



THE ROLE OF HEALTH CARE
PURCHASING POOLS IN IMPROVING
THE FUNCTIONING OF THE SMALL
GROUP AND INDIVIDUAL MARKETS

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NOTICE

This document is a synthesis of the concepts discussed at a roundtable meeting in which many stakeholders expressed their own views and those of their organizations. This paper is not meant to imply that there was consensus on any given issue. In fact, there was a wide range of opinion. The authors have made an attempt to capture that range of opinion while presenting a coherent overview of the discussion.

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I. Introduction

At the start of the twenty-first century, the United States health care system is, once again, nearing a crisis. Health care spending in the U.S. has reached 13.0% of the Gross Domestic Product,¹ yet 42.5 million people (15.5% of the population) remain uninsured.² In addition, after nearly a decade of manageable increases in commercial insurance premiums, many employers are now facing double-digit increases. Smaller employers are hardest hit by this trend. Much of the increase in premiums can be attributed to the availability of costly new pharmaceuticals and other technologies. At the same time, managed care, the primary cost-containment mechanism of the 1990s, has fallen out of favor with the public and has become mired in a plethora of federal- and state-level rules which, while they may be necessary to protect patients, have contributed to the increase in insurance premiums.

In this environment of escalating costs, the issue of health care reform has received renewed attention from policy-makers. Politicians and others are scrambling to develop proposals for overhauling Medicare, Medicaid, and private insurance to make them more affordable and to serve the greatest number of people. The private insurance markets are particularly difficult to influence because they are plagued by the twin problems of being both voluntary and particularly subject to adverse risk selection due to the high cost of coverage. As a result, policy-makers are concentrating on plans to pool risk in new ways (e.g., President Bush's proposed "association health plans" for small employers) and to make insurance more affordable (e.g., various tax credit proposals supported by President Bush and Congressional leaders from both parties).

Given the renewed attention to health care reform, the Kaiser Permanente Institute for Health Policy believed it was important to re-examine the reasons behind the failures found in both the small group and individual

insurance markets. To that end, the Institute held a roundtable meeting in June of 2000, in which health policy experts discussed ways of improving both markets. One of the central ideas that came out of that meeting was the concept that the small group and individual insurance markets work best when purchasing is organized by a "sponsor" that acts as an intermediary between the insurer and the purchaser. The concept of "sponsors" in the small group market is not new; it dates back to the early 1990s, when the Jackson Hole Group first introduced the concept of "health insurance purchasing cooperatives" or "HIPCs" as part of its managed competition approach.³

To better understand the role that "HIPCs" have played during the last decade and to better understand their potential to increase access going forward, the Institute for Health Policy sponsored a second roundtable discussion on this topic. **This paper provides an analysis of the current state of the health care purchasing pool market and explores the case for implementing public policy interventions to make these pools more viable. The paper is not an attempt to record the roundtable proceedings but does rely heavily on the thoughts and opinions shared by conference participants. The views expressed in the paper are those of the authors, however, and should not be attributed to conference participants or their organizations.**

The report begins with a review of the evolution of the health care purchasing pool concept, examining how expectations have changed over time. This analysis is based on the main questions addressed at the roundtable: what are the ideal roles of health care purchasing pools, and can or do they serve the public interest to such a degree that public policy interventions are warranted? The following section of this report describes the roundtable itself; the participants, the main themes and conclusions that could be gleaned from the discussion, and lists of possible public policy actions. The final section

1 Heffler, S., *et al*, "Health Spending Growth up in 1999; Faster Growth Expected in Future," *Health Affairs*, V20 N2, (March/April 2001) pp. 193-203.

2 *Health Insurance Coverage – 1999*, U.S. Census Bureau, U.S. Department of Commerce, September 2000.

3 Enthoven, A., P. Ellwood, and L. Etheredge, 1992, "The Jackson Hole Initiative for a 21st Century American Health Care System," *Journal of Health Economics*, V1 N3, pp. 149-168, October, 1992.

presents the authors' conclusions about main themes and next steps.

II. Background: Evolution of the Concept

In the past year, renewed attention has been paid to the concept of health care purchasing pools (HCPPs).⁴ In the face of significant growth in the uninsured population throughout the 1990s and increasing backlash against managed care, both major Presidential candidates in 2000 and many Congressional leaders have turned to the idea of pooling mechanisms. Such mechanisms are intended to enhance the purchasing power of small employers and individuals and to provide greater choice of plans, creating more competitive markets. The current dialogue about purchasing groups uses terms such as "Health Marts," but while the name and certain details are different, the general concept is the same – small employers banding together, under a model that promotes informed choice of multiple health plans or delivery systems, to be more effective purchasers of health insurance than they could be on their own.⁵

This concept is not new for 2001. In October of 1992, the Jackson Hole Group first introduced the concept of "health insurance purchasing cooperatives" or "HIPCs" as part of its managed competition approach.⁶ The concept was inspired by the success of large-scale individual-choice models, such as the Federal Employees Health Benefits Program (FEHBP) and the California Public Employees Retirement System (CalPERS), which provided a platform for offering selective health plans. In 1993, President Clinton's proposed Health Security Act envisioned a national health care system built around the concept of

⁴ For purposes of this paper, these purchasing groups will be referred to as "health care purchasing pools." They are also commonly known as "HIPCs" (health insurance purchasing cooperatives), "HPPCs" (health plan purchasing cooperatives), or "exchanges."

⁵ For an explanation of "Health Marts" and related concepts, see: Hall, M., E. Wicks, and J. Lawlor, "HealthMarts, HIPCs, MEWAs, and AHPs: a Guide for the Perplexed," *Health Affairs*, V20, N1 (January/February 2001), pp. 142-153.

⁶ Enthoven, A., P. Ellwood, and L. Etheredge, 1992, "The Jackson Hole Initiative for a 21st Century American Health Care System," *Journal of Health Economics*, V1 N3, pp. 149-168, October, 1992.

health care purchasing pools. While the Health Security Act itself ultimately failed to win legislative or public support, certain aspects of it found favor with the public and policy-makers, among them health care purchasing pools. Within the next several years, many states passed legislation either creating or allowing for the private-sector creation of purchasing pools to serve small employers. (Some purchasing pools had been in existence even before enabling legislation was passed.)

As originally imagined, health care purchasing pools were thought to be the answer to many aspects of market failure for both small groups and individuals.⁷ They were to promote cost-conscious, informed consumer choice which, in turn, would cause health plans to compete on quality, outcomes, and customer service, rather than on risk selection. This dynamic would result in a market characterized by affordable, high-quality insurance options for small businesses.

Health care purchasing pools were also intended to create markets in which prepaid group practices and other selective networks could compete against one another, unlike today's "single plan replacement" market, in which employers often offer one plan at a time (replacing it periodically). In a "single plan replacement" market, a plan has to satisfy all employees' provider choices and so must generally have a large, all-inclusive network. However competition among multiple plans offered simultaneously creates a market in which plans do not need to include all providers – employers can satisfy all their employees by offering a range of plans with different provider networks, rather than a single plan with one large network. It was thought that competition in such markets (i.e., in HCPPs) would eventually transform the whole medical delivery system. However, eight years later, few Americans are covered by HCPPs, and many of the old problems of accessibility and lack of choice in the small group insurance market persist. For example:

⁷ *Ibid.*

- In 2000, among firms with 3 to 199 workers that offered insurance, only 9% offered employees a choice among at least two plans.⁸
- Thirty-three percent of firms with 3 to 199 workers did not offer insurance in 2000, compared to 1% of firms with 200 or more workers.⁹
- In 1998, 47% of the nation's uninsured workers aged 18 to 64 (11.6 million people) worked for private firms with fewer than 100 workers. These workers represented more than a quarter (26%) of the nation's non-elderly uninsured.¹⁰

After several years of experience with health care purchasing pools, many analysts have asked why they have not resulted in the widespread market repair they initially promised. Some of the answers to this question are easy. For example, as proposed by the Jackson Hole Group, "HIPCs" were one part of a larger proposal for health care reform that included insurance for all, mandatory participation in state-designated health care purchasing pools, small-group and individual insurance market reform, nationally-standardized benefits, elimination of traditional financing-only insurers in favor of integrated systems of care, and consumer tax subsidies tied to the price of the lowest-cost efficient plan offering the standardized benefits. The only aspect of this proposal that has come to pass is small-group insurance reform in most states.

Without the other aspects of the Jackson Hole proposal, health care purchasing pools could not be expected to obtain the market share and power envisioned necessary to change the underlying dynamics of the small-group market. (The Jackson Hole Group suggested they should have close to one million covered lives each.) Nevertheless, such pools persist, albeit on a small scale, prompting observers to

wonder what they can realistically be expected to achieve in today's market.

It is interesting to note that in the original proposal for HIPCs, the Jackson Hole Group did not mention reduced price relative to the outside market as a benefit of such pools. This is because nearly everyone was assumed to be inside the HIPC, and the main benefits of the pool were to expand choice and access, ease administration, and promote the "right" kind of competition, all within the context of national health care reform. However, when the other aspects of the proposal largely did not come to pass, the rhetoric around purchasing pools began to focus on price. In the early- to mid-1990s, one of the great selling points of health care purchasing pools was that they would enable small groups to obtain better prices than they could otherwise obtain without such pools.¹¹ In addition, some analysts believed there might be some "spillover" effects on prices in the rest of the market.¹²

Today, there are probably fewer than 20 small-group health care purchasing pools that are close to the original "HIPC" concept.¹³ Few, if any, of these pools currently sell their products based on favorable price or even expanded access. Instead, pool sponsors focus on ease of administration for the employer, expansion of employee choice, and access to information about quality of care. When price is mentioned, it is usually in the context of maintaining rate stability over time.

There have been few empirical studies examining the ability of health care purchasing pools to reduce premiums. In one of the few studies available, researchers at RAND concluded that "pooling....does not seem to have enhanced the accessibility or

⁸ *Employer Health Benefits 2000 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust, September 2000.

⁹ *Ibid.*

¹⁰ Fronstin, P., *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1999 Current Population Survey*, Employee Benefits Research Institute Issue Brief 217, January 2000. (1999 data are not yet available.)

¹¹ For example, the stated intent of the legislation creating California's first small-group purchasing pool, the Health Insurance Plan of California, was to "help *make coverage more affordable* by establishing a purchasing pool for small employers" (emphasis added.) (California Statutes of 1992, Chap. 1127, "Legislative Intent.")

¹² T. Buchmueller, "Managed Competition in California's Small-Group Insurance Market," *Health Affairs*, V16 N2 (March/April 1997), pp. 218-228.

¹³ Wicks, E., M. Hall, and J. Meyer, *Barriers to Small-Group Purchasing Cooperatives*, Economic and Social Research Institute, March 2000, Washington, D.C.

affordability of insurance to employers.”¹⁴ Anecdotal evidence from the Health Insurance Plan of California, the nation’s largest small-group purchasing pool, supports this assertion.¹⁵

One of the major reasons for pools’ inability to deliver on the promise of reduced premiums has to do with the insurance regulatory context in which most pools were created. Recall that as first envisioned by the Jackson Hole Group, purchasing pools would exist in a reformed small-group and individual insurance market, and participation in the pools (and in health insurance in general) would be mandatory. Today, although there are no small-group or individual insurance mandates, all states do have some degree of small-group insurance reform (including reforms mandated by federal legislation), and it is in this environment (small-group reform *with no mandate to participate*) that purchasing pools exist.

The presence of insurance reform implies that accessibility is less of a concern for small groups than it was when the Jackson Hole Group and others first described “HIPCs.”¹⁶ Under the federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA), there is guaranteed issue of all products to all small groups, and pre-existing condition waiting periods are limited. In addition, most states have passed some form of small-group rating reform, which limits the amount insurance carriers can vary small-group premiums to a “rating band.” Some states have prohibited the use of health status as a rating factor at all. These rating reforms have eliminated some of the abuses that previously prevented groups from obtaining insurance when they needed it most.

However, small-group insurance reform may have made it somewhat more difficult for purchasing groups to deliver on the promise of lower premiums

¹⁴ Long, S., and M.S. Marquis, “Pooled Purchasing: Who are the Players?” *Health Affairs*, V18 N4, (July/August 1999), pp.105 – 111; also see: Long, S., and M.S. Marquis, “Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?” *Health Affairs*, V20 N1 (January/February 2001), pp. 154-163.

¹⁵ Yegian, J.M., T.C. Buchmueller, M.D. Smith, and A.F. Monroe, “The Health Insurance Plan of California: The First Five Years,” *Health Affairs*, V19 N5 (September/October 2000), pp. 158 – 165.

¹⁶ This statement is not meant to imply that the “access” problem has been solved. Even under insurance reform, many employers and employees are unable to afford insurance. Accessibility without affordability is of little value.

(although such laws are by no means solely to blame for HCPPs’ difficulties). While it may originally have been envisioned that purchasing groups would enable small employers to obtain the rate discounts enjoyed by large employers, this vision was rooted in the assumption that *all* small employers would participate in pools, i.e., there would be no “outside” market. In reality, purchasing pools do compete with the outside market, albeit a reformed outside market. It would be de-stabilizing to both purchasing pools and the outside market if pools were allowed or required to employ rating practices that were significantly different from the outside market. For example:

- If purchasing pools were not constrained by small-group rating bands and guarantee issue requirements, many small employers might be able to obtain rates significantly lower than those in the outside market (given a “critical mass” of members). This would encourage migration of small employers from the outside market to the pools and force carriers to contract with pools to maintain a presence in the small-group market. In most areas, pools are not required to contract with any willing plan, meaning that, in an extreme case, a pool could drive a carrier out of the small-group market by refusing to contract with it. To date, the political will to give purchasing pools such an advantage has not existed. In addition, some policy-makers fear that if pools were exempt from small-group rules, they might compete by selecting good risk, either intentionally or unintentionally.
- In contrast, if purchasing pools were required to use rating practices that were more “stringent” than the outside market, they could experience adverse selection.¹⁷ For example, assume a state allows the small-group carriers to rate groups up or down 10% based on health status, but the purchasing pool is only allowed 5% variation for this factor. As a result, sicker groups would find more favorable rates inside the pool, and healthier groups would find more favorable rates outside of the pool. The purchasing group could progressively become a

¹⁷ In this case, “more stringent” means “closer to community rating.” For example, if market rules require 20% rating bands, insurance carriers can use rating bands no larger than 20%, but they can also use tighter rating bands if they choose.

high-risk pool, which would provide little benefit to the vast majority of average-risk employer groups.

To avoid the first of these scenarios, and to prevent HCPPs from skimming off good risk, most states with purchasing pool laws on the books have determined that HCPPs must require their carriers to employ rating and underwriting methods that are *at least* as stringent as the market methods (although they can use more stringent methods if they choose). For similar reasons, small-group purchasing pools are currently required to comply with all other state insurance regulations, including benefit mandates, and are not entitled to preemption of state law under ERISA.¹⁸ In other words, purchasing pools are not a collection of small groups acting like a large group; they are a collection of small groups acting like a collection of small groups.

In this environment, the most value-added services a purchasing pool can provide are those *non-price related services* to which small groups normally do not have access, such as comparative quality information, choice, etc. However, such services cost money, and the administrative/overhead load added to premiums under a purchasing pool may be higher than the loads found in the direct-sales small-group market.

On the other hand, if large or sophisticated enough, purchasing groups may be able to provide insurance carriers with some administrative economies of scale by giving them access to many small employers in one place and performing marketing and other administrative functions. In any case, administrative savings have become purchasing pools' main hope for achieving cost savings going forward. The hoped-for premium reductions based on purchasing power have not materialized, both because purchasing groups tend to be fairly small (nothing like the one million members envisioned by the Jackson Hole Group) and because small-group reform laws temper the ability to wield such power, even if it existed.

¹⁸ However, the Congressional proposals to create Association Health Plans and HealthMarts do exempt these entities from many state requirements and are controversial for that reason. See: Hall, M., E. Wicks, and J. Lawlor, "HealthMarts, HPCs, MEWAs, and AHPs: a Guide for the Perplexed," *Health Affairs*, V20 N1 (January/February 2001), pp. 142-153.

Despite purchasing pools' difficulties in reducing prices (and thereby attracting members), such pools persist. Clearly, members value the increased choices and administrative ease offered by the pools. In addition, as discussed previously, renewed attention is being focused on pools in the context of the public's growing concern about the uninsured and dissatisfaction with managed care. Presidential candidate Al Gore promised that if elected, he would provide special tax credits to small employers who join health care purchasing pools. Then-candidate George W. Bush said that he supported the creation of "association health plans" for small employers (although it is not clear whether Bush intended for such entities to offer choice of plans at the individual level). Presidential candidates are not the only ones interested in small-group purchasing arrangements. Some health policy experts believe that purchasing pools may be the wave of the future for employers who are no longer willing to make health insurance decisions for their employees (due to legal liability concerns) and who are contemplating moving to a strict defined-contribution approach. Others see purchasing pools as an ideal vehicle for combining both private (employer or individual) funds and public subsidies (such as tax credits) for low-income individuals purchasing insurance outside a group.

III. The Roundtable on the Role of Health Care Purchasing Pools

It was in this environment of renewed attention to purchasing pools and confusion about their roles that the Kaiser Permanente Institute for Health Policy convened a group of experts from the industry to discuss the state of the market. On October 16 and 17, 2000, the Institute sponsored a roundtable discussion entitled, "Improving the Functioning of the Small Group and Individual Markets: the Role of Health Care Purchasing Pools." The goals of the meeting were:

- To develop an understanding of the roles health care purchasing pools can play in improving the functioning of the small group and individual insurance markets;

- To identify and address barriers and enablers to health care purchasing pools playing those roles; and,
- To identify elements of policy and/or market-based proposals to facilitate the success of health care purchasing pools.

Conference attendees included representatives from the managed care industry, academia, health policy organizations, the broker industry, and small- and large-employer health care purchasing pools and administrators. While the focus of the conference was on access to care for small groups and individuals, representatives of larger-employer purchasing pools were included in the meeting to facilitate learning and share insights. (A participant list is included as the appendix to this report.)

Purchasing pools represented at the meeting included:

- Buyers Health Care Action Group (Minneapolis)
- CaliforniaChoice
- Community Health Options (Montana)
- Connecticut Business and Industry Association
- Council of Smaller Enterprises (Cleveland, Ohio)
- Health Insurance Plan of California
- New Mexico Health Insurance Alliance
- New York City HealthPass
- The Alliance (Colorado)

One of the goals of the meeting was to discuss possible public policy actions that would enable health care purchasing pools to be more effective. However, there was no agreement that public policy actions were warranted. As one meeting participant pointed out, “Policy-makers won’t be interested in (interventions to

support) health care purchasing pools unless the pools change the underlying insurance market dynamics. It’s not just about selling more insurance...It’s not just about choice. It has to be about choice for a reason.”

Although this comment was made at the end of the meeting, it also serves to frame much of the discussion that took place during the previous two days. Meeting participants struggled with the question of whether purchasing pools deserved “special” protections that would allow them to decrease prices and/or increase their membership and if not, whether the other things they offered, or might be able to offer in the face of new reforms, were sufficient to warrant public support or concern.

The roundtable focused on five specific elements of health care purchasing pools and how they could function more effectively in a given area. Topics of discussion included:

- Enrollment
- Choice as a competitive tool
- Premiums
- Administrative efficiency
- Individual (non-group) access

A. Themes: Size and Price

Roundtable participants felt that most of the concerns facing HCPPs today had to do with their size and price. Major insights include the following:¹⁹

- Despite their current inability to deliver lower prices, HCPPs provide a model that many policy-makers still believe holds promise for structuring a small-group (and possibly an individual) market that works on the “right” kind of competition – based on quality and value, rather than on risk selection. HCPPs have the potential to create a market made

¹⁹ These insights were not necessarily shared or agreed upon by all participants. Rather, they are based on the authors’ analysis of the discussion.

up of organized selective delivery systems or networks that can manage care and are capable of improving quality and cutting costs, as opposed to a market of all-inclusive networks that can't select providers and can't manage care. The theory of HCPPs is still sound and has, to a certain extent, been tested in both CalPERS and FEHBP, but has never truly been tested on a market-wide basis, due to a failure of HCPPs to achieve significant enrollment.²⁰

- There is intrinsic value to the employee-choice aspect of health care purchasing pools, even though they are generally unable to lower prices. Choice of plans is valuable for a number of reasons: 1) Choice allows for continuity of care (i.e., provider) as people switch jobs and switch employers' health benefit programs. If more employers offered choice, fewer employees would be forced to switch either plan or provider when switching employers; 2) If more employers offered choice of plans, policy-makers might feel less compelled to create a myriad of consumer protection regulations designed to help consumers who are unable to "vote with their feet"; 3) Insurance market interventions are likely to work best when people have choices, and today's health care reform environment is characterized by market interventions, rather than by strict regulatory approaches (such as those of the 1970s and early 1980s); and, 4) Choice and competition among plans for consumers will pressure plans to be more efficient, which could lead to long-term price stabilization if not reductions.
- While these aspects of choice lend the concept an intrinsic value, it is a value that accrues to society, or to a market, rather than to an individual or employer. As a result, individuals and employers won't likely find these to be compelling reasons to pay more (if necessary) for choice. Instead, if one accepts this characterization of the benefits of

choice as public goods, an argument can be made for public support of the model.

- Health care purchasing pool participation has been disappointing. Despite the perceived advantages of HCPPs, the major factor that would enable them to grow their membership is reduced premiums. Due to small-group reform laws, and, in many cases, HCPPs' own social mission, they are often unable to offer premiums that are less expensive than generally available in the market. In some cases, HCPP premiums are higher than the market due to the extra administrative functions they perform.
- Even without the ability to offer lower premiums than the small-group market, a large HCPP could still offer many benefits to small employers, for example: significant quality and/or outcomes-related performance guarantees from carriers; state-of-the-art comparative quality information; on-line enrollment and administration; enhanced customer service, etc. Large size also could enable more effective performance of services that are attractive to carriers, such as more efficient processes for enrolling members, submitting billings, making timely payments, etc. The conundrum is that HCPPs must be large to efficiently provide these services, but to grow large, they must prove to prospective members and carriers that they already provide these services.
- While the current small-group market environment does not discourage HCPPs, it also does little to encourage them. Health care purchasing pools simply exist today. They are an option that is attractive to a large enough portion of the small-group market that they clearly provide a value-added service. At the same time, they are unattractive (or unknown) to such a significant portion of the small-group market that they generally have little effect on market dynamics.
- Significant increases in HCPP enrollment will have to occur before it will be possible to adequately test whether they can address the market failures they were designed to address. Factors that could

²⁰ Note also that CalPERS and FEHBP do not require participating employers to implement a lowest-cost plan contribution strategy, so price differences among plans in these pools may be somewhat transparent to the employee making the choice.

contribute to an increase in HCPP enrollment include:

- Significant premium savings available from HCPPs;
- Increased public awareness of HCPPs, the services they offer, and the benefits of those services;
- Increased political attention focused on HCPPs in various forms;
- Continued “managed care backlash,” with employers becoming increasingly unwilling to select a single managed care plan for their employees;
- Possible implementation of health care reform proposals that would put purchasing “credits” in the hands of individuals to purchase insurance on their own (i.e., tax credits), particularly if such credits were available as an incentive to join HCPPs (and if HCPPs were inclined to develop the capacity to serve individuals).

The roundtable was based on an understanding, for purposes of discussion, that increasing health care purchasing pool enrollment is desirable for the reasons stated above. The discussion allowed participants to clarify the forces acting for and against the success of health care purchasing pools and develop proposed public policy actions to enhance pools’ ability to provide value-added services to more people. The next section presents the proposed policy actions under each discussion topic. (Each proposed action listed was put forth by one or more members of the roundtable. Inclusion of a proposed action in this report does not imply consensus of the group.)

B. Enrollment

It was noted that the strongest and most influential forces acting on enrollment were price, choice, and plan participation. These three forces were also seen as being the most difficult to address. Because a

desirable price was viewed as a critical factor in increasing enrollment, participants developed several possible actions/interventions that might act on price (note that there is significant overlap with the actions proposed under the “Premium” section). Possible actions concerning price included:

- Discourage broad rating bands, or at least maintain the status quo in states that currently use rating bands, so that HCPP premiums are more likely to be in line with premiums in the outside market.
- Allow HCPPs to negotiate premiums with carriers, including limitations on administrative costs. In other words, permit HCPPs to behave like large employers, rather than as a collection of small employers.
- Exempt carriers selling products through HCPPs from state benefit and other mandates or have them meet lesser standards (for that product only). Allow HCPPs to operate under ERISA provisions available to self-insured large employers. (However, many policy-makers and analysts would argue that exempting HCPPs from state regulation would cause them to attract favorable risk, e.g., people who do not require state mandated benefits, etc. Such a dynamic could have a de-stabilizing effect on the non-HCPP market, eroding state jurisdiction over group insurance and ultimately making non-HCPP group coverage unaffordable.)

Another means of increasing HCPP enrollment would be to implement mandates or incentives for small employers to join. Proposed actions included:

- Make employer and/or employee tax subsidies available only when insurance is purchased through a health care purchasing pool; and,
- Increase enrollment by using HCPPs to administer State Children’s Health Insurance and Medicare Programs that enroll eligibles in private-sector risk-bearing plans.

A third means of increasing HCPP enrollment would be to combine the resources of multiple HCPPs to achieve common goals, such as increasing public awareness and developing more efficient tools for brokers. This collaboration may not require public policy changes but rather could likely take place under current laws. (However, it is possible that such collaboration among HCPPs could raise antitrust concerns, particularly if the pools were operating in the same service area. Further analysis of the issue is needed.) Foundations or the federal government might be a good source of grant money to start such collaborative activities. Specific activities that could be carried out by a coalition of HCPPs include:

- Joint marketing to increase the public's general awareness of HCPPs and the advantages they can provide;
- Joint negotiation with providers or insurers for ancillary benefits not provided by participating insurance carriers (e.g., hearing aids, chiropractic, alternative medicine, etc.); and,
- Development of on-line and electronic tools for agents/brokers to streamline the quoting and enrollment process.

C. Choice as a Competitive Tool

As noted by Long and Marquis, "Providing small employers with both the ability and a simple means to offer a choice of plans is widely cited as alliances' strongest selling point."²¹ Suggested actions or interventions to promote choice in health care purchasing pools include:

- **Increasing public awareness of the role of choice in controlling costs and improving service and quality.** HCPPs and other interested stakeholders could work to help educate the public about choice. It was suggested that, similar to the collective action of the dairy industry in promoting milk (the "got milk?" campaign), a "got choice?" campaign was also needed.

- **Development and proliferation of fair, viable, and affordable risk assessment and risk adjustment mechanisms.** To remove the effects of significant risk selection from prices faced by enrollees in different health plans, HCPPs and carriers would need to address data availability issues and the difficulties inherent in the "data lag" (the period of time between when risk is measured and when compensation is adjusted accordingly).
- **Promotion of the defined contribution model.** Under an employer-defined contribution model, employees receive a fixed-dollar amount to purchase health insurance, and if they choose to purchase a more expensive plan, they must pay the difference out of their own pocket. Such an arrangement allows employees to better understand the cost of their health insurance coverage and gives them a reason to make economical choices among plans (and to accept economizing behavior on their behalf by the chosen health plan). The model lends itself to a multiple-choice HCPP structure, as the pool can help organize choice for the employees and educate them about their options. More analysis is needed to determine which defined contribution models are the most fair and efficient and how they can be implemented so that they are appealing to both employers and employees.
- **Promotion of refundable tax credit proposals.** Similar to employer-defined contributions, refundable tax credits provide employees and/or individuals with a fixed-dollar (or percentage) credit toward the purchase of insurance. The credit-holder must shop for the best plan. As above, this model requires individuals to be informed consumers and to value understandable, meaningful choice.
- **Advocating for more selective and distinct provider networks.** As employers have demanded more choice for their employees, carriers have responded by expanding provider networks. This phenomenon makes it difficult for consumers to differentiate among plans on the basis of quality, as all plans include the same physicians. This situation also reduces plans' ability and incentive to compete based on quality for enrollees and providers, and it

²¹ Long, S., and M.S. Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs*, V20 N1 (January/February 2001), pp. 154-163.

makes provider competition for health plan contracts unnecessary. In addition, this arrangement may reduce plans' incentive to work with providers to implement new and innovative best practices or clinical information systems, because any returns on such investments will be shared by all plans contracting with the same providers.

- If health plans could be induced to be more selective in choosing provider networks, consumers would differentiate among plans on the basis of quality, and plans would be rewarded for quality-improvement efforts. An employer seeking to improve choice would therefore be able to offer multiple plans with different provider networks.²² To promote greater exclusivity in plan-provider relationships, policy-makers should resist "any willing provider" legislation, which prevents plans from selectively contracting.²³
- **Creation of "safe havens" for employers who offer choice.** Employers are increasingly concerned about legal liability they may face for adverse treatment decisions when they force employees into a given health plan. One means of promoting choice of health plans is to protect employers from such liability if they provide a choice of at least two plans (or possibly more in metropolitan areas with high managed care penetration). Qualified health care purchasing pools would provide a vehicle for such choice.

²² This is similar to the choice model used by the Buyers Health Care Action Group in Minnesota. This group, rather than contracting with plans, contracts with provider-based "care systems." Employees choose from among these provider systems. Note, however, that BHCAG employers are self-insured, so they are able to bear their own risk and do not require an insurance intermediary between themselves and the providers.

²³ It should be noted that there is a subtext to the issue of selective contracting that has to do with the provision of culturally competent care. Selective networks should not be created such that they exclude providers best able to understand the cultural environment in which their enrollees live. So, while networks should be built based on quality and cost, they must also take into account cultural competency, given the ethnic and cultural makeup of the population they serve.

D. Premiums

Roundtable participants were uncertain about the importance to HCPP viability of having lower premiums. The group wondered: if it were not possible to lower HCPP rates relative to the outside market, would (or do) HCPPs offer enough other advantages to make them viable and attract the public policy support they need? Participants felt that HCPPs could moderate rates, but that they would not be able to achieve significant premium reductions.

However, some participants believed that the HCPP model is important regardless of rates because it provides the choice platform that is so important today in addressing the consumer "backlash" to managed care. HCPPs can address this backlash, not by providing an alternative to managed care (as most HCPPs offer only HMOs and POS plans), but by offering a choice among managed care plans so that employees do not feel they have been forced into a plan that doesn't meet their needs. Also, recent research has found that workers who have a choice of health plans are more likely to be satisfied that their families' health care needs are being met than are workers with no choice.²⁴

In addition, HCPPs may become even more important as employers take steps to reduce their involvement in making health care choices for employees (e.g., moving to defined contribution models), especially if health care inflation continues.

Having agreed that HCPPs can provide important benefits to employers as long as prices are competitive, the participants acknowledged that reducing premiums, or keeping them in line with the outside market, was the key to keeping HCPPs attractive to employers. As discussed previously in this paper, HCPPs are often at a disadvantage relative to the rest of the small-group market because they provide a number of important but costly administrative functions. Furthermore, because many HCPPs have a public-service mission, they are often likely to be more stringent in their rating practices than is required by law (and practiced by carriers in the outside market).²⁵

²⁴ Schone, B.S., and P.F. Cooper, "Assessing the Impact of Health Plan Choice," *Health Affairs*, V20 N1, (January/February 2001), pp. 267-275.

²⁵ As above, "more stringent" means "closer to community rating."

As a result of these factors, HCPP premiums are often slightly higher than comparable premiums in the outside market.

Participants identified several sets of actions or interventions to help reduce HCPP premiums. The first set attempts to “level the playing field” between the rating practices and requirements of HCPPs relative to the rest of the market. The second set assumes that the playing field will remain un-level and attempts to address the risk profile of HCPPs relative to the rest of the market. The third set of interventions addresses the unavoidable start-up and administrative costs association with HCPPs.

- **Leveling the Playing Field** (note that there is considerable overlap here with the actions described under “Enrollment.”)

- Establish insurance market rules such that carriers in the non-HCPP market abide by the same rating and underwriting practices as HCPPs. For example, to promote fairness and comply with their social mission, many HCPPs use adjusted community rating in the context of markets that permit more flexibility. The intervention would be to encourage adjusted community rating throughout the small-group market and discourage broad rating bands, or at least maintain the status quo in states that currently use rating bands. However, it was also noted that adjusted community rating in the small-group market can have a de-stabilizing effect on the lower end of the market (groups of one and two), which may have the desire and ability to bounce from the small-group market, to the individual market, to being uninsured as serves their needs.
- Adopt National Association of Insurance Commissioners (NAIC) small-group rating reforms nationally to provide minimum standards for rate structures/ratios (e.g., family tiers, age, geography, gender, industry, etc.). The objective would be to eliminate pricing practices that undermine effective marketplace competition. Benefits could include improved equity, reduced risk selection, and (possibly)

more affordable health insurance for everyone. National standards could be enforced by states, consistent with their current oversight of insured plans. Requirements could be made nationally enforceable—e.g., administered by an entity such as FASB or SEC, which could also oversee development of standards and monitor compliance.

- For publicly-run or regulated HCPPs, provide the same flexibility to implement benefit changes as is found in the outside market (e.g., eliminate or reduce regulatory processes necessary to implement change).
- Risk-adjust contributions to remove the effects of significant differences in risk selection across HCPP plans and to make it feasible for plans (e.g., PPOs) to participate if they tend to enroll higher risk persons. Adopt prospective risk adjustment so that carriers will bid more accurately based on their expected risk.

- **Recognizing that the Playing Field is not Level**

- Provide subsidies for qualified (low-wage) HCPP members (employees) so that both healthy and less-healthy employees find it worthwhile to purchase insurance. This may improve the risk profile of HCPPs relative to the outside market.²⁶
- Provide tax breaks for employers to join HCPPs. As above, this would make insurance worthwhile for a broader range of employers, improving the HCPP risk profile.

- **Reducing HCPP start-up and overhead costs**

- Develop a national resource for HCPPs to support technical functions (risk adjustment, communication, evaluation, marketing). Use this

²⁶ Note, however, that a recent RAND study found that the risk profile of HCPPs, as measured by the age, sex, and earnings of enrollees, did not differ significantly from the risk profile of enrollees in the rest of the small-group market. See footnote 21.

group or a public (government) sponsor to develop HCPP internet applications for the public domain.

E. Administrative Efficiency

There are many forces acting against greater administrative efficiency for HCPPs, including small market shares, lack of resources to develop systems, and the need to interface with multiple carriers and employers. Interventions to address inefficiencies generally fall into two categories: actions that would improve standardization of HCPP and carrier processes; and, actions that would allow HCPPs to achieve economies of scale by joining together to buy certain services and develop certain capabilities.

- **Standardization.** HCPPs present carriers with administrative challenges – challenges that carriers are not inclined to address because HCPPs represent such a small portion of their business. HCPPs should try to work with carriers and third-party administrators to develop common information-sharing protocols and transactional definitions that are compatible with what carriers are already doing. (Changes implemented by carriers as a result of the 1996 Health Insurance Portability and Accountability Act may provide some of the standardization necessary for more efficient information-sharing.)
- **Combining HCPP resources.** If HCPPs worked together, they might be able to achieve some of the administrative efficiencies they have largely failed to achieve on their own. For example, a coalition of HCPPs could jointly enter into contracts with vendors for third-party administration services, presumably obtaining a better contract rate than could be obtained by a single HCPP. The purchasing pools could also work together to develop Internet capabilities, common data transfer protocols with health plans, and joint marketing strategies.

F. Individual Access

In general, individuals purchasing insurance on their own (not as part of an employer group) are unable to participate in HCPPs. Most HCPPs were formed to serve employer groups and did not ever intend to serve individuals. However, in the face of rising health care costs, many employers are feeling financial pressure to drop health benefits plans or freeze their contributions. For the time being, a strong economy and low unemployment have ameliorated the need for employers to take such steps. However, a downturn in the economy could increase pressure for employers to drop coverage, leaving more workers to shop for insurance on their own.

Proposed health care reforms involving tax credits for the purchase of non-group insurance could also lead to an increase in the number of individual purchasers. Health care purchasing pools could be an ideal vehicle for individuals to purchase insurance in a simple, one-stop-shopping manner. However, due to lack of reform in the individual insurance market, it is not currently possible for HCPPs to extend to individuals the same insurance rating and guaranteed issue protections that are available to small groups. Unless the rest of the market followed suit, HCPPs would quickly become a dumping ground for bad risks.

Even if rating restrictions, guaranteed issue, etc., were applied to the individual market, that market as a whole would likely experience significant adverse selection because individuals can, to some degree, anticipate when they will incur medical expenses. They can enter and exit the insurance market depending upon their expectations about needing care. Under such circumstances, the individual market is not likely to be very profitable for any insurer compared to other markets. Some participants thought this problem could be effectively overcome if (as outlined below) individuals were provided with sufficiently large subsidies, which, by making coverage affordable, would give them strong incentives to stay insured.

Understanding the current market barriers to HCPPs serving individuals, roundtable participants were asked to think about what would need to change to open up these purchasing vehicles to this population, not only providing a means of access to health care but also increasing HCPP enrollment. Participants noted that there were a surprising number of economic forces

that may increase the likelihood that HCPPs could one day serve individuals. These included:

- Possible implementation of refundable tax credits for the uninsured;
- Employers becoming increasingly reluctant, due to legal liability concerns, to make health insurance choices for their employees;
- The proliferation of employee leasing companies and a trend toward early retirement, possibly increasing the number of individuals needing to purchasing insurance in non-group settings; and,
- Growing employer interest in defined contribution health care strategies (although it is not at all clear that this “trend” is actually taking place).

In an un-reformed individual market, meeting participants believed that the most viable means of bringing individuals into HCPPs (and into the insurance market in general) without exacerbating current risk selection problems, is to provide substantial subsidies. A subsidy of \$1,000 per year (for a single, relatively young person) might be adequate to induce both the healthy and the sick to purchase health insurance. Such subsidies could be provided by the government, or jointly by the government and the private sector. HCPPs would be an ideal vehicle to administer the purchasing process for individuals with multiple sources of financing. For example, HCPPs could collect premiums for a single individual from multiple employers (if the person had more than one job, or if a family could pool contributions from each spouse’s employer), from the government, and from the individual. Some meeting participants believed that one or more HCPPs should seek private funding to establish a demonstration to determine the feasibility of pooling multiple payer sources to subsidize individual coverage.

Meeting participants also cautioned that HCPPs should be successful with small groups before tackling the individual market. Having noted this, however, participants identified the following possible public policy and/or HCPP actions that would improve HCPPs’ ability to serve individuals:

- Provide individuals with subsidies toward the purchase of health insurance only if they enroll in a health care purchasing pool.
- Consider legislation to promote individual access to HCPPs. For example, legislation would be necessary to authorize mechanisms for pooling of individual risk under HCPPs.
- Create standardized benefit packages for individuals that will be affordable for them and will promote informed choices.
- Risk-adjust premiums and payments to carriers to compensate for significant variations in the risk of individuals who are enrolled in different health plans.
- Age-adjust premiums to promote affordability for younger individuals with limited incomes.
- Place individuals in a separate rating pool from groups to minimize unintended cross subsidies of individuals by groups (and vice versa).
- Create high-risk pools for individuals in all states as a fall-back mechanisms for those who cannot be served by HCPPs.

IV. Conclusions

Much has changed since the concept of health care purchasing pools was first introduced in the early 1990s. Major changes include implementation of small-group rating reform (in most states), significant health plan consolidation, increasing health insurance premiums (fueled, in large part, by new drugs and technologies), and an increasingly litigious environment around health plan and employer liability in coverage decision-making. This paper has sought to address whether, in the face of these and many other changes, HCPPs remain a desirable and viable solution for small employers and/or individuals, and if so, what public policy interventions or actions are needed and warranted.

While it is difficult to draw conclusions from the day-and-a-half roundtable discussion, several themes do emerge:

- **Health care purchasing pools do provide benefits that are unrelated to premium savings.** Such benefits include administrative ease, but perhaps the most important benefit is the facilitation of choice, which is increasingly important in the environment of managed care backlash, employer reluctance to make coverage decisions, and a need to open the market to selective networks that can cut cost and improve quality.
- **Despite these benefits, HCPPs will remain an insignificant part of the market unless they can achieve *some* premium savings.** The potential for HCPPs to deliver significant savings in health care costs remains an unrealized promise. Under current market rules, the most promising avenue for achieving premium savings is through improvement of administrative processes.
- **Market competition will work best if based on broad, cost-conscious consumer choice.** One roundtable participant used the term “Wide, Responsible, Individual, Informed, Multiple Choice” to describe the characteristics of health care purchasing pool choice that are necessary to affect competition among plans and providers, allowing selective provider networks to achieve sufficient size to change market dynamics.²⁷
- **Health care purchasing pools have common goals and should work together to achieve them when appropriate.** On their own or with foundation support, HCPPs could work together to streamline administrative processes, develop shared technical assistance resources, and promote the choice concept.

- **In a voluntary market, HCPPs are plagued by the same risk-related access problems as are carrier selling directly.** HCPPs are no more able to open their doors to all-comers than is the rest of the market. Without individual or employer mandates or significant subsidies, both HCPPs and the rest of the market will need to continue to rate based, at least in some part, on expected risk.
- **Changing marketplace conditions may impel strong renewed interest in HCPPs.** Intensifying health care inflation, coupled with increasing demands upon employers to meet burdensome regulatory requirements and to assume new risks for liability may lead employers to drop defined health benefit programs. Such forces are likely to lead to greater individual purchase of health care. Individuals will welcome mechanisms that are designed to facilitate the affordable purchase of health insurance that meets their needs.

Despite their current difficulties, health care purchasing pools still have the potential to provide significant public good, in terms of increased health plan competition based on the “right” incentives, if they can achieve a size that would give them more power to structure competition and health plan terms of participation. Given that this outcome is a public good, public or foundation support, as well as additional development and experimentation, may be warranted.

²⁷ The term “Wide, Responsible, Individual, Informed, Multiple (WRIIM) Choice” was introduced by Alain Enthoven.

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