

HEALTH INSURANCE MARKET REFORMS AND POOLED PURCHASING: SELECTED STATE PROVISIONS

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Summary. This technical assistance memorandum provides an overview of selected health insurance market reforms in 13 states and pooled purchasing initiatives in 10 states. A profile of each state is provided, describing state laws governing guaranteed issue, guaranteed renewal, pre-existing condition clauses, and rating restrictions in the small-group market. The states' pooled purchasing initiatives include both state-sponsored and privately-sponsored health insurance purchasing cooperatives or alliances, as they have been implemented or proposed. The information provided in this memorandum is based on a survey of states that participated in a September 1995 group consultation meeting on *Implementing and Integrating Health Insurance Market Reforms and Purchasing Cooperatives*, sponsored by The Robert Wood Johnson Foundation under its *State Initiatives in Health Care Reform* program.

Health Insurance Market Reforms and Pooled Purchasing: Selected State Provisions

This technical assistance memorandum provides an overview of health insurance market reforms and pooled purchasing initiatives in 13 states. These states participated in a group consultation meeting on *Implementing and Integrating Health Insurance Market Reforms and Purchasing Cooperatives*, sponsored by The Robert Wood Johnson Foundation under its *State Initiatives in Health Care Reform* program and held September 27-28, 1995 in Denver, Colorado. This meeting explored the design and implementation of health insurance reforms and health insurance purchasing cooperatives as they are being pursued by a number of states in the program.

This memorandum profiles selected small group insurance reforms (guaranteed issue, guaranteed renewal, pre-existing condition clauses, and rating restrictions) as enacted in 13 states: California, Colorado, Florida, Iowa, Kentucky, Maryland, Maine, Minnesota, Nebraska, New Mexico, New York, Oregon, Washington. It also profiles the pooled purchasing initiatives (including both state-sponsored and privately-sponsored health insurance purchasing cooperatives or alliances) that have been implemented or proposed in 10 states: California, Colorado, Florida, Iowa, Kentucky, Maine, Minnesota, New Mexico, New York, and Washington. Based on the results of a survey of the states conducted in advance of the meeting, a number of summary tables are included:

Table 1: State Insurance Reforms of the Small Group Market

Table 2: Small Group Reform Rating Restrictions

Table 3: Description of Health Insurance Purchasing Cooperatives

Table 4: Monitoring and Evaluation Activities of States and Purchasing Cooperatives

For more information about these state initiatives, please contact the Alpha Center or the state officials who participated in the group consultation, as listed in Appendix 1. For those interested

in a broader discussion of health insurance market reforms, a list of additional readings is provided as Appendix 2.

I. State Insurance Reforms of the Small Group Market

In structuring their health insurance reforms, most of the 13 states took their lead from the model laws developed by the National Association of Insurance Commissioners (NAIC). While the details and degrees of reform vary from state to state, each state has enacted provisions pertaining to guaranteed issue and renewal, continuity of coverage provisions, and rating factors or limits (see Tables 1 and 2).

Group Size Affected: The definition of what constitutes the small group market varies among the states. Of the 13 states, 3 target groups of 25 employees or less, 9 target groups of 50 employees or less, and one targets groups of 100 employees or less. While reforms seldom extend to the individual market, New York is a notable exception, having adopted community rating across the entire market. However, several states consider a self-employed individual as a "group" of one.

Guaranteed issue and renewal: Nearly all of the 13 states have enacted guaranteed issue and renewal requirements. While these requirements are substantively the same from state to state, they may differ in whether the requirement applies to all products in the small group market or only to certain reform products. Eight states require guaranteed issue and renewal for all products. However, four require only that the standard and basic products (as defined by the reform statute) be offered as guaranteed issue and renewal. New Mexico requires that only those products sold through their purchasing alliance be offered as guaranteed issue and renewal.

Preexisting condition clauses and portability: Some states restrict the duration and application of preexisting condition exclusions in health insurance contracts -- including how far back in time they look to deem that a health condition is preexisting, how far forward in time that preexisting condition exclusions may apply, and whether these exclusions can be restarted when

consumers change insurance carriers. NAIC's model law (known as a "6/12" law) "looks back" 6 months and "looks forward" 12 months. While most of the 13 states have enacted a 6-month look-back, Washington's statute allows health insurance contracts to look back only three months.

Four states (California, Colorado, Kentucky and New Mexico) limit the forward application of preexisting condition exclusions to three months. When consumers change carriers, all of the states require that the new carrier credit past insured time against the contract's preexisting condition exclusions. To qualify for this "portability" protection, however, consumers who drop coverage must restart coverage within 30 to 90 days, depending on the statute.

Reinsurance: For the most part, reinsurance is voluntary and privately arranged. Only in New York is it publicly sponsored and mandatory.

Rating Restrictions: While the states have a number of rating restrictions in common, there are also some important differences across the states:

- * **Rating factors:** Four of the 13 states allow only age, geography and family composition as principle rating factors; two others allow insurers to establish rate classes based also on tobacco use (Florida) and the presence of a wellness program (Washington). Maine and Nebraska allow insurers to use as many as six factors -- including age, geography and family composition, as well as gender, industry type, group size and tobacco use or lifestyle considerations. In Oregon and New York (which also requires pure community rating within classes), only geography and family composition can be used to set rates. New Mexico intends to require modified community rating by 1998, at which time only two age groupings -- above and below age 19 -- will be allowed as a basis for rates. Iowa allows insurers to use only geography as a rating factor in the small group market.

TABLE 2. SMALL GROUP REFORM RATING RESTRICTIONS

	RATING FACTORS	BETWEEN-CLASS LIMITS	WITHIN-CLASS LIMITS	RENEWAL RESTRICTIONS	OTHER
CALIFORNIA	AGE/GEO/FAM ²	No limits	1.5:1 ratio (+/-20%) declining to 1.2:1 ratio (+/-10%)	No health adjustment allowed in cooperative	
COLORADO	AGE/GEO/FAM	1.5:1 ratio (+/-20%)	None	Increase may not exceed best rate for new business plus 10 percent	Rate bands decline to 1.2:1 ratio (+/-10%) as of 1/1/97; adjusted community rate by 1998.
FLORIDA	AGE/GEO/FAM, gender, tobacco use	Department of Insurance approval is required	Department of Insurance approval is required.	Department of Insurance approval is required.	
IOWA	GEO/FAM	None	2:1 ratio (+/-33%)	None	
KENTUCKY	AGE/GEO/FAM	None	3:1 ratio (+/-50%) on age	None	
MAINE	AGE/GEO/FAM, tobacco use, industry, occupation, wellness program	None	1.5:1 ratio (+/-20%) on rating factors	None	Minimum loss ratio of 65% is required for indemnity plans
MARYLAND	AGE/GEO/FAM	None	3:1 ratio (+/-50%)	None	Rate bands narrow to 2:1 ratio (+/-33%) as of 7/1/96.
MINNESOTA	AGE/GEO/FAM, industry, occupation, health status, claims experience	None	1.67:1 ratio on health status, claims experience and occupation; 3:1 ratio on age, 1.5:1 ratio on geography	1.67:1 ratio (i.e., increase may not exceed 25%) based on experience	Gender rating is prohibited.

²Age, geography and family composition.

TABLE 2, continued. SMALL GROUP REFORM RATING RESTRICTIONS

	RATING FACTORS	BETWEEN-CLASS LIMITS	WITHIN-CLASS LIMITS	RENEWAL RESTRICTIONS	OTHER
NEBRASKA	AGE/GEO/FAM, gender, industry, group size	1.5:1 ratio (20%)	1.67:1 ratio (+/-25%)	Increase may not exceed 5%	
NEW MEXICO	AGE/GEO/FAM, tobacco use, gender	None	None	Increase may not exceed 10% plus medical inflation	Community rating by 1998; then only above and below age 19
NEW YORK	GEO/FAM	Community rate	Community rate	Department of Insurance approval is required if loss ratio is less than 75%.	
OREGON	AGE/GEO/FAM	None	3:1 ratio (+/-50%) on geography; 2:1 ratio (+/-33%) on age	Increase may not exceed 15%	
WASHINGTON	AGE/GEO/FAM, wellness activities	Community rate	Community rate	None	

Date: Monday, June 16, 1997

FACT SHEET

Contact: HHS Press Office (202) 690-6343

HHS DISABILITY PROGRAMS

Overview: *In the United States today over 49 million people have physical and mental disabilities. For these individuals, disability affects all aspects of their well-being, and has emotional, social, and financial consequences. On behalf of Americans with disabilities, the Department of Health and Human Services is working to:*

- *ensure that publicly supported health programs address the needs of a diverse population of individuals with disabilities;*
- *support a social service infrastructure that helps people with disabilities fully participate in community life;*
- *coordinate with other federal agencies and the private sector to provide a seamless service system for individuals with disabilities and their families; and*
- *support and conduct a rigorous research program that promotes an understanding of the characteristics and needs of people with disabilities.*

In FY 1997, HHS devoted over \$62 billion to programs for people with disabilities. To help better understand the prevalence of disability and the needs of people with disabilities, the National Center for Health Statistics in 1994-95 conducted the first-ever comprehensive national disability survey in this country. The survey found that the prevalence of disabilities is disproportionately higher among minorities, elderly, poor and rural populations. Not only do disabilities have high costs for individuals, but also for states and for our nation as a whole. In 1997, the estimate of economic loss due to disability, including the increased cost of health care and reduced productivity, was over \$350 billion.

Health Care

Health care is a key component to helping people with disabilities lead independent lives and HHS is helping ensure that people with disabilities have access to quality health care throughout their lives.

- **Medicare and Medicaid:** Medicare will provide health insurance to about 5 million individuals in 1997 who are considered disabled based on federal criteria. Spending during FY 1997 is estimated at \$21 billion for health care and services under Medicare for people with disabilities.

Medicaid will provide health insurance to approximately 7 million individuals in 1997 who are considered disabled based on federal criteria. In FY 1997, the government is expected to make \$33 billion in Medicaid payments for services to disabled persons.

The President's FY 1998 budget proposal includes proposals to help people with disabilities lead more independent lives. Specifically there are proposed amendments to Medicare and Medicaid law that will enable people who receive SSI or SSDI to continue their health coverage by purchasing Medicaid or extending Medicare coverage after they start working.

- **Pre-existing Conditions:** As HHS' Health Care Financing Administration implements the Health Insurance Portability and Accountability Act of 1996, special care is being taken to protect the insurability of individuals with pre-existing conditions.

- **Managed Care Waivers:** The Clinton Administration has supported state demonstration projects that expand Medicaid coverage to more citizens through managed care. HHS ensures that individuals with disabilities continue to have access to high quality health care and services in these demonstrations. HHS has also encouraged states to develop and implement demonstration programs to offer health care services specifically targeted to people with disabilities.
- **Home and Community-Based Waivers:** HHS continues to support community-based long-term care for the elderly and people with developmental or physical disabilities through the home and community-based waiver program. Through the use of this Medicaid waiver provision, states have been able to scale down reliance on publicly funded institutions and promote the use of integrated community services.
- **Disability-Related Health Policy Research:** HHS supports and conducts a wide array of research activities on service organization and delivery, quality, and financing of health and long-term care for people with disabilities. In particular, the Agency for Health Care Quality helps policy makers plan for meeting the health needs of people with disabilities by examining their access to and use of health services, as well as their views of how the health care system works.
- **Healthy People 2000:** Healthy People 2000 is a national initiative to improve the health of all Americans, including those with disabilities, by establishing health objectives for the year 2000 and measuring progress towards those goals. Healthy People 2000 provides targets that government, private sector and volunteers can all work toward.

Disability Research at NIH

The National Institutes of Health are responsible for developing the scientific knowledge needed to promote the health, productivity, independence, and quality of life of people with physical disabilities. NIH Institutes involved include:

- **The National Institute of Child Health and Human Development:** the Institute's National Center for Medical Rehabilitation Research provides funds to support research and training to improve functioning in day-to-day activities in people with physical disabilities. Research is directed at assistive technology and developing more effective medical rehabilitation interventions. The NCMRR also helps coordinate research within NIH and among other agencies, and disseminates information to scientists, rehabilitation service providers, and to persons with disabilities and their families.

The lack of knowledge about the health needs of women with disabilities resulting from chronic physical impairments prompted NCMRR and NIH's Office of Research on Women's Health to sponsor programs on the development of health promotion activities. These programs are identifying barriers to health promoting activities as well as developing effective, well-defined interventions that will lead to improved health for women with disabilities.

- **The National Eye Institute:** conducts and supports research aimed at improving the prevention, diagnosis, and treatment of diseases that affect the eye and vision.
- **The National Institute on Deafness and Other Communication Disorders:** conducts and supports research in the normal and disordered processes of hearing, balance, smell, taste, voice, speech, and language and also supports efforts to create assistive devices. NIDCD is also collaborating with the Department of Veterans Affairs and NASA to, respectively, support the development of better hearing aids; and to search Federal laboratories for new technology applicable to improving hearing aids.
- **The National Institute of Neurological Disorders and Stroke:** conducts and supports research on head injury, spinal cord injury, stroke, developmental, demyelinating and neuromuscular disorders. NINDS' focus in neurorehabilitation research is on restitution of function, prevention of

secondary injury, and improving the quality of life.

Social Services

- **Welfare Reform:** The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 requires states to assist large numbers of individuals on public assistance to find and keep jobs. Many people receiving welfare are individuals with disabilities or parents of children with disabilities, and HHS has established a Work Group on Welfare Reform and People with Disabilities to provide states with technical assistance and to assist them in meeting the challenge of helping welfare recipients with disabilities to become productive members of the work force.
- **Head Start:** For the past 25 years, the Head Start programs have made at least ten per cent of enrollment opportunities available to children with disabilities. In the 1995-96 program year, children with disabilities comprised about 13 percent of the children enrolled in Head Start (approximately 96,000 of the 752,000 serviced). To promote quality in Head Start disabilities services, ACF also supports a network of resource access projects who provide Head Start programs with technical assistance and training to enable them to effectively include children with disabilities.
- **Children with Special Health Needs:** The Health Resources and Services Administration provides national leadership in health care for special needs children. Through the Maternal and Child Health Services Block Grant, HRSA supports community-based, family-centered care for children with special health needs, like HIV or hemophilia. Thirty percent of the block grant funds must be devoted to programs for children with special health needs.
- **Administration on Developmental Disabilities (ADD):** There are nearly four million Americans with developmental disabilities, or chronic conditions caused by physical or mental impairments. ADD funds four grant programs to address prevention, diagnosis, early intervention, therapy, education and employment.

ADD also funds three Projects of National Significance to increase access to quality child care services for children with developmental disabilities from birth through age five, and to increase the delivery of early intervention and related services to children in natural and inclusive environments.

- **President's Committee on Mental Retardation:** More than 7.5 million Americans of all ages experience mental retardation. The PCMR was established in 1966 to act in an advisory capacity to the President and Secretary of Health and Human Services on critical matters regarding programs and services for people with mental retardation. In 1995, the PCMR embarked on a five-year project to encourage state planning for life-long community involvement and participation by persons with mental retardation.

Other HHS Activities

- HHS' initiative to reduce teen pregnancy has a special component which targets young men and women with disabilities.
- CDC's Office on Disability and Health works to prevent secondary conditions and to promote the health and quality of life of disabled Americans.
- Disability rates increase with age and in 1994, nearly 40 percent of the elderly not living in institutions were limited by chronic conditions. Through research, demonstration and training programs, and direct services, HHS' Administration on Aging is helping improve care to older people and people with disabilities.
- Traumatic Brain Injury is one of the most common causes of disability in young people. CDC's National Center for Injury Prevention and Control provides assistance to States to develop TBI

MARKETPLACE

October 20, 1997

Florida CHPAs Seek a Way To Live Without State Money

When employers band together to purchase health insurance jointly, some of the problems of access and cost disappear and more workers end up with coverage. But how big a role does the government have to play in encouraging that result? Is it enough to merely remove regulatory barriers to such cooperation, or need the state provide seed money, or is there a permanent role government needs to play to keep coalitions serving small businesses?

One of the laboratories the rest of the country is watching for answers to those questions is Florida, which created Community Health Purchasing Alliances in 1994, appointed their initial boards, and provided start-up money. But that public coffer funding was for only three years. Now that it has ended, some of the CHPAs are just holding on, while others are prospering by setting off in a far more entrepreneurial direction.

The law establishing the CHPAs divided Florida into 11 geographic regions and set up an alliance in each. The state certifies carriers, and the alliances are barred from turning down any certified carrier or its plan. When a small business signs up through a CHPA it must buy through a designated agent. The agent then sells each employee any CHPA policy.

To assuage the loss of money, the state legislature passed two measures which may help the CHPAs hold on to business. One is a miniCOBRA law which requires businesses employing 20 or under to continue to offer 18 months of coverage to employees after they depart. The other is a change that allows businesses enrolled in a CHPA to stay with the alliance for a year after the number of people employed rises beyond 50, although they still must drop out if the payroll tops 75.

More Business Than Bureaucracy

Among the winners in the new environment seem to be the two CHPAs covering the Orlando, Jacksonville and Daytona Beach areas. In response to the demise of state financial support, the staffs have formed a management company. That organization now is contracting with its two CHPAs, but can take on other contracts as well. Terry McCorvie, executive director for both districts, says that within five years, he expects that company will be managing both the CHPA and a series of other products — including those designed for

self-insured big employers. "Every business association out there is a potential customer, and we want to be in a position to serve them," he says.

Meanwhile, McCorvie contends that the new arrangement reduces the risk to his CHPAs. That's because the fees the CHPA receives are passed through to the management company. If there's an operational shortfall, the management company will have to live with it. Until now, a cash shortage meant that the CHPAs had to dig into their reserves. Furthermore, McCorvie said that the CHPA will save money because it will share the expenses of the fixed costs with the management company and cross-utilize its employees.

In recent months, Orlando's McCorvie has added three full-time marketing people. The new staff persons do more than distribute materials. They also go out with agents and make cold calls. The move has been especially effective in Jacksonville. When the marketing office there was opened a year ago, it was sixth in enrollment of the 11 CHPAs. Now it's one of the largest. "We get a record enrollment every month. Orlando and Jacksonville, they're on fire. We have lots of new health plans," McCorvie boasts.

McCorvie may have expanded his marketing staff but he has narrowed his marketing focus. He used to do a lot of marketing aimed straight at consumers. Now, he markets largely to agents. "It's a heck of a lot cheaper to market through an agent. That's because he goes out and markets to employers," McCorvie says.

His CHPA also uses agent incentives, including contests and a bonus for selling a certain number of policies and contests. The pitch he uses with agents: Though initial sales take time, because every employee must be sold separately, McCorvie believes agents gain customers for life through the process.

The Miami-area CHPA may take an even bolder step. Its board has been looking at ways to influence premiums. The board is considering turning the CHPA into the South Florida Purchasing Alliance, restricting the number of carriers it will offer and negotiating rates. The alliance, if created, could even be offering its networks to businesses of all sizes. "We may be coming to a fork in the road," said Shara Toursh Pavlow, the Miami-area CHPA executive director, that would steer the organization away from the state program entirely.

The Miami-area CHPA markets itself largely to consumers. It does direct mailings all year round. It has two campaign seasons, fall and spring, when it does newspaper campaigns, largely in the *Miami Herald*.

The Miami-area district has some statistics at vari-

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Daniel B. Moskowitz, Editor

ance with many others. While many CHPAs show PPO participation in the very low teens at best, that's not the case here. Of the 9,233 covered lives as of July, 1997, 2,682, or 29 percent, are covered by PPOs.

"We see movement here. What seems to be selling is a customer-driven demand toward a point-of-service model that allows for out-of-network benefits. They want open access HMOs or PPOs with a gatekeeper. There's definitely a trend toward allowing the consumer to make informed choices," Pavlow said.

Holding On

Other CHPAs are reacting to the loss of state money by making more conservative choices, holding on to their present structure and trying to shave expenses. Margi Silberman, executive director for the Palm Beach-area CHPA, says she has no plans copy Orlando's entrepreneurial approach. Instead, she intends to simply grow the business she has.

The West Palm Beach organization does a considerable amount of marketing. Silberman accepts numerous speaking engagements and occasional trade shows and health fair appearances. She does a lot of media interviews. The organization also sponsors the business show of a local TV station. In addition, her CHPA partners with HMOs and insurance companies in massive direct mail and newspaper inserts. She also runs classes for agents and publishes a newsletter for them as well.

Cynthia Sampson, the Tampa-area CHPA executive director, stresses that keeping expenses down is her main priority. "We have been very conservative in our expenditures. We have one of the largest enrollments in the state, yet we have two full-time employees. We have always been lean and mean," she says.

Sampson energetically promotes her alliance at health fairs, as well as meeting with professional organizations and civic groups such as Rotary and chambers of commerce. She also markets hard to agents. She will make sales calls with them if asked and help them enroll groups.

It has all paid off. As of July, her CHPA had 13,559 covered lives, only 1,730 of which are covered by PPOs. The CHPA and the agents act as the benefits administrators for small businesses. Sampson explains: "We're dealing with the owner. They rely on us and the agent. They don't have to have every bit of information at their fingertips."

Premium Problems?

While keeping focused on the growth of their own businesses, the CHPA directors are casting some-

times-anxious looks at HMOs in the state. Financially, the health organizations are being battered. The state insurance department recently announced that 26 of the 39 HMOs don't meet the agency's minimum financial requirements. Sixteen of these now are on a watch list because their finances have been subpar during four consecutive quarters.

"HMO premiums have been fairly level since 1994. I wouldn't be surprised with 10-15 percent increases over the next year," McCorvie forecasts. "But I think they will go up across the board. I think HMOs will be more expensive than before, but less expensive than the alternative."

This hike will, however, be from levels that elsewhere in the country would be considered bargain rates — rates that seemed to go hand-in-hand with restrictive coverage. "South Florida probably is reflective of future trends," Pavlov says, "and these trends go more to extremes. We've been the slimeball capital of managed care. We've had the worst of the worst. It set the lowest common denominator mentality among other plans, selling on price." She's found that higher-quality plans had to dilute their offerings just to compete. Some better plans even fled the market rather than take that step.

Now there's a backlash. Pavlow says he's seeing a much higher demand among the higher-educated and higher-income consumers for top-of-the-line plans and out-of-network choices. These consumers are willing to pay higher premiums to get higher quality coverage.

The bigger battle, in her view, is over patient direct access to specialists. Pavlow maintains managed care companies don't want direct access and patients do. She sees room for a product which doesn't bar patient direct access to specialists, but discourages it with a lower level of reimbursement.

Capitation, however, no longer reigns supreme. Pavlow's CHPA offers plans with physician reimbursement ranging from capitation putting the primary care provider at risk to HMOs using no capitation at all.

That may be a major trend. John Erb, principal with the William M. Mercer consulting firm and former head of South Florida Health Coalition, one of the original CHPAs, says that some HMOs are moving away from capitation to fee-for-service because capitation makes doctors less productive and less motivated to see patients since they are being paid for their care whether they treat them or not. One major company, United Healthcare, is already offering an open access HMO which uses virtually every doctor in the market. There are sure to be other similar offerings coming soon, Erb believes. — *David Kohn, adapted from the forthcoming F&G 1998 Health Network & Alliance Sourcebook*

Medicine & Health **PERSPECTIVES**

Fawell Bill Returns; ERISA Questions, HIPAA Thicken Plot

The jury is still out on Rep. Harris Fawell's ten-year quest to obtain "the same breaks that Ford Motor Company gets" for small businesses that want to buy health coverage — namely, exemption from state insurance laws under the federal Employee Retirement Income Security Act (ERISA).

The Senate Labor and Human Resources Committee held hearings early this month on the Illinois Republican's Expanded Portability and Health Insurance Coverage Act (EPHIC), with Chair Jim Jeffords (R-VT) affirming "my intent to review the testimony and develop legislation that promotes voluntary efforts to expand health insurance coverage for working adults and their dependents."

Earlier this year, the House passed Fawell's proposal — then mislabeled a "MEWA bill," for multiple employer welfare arrangements — as part of the Balanced Budget Act, but it was later dropped in conference. Senate Majority Leader Trent Lott (R-MS) strongly supports the legislation, which provides for federal certification of "association health plans" (AHPs) and places them under supervision of the Dept. of Labor. After enactment of insurance market reforms, Medicare and Medicaid changes, and child health legislation in rapid succession, the momentum of incrementalism is bearing down on the issue of affordable coverage for 23 million low-wage workers who are now uninsured, to whom Fawell has dedicated his efforts.

"I think Congress would like some way out," says Frank Duggan, lobbyist for a coalition of pro-EPHIC trade and professional organizations. Lott "wants to do something, and he's the majority leader," says Duggan. "Jeffords has promised that he will do something and that he will work it out with Fawell."

But proponents of the Fawell bill, with a companion measure in the Senate sponsored by Tim Hutchinson (R-AR), will have their hands full with Jeffords, whose inclination in the past has been to narrow, rather than expand, the reach of the ERISA preemption. Moreover, Jeffords says, "I have been a long time supporter of private health plan purchasing coalitions" and cosponsored a bill in the 104th Congress to encourage coalitions, which are viewed by some in the Fawell-Hutchinson

camp as the antithesis of EPHIC.

"We have a big concern when the states start to regulate the pricing and the benefit package," says Vicki Caldeira, Senate legislative affairs manager for the National Federation of Independent Business (NFIB), characterizing the approach to purchasing coalitions that she believes Jeffords favors, on the basis of discussions with his staff. "Most of our members wouldn't want to participate in a state run program under any circumstances," Caldeira says, even if premiums were subsidized.

Looming in the background of the coming debate over EPHIC is the future of ERISA itself. The unified support of business and labor has made the 1974 law virtually sacrosanct for two decades. But cracks in the wall insulating self-insured health plans from state regulation have finally begun to appear. Provisions of the Health Insurance Portability and Affordability Act of 1996 apply to self-insured plans, as do federal maternity stay and mental health parity laws passed after HIPAA. State and federal legislators are seeking to remove ERISA as a shield from malpractice claims. Jeffords is one of several congressional leaders working on legislation to protect consumers in managed care plans which would apply to ERISA plans as well as commercially insured enrollees.

"The outstanding achievement of the persons who crafted HIPAA and secured its passage was establishing the portability and accountability of both commercial and self-insured health coverage," wrote Brian Atchinson and Daniel Fox in the May/June *Health Affairs*. "It took 22 years to puncture the ERISA vacuum," says Fox, president of the Milbank Memorial Fund in New York. "It took 22 years before there was enough political will in the Congress to take on the interest groups which had preserved the ERISA preemption. Everybody's noticed that having been done once [with HIPAA], it was then done again [with maternity stays and mental health parity] and it becomes progressively easier." The willingness of big business to accept federal managed care legislation may further erode the solidarity of the business community behind the inviolability of the preemption, he suggests.

Others contend that business will close ranks against a federal consumer protection bill for managed care precisely because of the implicit threat to ERISA. In any case, with Jeffords' committee likely to address both EPHIC and managed care legislation in 1998, the

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peculiarities of ERISA and its pervasive effects on the balance of state and federal health policy will be under greater scrutiny than ever before.

Tough Cookies

The maximal claims made on behalf of EPHIC seem to attribute to ERISA almost all of the advantages the large group private health insurance market has over the small group market — lower premiums, richer benefits, lesser cost sharing, and a much higher percentage of covered employees. "Indeed, administrative costs for larger employers operating under ERISA can be 30% lower than for small businesses, and health premiums for large employers can also be 30% lower than those for small businesses. ERISA enables large companies to keep their costs under control, thus making insurance for their employees more affordable," said Donald Dressler, president of insurance services for the California-based Western Growers Association, in written testimony on behalf of The Association Healthcare Coalition (TAHC) for the Oct. 1 Labor and Human Resources hearing. Fawell cited estimates "that as many as half of the uninsured could gain access to affordable coverage under EPHIC."

It is not just ERISA, though, that gives Ford Motor Co. more clout in health insurance negotiations than the car repair shop in La Grange IL where Fawell says he was first inspired to seek an equalizer. Skeptics note that steep provider discounts are usually contingent on a concentration of employees in hospital and physician service areas, which the typical association health plan — with members scattered in small pockets across diverse communities — does not represent.

The large difference in administrative costs between the large and small groups, reflecting economies of scale in the marketing and enrollment process, predates ERISA and may have double-edged import in the EPHIC debate. If association plans cannot persuade their members to invest in a substantial administrative infrastructure comparable to the benefits department in a large corporation, critics of the Fawell proposal argue, they will be unable to bring to bear the data and expertise needed to bargain effectively and monitor plan performance; and will be subject to capture by insurance carriers, who will simply exploit the associations as marketing vehicles and "price takers" without offering better service and benefits or significant price concessions in return.

Duggan avoids the extravagant claims of some EPHIC supporters. "The issue is not the uninsured," he says, speaking of the established association plans in TAHC that he represents. "It's keeping what they have." Increasingly aggressive state benefit mandates and

health insurance regulation in general are creating a fragmented and expensive interstate environment for association plans that many carriers are finding too burdensome to endure. "The insurance industry is simply bailing out," Duggan says. "Hundreds" of association plans have left the market or been dropped by carriers in the past five years, according to a recent survey by Virginia-based W.F. Morneau & Associates.

The Boys & Girls Club Workers Association, for example, which provides coverage for 4,000 workers at 230 clubs nationwide, had to drop coverage for 600 people at 46 California sites when the Florida-based American Heritage Life Insurance Company dropped out of association market in California in 1995 because of the "overwhelming cost" of state small market regulations, according to the Senate testimony of Patricia Gagne, VP of an Iowa brokerage and administrative firm that serves the association. Clubs in New York have dropped association coverage after two-year premium increases of more than 75 percent, Gagne said, and the association's current carrier, Chicago-based CNA Companies, has stopped enrolling new clubs and "asked the Workers Association to find another carrier" because of compliance costs.

TAHC members are neither rushing to escape regulation under ERISA or rolling over for carriers as marketing patsies, Duggan contends. Only about 20 percent of the coalition's members self-insure and "we have professionals who work for us — not insurance companies," he says. "There was a time when a broker could go to a small association and say 'Let me run the show for you,'" Duggan admits. But now, "the people that negotiate benefits for associations are really tough cookies... We're not getting in bed with anybody."

Bluegrass Breakdown

It was clearly a challenge for Fawell, in his Senate appearance, to speak honestly of his views on recent insurance market reforms without offending the committee that crafted HIPAA just last year. He softened his prepared remarks to acknowledge that state reforms such as guaranteed issue and modified community rating may have yielded some increases in coverage for small employer groups, while his written testimony derided "the much-heralded 'state health insurance reforms'... that lack almost any conceivable benefit" and "have 'protected' most of America's smallest businesses and their workers *right out of having any insurance whatsoever.*"

Dan Danner, VP for federal government relations for the NFIB, cited Kentucky as an example of the potential for mischief in market rules, noting that 49 insurers have left the small group and individual markets in the

Bluegrass state since reforms were enacted in 1994. But North Dakota Insurance Commissioner Glenn Pomeroy, representing the National Association of Insurance Commissioners (NAIC), told the Senate panel that Kentucky's 1996 exemption from market reforms for association plans is at the heart of the state's problems. The Kentucky General Assembly has been in special session this month weighing proposals to rescind modified community rating and close down the state's unique small group and state employee purchasing alliance.

The '96 exemption was designed as a "safety valve" to relieve the business community's discontent with rate increases for relatively healthy small groups and individuals that resulted from guaranteed issue and renewal and modified community rating provisions enacted in '94, according to Rosemary Weathers, director of communications for the state Dept. of Insurance. The exemption lifted rating restrictions for association plans, grandfathering in those groups that were already sponsoring coverage and creating a virtually automatic approval process for associations that wanted to begin doing so, Weathers says.

"You cannot believe how many are out there selling health insurance. There's the broken-down truck towers' association, the meat freezers' association. They came out of the woodwork," she says. Other organizations such as chambers of commerce also applied and received approval to sponsor coverage, as did a service organization called Metro Seniors that marketed coverage to individuals. "If it's not trade-specific, if it's a chamber and any business could join that chamber, then any business can go and get exempted from the health insurance law, the reforms, and just go under this association rule," Weathers notes. Metro Seniors contracted with Anthem Blue Cross and Blue Shield, the only carrier left in the individual market after the mass exodus sparked by market reform. Because of the association loophole, Anthem coverage sold through Metro Seniors "could experience-rate all the individuals who bought health insurance. Anybody could join," Weathers says, not just senior citizens.

Rate filings for this year's annual fall enrollment season in the purchasing alliance saw proposed increases of 14, 18, 20, and 30 percent, she says, a barometer of the adverse selection spiral triggered by the association loophole. "What we saw was that in another year anybody who wanted to get a decent price on health insurance and who was healthy was going to go shopping at

"You cannot believe how many [associations] are out there selling health insurance. There's the broken-down truck towers' association, the meat freezers' association. They came out of the woodwork..."

an association. If you're a business and you're working with an agent, most agents will tell you, 'Join the chamber of commerce for \$100 and I can sell you this plan,'" Weathers explains. If a group member incurs high costs, the carrier will raise the rates and that group or the unhealthy individual in it will go back to the regulated market, further skewing premiums.

"If you don't have rules on your association market, it just kills your insurance market. We figured two years at the most the whole market would be destroyed. You would have nothing but a risk pool," she says. But

the associations comprise a potent political force whose needs can't be ignored, Weathers says — bankers, homebuilders and chamber members who are "the backbone of your society. These are people who are going to be listened to in the legislature." During this month's special session on health, legislators had agreed on a proposal to put associations under the same rules as the rest of the small group and individual market, which included relaxed rating rules that allowed medical underwriting and created a high risk pool. But a competing proposal to require plans that reject high-risk individuals to pay an assessment led to a stalemate, and the legislature adjourned Oct. 15 without acting.

Federal-State Parfait

Market fragmentation and adverse selection are just the dangers that the NAIC, the National Governors' Association (NGA) and insurance groups like the Blue Cross and Blue Shield Association and the American Academy of Actuaries have warned against in the the Fawell-Hutchinson EPHIC proposal. "We believe the methods called for in this bill will set back — if not destroy — the recent efforts made by both the states and Congress, and would result in unintended consequences that would be devastating to the small group health insurance market," NAIC VP Pomeroy told Jeffords' committee. "Many employer groups would flock to the unregulated, inexpensive, and inferior AHPs. These plans, while providing little in the way of benefits, could function knowing full well that as soon as a health condition developed requiring meaningful benefits, HIPAA would provide automatic passage into whatever remained of the small group market. The healthy would leave the regulated market, the sick would remain."

NFIB's Danner, however, pointed out a number of protections built into the legislation. "Unlike MEWAs of the past, the new federal rules in [EPHIC] only apply to

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group health plans established by legitimate bonafide trade associations" that serve purposes other than purveying insurance and have existed more than 3 years, he said. Self-insuring AHPs must have reserves equal to 25 percent of expected claims or \$400,000 and carry stop-loss coverage. All AHPs must offer at least one fully-insured option, and the association plans may not deny coverage or charge higher premiums to businesses or individuals because of health status.

"Concern has been raised, however, about the ease with which organizations might qualify as associations under the bill and the possibility that virtually any employer might qualify as an 'affiliate member' of an association," writes Karl Polzer, in a thorough and balanced examination of the AHP issue for the National Health Policy Forum at George Washington University, where he is a senior research analyst.

"Depending on the beholder, the Fawell bill's solvency standards can be viewed as a glass half-empty or half-full. They are more stringent than ERISA's solvency standards for health plans -- ERISA currently has none even for small firms that self-insure without purchasing stop-loss coverage," explains Polzer, noting a 1993 R.W. Johnson Foundation survey finding that more than half of self-insured firms with 25 or fewer employees had no stop-loss. "In fact," he goes on, "arguments by the Fawell bill's proponents about the merits of establishing solvency standards for self-insured association plans seem to underscore the question of why ERISA has no such standards for other types of self-insured plans, particularly those involving small groups for which claims costs may fluctuate widely from year to year. Although they are greater than what ERISA imposes now, the solvency standards in the Fawell bill are significantly less stringent than those applied by most states to HMOs and insurers." The American Academy of Actuaries recommends a minimum capital level of \$2 million for association plans, or \$500,000 with stop-loss.

According to Polzer, an earlier version of the Fawell bill that passed in the House during the 104th Congress competed head-to-head with a Senate-passed proposal to foster purchasing alliances, with the net result "a policy standoff in which opposing factions so far see little or no room for compromise." Duggan suggests gaps in understanding between the pro- and anti-EPHIC camps that might be repairable. One is the perception that associations merely wish to elude state regulation by self-insuring, when an estimated 75 percent

of association plan coverage is under insured products subject to state oversight.

"While we prefer the ERISA process, the associations which comprise The Association Healthcare Coalition (TAHC) are more than willing to abide by any reasonable procedural or benefit rules which Congress may wish to institute, as long as these rules apply equally to everyone, including insurers, self-funded single-employer plans, and association group plans alike," wrote Dressler of the Western Growers group in a May 12 letter to Rep. Marge Roukema (R-NJ).

Duggan also sees a "disconnect" between the Blue Cross and Blue Shield Association's vigorous lobbying effort against EPHIC and the longstanding customer relationships that many TAHC groups have with Blue plans around the country. "Their Washington representatives are incurring the wrath of the entire business community," he says. "We're not the enemy. We're the customer."

Meanwhile, the NAIC, NGA, and the National Conference of State Legislatures voiced their support for "development of public and private purchasing cooperatives and other innovative ventures" while standing fast against "preemption of state insurance laws" in a June letter to House leaders Newt Gingrich and Richard Gephardt. Representing the Clinton Administration, Asst. Labor Secretary Olena Berg told the Labor and Human Resources Committee that "purchasing cooperatives already successfully operate in a number of states while remaining fully within state insurance regulation." Berg renewed the Administration's call for a 5-year, \$125-million program to nurture alliances that sell competing, fully insured products, with an option to latch onto the structured market of the esteemed Federal Employee Health Benefit Program as an enhancement.

Is synthesis of the alliance and association concepts a possibility? Jeffords' staff says association plans should have "consumer protections, benefits standards, and solvency requirements" and "should not undermine states' efforts in achieving small-group and individual market health insurance reform," among other criteria, according to Polzer. Milbank's Fox notes that the recently-enacted State Children's Health Insurance Program sets an interesting precedent with its layer cake of federal benefit standards and equivalent state options. HIPAA creates a similar hybrid of state and federal regulatory options in the small group and individual markets.

In such a climate, ERISA may have to adapt to survive. — R.C.

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A Comparison of Consumer Choice Health Purchasing Groups

	Health Insurance Plan of California	The Minnesota Employees Insurance Program (MEIP) and the Public Employees Insurance Program (PEIP)	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliances (CHPA)	Texas Insurance Purchasing Association	CBA Health Connections (Connecticut)	The LIA Health Alliance	The Kentucky Health Purchasing Alliance	The Cooperative for Health Insurance Purchasing	Carobance	HealthChoice*	Associated Oregon Industries	Community Health Options*
Contact, address, phone and fax number¹	Sandra Shewry Executive Director, Managed Risk Medical Insurance Board 818 N. Street, # 200 Sacramento, CA 95814 916-324-4895 1-800-NIPC YES	Bill Eszack Manager of the MEIP and FEIP Program, Employee Insurance Division, State of Minnesota 618 Cedar Street, 200 Centennial Bldg. St. Paul, MN 55155 612-297-2115 612-296-5445 fax 1-800-629-5601	Anta Boone Executive Director, The Employers Health Purchasing Cooperative 1300-114th Ave. SE Suite 205 Bellevue, WA 98004 206-846-4392 206-846-4282 fax e-mail: apec@acessa one.com	Florida Agency for Health Care Administration 954-922-8443 for general inquiries 1-800-4MY CHPA	Clark Jobe Director, Texas Insurance Purchasing Alliance 1005 Congress Avenue Suite 550 Austin, Texas 78765 512-472-9954 512-474-2587 fax 1-800-839-6472	Nancy DeGroot V.P. of Insurance Marketing, Connecticut Business and Industry Association 370 Asylum St. Hartford, CT 06104 860-244-1903 860-278-8562 fax	Fred Barba Executive Vice President/Chief Operating Officer, LIA Health Alliance 80 Hauppauge Road Commack, NY 11725-4495 516-493-5007 516-499-0167 fax 1800-LIA-5613	Felen Barakauskas Executive Director, 609 Leewood Drive Frankfort, KY 40601 502-564-4747	Elisa Hamil Executive Director, The Colorado Health Care Purchasing Alliance 501 South Cherry, Suite 900 Denver, CO 80226 303-333-6767 303-322-3830 fax 1-800-896-CHIP	State Health Plan Purchasing Alliance Board 501 N. Stout Street Raleigh, NC 27604 919-715-4440 919-715-4429 fax 1-800-673-6464	Don Brunell President, Association of Washington Business P.O. Box 858 Olympia, WA 98507-0858 (206) 543-1800 (206) 543-5811 fax (800) 521-9325	Kevin Esrie Vice President Associated Oregon Services Corporation P.O. Box 12518 Salem, OR 97309- 0518 (503) 566-9950 (503) 566-0052 fax (800) 452-7852	Bill McDonald President Community Health Options P.O. Box 4121 Mascota, MT 59638 (406) 721-6275 voice and fax
Geographic area	State of California 8 rating regions	Most of the state of Minnesota	The State of Washington	8 CHPAs cover the entire state of Florida.	State of Texas with 7 service regions.	State of Connecticut with 4 rating regions	Long Island	State of Kentucky with 7 rating regions.	State of Colorado	State of North Carolina with 6 regional organizations.	State of Washington with several rating regions.	Intend to offer coverage throughout Oregon	Health plan coverage will be made available in many areas of Montana. Indemnity will be made throughout Montana.
Size of employers	3-50. Group size will drop to 2 on 7/1/97. Employers of any size if they obtain coverage through a qualifying trade association.	2 or more employees for the MEIP. For PEIP employee size is 1 or more.	The minimum is 4 employees living in separate households. There is no maximum number of employees.	1 to 50 employee firms, potentially government employees, Medicaid, and Medicaid buy-in. Employers with more than 500 employees may participate to obtain information on AMPs.	3-50	3-50	2-50 as of July 1, 1997	2-50, individuals, and public employees. Mandatory for state employees. Voluntary for local units of government and universities.	Any size	Self-employed, individuals, and businesses with fewer than 49 employees.	Employers with more than 3 employees, with focus on those with 100 or fewer employees	Employers with 1 or more employees, with focus on those with 50 or fewer employees	Employers with 2 or more employees
Date coverage is or will be available	July, 1993	3/5, 1993 (MEIP) 1989 (PEIP)	March, 1994	June 1, 1994	July 1, 1994 for the Gall region, Feb. 1, 1995 for the other 6 regions.	January 1, 1995	February, 1995	July 15, 1995	Fully insured: October 1, 1995 Self insured: Jan. 1996 Derrick Max, 1997	November 15, 1995	Began enrollment on May 1, 1996 with coverage effective on June 1, 1996.	Effective date of coverage scheduled for June 1, 1997.	Effective date of coverage scheduled for July 1, 1997.
Number of employer groups (as of 3/97)	8,647. Average group size is 18 employees.	360 groups for MEIP, 50 groups for FEIP.	780	18,838 groups statewide	1,054 groups. Average group size is 7 employees.	3481. Average group size is 6 employees.	1,839. Average size group is 8-12.	see below	Average group size is 10. 900 fully insured employers. 150+ self insured employers.	638	32 groups as of 8/2/1996	Not applicable	Not applicable

* Last revised 1/1996. All numbers are as of that date.

¹ Alliances on this chart have a Board of Directors with a mix of business providers and members who represent small employer consumers, offer a choice of multiple competing health plans, and have standards of care. Alliances meeting these requirements may not be included. Please contact Kevin Hough if you know of a small employer purchasing program that should be included.

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rev. 4/1/97 Page

2

	Health Insurance Plan of California	The Minnesota Employees Insurance Program (MEIP) and the Public Employees Insurance Program (PEIP)	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliance (CHPA)	Texas Insurance Purchasing Association	CBIA Health Connections (Connecticut)	The LIA Health Alliance	The Kentucky Health Purchasing Alliance	The Cooperative for Health Insurance Purchasing	Carollance	HealthChoice ¹	Associated Oregon Industries	Community Health Options ²
oversees direct in all	124,243	7100 (MEIP) 8700 (PEIP)	8,000	75,274	11,844	55,000	12,000	Total is 317,000: 21,000 for small employer groups, 16,500 individuals and dependents, and 280,000 state/local employees.	15,500 LIA insured and 100,000 self insured	2,500	377 employees as of 8/21/96	Not applicable	Not applicable
legal structure	Part of the Managed Risk Medical Insurance Board which is a state agency	Part of the Department of Employee Relations, a state agency that also administers the state and local government employees purchasing programs.	Private, non-profit cooperative	82% chartered, private, not-for-profit	Private, not-for-profit	Subsidiary of private association of employers (membership available to all businesses in Connecticut)	Private, not-for-profit	Independent government agency	Private, cooperative	State chartered, not-for-profit		Private, non-profit	Taxable, state not-for-profit mutual benefit corporation
governance structure	Governed by a 5 member Board—the California Managed Risk Medical Insurance Board—appointed by the Governor, Speaker of the Assembly, and Senate Rules Committee.	10 person advisory committee made up of private sector employers chosen by the Commissioner of Employee Relations. The committee meet quarterly and oversees both programs.	Board has 7 current members with the capacity to have up to 15. Members are elected by the membership ³ and are typically those members interested in serving.	Each governed by a 17 member Board of business and industry, consumer and state and local government representatives; appointed by the Governor, President of the Senate and Speaker of the House. None may have any health care conflict ³	Nonprofit organization governed by a 8 member Board of Trustees appointed by the Governor with advice and consent of the Senate. Board consists of employers, employees and a public representative.	Overseen by CBIA's Board of Directors.	8 person Board of Directors made up of 5 small employers, one bank, one accounting firm and the executive vice president. The Alliance was developed by the Long Island Association which is a business and civic association focused on improving the economic viability of Long Island.	Governed by a 5 member Board appointed by the Governor and confirmed by the Senate. Certified and annually reviewed by the Department of Insurance.	Sponsored by the Colorado Health Care Purchasing Alliance which is a cooperative of self-funded employers. One Board and operating structure for the CHIP and offering services for self insured employers. 17 member board of directors made up of its members.	Each regional alliance is governed by an 11 member Board. All members elected by the membership.		Undetermined at this time.	11 member Board of Directors, of which 7 seats are filled by 5 large employers (including the state of Montana and the University System), with the other two occupied by the Montana Chamber of Commerce and the Montana Logger's Association.
ability to selectively contract	Yes. Entered in negotiations with 29 health plans; 19 contracts were signed. Negotiated a 5.5% reduction in premiums for second year and a 3.5% reduction for third year and flat pricing in fourth year.	Yes. 5 responses to the RFP were received; 4 contracts were chosen.	Yes. 16 responses were received; 3 plans were chosen.	No. Health plans that wish to sell through the alliance must be certified by the state. All AHPs are certified.	Yes. 7 carriers chosen.	Yes. 16 RFPs were mailed out; 8 responses were received; 4 plans were chosen.	Yes	Yes	Yes. 11 of the 14 certified HMOs responded to RFP. 4 were chosen ⁴ . Direct contract with 5,000 providers for the self insured.	No. Health plans that wish to sell through the Alliance must be designated by the state. 14 Accountable Health Carriers (AHCs) have been designated.	Yes. Nine health plans responded to the RFP. Four were chosen.	Yes.	Yes.

¹ Two membership classes exist: class A and class B. Class B members are supporting organizations and health plans and insurance carriers. Class A consists of non-provider organizations that obtain coverage through the cooperative. Only class A members may be Governing Board members.

² Generally this means that they may not have a financial conflict of interest associated with a health carrier, provider or other similar health related organization or individual.

³ HMOs have a three year contract and other HMOs will not be allowed into the CHIP during this time period.

	Health Insurance Plan of California	The Minnesota Employees Insurance Program (NEIP) and the Public Employees Insurance Program (PEIP)	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliance (CHPA)	Texas Insurance Purchasing Association	CBSA Health Connections (Connecticut)	The LIA Health Alliance	The Kentucky Health Purchasing Alliance	The Cooperative for Health Insurance Purchasing	Carrollance	HealthChoice [®]	Associated Oregon Industries	Community Health Options [®]
number of participating health plans	Currently, 22 companies offering 22 HMOs, 3 POS, and 3 PPO.	4 HMOs and 3 indemnity plans. However, the indemnity plan is offered only in areas where 1 or no HMOs are available.	3 POS plans with 3 plan designs are offered providing consumers with a choice of 9 plan options.	Statewide: 32 AHPs offering 75 plan options.	7 carriers representing HMO, PPO and indemnity delivery options.	4 insurance companies each offering an HMO and a POS plan.	3 insurance companies each offering 3 versions of an HMO and 3 versions of a POS plan.	11 accountable health plans offering a total of 28 different products.	4 insurance companies each offering an HMO and POS plan.	3 insurance companies offering HMO, PPO, and POS plans.	4 health plans, each offering all products.	Intend to contract with multiple health plans.	Intend to contract with multiple health plans.
standardized riders	Yes. A high and low option for each option HMO and each PPO plan.	One benefit plan is offered for the HMO plans with four co-pay options and a Point of Service option. The plan is comparable to the state employee plan and is more comprehensive than the minimum benefits plan mandated by the state.	Yes. Each of the three plans are standardized.	Basic, standard and plus options. The plus option is a CHPA designed unique plan option. Different deductible levels are allowed; the state must certify each plan with a different deductible. The legislation states that other than standard plans are prohibited. Riders may be offered, but each CHPA must gain approval from the state.	Yes. 2 Alliance-developed benefit plans, plus 2 state-mandated plans.	Yes. Each insurance company must offer a high and a low option HMO and a high and low option POS. Employees have a choice of 18 standardized insurance options.	Yes. High, low and value HMO options. High, low and value POS options.	Yes. 18 different plan options that vary in services, delivery model, and co-pay levels. Several standardized riders also available.	Yes. Employees have a choice of three benefit levels: standard, basic, and standard with a POS option.	Yes. Three benefit levels: Standard, Basic, and Select.	Yes. An HMO product and a POS high and POS low product. Also an indemnity product for out-of-state or out-of-service area employees.	Yes. HMO with high and low options and a POS.	Yes.
insurance coverage for dependent children	70% of eligible employees must participate.	75% of eligible employees must participate.	75% of eligible employees must participate.	70% of eligible employees must be insured either through the CHPA or through any public or private insurance.	75% of eligible employees must participate.	75% of eligible employees must participate.	50% of eligible employees must participate.	60% of eligible employees must participate.	75% of eligible employees must participate in an Alliance plan ⁵ .	70% of eligible employees must participate.	75% of eligible employees must participate. 80% of employees must be in the state of Washington.	75% of eligible employees must participate. More than 50% of employees must be in the state of Oregon.	75% of eligible employees must participate. More than 50% of employees must be in the state of Montana.
employer or employee choice	Employee	Employee (Employer chooses the benefit level and employee chooses the plan.)	Employer. However within each plan, employee can choose HMO, PPO or indemnity coverage.	Employers choose plans from which employees then choose. Firms of more than 30 employees must choose at least 3 health plans, firms of 30 or fewer employees must offer at least 2 health plans. ⁶	Employee (Employer chooses the benefit level and employee chooses the carrier and delivery.)	Employee	Employee	Employee	Employee (Employer chooses the benefit level and employee chooses the plan.)	Employer must pay at least 50% of the lowest cost plan offered. Employers who pay 70% or more may choose only 1 plan.	Employee choice of health plan and benefit level.	Employee (Employer chooses the benefit level and employee chooses the plan.)	Employee choice (benefit level may be selected by employer or the HPC depending on the size of the employer and the structure of any self-funded options).

employers with over 50 employees may have employees in both insured and a self-insured plans.
 while plans with the same benefits, but different deductible levels are considered different health plans.

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rev. 4/1/97 Page 3

	Health Insurance Plan of California	The Minnesota Employees Insurance Program (MEIP) and the Public Employees Insurance Program (PEIP)	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliance (CHPA)	Texas Insurance Purchasing Association	CBIA Health Connections (Connecticut)	The LIA Health Alliance	The Kentucky Health Purchasing Alliance	The Cooperative for Health Insurance Purchasing	Carollance	HealthChoice	Associated Oregon Industries	Community Health Options
Start up funding	Loan from the state repaid with a surcharge on premiums.	For MEIP, a loan from the state, repayment to begin in 1999. Appropriations from state are derived from a provider tax passed as part of the health care reform bill. For PEIP, a loan from the state that was repaid in 3 years.	Grants from the Hartford Foundation and the National Cooperatives Bank as well as donations from member employers.	\$275,000 per alliance provided by the state. State funding ended in 1997.	\$250,00 provided by the state in 1995.	CBIA Service Corporation, a for-profit subsidiary of CBIA provided start up funds.	Funding provided by the Association and participating insurers.	State lending and grants.	A grant from the Hartford Foundation, other grants, and employer contribution.	Varies by region. State lending.	Funding provided by the Association, the participating healthplans, and the Administrator.	Funding provided by the Association to date.	Start-up and initial operating funding contributed by founding large employer members and potentially by participating healthplans.
Source of ongoing funding	Surcharge on premiums.	MEIP is currently using loan and a surcharge on premiums. For PEIP a surcharge on premiums.	Membership dues range from \$50-200 depending on the number of employees. A \$3 per employee per month fee.	For first year \$275,000 per alliance provided by the state. Second year \$138,638 provided by state. Ongoing: a membership fee and administrative fees. State funding ended in 1997.	Surcharge on premium: \$9.00/employee/month	Current membership fees and a surcharge on premiums.	Percentage of premium: 1% to the Alliance to cover administrative expenses, telemarketing, and marketing expenses and 1% to outside ASO vendors to cover encoding, billing, collection, and quality report card.	Monthly premium assessment of 1.75%.	Surcharge on premiums and sign-up fee.	Membership fees dues and a monthly per member administrative fee.	5% surcharge on premiums. 4% goes to the administrator and 1% to AHB.	Plan to implement a surcharge on premiums.	Plan to implement a surcharge on premiums.
Agent commission	Paid through a fee schedule based upon group size. Fees are identified separately on billing statement and paid by the employer.	For MEIP, a set fee (per employee per month) is paid to agents that is equivalent to approx. 4% of monthly premiums. For PEIP a general sales agent is used.	Agents are paid a commission of 4% for employers with less than 100 lives and may set any commission for groups over 100 lives. The 4% commission is noted on the plan proposal sent to employers.	Employers must enroll through an agent. AHPs (not the CHPA) determine how agents are paid. In cases where AHP doesn't pay the commission, the CHPA may pay commission.	7.5% of premium	All employers must enroll through an agent. During the first year agents will receive 5% of premium.	% of premium	5% of premium. Agents are not mandatory. The majority of participants do not use agents.	Commission based upon annualized premiums. Uniform for all health plans.	Employers must enroll through the use of an agent. AHCs determine commission.	5% commission on new business and renewals for groups of under 100 eligible employees. Commissions on groups over 100 determined on a case-by-case basis.	Currently planning a fixed commission on new business and renewals.	Currently planning a fixed commission on new business and renewals.

5

	Health Insurance Plan of California	The Minnesota Employee Insurance Program (MEIP) and the Public Employees Insurance Program (PEIP)	Employers' Health Purchasing Cooperative	Florida Community Health Purchasing Alliance (CNPA)	Texas Insurance Purchasing Association	CBA Health Connections (Connecticut)	The LIA Health Alliance	The Kentucky Health Purchasing Alliance	The Cooperative for Health Insurance Purchasing	Carolina's	HealthChoice ⁷	Associated Oregon Industries	Com Union
Quality measures	Plans must report utilization and cost data to the state. Report cards and member satisfaction survey planned.	Much of the quality reporting has been done for the state employees program which uses some of the same plans as the MEIP and PEIP. Quality reporting specifically for MEIP is planned for next year.	4 report cards planned: Access to Qualified Providers, Accountability for Claims and Service, Consumer Satisfaction, and Medical Performance Measures.	AMPs must report quality indicators to the state.	Monthly customer satisfaction survey with billing. Report cards based on NCOA Quality Comparison data to be introduced in 1997.	Will collect claim information and report trends. Report cards and member satisfaction survey planned.	Will have quality performance report cards which include the member satisfaction surveys. Health plans must be certified by the National Committee on Quality Assurance by the end of 1997.	All health plans must report some data to the state.	A 2% health plan withhold for quality improvement based upon data collection and monthly report cards. Quality standards based upon clinical, service, and employee satisfaction measures.	AMCs are required to provide for the collection and reporting of information on the performance of AMCs regarding the effectiveness of outcomes in providing selected services.	Health plans will submit some specific HEDIS 2.5 measures.	Plan to collect and present CAHPS and HEDIS-based performance measures and consumer satisfaction survey results to enrollees.	Plan to present based on consumer satisfaction results to enrollees.
Number of FTEs ⁷	13 (All employees who work on 2 other programs.)	4 FTEs cover both MEIP and PEIP.	3	All CHPA's have 2 or 3 employees: an Executive Director and a clinical person; some CHPA's may also have an operations or a marketing person.	2	12	4	8		All regions have between 2 and 4 employees, an executive director and a clinical person. Some regions may also have an operations or marketing person.	The Administration employs 3-4 individuals who spend at least a majority of their time on HealthChoice.	Over 7,200 FTEs	Currently 1 FTE
Services contracted out	Enrollment, premium collection/distribution, and marketing is contracted out to Employers Health Insurance. Adversarial services are contracted out to Coopers and Lybrand.	Enrollment and premium collection/distribution is contracted out to a Third Party Administrator (TPA), one staff person coordinates marketing with a local advertising firm. The brokerage house of Sedwick James handles quotes and sales. Deloitte & Touche oversees and provides actuarial services.	None. The cooperative currently does not perform the functions of enrollment and premium collection/distribution; the employers contract directly with the health plans.	For all CHPA's, enrollment and premium collection/distribution and marketing is contracted to Health Plan Services.	Enrollment, premium collection/distribution, and marketing is contracted out to Blue Cross of Texas.	Enrollment, premium collection/distribution, marketing, and claim reporting done in-house. Quality analysis done by Value Health Management.	Enrollment and premium collection/distribution is contracted out to Benefit Plan Administrators. The quality reporting system is contracted out to KPMG. Marketing is directed by the alliance.	Enrollment, premium collection/distribution, and marketing contracted out to Health Plan Services.	Enrollment and premium collection/distribution is contracted out to Network Management Services (NMS). All other services including marketing and data collection performed in-house. Dental coverage is contracted out.	All regions have signed a contract with Health Plan Services, Inc. for enrollment, premium collection and marketing functions.	Enrollment, premium collection/distribution, actuarial services, customer service, and marketing are contracted out to Synergy and Company in Denver, CO.	Enrollment, premium collection/distribution, actuarial services, customer service, and premium marketing will be contracted out to Synergy and Company in Denver, CO.	All enrollment and premium distribution will be contracted out to administrator.

⁷ Full time employees for program only. When administration is contracted out the administrator uses many of its employees to perform functions for the alliance. Because they do the administration (enrollment and premium collection) themselves, the CBA/MEIP and PEIP programs have many more FTEs.

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March 24, 1994

ENTERPRISE

Small-Business Program in California Cuts Health Premiums by Average 6.3%

By LESLIE SCISM

Staff Reporter of THE WALL STREET JOURNAL

An innovative small-business health-insurance program in California that pools employees into purchasing cooperatives is cutting premiums by an average 6.3%.

Michael Roush, an official with the National Federation of Independent Business in Washington, D.C., a group of 600,000 small businesses, said the California co-op's success comes as most small businesses nationally experience "low- to mid-single-digit increases, compared to double-digit increases as recently as last year."

The nearly year-old Health Insurance Plan of California announced that it has negotiated the premium cuts with 23 health plans to take effect July 1. The plan, which covers 2,500 businesses with 44,000 employees and dependents, is the nation's first statewide government-backed health-insurance purchasing co-op. Many experts consider it a model for the various sorts of purchasing pools being debated by national health reformers.

Under the California plan, employers voluntarily join the cooperatives. This gives them the same bargaining clout as large businesses. Employees at participating small businesses can pick among several plans and employers are required to cover at a minimum the cost of 50% of the cheapest plan, with employees paying the rest.

"The rate decrease that members are receiving will come as welcome news to all proponents of managed competition," said Richard Figueroa, deputy director with the California Managed Risk Medical Insur-

ance Board, a 13-person agency overseeing the alliance. "It shows that alliances can be put together in a short period of time with a lot of insurance-company participation."

The premium cut comes on the heels of a 1.1% premium reduction announced by the giant California Public Employees Retirement System for members in 18 health-maintenance organizations. Announced last month, Calpers' new rates will benefit 820,000 public employees and family members.

In the most recent round of negotiations for the California co-ops, "competition was intense," said Ronald Brewer, a regional director for Aetna Life & Casualty Co., which captured nearly 40% of the program's business in its first year. "Through our success, others have seen that there's a lot of business to be written, and people who weren't aggressive last year came back much more aggressively."

The heightened competition is most evident when comparing the negotiated rates, Mr. Figueroa said. Beginning July 1 in the Los Angeles area, for example, six of the 17 participating companies will offer monthly rates below \$100 for an individual between 30 years and 39 years old, with the lowest one at \$87. Last year, only one of 15 participating companies offered a monthly rate below \$100. The rate: \$88.29.

Robert Laszewski, a consultant with Health Policy and Strategy Associates, Washington, D.C., said the California co-ops are "probably the best example of what the marketplace will be happy with." The program, however, still has a small market share, just several percent of the small business market.

Los Angeles Times

March 23, 1994

State Alliance Gives Workers Health Clout

By ROBERT A. ROSENBLATT
TIMES STAFF WRITER

WASHINGTON—Forty thousand workers at small California businesses will get an extraordinary piece of good news on Tuesday. At a time when health insurance costs are climbing by 6% to 8% a year, their premiums will actually be reduced for the year starting July 1.

These fortunate few are members of the state's unprecedented health alliance, a purchasing agency that gives companies with five to 50 workers an opportunity to band together and achieve the same buying clout in the health care market as giant corporations. Please see HEALTH, A24

mons.

Even as President Clinton's proposal for alliances covering every citizen is being denounced in Washington as a blueprint for a menacing new bureaucracy, a staff of just 12 state workers in Sacramento has put together a working alliance, the first in the nation. And its customers seem delighted.

"It was heartbreaking to want to get insurance for your workers and not be able to afford it," said Cynthia Chauvis of Van Nuys, whose precision-instrument repair firm was once quoted an impossible \$2,500-a-month premium for its seven workers. Last July she joined the new state health alliance, and now she pays \$750 a month for the whole office.

"It's a great relief to have coverage for all of us," she said.

The alliance, formally called the Health Insurance Plan of California, offers something never before available for employees of small companies: a wide choice of different insurance programs, with

workers—not management—making the selection.

In Los Angeles County, for example, a worker whose small company has joined the HIPC can choose among 15 plans—12 health maintenance organizations and three preferred provider organizations—including such well-known names as Kaiser, Aetna, FHP, Healthnet and Prucare. That differs dramatically from the conventional situation in which the company makes available one or perhaps two health plans.

All plans must offer the same benefits, but the doctors and hospitals are more desirable in some than others. Monthly fees range from \$84 to \$173.14 for a 25-year-old worker and from \$342.80 a month to \$674.44 for a 35-year-old employee with a spouse and children. The company must pay an amount equal to at least half of the cost of the lowest-priced plan; the worker pays the rest.

"You get one monthly bill whether you have 13 employees in one health network or in 13 different networks," said Diane Bourassa, office manager for Telenet-works, a software firm in Petaluma. "It's a great variety of choices and avoids a tremendous administrative load on small companies like us, where typically you have one person running the office."

Rates are 10% to 15% below many comparable plans in the conventional insurance market, according to a recent study by a HIPC board member. The reason: Providers are willing to offer discounts to gain access to as many as 40,000 customers.

"There's no mystery here," said John Ramey, the HIPC's executive director. "We're trying to get a large-volume deal for our small employers."

In May, Florida will become the second state to try voluntary alliances when it begins enrolling small businesses in a voluntary purchasing group called the Community Health Purchasing Alliances.

The California and Florida experiences may offer some direction for the increasingly bitter national debate over health care reform. Clinton's plan is being torn apart in Washington by partisan Republicans and skeptical Democrats, with

enthusiastic lobbying by businesses large and small.

California and Florida officials are betting that their voluntary approach will be a giant step toward Clinton's goals of providing insurance protection for everyone while controlling the soaring costs of medical care.

By offering wide choice and low prices, they hope to woo enough businesses to make significant inroads in the ranks of the uninsured; among the nearly 40 million Americans without coverage, about 80% are full-time, low-wage workers, their spouses and children.

Clinton wants to require all employers to offer insurance and pay 80% of the cost of an average-priced plan. He also wants to require everyone except workers in firms with more than 5,000 employees to enroll in health alliances that would negotiate on their behalf with insurance companies, health maintenance organizations and other networks of health care providers.

Fear of a compulsory national program of alliances made it easier for all factions in Florida—businesses, insurers and politicians—to work together for a voluntary program. Gov. Lawton Chiles said he was grateful that the President's plan prodded everyone to get down to work.

Florida officials say they hope to get prices down simply by publishing the bids offered by insurers to small firms through the alliance. Side-by-side comparisons will make businesses aggressive in seeking better deals and force the high-priced insurers to bring their prices down, they say.

"A lot of what we do in Florida will send a message to the nation," said Lynn Kislak, chairwoman of the alliance for Dade County. "The wonderful thing Florida has is choice."

But California took a bigger step: Republican Gov. Pete Wilson and the Democrat-controlled Legislature decided to give the health alliance real muscle by granting it the authority to negotiate rates with insurers.

When the first set of bids came in last year, the HIPC gave the companies 48 hours to lower rates—and many of them did.

On Tuesday, the HIPC board will

continued from the previous page...

approve its second rate schedule, the figures covering 40,000 people from 2,300 employers for the 12 months starting July 1. The HIPC will announce that the average insurance premium will decline in price, a testament to the negotiating skills of the organization and the desires of the insurance companies to crack the important small-group market.

The average company now enrolled in the HIPC has 10 workers. Companies with as few as four employees will be able to join as of July 1, and the threshold will drop to three a year later. About three-quarters of the employers in the HIPC bought their coverage through insurance agents, a fact that has made agents friendly rather than antagonistic toward the alliance.

HIPC membership should double in the coming year and could grow even faster as word spreads, Ramsey and his staff estimate.

Beyond that, the competitive impact of the HIPC is being felt in the rest of the state's sprawling insurance market, where companies are offering more choices and trying to slow the rate of increase in premiums.

The HIPC is the "standard by which every other health plan's offerings and prices are compared," said Mark Weinberg, executive vice president at Blue Cross of California, which covers 5 million Californians and dominates the small-group market.

"If anything, we are having to be more competitive than ever to compete with the HIPC," he said. It was no coincidence, he added, that a slowdown in California insurance inflation began last July when the HIPC opened for business.

At the beginning of the decade, California was grappling with the same thing the President and First Lady Hillary Rodham Clinton, who headed the Administration's health care reform task force, denounce again and again in speeches attacking insurance companies: the specter of sick people crying in vain for help and uninsured families ruined by costly medical bills.

Many insurers engaged in "cherry-picking"—insuring the healthy but not those who were likely to face big medical bills. This meant seeking out firms with young, edu-

cated workers in white-collar jobs and giving them bargain rates. If their medical bills were higher than expected, insurers' rates would go up or the firm's coverage might be canceled without explanation.

Some industries were to be avoided. Insurers didn't like to write policies for restaurants because many cooks, busboys, waiters and waitresses were transients. They avoided lawyers because they might sue and doctors because they would demand a lot of high-cost care.

Addressing this problem, the California law guarantees that no individual or company could be refused coverage for any reason. Any insurance product must be available to all customers.

Premiums may vary with the age, family composition and geographic location of the insured. An insurer may ask a 60-year-old to pay more than someone who is 30, a married woman with three children to pay more than a single woman, and a resident of Los Angeles, where medical costs are high, to pay more than someone who lives in Ukiah.

But insurers may make only small adjustments in rates to compensate for different health conditions. If the cost of insurance for a typical group of five people is \$100 a month, the insurer cannot charge more than \$120 for a group of five people in which two have cancer, two have heart disease and the fifth suffers from diabetes. A group of four marathon runners in perfect health cannot get a rate lower than \$80.

These ground rules enable the HIPC to avoid becoming the dumping ground for companies with sick workers who couldn't get coverage elsewhere. The HIPC's aggressively low rates and broad selection of plans make it attractive for healthy as well as high-risk groups of workers.

At LG2WB Engineers in Costa Mesa, for example, the \$2,000-a-month premium under the HIPC represents a savings of as much as 20% from the firm's old insurance plan.

The range of choices is welcome, if a bit intimidating, Marilyn Hall, the firm's vice president, says the 45 workers have enrolled in 11 networks.

"Some employees come to me and say, 'Which one should I choose, Marilyn?' I say, 'If you have a doctor, find out which network he belongs to.' Once they understand it, people love the choices."

Before the HIPC, Steve Levine, who owns an ad agency in Venice, got several calls a week from people trying to sell him insurance. "I would tell them I'm a diabetic who had a kidney transplant, and the phone would go 'click,'" he said.

He paid \$1,000 a month for insurance for the four workers at his agency, plus \$1,500 out of his own pocket for special drugs to ensure that his body did not reject the kidney.

Now a monthly bill of \$851 from the HIPC covers both Levine and his employees—and drugs are part of the package.

The state has kept down costs and avoided building a new bureaucracy by hiring a private firm to act as the HIPC's sales agent, record-keeper and administrator. Employers Health Insurance won the contract and collects a fee for each person enrolled. The company started with 15 sales representatives and now, anticipating a boom year, has 30.

"We have forced the market to respond," said Kirk Rothrock, executive vice president of the HIPC, talking about the alliance's influence far beyond the comparatively small number of people enrolled.

Alliance backers in Florida agree. "You don't measure success by the number of small businesses they insure but by the impact they have on the market," said Bill Hinkle, a Florida business lobbyist. "You invent them to bring health care prices down."

The alliances ultimately could fall short of bringing insurance to everyone. After all, they are voluntary and employers remain free to refuse to spend money on health insurance.

Three-quarters of the HIPC's enrollees already had coverage elsewhere; only one-quarter come from the ranks of the uninsured. California still has a staggering 6.3 million uninsured people under age 65, and 83% of them are workers and their dependents, according to Richard Brown, director of the UCLA Center for Health Policy Research.

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About CHPA

CHPA (pronounced "Chippa") combines the purchasing power of small businesses to make buying health insurance easy and truly affordable. With coverage offered from dozens of well known insurance companies and HMOs, think of CHPA as one-stop shopping to compare and select the right insurance at the right price for small businesses and their employees.

Great Benefits - Great Price

With CHPA you can choose from four benefit plans with a wide variety of deductibles and coinsurance levels:

- The Plus Plan offers enhanced benefits at a high level of coverage
 - The Standard Plan offers a solid level of benefits at competitive rates
 - The Basic Plan offers limited benefits at the most economical rates
 - The Flex Plan, offered by a select few carriers, is a carrier's best-selling plan
- Each Flex Plan will differ in benefits and cost-sharing arrangements

Within these plans are different types of coverage - Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) - each offering a variety of plan features to meet your specific needs.

Choice and More Choice

Through CHPA you can select from many different health plans, and because CHPA plans are standardized, you can easily compare rates from different insurance companies and HMOs on an apples-to-apples basis.

Employers may offer as many plans as they want to their employees, then the employees are free to select a plan. Only through CHPA can each employee choose a plan that's right for their individual needs with the doctors, hospitals and benefits they want. It's easy; no matter how many different plans are selected, there will be one simple bill.

Designed Just for Small Business

You can buy health insurance through CHPA if you are self-employed or if your business has 50 or fewer employees who work at least 25 hours per week. Now a small business can have access to the same quality health plans that a larger business offers to its employees.

One Simple Call -- One Detailed Quote

It's easy to compare rates with CHPA. Call **1-800-4MY-CHPA** (1-800-469-2472), or send us an e-mail

(buychpa@healthplan.com) for a rate quote customized for your business. The easy-to-read quote ranks all available plans from the lowest to the highest. We can also provide a referral to an insurance agent who is knowledgeable about CHPA health plans.

Whether you are looking for better value than your current health insurance or you are currently uninsured, you'll find that CHPA is the simple solution to affordable health care coverage. Enroll today and start enjoying the benefits. For more information contact:

CHPA
Community Health Purchasing Alliance
1-800-4MY-CHPA
1-800-469-2472

The [Map of Office locations](#) will show you the CHPA office locations with addresses and phone numbers.

[Return to About CHPA](#)



[Tour the Agency](#)[Publications/Forms](#)[Health Data](#)[Home](#)[Services](#)[CHPA Menu](#)

An Introduction To CHPA Benefits

Below are the most common questions about CHPA. Click on the question and go right to the answer, or you may scroll through the questions and answers.

[Who is eligible to join CHPA?](#)

[Do I have to buy coverage if I join CHPA?](#)

[Is there more than one CHPA?](#)

[Are there membership fees?](#)

[What benefits do CHPAs offer?](#)

[How many plans do I offer my employees?](#)

[Can my employees be denied coverage?](#)

[Are pre-existing conditions covered and is there a waiting period?](#)

[Is there a rate guarantee?](#)

[Can I buy some coverage through CHPA and some outside of CHPA?](#)

[Are employees working out-of-state eligible?](#)

[How much do I have to contribute toward employee coverage?](#)

[Are dependents eligible for coverage?](#)

[What if an employee does not want coverage?](#)

[Will I be able to keep my present doctor?](#)

[Can I be denied coverage?](#)

[When does coverage start?](#)

[What materials will I get once I am enrolled?](#)

Who is eligible to join CHPA?

If you have been actively engaged in business in Florida for at least thirty days and have no more than 50 full-time employees eligible for health care coverage, you are eligible to join CHPA. Full-time employment is defined as 25 hours a week.

Do I have to buy coverage if I join the CHPA? Do all the employees have to join the CHPA?

No. If you want to buy health care coverage through the CHPA, 70% of eligible employees must have coverage and all of your group coverage must come through CHPA. Most plans require the employer to pay at least 50% of the cost of the lowest cost plan; employees pay the rest.

Is there more than one CHPA?

Yes. Florida has 11 CHPA districts. Membership is determined by the county in which your business is

headquartered. Through cooperation among CHPAs, employees are served either by the CHPA where they live or where they work. It's their choice. To learn your CHPA district, click on [Map of Office Locations](#).

Are there membership fees?

Yes. Your CHPA charges a small monthly fee per employee to cover administrative costs. Your CHPA may also have a nominal annual membership fee. Fees for your CHPA will be explained in detail when you get rate information.

What benefits do CHPAs offer?

Several levels of benefits are available with a wide variety of deductibles and kinds of coverage. For details, please see [Health Plans Available Through CHPA](#).

How many plans do I offer my employees?

Choice is a key CHPA feature. If you have 30 or fewer employees, you must offer at least two plans. Otherwise you must offer at least three plans. But it costs no more and it takes no more trouble to offer your employees all the plans in your area. You still write only one cost-of-coverage check a month. CHPA is the only place where small business employees can select plans from different insurance carriers. Click on [Health Plans Available Through CHPA](#) to find the names of companies offering coverage in your area.

Can my employees be denied coverage?

No. Florida has a "guaranteed-issue" law for small businesses. This means your employees and their families cannot be turned down and cannot have coverage canceled because of prior medical history or number of claims. Coverage can be denied only for failure to meet eligibility requirements.

Are pre-existing conditions covered and is there a waiting period?

A pre-existing condition is defined as a condition that manifested itself in such a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment for which medical advice, care or treatment is recommended or given; or a pregnancy existing on the effective date of coverage.

There may be a pre-existing waiting period if an employee or covered dependent did not have qualifying coverage before enrolling in CHPA. Qualifying coverage includes individual or group-issued major medical or hospital/medical/surgical expense coverage, COBRA, Medicaid, Medicare, or CHAMPUS.

For groups with 3 or more persons, any individual without qualifying previous coverage will be subject to a 6-month "look back" (a review of medical history) for pre-existing conditions and an exclusion of 12 months for any pre-existing conditions. For individuals in a 1-2 person group without qualifying previous coverage, there will be a 24-month look back for pre-existing conditions and an exclusion of 24 months for any pre-existing conditions. All other medical conditions, other than pre-existing conditions, will be covered during the waiting period.

For any size group 1-50, if an individual's previous group or individual qualifying coverage has been in force 12 months or more there is no pre-existing waiting period under CHPA as long as there has not been a lapse in coverage of more than one month between a prior plan and the CHPA plan.

If the prior plan was group coverage, credit will be given for the partial satisfaction of a pre-existing waiting period if the individual was subject to a pre-existing waiting period under the prior coverage and had not satisfied at least a 12-month waiting period. For example, if the employee had fulfilled 10 months of a waiting period under the previous group coverage, he/she would receive credit for those 10 months, leaving only a 2-month waiting period under CHPA coverage.

Is there a rate guarantee?

Yes. Once you are enrolled, your rates are guaranteed for 12 months. "Life Events" such as marriage, divorce, birth and death may affect individual rates. Insurance companies and Health Maintenance Organizations (HMOs) can adjust their rates every quarter, so the rate you pay depends on when you enroll in the plan.

Can I buy some coverage through CHPA and some outside CHPA?

With the exception of out-of-state and/or part-time employees (under 25 hours), all health benefits must be purchased through CHPA, (excluding any supplemental coverage such as dental, vision or Medicare gap coverage).

Are employees working out-of-state eligible?

Insurers and HMOs are encouraged to provide service to out-of-state employees. However, since a number of states require the insurer to have policies approved in the state where the employee resides, it may be administratively impossible for an insurer or HMO to provide coverage to an out-of-state employee. These requests are handled on a case-by-case basis. Please call your agent or 1-800-4MY-CHPA (1-800-469-2472) for further information.

How much do I have to contribute toward employee coverage?

The calculation is based on 50% of the lowest-cost plan offered. Your insurance agent can help you calculate the amount, based upon the plans you choose. Some plans require only a 25% or 0% contribution level. Of course, employers may choose to pay up to 100% of the employee premium and/or cover employees' dependents.

Are dependents eligible for coverage?

Yes. The employer is under no obligation, however, to contribute to the dependent's coverage.

The types of coverage available include:

- Employee only
- Employee and spouse

- Employee and dependent children
- Employee, spouse and dependent children.

A dependent is a spouse or any child under age 25 who is economically dependent upon the parent. The dependent child also must either be a part-time or full-time student, or be living in the household of the insured employee.

A child stops being a dependent at the end of the calendar year in which he/she reaches age 25. An exception is made if the child became incapacitated before age 25 and is unable to be self-supporting because of a mental or physical handicap. CHPA will advise what documentation is needed for these types of cases.

It is important to make the decision about who will be covered at the time the employee enrolls. Coverage cannot be changed until the next open enrollment period unless the employee has a "Life Event" (birth, death, marriage, divorce).

What if an employee doesn't want coverage?

Individual employees can decline coverage if they wish; however, their dependents will not be able to enroll. Remember, in order for a group to qualify for CHPA coverage, 70% of its eligible employees must have some form of health coverage.

Will I be able to keep my present doctor?

This will depend on the type of plan you select. If you choose an indemnity plan, you may use any physician or hospital. If you choose a managed care plan such as an HMO, benefits are payable only if network providers are used. A traditional PPO gives employees incentives to use network doctors, but you may still choose to use out-of-network providers.

Before you make a selection, you may want to find out which plans your doctor participates in and also review the directory of providers for the plans you are considering. Directories are available through the health insurance companies and HMOs.

Can I be denied coverage?

No, neither your employees who work 25 hours a week or more, nor their dependents, can be turned down or dropped from coverage due to prior medical history or current health status.

When does coverage start?

You have two choices for group coverage effective dates - the 1st or the 15th of the month. For 1st of the month effective dates, all materials must be received by the 15th day of the preceding month. For 15th of the month effective dates, all materials must be received by the 1st day of that month. If any applicant is found to be ineligible, CHPA will contact you.

What materials will I get once I'm enrolled?

Upon enrollment, you will receive a welcome kit from CHPA which will include your effective date and administrative instructions, e.g., how to add or terminate employee and dependent coverage. In addition, the insurance carriers you selected will provide a certificate of coverage which explains benefits and exclusions, a CHPA health plan identification card and information on the network of providers (if applicable) and how to use the plan selected.

[Return to An Introduction to CHPA Benefits](#)

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SMALL BUSINESS HEALTH PURCHASING COALITIONS

This three-part initiative would encourage the development of and participation in small business health purchasing coalitions. These coalitions pool employees across firms to gain market power; negotiate with insurers over benefits and premiums; provide comparative information about available health plans; and administer premium payments made by small employers and their participating employees. Despite these advantages, there are few small business health purchasing coalitions today. This in part reflects the lack of up-front funding to develop coalitions. Small businesses are willing to pay membership fees to cover the ongoing operation of coalitions, but the start-up costs -- hiring staff, developing a negotiating strategy, marketing to small businesses, etc. -- can be prohibitive. Additionally, coalitions that cannot quickly attract a large enough number of small firms to join them could find themselves without the bargaining power that they need to reduce costs.

TAX CREDIT FOR SMALL EMPLOYERS JOINING COALITIONS

- **Tax credit:** Eligible employers would receive a credit equal to ten percent of their contributions to employee health plans, up to \$200 for a single plan and \$500 for a family plan. This credit is temporary (up to two years) since it intended to encourage the one-time action of joining the coalition. The small business health plan credit would be treated as a part of the general business credit, and would be subject to the limitations of that credit. The credit would be available only for employers taking this option before December 31, 2003.
- **Eligibility of firms:** To receive this credit, a small business would have 50 or fewer employees and purchase coverage through a qualified coalition. To target the credit to employers who would not otherwise offer coverage, eligible employers could not have had an employee health plan during any part of 1997 or 1998. Employers would need to cover seventy percent of those workers who have wages (including deferred wages) in excess of \$10,000 and who are not covered elsewhere by a health plan and at least three employees. These conditions are typical in the group market.
- **Definition of "coalition":** A qualified coalition would be a certified, non-profit organization that negotiates with health insurers for the purpose of providing health insurance to the employees of its small business members. Its members would include all interested employers with 50 or fewer employees in its area, without regard to the health status or occupation of their employees. It would collect and distribute health insurance premiums but would not be an insurer (bear risk) itself. Its board would include both employer and employee representatives of small businesses, but could not include service providers, health insurers, insurance agents or brokers, and others who might have a conflict of interest. Where feasible, the cooperative would offer several health plan choices and at least one open enrollment period per year. These plans would follow state requirements and their premiums could not be rated according to the occupation or existing health status of employees.

FINANCIAL ASSISTANCE IN CREATING COALITIONS

- **Limits on foundation support.** Private foundations are prohibited under the Internal Revenue Code from making grants for other than charitable purposes. Currently, funding the start-up expenses of small business health purchasing coalitions would not qualify as a “charitable purpose.” Consequently, private foundations are reluctant or, in some cases, prohibited by their own rules from offering grants for this purpose. Notwithstanding this limit, foundations would likely support coalitions given the recent increase in the number of foundations due to not-for-profit conversions, greater foundation spending due to the strength of the economy, and the general interest in helping small employers access health insurance.
- **Changing the tax status for contributions to coalitions.** Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This special rule would apply only to grants (or loans) made to qualified cooperatives for the purpose of funding qualified cooperative start-up expenses made during the first two years of their operations. As with any other grant to a non-charitable organization for a charitable purpose, private foundations would be required to comply with the “expenditure responsibility” record-keeping and reporting requirements under current law. The special foundation rule would apply to grants and loans made prior to December 31, 2003 for start-up expenses incurred prior to December 31, 2005.

TECHNICAL ASSISTANCE IN CREATING COALITIONS

- **FEHBP as a model.** The Office of Personnel Management (OPM) runs the Federal Employees Health Benefits Program (FEHBP). This program serves as a model for consumer choice of health plans.
- **Technical assistance from OPM.** OPM has considerable experience in working with private plans in coordinating a bidding process, negotiating benefits and premiums, and distributing consumer information. To help small business health purchasing coalitions do the same, it would provide any needed technical assistance to qualified coalitions, sharing its administrative experience.

DRAFT: PRESIDENT CLINTON'S INITIATIVE ENCOURAGING SMALL BUSINESSES TO PURCHASE HEALTH INSURANCE

This initiative would encourage small businesses to offer health insurance to their workers by developing and/or joining purchasing coalitions for purchasing health insurance. Fewer small businesses offer health insurance because of their higher administrative costs and premiums relative to large businesses. As a result, nearly half of uninsured workers are in firms with fewer than 25 employees. This three-part initiative would: (1) provide a tax credit to small businesses who decide to offer coverage by joining coalitions; (2) encourage private foundations to support coalitions by allowing their contributions towards these organizations to be tax exempt; and (3) offering technical assistance to small business coalitions from the Office of Personnel Management, which runs the Federal Employees Health Benefits Program (FEHBP). This initiative would cost about \$44 million over 5 years, and provide thousands of workers and their families the option of affordable health insurance.

INSURANCE AND SMALL BUSINESSES

- Workers in small firms are less likely to have access to affordable, job-based health insurance. Nearly half of uninsured workers are in firms with fewer than 25 employees (relative to 30 percent of all workers). Over a quarter of private-sector workers in firms with fifty or fewer employees lack health insurance -- significantly more than the national average (about 17 percent of workers). Only one-third of firms with fewer than 10 employees and two-thirds of firms with 10 to 24 employees offer coverage, compared to over 95 percent of large firms.
- About the same number of small businesses are offering insurance, but, because of higher cost sharing for employees, fewer employees are participating.
 - The family take-up rate for workers in small firms dropped from the 90 percent range to the mid-80 percent range between 1987 and 1996.
 - More white-collar small firms are offering coverage, while the rate among blue-collar firms has been declining.
- Small employers state that high premiums and the uncertainty in premiums costs are major reasons why they do not offer health insurance.
- Premiums for the same benefits are higher for small firms than large firms because there are fewer people who can share in the risk of illness and because administrative costs are higher. Insurers' administrative expenses ranged from approximately 5 percent of premiums for the largest employers plans to 30 percent or more of premiums for the smallest employers. As a result, small firms typically offer less generous benefits -- or do not offer coverage at all.

Small-employer co-ops pick up speed

Offering the combined advantages of pooled purchasing and employee choice, health plan cooperatives are taking off.

In late 1984, Health Choice in Portland, Ore., developed the nation's first small-employer health plan purchasing cooperative (HPC). A spin-off of a county Medicaid demonstration, the not-for-profit co-op gave employees a choice of four HMOs offering standardized benefits—an opportunity unheard of for small firms at the time. But it never took off. After a year-and-a-half, enrollment hadn't broken 1,000, far too little to cover administrative costs.

The reasons for its failure? For one thing, the co-op's initial benefit package proved too expensive for many small employers. For another, the organizers tried at first to reach prospective members without the help of agents. On top of that, the HPC lacked a fee-for-service plan, which many small employers preferred.

Fast forward to mid-1996, and zoom in on Associated Oregon Industries (AOI), which is on the brink of launching the country's newest HPC. Highly regarded by the business community, AOI will offer affordable benefits market-

BY RICK CURTIS
AND KEVIN HAUGH

ed exclusively through agents and brokers and include options that extend to out-of-network providers. Little wonder that we expect it to fare far better than its long-ago predecessor.

Large employers' success in curbing costs has made it clear that purchasing cooperatives have much to offer small firms, which have had little chance to contract for defined panels of efficient physicians while offering their employees a choice. Nor have point-of-service plans been a viable solution, since many workers in the nation's smallest companies can't afford the higher cost-sharing and substantial balance-billing that comes with out-of-network care. That's where HPCs come in and why they're taking root.

A spate of initiatives followed the launch of the Health Insurance Plan of California in 1993, with co-ops cropping up in a variety of markets nationwide. In addition to those detailed in the table on pages 32 and 33, private HPCs are being developed in at least eight states, including Iowa, Illinois, Montana, Oregon and Texas. At the same

time, enrollment in other co-ops has rapidly taken off.

Colorado's Cooperative for Health Insurance Purchasing (CHIP), for example, exceeded its first-year projection of 500 employers and 10,000 covered lives in only six months of operation. Health Connections, the Connecticut Business and Industry Association's HPC, covered 45,000 lives a year-and-a-half after its inception.

The Health Insurance Plan of California had an enrollment of 40,000 soon after its launch, in part because its rates were about 15 percent below prevailing small-employer prices. The staff of the California group attributes its success to a combination of tough negotiating, stiff competition for enrollees in a price-sensitive, individual-choice environment and insurance market reform implemented just as the co-op got started. Its enrollment now exceeds 100,000, and its HMO rates have declined for the fourth year in a row.

In addition to such market-specific factors, HPCs' widespread appeal is not hard to understand: They combine the advantages of pooled purchasing and employee choice, directly represent purchasers and require every plan to

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COALITIONS: HPCs

HPC legislation nationwide

Repealed
fictitious
group law

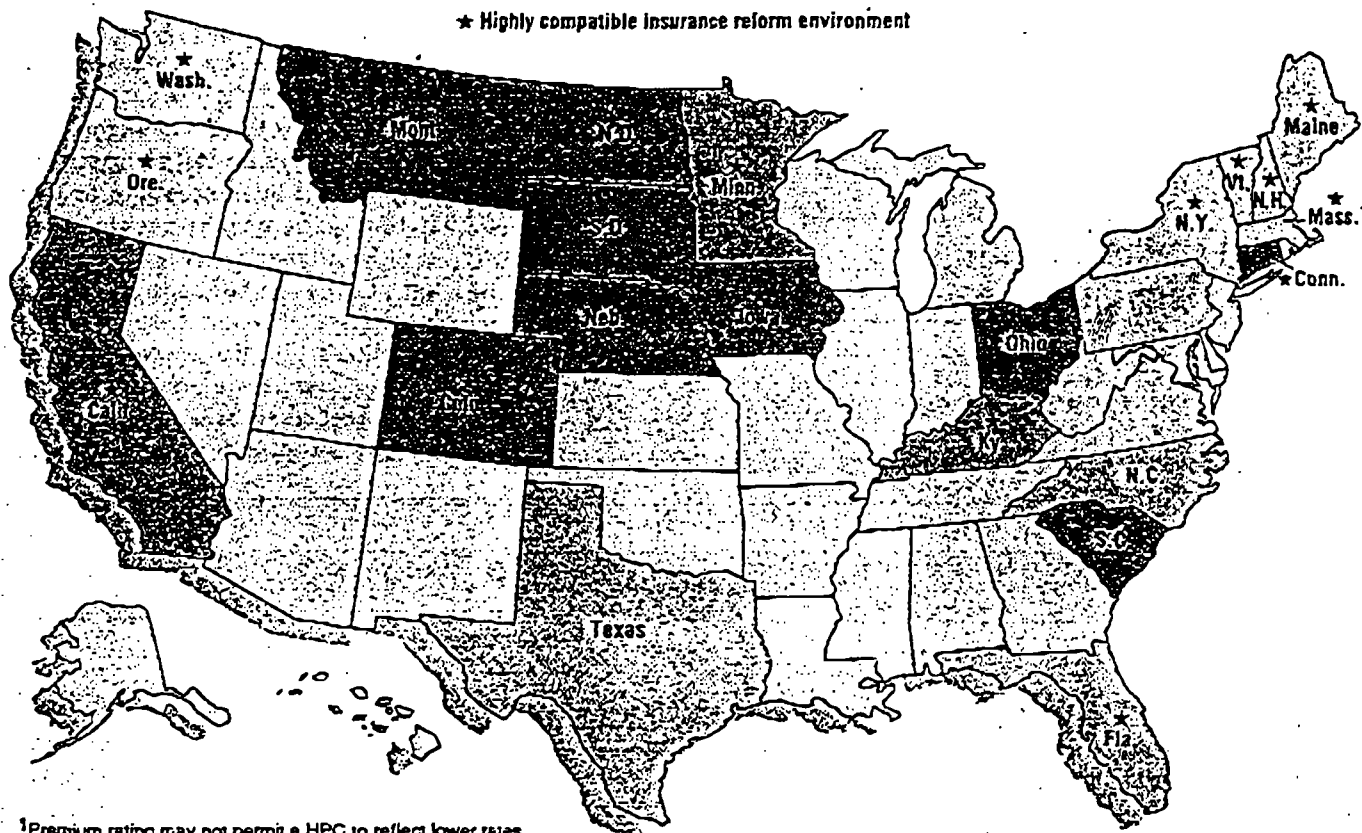
New rules
for multiple employer
purchasing groups

Certifies
private HPCs

Initiated
private HPC
formation

State-run
HPC

★ Highly compatible insurance reform environment



¹Premium rating may not permit a HPC to reflect lower rates.

Source: Institute for Health Policy Solutions, Washington, D.C.

offer the same standardized benefits. But, unlike other multiple small-employer arrangements, HPCs do not bear insurance risk, pay individual providers or manage care.

INSURANCE REFORM IS CRUCIAL
While small-employer co-ops are intended to harness private market forces, state legislation created the supportive environment for the initial wave of HPCs. As the map above indicates, the construct varies. The California and

Kentucky co-ops are state-run, for instance, while Florida and North Carolina charter exclusive regional organizations and Iowa and Colorado set requirements for state certification of private purchasing cooperatives. The states shown as having a "compatible" environment guarantee small employers access to health plans and sharply limit rate variations based on health.

Small-group insurance reform—also addressed in the federal Kennedy-Kassebaum bill now in negotiation—is crucial to the

success of purchasing co-ops and their ability to promote competition based on both quality and cost. Because of the limited risk-spreading in small-employer groups, in any given year the burden is likely to fall heavily only on certain members. Without adequate reforms, health plans that devote their resources to providing value are often outflanked by those that spend heavily on marketing, underwriting and pricing aimed at attracting low-risk groups.

In states that allow carriers a

wide variation in small-employer premiums depending on health status or claims experience, a consumer-choice model HPC is extremely difficult to implement. That may be the most important lesson to be learned from the experience of the Texas Insurance Purchasing Alliance, which was determined to avoid becoming a high-risk dumping ground. TIPA not only found assessing the risks of each applicant group and adjusting

plans' prices quite cumbersome, but it also discovered that carriers were reluctant to be involved and unlikely to offer competitive rates.

Other equally poor options for a HPC: Allowing each plan it offers to assess the risks of each small employer and set prices accordingly, and setting itself up as the only source of small-employer coverage that offers the same price across-the-board. The former is expensive and precludes consumer-friendly

price comparisons, and the latter invites the kind of risk-selection death spiral that befell several Blue Cross-Blue Shield plans. Employer groups like one in Milwaukee have shelved plans for HPCs because inadequate state insurance reform would have forced them into such bad choices.

A HPC would be at a severe disadvantage, too, if it guaranteed issue of all its plans to all small-employer applicants while its competition only had to guarantee one or two state-specific benefit packages and could underwrite any other product. That's the conundrum created by the state law establishing North Carolina's Caroliance. Not surprisingly, Caroliance administrators were forced to accept high (non-competitive) rates and had only

In the states: Small-group purchasing alliances

The table below is a partial list of small-employer groups, including both state-run and private co-ops. While the alliances featured here span a wide range of sizes—the largest has more than 17,000 employer groups, the smallest just 200—and structures, they have some common features: All offer employees standardized benefits and a choice of competing health plans, and all have employer representatives on their boards.

Alliance	Geographic area	Eligibility	Number of purchasing groups	Number of covered lives
California: Health Insurance Plan of California	Statewide (6 rating regions)	3 - 50 employees; trade associations	5,814	107,000
Colorado: The Cooperative for Health Insurance Purchasing	Statewide (8 rating regions)	No size restriction	544	11,000
Connecticut: Health Connections	Statewide (4 rating regions)	3 - 50 employees	2,800	46,000
Florida: Florida Community Health Purchasing Alliance	Statewide (9 CHPAs)	50-employee maximum	17,223	76,742
Kentucky: PlanSource	Statewide (7 rating regions)	Individuals; public employees; businesses with 2-50 employees	11,278	165,409
Minnesota: The Minnesota Employees Insurance Program (MEIP) Public Employees Insurance Program (PEIP)	Most of Minnesota	2-employee minimum (MEIP only)	352 (MEIP) 94 (PEIP)	5,000 (MEIP) 6,400 (PEIP)
New York: The LIA Health Alliance	Long Island	3 - 50 employees	500	6,000
North Carolina: Caroliance	Statewide (6 co-ops)	Self-employed individuals; businesses with fewer than 49 employees	200	1,000
Texas: Texas Insurance Purchasing Alliance	Statewide (7 rating regions)	3-50 employees	560	7,100
Washington: Employers' Health Purchasing Cooperative	Seattle area	4-employee minimum	225	8,000

Source: Institute for Health Policy Solutions, Washington, D.C.

COOPERATION

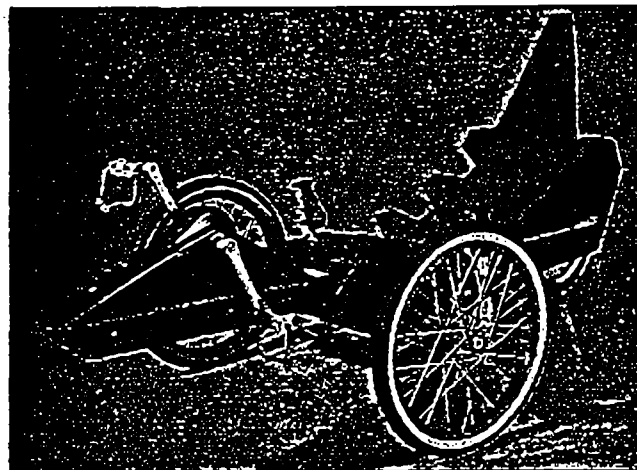
1,000 covered lives after seven months of operation.

LEVELING THE PLAYING FIELD

Even when state regulation is ideal, employee choice can exacerbate the potential for risk selection among competing health plans within a purchasing co-op. While standardized benefits level the playing field, offering a PPO alongside more tightly constrained HMO plans raises the possibility that the open-ended plans will be left with the higher risks. An employer-choice model, on the other hand, at least helps to ensure that some healthy workers enroll along with individuals at high risk.

HPCs have found a number of ways to address risk-selection concerns and to preserve employee

choice, however. Perhaps the most promising is the risk-adjustment mechanism the California cooperative developed with support from a Robert Wood Johnson Foundation grant. To determine the relative risk profile of each plan's enrollees, the co-op collects information on inpatient medical diagnoses as well as demographic characteristics of enrollees. Funds are collected from the plans with an enrolled population with a low-risk profile and paid to the plans with disproportionately high risk. The first-year experience in the California purchasing group confirms that a



practical way to address risk differences is indeed possible.

Risk adjustment in the small-employer market has another important purpose: By reducing plans' ability to compete on the basis of risk, it drives competition

Legal status	Selective contracting	Number of participating plans	Standardized benefits	Contact
State-run	✓	20 companies	High and low options	800-447-2937
Private cooperative	✓	4 companies	High and low options	303-333-6767
Private not-for-profit	✓	4 companies	High and low options	203-244-1900
State-chartered private not-for-profit	No, all state-certified plans accepted	33	Basic and standard options, deductibles vary	800-469-2472
Independent state agency	✓	13	18 options	800-677-7323
State-run	✓	7	3 options	612-296-6251
Private not-for-profit	✓	13	18 options	516-493-3007
State-chartered private not-for-profit	No, all state-certified plans accepted	8	3 options	800-873-6464
Private not-for-profit	✓	19	3 benefit plans, high and low options	512-472-3956
Private cooperative	✓	3	3 benefit levels	206-646-4302

COALITIONS: HPCs

based on value. In fact, it can provide the incentives plans need to develop innovations such as centers for excellence, knowing they won't be penalized for treating high-cost conditions. The problem is, risk adjustment is a tough and expensive undertaking for a fledgling HPC. Health plans are also likely to balk at the burden.

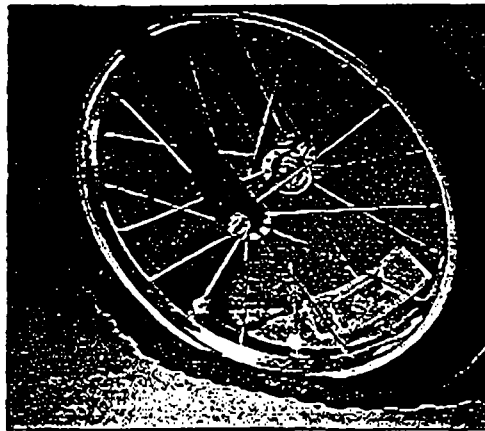
The California co-op has found another way to control risk selection and encourage value-based competition: Design sales compensation so that agents and brokers earn the same commission regardless of an employee's choice. A HPC can also ask each employer to select the benefit level or type of plan (for example, an HMO vs. a PPO) while the employees choose among plans of that kind. Colorado's new CHIP has adopted this approach, which prevents healthier and sicker employees from segregating themselves into different types of plans.

THE DIFFERENCE SIZE MAKES A HPC that combines large and small employers offers advantages to both groups, but, as with risk selection, designing an attractive product is difficult. Here, too, CHIP is one of several co-ops that's stepped up to the challenge.

The Colorado co-op has different pricing approaches to address risk issues for three groups: small (up to 50 employees), medium (51 to 200 employees) and large (over 200 workers). Up and running since last fall, CHIP is already highly successful in the small-employer market, but participation has been modest by medium-sized firms. And bigger companies apparently have been unimpressed by health plan bids under its large-employer pricing

strategy, which allows each participating plan to vary its (age-adjusted) rates for any given employer.

To attract big firms, CHIP executives say, they will likely change this component in the near future. They might try a method that a Topeka, Kan., HPC used with excellent results: It garnered highly competitive rates for its large-



employer members by adopting a one-price-for-all-comers (with demographic adjustments only) model.

The Community Health Purchasing Corp. in Des Moines, Iowa, uses a different approach. The co-op—which will phase in fully insured plans for small employers next year—has contracts with three integrated systems to provide coverage to larger employers. Most of these big firms purchase health coverage on a self-insured "target budget" basis copied from the model being piloted by Minnesota's Buyers' Health Care Action Group. If the claims target is exceeded, administrative payment to the integrated care systems is reduced.

BOOSTING CONSUMER CHOICE

Small employers have more to gain than their larger counterparts from participation in a health

purchasing cooperative, especially when it comes to consumer choice. Without a co-op, small firms wishing to offer employees a selection of plans face significant complications. For one thing, carriers typically will not allow a small firm to offer competing plans. A more obvious problem is the administrative burden.

When small employers contract with single carriers, the carrier generally performs the full range of administrative functions, including enrollment, billing and general customer service. For many small firms, selecting, contracting and interacting with one carrier's billing and enrollment process is a challenge, never mind the difficulty of dealing with a number of plans. HPCs streamline the process by consolidating the enrollment, billing and premium collection functions and then giving their member employer a single bill.

Helping individuals maintain a relationship with their personal physicians is at the heart of employee choice and employer participation in a purchasing co-op, and new, low-cost technology is making that easier to do. PC-based software developed for Florida's Community Health Purchasing Alliances (CHPAs) and an on-line system developed by Health Partners in Minneapolis, for example, allow employees to easily identify which participating health plans (or group practices) include their doctors. Rather than wading through separate directories for each participating plan, an enrollee can simply ask the computer system which plans include, say, the pediatrician, gynecologist and general practitioner his or her family members prefer.

COALITIONS: HPCs

MARKETING MATTERS

One of the great truisms of the business world is that a bad product can be successfully marketed but even the best product will fail if it is not marketed well. HPCs are no exception. "Field of Dreams" notwithstanding, building an ideal ballpark does not ensure that the players will come.

Small employers typically have little time or resources to negotiate the health insurance system on their own, so the vast majority rely heavily on agents. The Long Island Association Health Alliance, a private health plan cooperative in New York, learned this the hard way. Its initial intent was to sell directly to employers. After suffering through very slow enrollment growth, the Alliance developed successful partnerships with agents. California's HPC took another tack: allowing employers to choose whether or not to use—and pay for—the services of

expectations. So they took away the option. As of July 1, all new enrollees pay the same premiums, which include agent commissions.

By a wide margin, the Connecticut Business and Industry Association (CBIA) has achieved the most rapid market penetration of any HPC to date. In a state with one-tenth the population of California, its enrollment approached 50,000 after less than a year-and-a-half of operation. While Health Connections, CBIA's strong offering, and the association's proven track record in serving employers clearly helped, CBIA officials attribute much of their success to their close relationship with the agent community. Like other successful cooperatives, CBIA's staff train, certify and pay agents to sell their product. Following a similar strategy, Colorado's CHIP offers credits toward the state's agent certification requirements.

Here, too, state rules and regulations can help or hinder. Florida's state-chartered Community Health Purchasing Alliances, for example, have been shackled by a statute that requires agent compensation to be set—and directly paid—exclusively by health plans. Such a regulation, which means different plans pay different commissions, clearly makes competition based on value and informed choice hard to achieve. The success of Florida's CHPAs—after two years their collectively enrollment exceeds 76,000—attests to their hard work and the attractiveness of the one-stop shopping and employee-choice option they offer the state's small employers. But enrollment would likely be much higher without the statutory constraints.

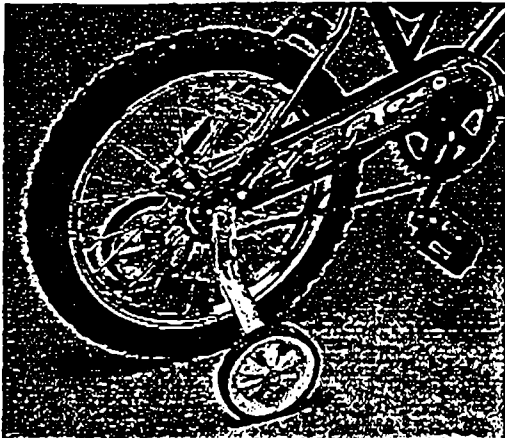
ON THE NATIONAL FRONT

The Kennedy-Kassebaum bill includes measures to assure that

private HPCs meeting certain criteria can be implemented. The bill would allow them to negotiate price reductions even in states where community rating laws would otherwise preclude their doing so. However, HPCs would be authorized to negotiate savings from health plan efficiencies—but not from differences in risk status. The Senate bill would also preempt so-called "fictitious group" laws, state provisions that bar employers from coming together for the sole purpose of purchasing health insurance.

While the House version of the health reform bill shares the Senate's intent of giving small employers the kinds of deals their larger counterparts enjoy, its approach is fundamentally different: The House would simply provide broad ERISA preemption of state insurance law for some multiple-employer arrangements. Among other things, that would mean these small-employer groups would not be subject to state-mandated coverage for specified services and providers, insurance premium taxes and anti-managed care stipulations requiring freedom of choice of providers.

Regardless of the outcome of this year's federal legislation, both the impetus for its adoption and the concerns about specific provisions will doubtless generate debate and future laws. Small employers that want to provide health insurance have long been frustrated by a system that relegates them to the losing end of the cost-shift chain. Many experts and policymakers intent on solving this problem also want to ensure that employees get the health insurance protection they need. These forces portend both improved insurance market rules and continued growth of HPCs around the country. □



an agent or broker.

The result? Roughly two-thirds of its enrollees have come through agents. But the co-op's representatives say the knowledge that employers could bypass them (and their commission) stopped many agents from actively promoting their product. They also discovered that the time and expense involved in direct enrollment exceeded their

Research Agenda Brief

July 1994

Will Subsidies Meant for Health Services Go to Excess Insurance System Overhead?

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There are a number of reasons for the differences in administrative costs by purchaser size, but most relate to the fact that small employers and individuals purchase coverage as small, disparate units. They do not benefit from the economies of scale achievable through larger purchasing units. Key health plan administrative functions that are more costly for small employers and individuals include the following: enrollment and education, marketing, and premium collection and distribution.

Enrollment and Education

Large employers and other large purchasers typically have an internal, expert benefit staff which consolidates and standardizes the enrollment process for the entire firm. Typically, this staff, often aided by the health plans, assumes responsibility for giving employees information they need to make intelligent choices among plans the employer offers. In contrast, these functions are highly fragmented for the small-employer and individual markets, where brokers and agents typically perform much of the enrollment and educational function. Health plans also play an educational role for their own individual products. Costs associated with enrollment are further increased by the short life of many small business and by the high turnover rate among their employees.

Marketing

There are substantial diseconomies in the way health plans are marketed to small employers and individuals. Health plans make extensive use of agents and brokers in these markets. Agents are typically paid on a percentage-of-premium basis (often around 10%). This commission structure provides incentives for agents and brokers to seek customers among more difficult-to-reach and diffuse smaller purchasers. It also rewards agents and brokers more for selling higher-priced plans. If a plan reduces its commissions, it runs the risk that agents will more aggressively market competitors' plans that pay higher commis-

sions. Large employers, on the other hand, typically hire consultants or brokers on an "as-needed" basis, and health plans commonly do not build ongoing agent or sales commissions into their premiums. For both large and small purchasers, however, health plans incur some costs associated with general marketing.

Premium Collection and Distribution

The premium collection process is more expensive when premiums must be individually collected from large numbers of small purchasers, since a separate billing and submission transaction must occur for each purchaser. Furthermore, in the present market, each separate health plan conducts its own billing process. However, larger purchasers often can achieve economies to the extent that the collection of funds is performed in a more consolidated fashion.

ADMINISTRATIVE COSTS IN PRIVATE PURCHASING COOPERATIVES

Purchasing cooperatives can realize savings by consolidating and standardizing administrative functions such as enrollment, education, premium collection, and distribution. In the present small-group and individual markets, hundreds of different health plans have their own systems and procedures for performing essentially the same functions, which is, of course, more costly because of the duplication.

As documented in Table 1, experience suggests that purchasing structures that are much like purchasing cooperatives can achieve substantial administrative economies. The Health Insurance Plan of California (HIPC), which serves the small-group market, performs its administration for less than 3% of program costs. Participating health plans report average administrative expenses of 12%. Thus, the total combined HIPC and plan administrative expense is approximately 15% (see Table 1). Employers may choose to utilize the services of an agent or broker and pay an additional fee, but the fee does not vary with the premium.

SUMMARY

The Problem

Because a large proportion of uninsured and low-income workers and their families work for small firms, most new subsidies under health reform bills will be channeled to people who would need to seek coverage in the small-group insurance market. Most committee-approved bills would base the subsidy on the cost of the average-priced plan, which includes the high administrative costs found in the existing small-employer and individual health insurance markets. This analysis shows that in a number of circumstances 10% to 50% of a given federal subsidy expenditure could go to cover the extra cost for such administrative overhead.

Alternative Solutions

Several alternative approaches to avoiding these unnecessary federal outlays are outlined below. One is to require all small employers to make health plans available to their employees through health purchasing cooperatives, which typically have administrative costs that are less than half those of the traditional market. While the Senate Committee on Labor and Human Resources adopted a variation on this approach, other committees rejected it. A second alternative might be stringent "loss-ratio" limits on insurers' administrative costs; but there are serious shortcomings to that strategy. A third would be to require just those employers or individuals who receive federal subsidy dollars to purchase plans through purchasing cooperatives. A fourth might be to require that employers make purchasing cooperatives available, at least as an option, to employees receiving subsidies.

DESTINATION OF NEW SUBSIDIES

Whether proposed subsidies for covering uninsured low-income populations are targeted principally to firms paying low wages or directly to low-income working families, they will go largely to small-firm employees

and their dependents. The reason is that a disproportionate share of low-income and uninsured workers are employed by small firms. For example, 67% of all workers (and 81% of uninsured workers) employed by firms with fewer than 10 employees had total earnings of under \$20,000 per year.¹ And the average wage in establishments with fewer than five employees is half that of those with 1,000 or more employees.² Further, while workers employed by firms with under 100 employees constitute only 43% of all workers, they account for 63% of uninsured workers.³

ADMINISTRATIVE COSTS IN SMALL-FIRM AND INDIVIDUAL MARKETS

Administrative costs in the small-employer and individual health insurance markets are substantially higher than those for larger purchasers. According to one estimate, health insurance administrative expenses range from approximately 5% of premiums for the largest employers' plans⁴ to 30% or more of premiums for those of the smallest employers.⁵ Administrative expenses in the individual market are even higher: they averaged 39% over a five-year period between 1986 and 1990.⁶

¹Employee Benefit Research Institute, *EBRI Special Report: Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1993 Current Population Survey*, January 1994, Table 34.

²U.S. Bureau of the Census, *County Business Patterns*, 1988.

³Employee Benefit Research Institute, Table 34.

⁴These are typical for fee-for-service plans. Depending on how they report costs, HMOs typically have higher administrative costs reflecting internal health care cost-management functions.

⁵Hay/Huggins estimates published in *Health Insurance and the Uninsured: Background Data and Analysis*, Congressional Research Service, Washington, DC, 1988.

⁶*Source Book of Health Insurance Data 1992*, Health Insurance Association of America, Washington, DC, Tables 2.7 and 2.11. The individual data are averaged over a five-year period to reduce the effects of the health insurance premium cycle on the level of administrative expenses as a percent of premium from year to year.

Table 1: Total Administration Costs for Selected Pooled Purchasing Arrangements and for the General Small-Employer and Individual Markets

	<i>Purchasing pool administrative costs</i>	<i>Health plan administrative costs</i>	<i>Total administration*</i>
Health Insurance Plan of California (HIPC)	<3.0%	12%	15%
Council of Smaller Enterprises (COSE)	1.6%	11%	12.6%
The Minnesota MEIP & PEIP	3.5%	8-12%	11.5-15.5%
CalPERS	0.5%	N/A	N/A
Wisconsin ETF	0.33%	10%	10.33%
Average small- employer market		25-30%	25-30%
Average individual market		39%	39%

Source: General Accounting Office, *Access to Health Insurance: Public and Private Employers' Experience with Purchasing Cooperatives*, May 1994; Elizabeth W. Hoy, Institute for Health Policy Solutions, *Budget and Management Issues for Health Purchasing Cooperatives*, Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, 1994; Health Insurance Association of America, *Source Book of Health Insurance Data*, 1992.

Note: Because a high proportion of participants in pooled purchasing arrangements are enrolled in HMOs, the health plan administrative costs reflect the higher health system management costs typically included in HMO administrative costs. Similar costs are also reported by HMOs that participate in Medicare and Medicaid.** Similarly, published data on administrative costs for the Federal Employees Health Benefit Plan do not include the administrative costs for participating community-rated HMOs.†

*None of these estimates includes the administrative and relative time costs that employers and individuals must bear in choosing and handing the administration of a health plan. However, the authors believe that these uncounted costs would tend to be higher on average for smaller employers and individuals acting on their own than acting as part of a larger unit that assumes many activities.

**This paper does not calculate the extra administrative costs for current Medicaid recipients who would become eligible for the subsidized purchase of plans in the private market. Because these recipients typically would not have a family member who could participate in an employer-sponsored plan, administrative costs would usually be those found in the individual insurance market, which have averaged 39 percent over the last 5 years, as indicated on Table 1.

†The 7 percent health administrative cost figure reported by FEHBP is calculated by assuming that the 7 percent administrative cost average reported by experience-rated plans are the same as that for community-rated HMOs. Since about one-third of FEHBP enrollment is in HMOs, the 7 percent figure almost certainly understates actual health plan administrative costs.

The Council of Smaller Enterprises (COSE), which also serves the small-employer market, reports administrative costs of 1.6% of total costs and plan administrative expenses averaging 11%. A number of public employee programs also resemble purchasing cooperatives. The Wisconsin public employee program (ETF) reports administrative expenses of 0.33% and plan expenses of 10%. (The unusually low administrative expenses of many public programs may in part reflect the large size and stable nature of their covered work force and associated lower premium-collection and marketing⁷ costs. Furthermore, at least part of these costs—those related to payroll deduction of premium contributions—are often allocated elsewhere in state government. Nonetheless, experiences of public programs do demonstrate the potential for substantial savings more generally.)

SUBSIDIES UNDER CURRENT MARKETS AND PURCHASING COOPERATIVES

A number of congressional committee-approved bills would subsidize low-wage small employers and individuals to purchase health insurance. They would tie limits on the amount of subsidies to the cost of the average-priced plan in each area. The examples below show subsidy outlays that could go to administrative costs under such subsidy arrangements. Because these examples reflect specific employer wage levels and employee income levels, the examples are only *illustrative* of the kinds of extra subsidy costs that might result. Consistent with the figures presented earlier, the authors assume that administrative costs are 25% for the average plan in the small-group and individual market but that they would need to be only 12.5% if the plans were made available through a purchasing cooperative. The pre-

mium levels used are the Congressional Budget Office estimates for the administration's Health Security Act benefit plan.⁸

Table 2 gives examples of subsidy spending for administrative costs that could occur under the employer subsidy schedules in bills reported by the Senate Labor and Human Resources and Senate Finance Committees.^{9,10} The increased cost of subsidizing existing small-employer and individual market administrative costs could be substantial. As the last column shows, the subsidies required with current market administrative costs could range from 13% to 26% higher than they

⁸Since the Health Security Act would make plans available to smaller employers exclusively through health alliances, and alliances' administrative costs would be limited to 2% of premium (comparable to the existing HIPC and alliance cost experience cited earlier), the authors assume that administrative costs would represent approximately 12.5% of the CBO premium figures. However, even if these premium estimates should be moved up or down to precisely reflect 12.5% administrative costs, the proportionate increase in total premiums caused by increasing from 12.5% administrative costs to 25% would be the same.

⁹The Senate Labor and Human Resources bill would subsidize small employers on a sliding scale basis; the required contribution as a percentage of the average wage would be larger for firms with 15 to 24 employees than for smaller employers, and the required contribution would increase with the average wage, from a minimum of 4.2% for the smallest firms with average wages of no more than \$12,000 up to 12% for firms with average wages of \$24,000 or more.

The subsidies to working families would also be on a sliding-scale basis related to income. The maximum percentage that families would be required to spend for a plan costing up to the price of the weighted-average-priced plan for the region is 3.9% of income. People with incomes below 150% of poverty would pay less than 3.9% (starting at the lowest income levels at 3% of income above the first \$1,000 of income.)

¹⁰The Senate Finance Committee bill would provide employer subsidies only if an employer mandate were triggered at some point in the future. If that occurred, the subsidy schedule that would go into effect for low-wage employers with fewer than 25 employees is identical to the scale for employers with 15 to 25 employees in the Labor and Human Resources bill and reflects the scale illustrated in Table 2.

⁷These programs typically have a captive market and do not need to market to attract business.

Table 2: Examples of Potential Federal Spending on Extra Administrative Costs for Employer Subsidies (based on the subsidy schedule contained in two Senate bills*)

	<i>Adminis- tratively Efficient Premium: assuming 12.5% admin. cost</i>	<i>Market Average Premium: assuming 25% admin. cost</i>	<i>Firm's Average Wage</i>	<i>Maximum Employer Contribution as % of Payroll: assuming employer pays 80%</i>	<i>Subsidy for Adminis- tratively Efficient Premium</i>	<i>Subsidy for Market Average Premium</i>	<i>Difference Between Market Average Premium and Administra- tively Efficient Premium</i>	<i>Percent Extra Subsidy Cost</i>
Single Coverage	\$2,100	\$2,333	\$10,000	5.5%	\$1,130	\$1,317	\$187	17%
Single Coverage	\$2,100	\$2,333	\$20,000	9.4%	none	none		
One-parent family	\$4,095	\$4,550	\$10,000	5.5%	\$2,726	\$3,090	\$364	13%
One-parent family	\$4,095	\$4,550	\$20,000	9.4%	\$1,396	\$1,760	\$364	26%
Family Coverage	\$5,565	\$6,183	\$10,000	5.5%	\$3,902	\$4,397	\$495	13%
Family Coverage	\$5,565	\$6,183	\$20,000	9.4%	\$2,572	\$3,067	\$495	19%

*(Senate Labor and Human Resources Committee subsidy schedule: subsidies to low-wage small employers with 15 to 25 employees; Senate Finance Committee subsidy schedule: provisional subsidies to low-wage employers with fewer than 25 employees)

Note: The Senate Labor and Human Resources Committee bill avoids the extra subsidy cost by requiring that non-self-insured employers make purchasing cooperatives available to their employees.

would be for the same health care plan obtained through a purchasing cooperative.¹¹ (The Senate Labor and Human Resources Committee bill avoids the extra subsidy cost by requiring that non-self-insured employers make purchasing cooperatives available to their employees.)

Table 3 shows the combined effects of the subsidies to employers and to low-income individuals under the subsidy schedule of the Senate Labor and Human Resources bill. If the committee's requirement to offer a purchasing cooperative were dropped, the increase in administrative costs of the combined subsidies could be substantial—from 14% to as much as 54% in the authors' illustration.¹² But these tables merely illustrate individual examples of the extra subsidy spending that could occur. The actual levels for other firm-wage and family-income level combinations would range both higher and lower than those shown in these tables.

Table 4 illustrates the individual and family subsidies under the Senate Finance Committee bill, which would vary subsidies based on income level. Those persons at or below the poverty level would be subsidized for 100% of the cost of the average-priced

plan in the area, and the subsidy would be rapidly phased out for those above the poverty level. (In 1997, subsidies would be eliminated at 125% of poverty.) Under the authors' estimates of the difference in the cost between the average market plan costs and administratively efficient plan costs, the extra subsidy cost would be a constant 11% for all persons eligible for subsidies (the premium difference between a health plan offered through a 25% administrative cost mechanism and the same plan with a 12.5% administrative cost vehicle).

While the proportion of additional subsidy spending is the same for all affected persons under this approach, aggregate subsidy spending for the near-poor would likely be low because many could remain uninsured. The rapid phasing out of subsidies for those above the poverty line in the initial years would probably not induce many families in this group to buy coverage on their own. Under the straight-line phase-out assumptions used, a family of four at 120% of poverty typically would have to pay at least 30% of income in 1997 to buy coverage if no family member worked for an employer who contributed toward coverage (see the bottom part of Table 4).

As these examples illustrate, the extent of increased spending for insurance administrative costs is sensitive to the specific subsidy structure. But under any of the structures that channel subsidies for small firms and individuals to purchase coverage in the existing market, the amount of subsidy money spent for extra overhead would be substantial.

EFFECT OF INSURANCE REFORM ON ADMINISTRATIVE COSTS IN SMALL-GROUP AND INDIVIDUAL MARKETS.

Some will argue that government need not worry about wasting subsidy dollars on unnecessary administrative costs. They contend that market forces will be sufficient to channel subsidized enrollment to more efficient volun-

¹¹The committee bill further specifies that the Federal Employees Health Benefits Program would be a purchasing cooperative that would be available in each state-designated region (a second cooperative would be permitted).

¹²As the examples illustrate, under this subsidy schedule the percentage increase due to extra administrative cost is smallest for those who would receive the biggest subsidies. Because a large proportion of the subsidy dollars would go to people receiving relatively large subsidies, the percentage increase in total subsidy spending would likely be in the middle to lower range of the examples. On the other hand, the weighted average would be driven up by very-low-income populations without a worker in the family. They would receive large subsidies and would typically buy a health plan in the individual market, where administrative costs are substantially higher than those used in the examples. Analysis of this aspect of the issue is beyond the scope of this paper.

Table 3: Examples of Potential Federal Spending on Extra Administrative Costs for Combined Employer and Individual Subsidies (based on the subsidy schedule in the Senate Labor and Human Resources Committee's bill)

	<i>Firm's Average Wage</i>	<i>Individual/ Family Income</i>	<i>Employer plus Family Contribution (maximum 3.9% of income)</i>	<i>Combined Subsidy for Admin. Efficient Premium</i>	<i>Combined Subsidy for Market Average Premium</i>	<i>Difference between Market Average Premium and Admin. Efficient Premium</i>	<i>Percent Extra Subsidy Cost</i>
Single Coverage	\$10,000	\$10,000	\$921	\$1,179	\$1,412	\$233	20%
Single Coverage	\$20,000	\$15,000	\$2,336	none	none	N/A	N/A
One-parent family	\$10,000	\$10,000	\$895	\$3,200	\$3,655	\$455	14%
One-parent family	\$20,000	\$35,000	\$3,245	\$850	\$1,305	\$455	54%
Family Coverage	\$20,000	\$15,000	\$2,336	\$3,229	\$3,847	\$618	19%
Family Coverage	\$20,000	\$35,000	\$3,245	\$2,320	\$2,938	\$618	27%

Note: The Senate Labor and Human Resources Committee bill avoids the extra subsidy cost by requiring that non-self-insured employers make purchasing cooperatives available to their employees.

Table 4: Subsidies to Individuals and Families under the Senate Finance Committee Bill (based on a sliding scale according to income)

Subsidies to Families for 1997

		Premiums		Subsidy at 105% of Poverty				Subsidy at 120% of Poverty			
	Poverty Income Level	Admin. Efficient Premium: assuming 12.5% admin. cost	Market Avg. Premium: assuming 25% admin. cost	Subsidy, Admin. Efficient Premium: assuming 12.5% admin. cost	Subsidy, Market Avg. Premium: assuming 25% admin. cost	Excess Subsidy	Percent Excess Subsidy	Subsidy, Admin. Efficient Premium: assuming 12.5% admin. cost	Subsidy, Market Avg. Premium: assuming 25% admin. cost	Excess Subsidy	Percent Excess Subsidy
Single Coverage	\$7,357	\$2,100	\$2,333	\$1,680	\$1,867	\$187	11.3%	\$420	\$467	\$47	11.3%
Family Coverage	\$14,764	\$5,565	\$6,183	\$4,452	\$4,947	\$495	11.1%	\$1,113	\$1,237	\$124	11.1%

Family Contribution Amounts for 1997

		Premiums		Subsidy at 105% of Poverty				Subsidy at 120% of Poverty			
	Poverty Income Level	Admin. Efficient Premium: assuming 12.5% admin. cost	Market Avg. Premium: assuming 25% admin. cost	Amt. Employee Pays: assuming 12.5% admin. cost	Percent of Income Employee Pays: assuming 12.5% admin. cost	Amt. Employee Pays: assuming 25% admin. cost	Percent of Income Family Pays: assuming 25% admin. cost	Amt. Employee Pays: assuming 12.5% admin. cost	Percent of Income Employee Pays: assuming 12.5% admin. cost	Amt. Employee Pays: assuming 25% admin. cost	Percent of Income Family Pays: assuming 25% admin. cost
Single Coverage	\$7,357	\$2,100	\$2,333	\$420	5.7%	\$467	6.3%	\$1,680	22.8%	\$1,867	25.4%
Family Coverage	\$14,764	\$5,565	\$6,183	\$1,113	7.5%	\$1,237	8.4%	\$4,452	30.2%	\$4,947	33.5%

* Levels for 1993 for single person under 65 and for a family of four.

tary purchasing cooperatives. Experience shows this to be unlikely. For example, small employers have been able to enroll in the highly acclaimed Health Insurance Plan of California (HIPC) for over a year. The HIPC's 54,000 enrollees represent under 2% of California's small-group market. The vast majority of small groups using plans with market-average or below-average prices obviously obtain coverage through more traditional venues. The subsidy structures proposed in the committee-approved bills would not change this outcome. Employers who would be eligible for subsidies have little if any incentive to choose an administratively efficient vehicle: their contribution is likely to be the same (e.g., 5.5% of payroll), regardless of the price of the plan that they choose, so long as they choose a plan with a price that is equal to or less than the average market cost. And there is no reason to believe that small employers would be more sensitive to price effects when the employees' share is reduced (i.e., subsidized) than now, when employees pay the full share.

Some people maintain that administrative costs in this market will be reduced once enrollment forms are standardized for smaller employers and individuals, benefits are standardized, and medical underwriting is eliminated. These changes should have some dampening effect on administrative costs and are desirable, regardless of what other reforms are pursued. However, they cannot produce the economies of scale that can be realized through aggregation and consolidation.

SOLUTIONS

There are a variety of strategies to avoid subsidizing extra administrative costs. One solution is to require all small employers to make purchasing cooperatives a voluntary option for their employees, as adopted by the Senate Labor and Human Resources Committee. A second possible solution would be to place limits on the proportion of premium dollars that health plans can spend on administration. This approach, while problem-

atic, has been taken by the federal government with Medicare supplement policies, through so called loss-ratio standards. It is also used by a number of states. There are a number of practical hurdles which make it very difficult to impose such loss-ratio standards effectively and fairly.¹³ Such limits on spending for administrative functions could be structured in a variety of ways, but each has disadvantages.

For example, if stringent *marketwide* limits were placed on how much health plans could spend on administrative functions (marketing, enrollment, and premium collection), unnecessary subsidy spending would be significantly reduced. But unless an employer or individual mandate were also in effect, the number of uninsured people could rise as health plans spent less to attract business. Such standards could pertain to just those plans that choose to be eligible to enroll the subsidized population. But this could easily result in serious income tiering problems and lead to poorer service to low-income individuals. Such standards could be imposed on all plans for the coverage they offer to subsidized populations; that is, each plan with higher administrative costs would be required to offer a lower premium level for the subsidized population. This would shift all excess administrative costs to the nonsubsidized population and could, therefore, make the price of plans that enroll a large subsidized population noncompetitive. Finally, this option

¹³For example, to the extent that health reform allows plans of different levels or comprehensiveness to be offered, a strong case could be made for varying such administrative allowances based on the comprehensiveness of the plan. It can also be difficult to delineate comparable administrative costs across different types of health plans (e.g., HMO, PPO, fee-for-service). Therefore, such an approach would need to define administrative maximums for functions that can be readily and objectively reported and compared across plans. These might include marketing, enrollment, and premium collection. Certain other administrative costs should probably be explicitly eliminated from these maximums (such as those that are aimed at health care cost and delivery management).

also explicitly creates incentives for plans to provide poorer service to low-income, subsidized populations.

A third solution involves requiring that those health plans that are purchased with subsidies be acquired through a purchasing cooperative. (The purpose here is not to limit the way people spend their own money but rather to ensure that taxpayer dollars that subsidize health coverage are not spent on unnecessary administrative expenses. Furthermore, this approach would typically not require a change in coverage source, since most low-wage, small firms do not offer coverage.) For example, small, low-wage employers who receive subsidies would be required to participate in the purchasing cooperative. Similarly, individuals who receive subsidies could use the subsidy only for the purchase of plans offered through the purchasing cooperative; the employers would be required to contribute their standard contribution amount to the cooperative for such an individual. (Health plans would not be per-

mitted to consider these employees in calculating an employer group's compliance with any participation requirements).

A less restrictive approach would be to require that employers who are subsidized or whose employees receive subsidies make the purchasing cooperative available as one option for purchasing coverage. This approach, while not requiring subsidized people to enroll in cooperatives, would at least reduce the likelihood that federal tax dollars would go to high insurance overhead.

Under the latter two approaches, low-income people could constitute a large proportion of purchasing cooperative enrollment. But a likely stigma could be avoided by requiring that "mainstream" health plans participate and by prohibiting a health plan from in any way distinguishing subsidized people from other people enrolled in that plan.