for the POS plan fall in between the two HMO options—copayments of \$10 per office visit and \$100 per admission. Patients opting to go out-of-network face a deductible of \$250 or \$500 (depending on whether they choose the standard or preferred option) and a 30 percent coinsurance rate.
- ⁴ Eligible employees are those that work at least 30 hours per week, and have been employed for at least 30 days; the definition excludes workers who are part-time or temporary, and those who waive coverage because they are covered elsewhere.
- ⁵ T. C. Buchmueller, "Managed Competition in California's Small Group Market," *Health Affairs* (Mar/Apr 1997): 218-228.
- ⁶ D. Lipson and J. De Sa, "The Health Insurance Plan of California: First Year Results of a Purchasing Cooperative," (Washington: Alpha Center, January 1995).
- ⁷ D. Lipson and J. De Sa, "The Health Insurance Plan of California: First Year Results of a Purchasing Cooperative," (Washington: Alpha Center, January 1995).
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- ¹⁰ Federal Poverty Level for 1998 is \$16,450 for a family of four.
- ¹¹ T. C. Buchmueller, "Government Sponsored Employer Purchasing Cooperatives: The Early Experience of the Health Insurance Plan of California," in *Competitive Managed Care*, ed. J. D. Wilderson, K. J. Dovers and R. S. Givens (San Francisco: Jossey-Bass, 1996).
- ¹² The 32 percent figure comes from a UCLA-KPMG survey cited in H. Schauffler et al., *The State of Health Insurance in California, 1997*. (University of California, 1998). The 30 percent figure comes from a survey conducted by King, Brown & Partners, Inc., *HIPC Research Study Quantitative and Qualitative Results*, Report to the California HealthCare Foundation, July 1997.
- ¹³ C. G. McLaughlin and W. Zellers, *Small Business and Health Care Reform: Understanding the Barriers to Employee Coverage and Implications for Workable Solutions*, University of Michigan, School of Public Health (1994).
- ¹⁴ K. E. Thorpe et al, "Expanding Employment-Based Health Insurance: Is Small Group Reform the Answer?" *Inquiry* (Summer 1992): 128-136.

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15 M. A. Morrissey and G. A. Jensen, "State Small Group Health Insurance Reform," in R. F. Rich and W. D. White (eds.) *Health Policy, Federalism and the American States*. Washington, DC: Urban Institute Press (1996).

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most important reason for not enrolling. T. C. Buchmueller, "Government Sponsored Employer Purchasing Cooperatives: The Early Experience of the Health Insurance Plan of California" in *Competitive Managed Care*, ed. J. D. Wilderson, K. J. Devers and R. S. Givens (San Francisco: Jossey Bass, 1996).

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To: Jeff Gabardi
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- 28 A complete description of the risk adjustment/assessment methodology can be found in a number of public documents available from the MRMIB. See also, S. Shewry et al, "Risk Adjustment: The Missing Piece of Market Competition," *Health Affairs* (Summer 1996): 171-181.
- 29 The method used to translate the data on the number of enrollees with marker diagnoses into a risk index accounts for the fact that the probability of having a high cost condition increases with age.
- 30 It is likely that the decision of plans to remove their PPO products was affected by the prohibition on underpricing their HIPC products in the outside market. That is, while the PPOs might have been viable in the HIPC at a higher price, increasing premiums within the alliance would require doing so in the outside market as well.