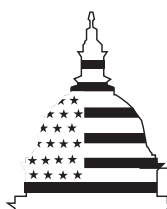


March 2000

PRIVATE HEALTH
INSURANCE

Cooperatives Offer
Small Employers Plan
Choice and Market
Prices



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United States General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-282868

March 31, 2000

The Honorable Thomas J. Bliley, Jr.
Chairman, Committee on Commerce
House of Representatives

Dear Mr. Chairman:

Nearly two-thirds of nonelderly Americans rely on employer-sponsored coverage for their health insurance. Yet, despite low rates of unemployment, the number of uninsured individuals has increased during the 1990s. More than 70 percent of the working-age uninsured in 1998 were employed, and many uninsured employees worked for a small firm. Of the 44 million uninsured individuals in that year, nearly 16 million (more than one-third) were in families where the family head was employed by a firm with fewer than 100 employees.¹ Small firms are much less likely than other employers to offer health insurance to their employees, and when offering coverage, they usually offer only a single plan.

Concerned about the increasing number of uninsured, policymakers have sought ways to improve the accessibility and affordability of health insurance for individuals working for small employers. One approach that attempts to create better access and choice as well as lower costs for employees of small firms is to facilitate cooperatives and other pooled purchasing arrangements that employers can join to purchase health insurance.² Recent congressional proposals would create a new type of pooled purchasing arrangement for small employers known as a "Healthmart." According to proposed legislation, Healthmarts would be nonprofit entities offering a choice of health insurance plans to employers with 2 to 50 employees. To assist the Congress as it considers proposals to facilitate the development of such purchasing arrangements, you asked us to examine the experiences of small employer health insurance purchasing

¹See Paul Fronstin, "Both Job-Based Health Coverage and Uninsured Continue to Rise, CPS Shows," *EBRI Notes* (Nov. 1999), based on an analysis of the March 1999 Current Population Survey by the Employee Benefit Research Institute.

²These small employer purchasing cooperatives are also sometimes referred to as "alliances."

cooperatives, in particular, those sharing some key design features with the proposed “Healthmarts.” Specifically, we answered the following questions:

1. What advantages do health insurance purchasing cooperatives offer to small employers, and to what extent have these advantages been effective in attracting employers?
2. How successful have cooperatives’ strategies been to obtain premium reductions?
3. How do health purchasing cooperatives maintain their viability in the small group market?

To address these questions, we (1) reviewed a bill that would establish Healthmarts,³ (2) reviewed studies of small employer purchasing cooperatives and the small group market, (3) interviewed health policy association officials and experts, and (4) examined the experiences of five small employer health purchasing cooperatives. These five cooperatives were drawn from a list of small employer purchasing cooperatives identified by the Institute for Health Policy Solutions.⁴ Similar to the proposed Healthmarts, all five of the cooperatives we examined provide coverage to firms with 50 or fewer employees and offer at least two fully insured coverage options. Three that we examined—the Pacific Health Advantage in California,⁵ the CBIA Health Connections in Connecticut, and Florida’s Community Health Purchasing Alliance⁶—are among the largest small employer cooperatives in the nation. We also examined two smaller cooperatives—North Carolina’s Caroliance and the Texas Insurance Purchasing Alliance. In our review of the cooperatives, we interviewed their officials and selected participating employers and insurers. In addition, we reviewed documents from the cooperatives and the insurers, as well as state laws regulating premiums in these small group markets. While these five cooperatives share many features with the proposed Healthmarts, their experiences may not be fully generalizable to other types of purchasing arrangements or those operating under other state insurance regulations or in different health insurance markets. We conducted our review between May 1999 and January 2000 in accordance with generally accepted government auditing standards.

³Our analysis was based on the Healthmarts proposal in H.R. 2990, *The Quality Care for the Uninsured Act of 1999* (Oct. 1999).

⁴As of March 2000, the Institute for Health Policy Solutions identified 15 health purchasing cooperatives. See Institute for Health Policy Solutions’ Internet listing of “Consumer-Choice Health Purchasing Groups” at <http://www.ihps.org/> (Nov. 11, 1999). The Blue Cross and Blue Shield Association identifies 21 purchasing cooperatives, some of which also serve larger employers or government employees. See *State Legislative Health Care and Insurance Issues, 1998 Survey of Plans* (Blue Cross Blue Shield Association, Dec. 1998).

⁵As of July 1, 1999, Pacific Business Group on Health assumed administrative responsibilities for the cooperative, formerly known as the Health Insurance Plan of California. Our review primarily represents the experiences of the Health Insurance Plan of California, which was administered by the state of California’s Managed Risk Medical Insurance Board.

⁶Florida’s Community Health Purchasing Alliance is based on a regional governance structure. Each region is governed by its own board, which enjoys wide autonomy in operation and decision-making. For the purposes of this study we interviewed representatives of region 6, located in central Florida, including the Greater Tampa Area.

Results in Brief

Small employer purchasing cooperatives have been an important component of several states' efforts during the 1990s to improve small groups' health insurance options. Established either by state legislation or private employer associations, purchasing cooperatives aim to provide small employers with some of the same advantages larger employers have in offering health insurance, such as administrative simplicity, choice of multiple insurers and benefit packages, and leverage in negotiating lower premiums. The five small employer purchasing cooperatives we examined have demonstrated that these cooperatives can offer two of these advantages—administrative services and a range of benefit options to participating small employers. By participating in a cooperative, small employers have a single point of entry to multiple insurers' plans with standardized benefit packages that can be compared easily instead of having to individually identify insurers and their agents, review widely varying benefit options, and determine price and terms of coverage. Furthermore, since cooperatives typically offer plans sponsored by a variety of insurance carriers with different benefit levels and managed care features, participating small employers can offer their employees a choice of multiple health insurance products—a sharp contrast to the single-plan option offered by most small and many large employers. These advantages have led some small employers that previously had not been offering health insurance to join a cooperative. However, even the largest cooperatives cover only a small fraction (typically about 5 percent or less) of the small group health insurance market in their states.

The experiences to date of small employer purchasing cooperatives typically have not resulted in a third advantage, which is available to large employers: leverage in negotiating lower premiums. Officials of the purchasing cooperatives and participating insurers as well as several recent studies reported that cooperatives typically offer plans at market prices for plans with similar benefits offered to small employers outside the cooperative. This similarity in premiums is also reflected by rate quotations we obtained from several insurers. The cooperatives' potential to reduce overall premiums is limited because (1) they lack sufficient leverage as a result of their limited market share; (2) the cooperatives have not been able to produce administrative cost savings for insurers; or (3) their state laws and regulations already restrict to differing degrees the amount insurers can vary the premiums charged different groups purchasing the same health plan. Cooperatives can potentially offer lower premiums for firms with high-risk, high-cost individuals if they restrict the premiums insurers may charge individual firms more than restrictions already imposed by

state statutes and regulations for all small groups. The Texas cooperative initially imposed significantly more restrictive rating criteria than were required by the state and as a result attracted a disproportionate share of high-risk groups. Concerned about this trend, and the defection of insurers, the cooperative attempted to make premiums more comparable to those available in the small group market by eliminating restrictions and allowing participating insurers to set premiums under the same terms allowed by the state for the small group market.

Finally, to ensure their viability in the small group market, the purchasing cooperatives we examined have had to take several steps to maintain a sufficient number of participating insurers and employers. Recognizing and countering insurers' perceptions that high-risk individuals and groups are likely to enroll through the cooperative is key to gaining insurer participation. Therefore, the cooperatives have attempted to manage potential risk selection through their design of standard benefit packages and other approaches. Furthermore, to increase employer participation, the cooperatives have maintained insurance agents' principal role in guiding employers to the cooperative. The cooperatives have had mixed success in maintaining their viability. While the Connecticut and California cooperatives continue to enjoy relatively stable employer participation, other cooperatives have faced declining participation, and a few, including the one in Texas, have disbanded.

Background

While nearly two-thirds of nonelderly Americans rely on employer-sponsored coverage for their health insurance, only about one-half of very small firms (those with three to nine employees) offered health insurance in 1998, compared with more than 95 percent of those with 50 to 199 employees. In addition, a recent employer survey found that, compared with plans offered by large employers, very small firms paid premiums that averaged about 10 percent higher for plans that covered fewer benefits, and required deductibles twice as high.⁷ Furthermore, employees of small firms frequently have lower incomes than those in larger firms. Lower-wage employees are less likely to accept coverage if they must pay part of the premium.⁸

Studies in the early 1990s consistently pointed to the high and rising cost of insurance as the key factor preventing small employers from offering coverage to their workers. In addition, some insurance practices exacerbated the problem by substantially increasing the costs or denying coverage for some higher-risk firms or workers. Consequently, in the early and mid-1990s, most states adopted some type of insurance market reform designed to improve access and affordability for small employers. Reforms passed in many states included measures to ensure that

- employers who want health insurance coverage for their employees will be accepted and renewed by insurers for at least one plan (“guaranteed issue”);
- premiums charged different employers purchasing coverage cannot vary by more than a specified percentage (rate restrictions); and
- small employer purchasing cooperatives can be established to improve firms’ access to multiple insurers and to seek lower premiums potentially available to larger firms.

⁷See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 1999 Annual Survey*.

⁸Philip F. Cooper and Barbara Steinberg Schone, “More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 And 1996,” *Health Affairs*, Vol. 16, No. 6 (Nov.-Dec. 1997), pp. 142–9.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set federal standards for certain aspects of private health insurance that apply to all small employers.⁹ One such standard is a requirement that insurers that provide coverage in a group market must accept all small employers that apply for any of the plans they offer (guaranteed issue). The extent to which HIPAA's guaranteed issue provision improved market access for small employers in a given state, however, is largely dependent on the extent of state reforms preceding HIPAA. Further, while HIPAA may have improved the choices of products available to small employers, the cost of coverage, especially for high-risk groups, may still be unaffordable.

Various pooled purchasing arrangements, including large employer purchasing cooperatives,¹⁰ multiple employer trust or welfare arrangements,¹¹ trade or other associations,¹² and small employer health insurance purchasing cooperatives, have been used as strategies for improving the provision of employer-sponsored health insurance. The pooling arrangements may vary significantly in terms of their coverage options, who can participate, and the geographic area in which they operate.

More than 20 states have adopted legislation allowing for the establishment of small employer purchasing cooperatives. Many of the small employer purchasing cooperatives started in the 1990s were based upon the National Association of Insurance Commissioners' (NAIC) purchasing alliance model acts and differ from previous pooled purchasing arrangements in several ways. Some tenets of the NAIC model acts that are also reflected, in varying degrees, in the five cooperatives we reviewed include the following:¹³

⁹For additional information on HIPAA, see *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100, May 12, 1999).

¹⁰See *Access to Health Insurance: Public and Private Employers' Experiences with Purchasing Cooperatives* (GAO/HEHS-94-142, May 31, 1994).

¹¹See *Employee Benefits: States Need Labor's Help Regulating Multiple Employer Welfare Arrangements* (GAO/HRD-92-40, Mar. 10, 1992).

¹²See *Employer Association Health Plans* (GAO/HEHS-96-59R, Dec. 6, 1995).

¹³See the "Single Health Care Voluntary Purchasing Alliance Model Act," and "Regional Health Care Voluntary Purchasing Alliance Model Act," NAIC, Model Regulation Service, Oct. 1996.

- accepting any small employer choosing to join the cooperative;¹⁴
- establishing a governing board that is dominated by participating employer and employee representatives;
- prohibiting any financial risk for the cost or provision of health services to be borne by the cooperative, but instead contracting with at least three unaffiliated insurers to make a variety of fully insured plans available to its members;¹⁵
- obtaining insurers' participation by contracting with qualified group carriers meeting objective criteria established by the cooperative¹⁶ through a fair, competitive process;
- negotiating the administrative portion of premiums with participating insurers to reflect any cost savings the insurer experiences in the coverage it offers through the cooperative; and
- allowing employees to enroll with any insurer or plan offered through the cooperative.¹⁷

See table 1 for more specific characteristics of the five cooperatives examined in our study.

¹⁴Employers must agree to pay membership fees and the coverage premium as well as follow the bylaws and rules of the cooperative. Additionally, cooperatives may require employers to pay a minimum share of the total premium and that all or a certain percentage of employees eligible to purchase the employer sponsored coverage do so through the cooperative.

¹⁵The state's commissioner of insurance may, upon a showing of good cause, waive the requirement for three unaffiliated insurers.

¹⁶Objective criteria may include requiring the insurer to obtain certification from the state insurance commissioner that the insurer is licensed in the small group market, satisfies state financial requirements, and is in good standing.

¹⁷Employees can be limited to those plans that provide coverage where he or she lives. In addition, an alternative allows the employer to limit employee choice to at least three insurers, of which one must provide out-of-network coverage and one a managed care plan, if available.

Table 1: Characteristics of Five Small Employer Health Purchasing Cooperatives

State	Name of small employer purchasing cooperative	Date coverage available	Size of employer eligible to participate	Average employer size	Number of employer groups and enrollees, 1999	How sponsored or established
California	Pacific Health Advantage	1993	2 to 50	10	8,216 groups, 144,424 lives	State-established
Connecticut	CBIA Health Connections	1995	3 to 50	8	3,500 groups, 55,000 lives	Privately established
Florida	Florida Community Health Purchasing Alliance	1994	1 to 50	2	18,000 groups, 75,000 lives ^a	State-established
North Carolina	Caroliance	1994	1 to 50	4	920 groups, 2,900 lives ^b	State-established
Texas	Texas Insurance Purchasing Alliance	1994-July 1999	2 to 50	6	Ceased operations in July 1999 ^c	State-established

^aFlorida's cooperative reached a peak enrollment of 24,000 groups and 92,000 lives in 1998.

^bNorth Carolina's cooperative had a peak enrollment of 1,200 groups and 5,000 lives in 1995.

^cTexas' cooperative had a peak enrollment of 13,000 lives in 1997.

To create an additional option for small employers seeking health insurance coverage, recent congressional proposals would create a new pooled purchasing arrangement for small employers known as a Healthmart. As proposed, Healthmarts share many design characteristics with existing purchasing cooperatives. Unlike most existing small employer purchasing cooperatives, however, Healthmarts would be operated jointly by employers, providers, insurers, and employees; would be exempt from state-mandated benefits¹⁸; and could operate in more than one state. Table 2 displays some key features of purchasing cooperatives and how they compare with the proposed Healthmarts.

¹⁸Our 1996 report summarized studies in six states showing that mandated benefits represented between 5 and 22 percent of total claims costs. This report also found that most employers voluntarily offered commonly mandated benefits, such as obstetrical care, mental health benefits, and mammography screening, even if they were not required to do so. Therefore, to the extent that employers typically offer these or similar benefits, the potential premium savings from preempting mandated benefits may be less than their share of claims costs. See *Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance* (GAO/HEHS-96-161, Aug. 19, 1996).

Table 2: Comparison of Healthmart Proposal and Typical Existing Small Employer Purchasing Cooperatives

Design feature	Healthmarts	Small employer purchasing cooperatives
Choice of insurers/plan options	Would offer at least 1 insurer and 2 coverage options	Offer more than 2 insurers and coverage options
Risk of pooled arrangement	Would offer fully insured health plans; Healthmarts would bear no financial risk	Offer fully insured health plans; cooperatives bear no financial risk
Subject to state insurance regulations	Exempt from state-mandated benefits, otherwise subject to state regulation	Subject to state regulation
Size of eligible group	Open to all firms with 2 to 50 employees	Open to all firms with 50 or fewer employees. While some exclude firms with fewer than 2 or 3 employees, others include self-employed individuals or employers with more than 50 employees.
Governing board	Equal representation from employers, employees, providers, and insurers	Typically represent employer and employee purchasers
How sponsored or established	Nonprofit entity operated jointly by employer, employee, provider, and insurer representatives	Varies. Some established by state, some by private associations of employers

Source: Information for Healthmarts is based on the Healthmarts proposal as approved by the House of Representatives in H.R. 2990, The Quality Care for the Uninsured Act of 1999, Oct. 1999. Information for the small employer purchasing cooperatives is based on a summary of 13 small employer purchasing cooperatives by the Institute for Health Policy Solutions. See <http://www.ihps.org/chpglist.html> (Nov. 2, 1999) and Jack Meyer and others, *Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?* (Economic and Social Research Institute, May 1999).

Cooperatives Help Small Firms Offer Insurance and Choice of Plans but Represent a Small Portion of the Small Group Market

Small employer cooperatives offer administrative services to employers seeking coverage by preselecting a group of insurers, standardizing benefit packages, and obtaining rates on behalf of the small employer purchasers. Employers participating in the cooperatives typically offer their employees a wider range of plan choices than do nonparticipating small employers. The five small employer purchasing cooperatives we reviewed also enrolled some very small employers as well as employers that had not previously offered health insurance coverage. Nevertheless, the

cooperatives remain a very small fraction of the small group market in their states.

Cooperatives Assist Small Employers Seeking to Purchase Health Insurance Coverage

Small employers seeking health insurance for their employees outside of a purchasing cooperative can be faced with significant administrative burdens. Cooperatives seek to facilitate the purchase and choice of insurance available to small employers and their employees by providing them with a single point of entry to a choice of plans offered by multiple insurers. In addition, cooperatives simplify the selection of coverage by collecting and publishing premiums for sets of standardized benefits. Specifically, each of the five cooperatives we reviewed offered at least two standard sets of benefits and copayment levels. According to the literature and cooperative officials we interviewed, having standardized benefits not only helps consumers evaluate the costs and benefits of each plan option but forces insurers to distinguish themselves through other features such as premiums and provider networks rather than differences in covered services. Further, another benefit to a firm's participating in a cooperative is assistance in providing information to the firm's employees about the insurer's benefits and, in some cases, helping to resolve conflicts that may arise between an insurer and the firm's employees.

Cooperatives also facilitate access to coverage for newly formed or very small businesses because they impose fewer barriers to enrollment. Both officials of the cooperatives and an insurer reported that some insurers require more extensive documentation, for example, to show that an employer has been in business a sufficient period of time prior to offering the employer coverage. For example, a Florida cooperative official reported that new employers can demonstrate their eligibility for coverage by simply submitting their estimate of taxes, while outside the cooperative, insurers may request additional documentation, such as a copy of an employer's tax returns. Although this makes it easier for new businesses to purchase insurance through cooperatives, one Florida insurer cautioned that this practice resulted in some fictitious groups gaining coverage, such as a self-employed individual who adds a family member or friend to the rolls of the firm solely for the purpose of purchasing group health insurance.¹⁹

Cooperatives Result in More Small Employers Offering Multiple Plan Options

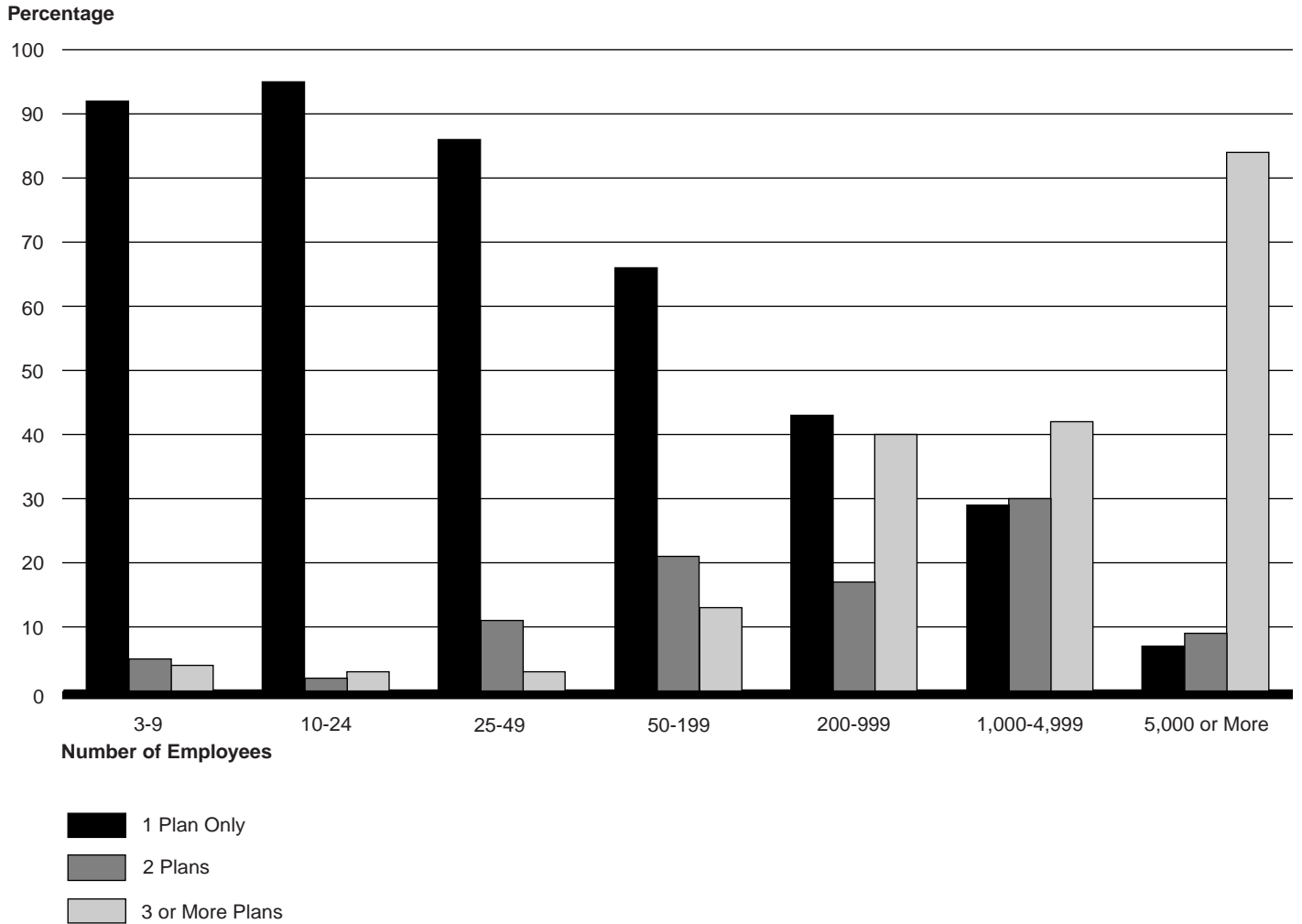
By participating in a cooperative, small employers have more opportunity to offer their employees multiple plan choices. Choice within a cooperative also provides collateral benefits to employers and employees. For example, a greater choice of insurers inside the cooperative may assist participating employers in their recruitment and retention efforts, and creates a better likelihood that their employees are able to select a plan that includes the provider of their choice. Employees do not always have access to all plans offered through the cooperative, however, depending on their location or employer.

¹⁹Insurers are concerned about fictitious groups because these individuals may be obtaining coverage only when they expect to incur medical expenses. By seeking group, rather than individual, coverage, they are guaranteed coverage and may be able to obtain lower rates than in the individual market.

Employers in each of the five cooperatives we reviewed offered their employees a greater choice of health plans than did small employers outside of the cooperative. When small firms sponsor health insurance outside of a cooperative, they usually make only one plan available to their employees. Results of a 1999 survey of nearly 2,000 employers showed that only a single plan choice was available to more than 90 percent of covered workers in firms with 3 to 49 employees. In contrast, at least three plan choices were available to nearly 84 percent of covered employees in firms with more than 5,000 employees. See figure 1 for the number of plan choices by firm size.²⁰

²⁰See Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 1999 Annual Survey*.

Figure 1: Percentage of Covered Employees and Choice of Health Plans, by Firm Size, 1999



Source: Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 1999 Annual Survey*.

Furthermore, each of the cooperatives we examined offered multiple managed care plans, insurers, benefit packages, and premium options. Most cooperatives offered at least two types of managed care plans, usually several health maintenance organizations (HMO) and either a point-of-service (POS) plan or a preferred provider organization (PPO) option. Among the cooperatives, the California cooperative currently has the largest number of plan options and the North Carolina cooperative has the

fewest (see table 3). In choosing among different plans, an individual could see variation in total premiums of as little as 28 percent in the Florida cooperative to more than 100 percent in the California cooperative.

Table 3: Plan Types and Premiums Available Through Four Cooperatives, 1999

State/cooperative	Available insurers	Available plan types ^a	Available standardized benefit packages	Monthly premiums (employee-only coverage for a 30- to 39-year-old enrollee)
California–Pacific Health Advantage	18	HMO, POS	3	\$89.22 to \$204.02 ^b
Connecticut–CBIA: Health Connections	4	HMO, POS	2	\$130.81 to \$233.08
Florida ^c	8	HMO, HMO open-access ^d	2	\$89.51 to \$147.89 ^e
North Carolina–Caroliance	3	HMO, PPO, indemnity	2	\$81.29 to \$160.64

Note: The Texas cooperative is not included in this table because it ceased operations in 1999 and thus information comparable to that for the other cooperatives was not available.

^aAll plan types may not be available in all locations.

^bRates are for July 1, 1998, through June 30, 1999.

^cIncludes information only for region 6 (Central Florida) of Florida's Community Health Purchasing Alliance.

^dAn open-access HMO permits enrollees to visit a specialist without a referral from a primary care doctor or other gatekeeper.

^eRates for a 30-year-old male in Hillsborough County (Central Florida) available between October 1999 and December 1999.

Even though cooperatives attempt to offer choice to their participants, not all plans are available in all areas served by each cooperative, and individual employers using some cooperatives may limit the choice of plans their employees can select. For example, the Connecticut cooperative made 16 plan options available to employers, but only one-half of surveyed employers offered all of the plans to their employees. Similarly, the Texas cooperative offered as many as eight plans in urban areas but only two plans in rural areas.

Cooperatives Represent a Small Portion of the Small Group Market

The five small employer purchasing cooperatives we reviewed have attracted some very small employers as well as varying proportions of employers that had not previously offered health insurance coverage.

However, small employers participating in the cooperatives represent only a very small share of their states' small group health insurance market. Furthermore, the HIPAA requirement that insurers must issue health insurance to any small employer willing to purchase it, regardless of the health condition or anticipated costs of the employees, may have reduced the incentive for some small employers to join a cooperative. At the same time, it may have enhanced cooperatives' viability by reducing the differences between purchasing through a cooperative and in the general small group market.

The purchasing cooperatives that we examined appeared to have enrolled primarily very small employers, but they attracted very different proportions of employers who previously did not offer coverage. For example, the average employee group size in the cooperatives ranged from 2 in Florida to 10 in California. In addition, cooperative officials reported that about half of the newly participating employers in the Florida, North Carolina, and Texas cooperatives had not sponsored coverage in the prior year. In contrast, just over one-quarter of the newly participating employers in the California cooperative and fewer than an estimated 10 percent of employers newly participating in the Connecticut cooperative had not sponsored coverage in the prior year. However, these newly participating employers might have offered health insurance even in the absence of the cooperative.²¹

None of the purchasing cooperatives we reviewed had a large enough market share to create bargaining leverage and therefore had a limited ability to significantly increase the percentage of small employers offering coverage in their states. For example, the Pacific Health Advantage, with 144,000 covered lives, is one of the largest small employer purchasing cooperatives in the nation, but it accounts for only about 2 percent of the small group health insurance market in California. Except for the Connecticut cooperative, which accounted for 5 to 8 percent of the small group market in the state, the other purchasing cooperatives we reviewed accounted for less than 5 percent of their state's market.

²¹Many of the employers that were newly offering health insurance through the cooperative may represent businesses that are just starting up as well as other employers that might have begun offering coverage even in the absence of the cooperative. Also, an employee of a firm that does not sponsor insurance might still have coverage through another source, such as individually purchased insurance or employer-sponsored coverage through a spouse.

Cooperatives' Ability to Obtain Premium Reductions Is Limited

Despite efforts to negotiate lower premiums, cooperatives have only been able to offer premiums that are comparable to those in the general small group market. The cooperatives we reviewed typically did not obtain overall premium reductions because (1) their market share provided insufficient leverage, (2) they could not produce administrative savings for insurers, or (3) premium variation is already restricted by state laws and regulations. While one cooperative attempted to impose more stringent restrictions on the premiums that could be charged for high-risk individuals than the restrictions already imposed by the state, insurers withdrew from the cooperative because they were concerned they would receive a large proportion of high-risk, high-cost individuals. As a result, the cooperative abandoned this practice.

Cooperatives Adopted Multiple Strategies to Attempt to Obtain Lower Premiums

The cooperatives we reviewed used a number of strategies to obtain lower premiums from insurers that could benefit either the cooperative as a whole or, in some cases, employers who were likely to face higher premiums outside. In one strategy, the cooperatives attempted to use their pooled market strength to generate competition among insurers and negotiate favorable rates for all participants comparable with the rates of a large purchaser. To participate in the California cooperative, insurers are precluded from offering a plan outside of the cooperative at a lower price if it is equal to or greater in actuarial value than the one offered inside the cooperative. The California and Connecticut cooperatives also encourage participating insurers to resubmit bids that are at the high end of rates allowed by state insurance rules. Also, since its second year of operation, the California cooperative has restricted the entry of new insurers to those that offer lower-priced plans than those currently available or those whose plans otherwise improve the cooperative's selection of available providers or product lines.

Another strategy cooperatives used was attempting to obtain lower premiums from insurers by assuming administrative responsibility for activities such as billing and enrollment that are currently performed by the insurers. One Connecticut insurer reported that since the cooperative was responsible for billing and collecting premiums, this insurer was able to set up one account to receive payments from the cooperative instead of managing individual accounts for each employer. In addition, in an effort to achieve administrative efficiencies for participating insurers, the Florida cooperative's new third-party administrator intends to apply new

technologies to electronically scan enrollment applications and transmit billing data to insurers and agents.

To make insurance more affordable for employers with high-risk individuals, one cooperative employed a third strategy—restricting how much insurers could vary premiums for different firms. This meant that some employers could potentially find more affordable insurance through the cooperative than in the general small group market.

Cooperatives Typically Obtain Premiums Comparable to Those Available to Other Small Employers

Officials of the cooperatives and selected participating insurers reported that premiums available through the cooperatives were typically similar to those available in the market, and might be slightly higher or lower in certain instances. As shown in table 4, premium quotations we obtained from selected insurers participating in several cooperatives indicated that prices of plans offered through the cooperative were approximately the same as those for similar plans available to nonparticipating small employers.

Table 4: Selected Insurers’ Premiums for a Plan Offered Through a Cooperative and a Similar Plan Outside the Cooperative

State	Plan type	25-year-old		55-year-old	
		Cooperative’s monthly premium	Similar plan’s monthly premium	Cooperative’s monthly premium	Similar plan’s monthly premium
California	HMO	\$108	\$101	\$231	\$216
Connecticut ^a	HMO	138	147	277	296
	POS	187	169	375	338
Florida ^b	HMO	127	127	357	357

Note: The premium quotations are based on two age groups of 10 individuals each—employees aged 20 to 25, and employees aged 55 to 59. The premium quotations we received from the Connecticut insurer for these two groups are for individuals less than 30 years of age and individuals 50 to 59 years of age, respectively. All premium quotations are preliminary and could change on the basis of additional information received by the insurer.

^aPremium quotations are for Hartford, Connecticut.

^bPremium quotations are for the cooperative’s region 6, which includes Central Florida.

Similarly, a national survey of over 21,000 employers also found premiums within pooled purchasing arrangements to be comparable to those outside. Specifically, this survey found that 1997 monthly single (self-only) premiums for small employers participating in any pooled purchasing group, including cooperatives, multiple employer welfare arrangements, and association plans, were \$180, compared with \$172 for nonparticipants.²²

By initially imposing greater restrictions on insurers' ability to vary premiums than the restrictions imposed by state law for insurers in the small group market, the Texas cooperative was able to temporarily offer significantly lower rates to employers with high-risk employees. Specifically, participating insurers were not allowed to vary premiums on the basis of group health status, group size, or industry, as they could outside of the cooperative. As a result, a cooperative official reported that less healthy individuals could obtain premiums about 30 percent lower through the cooperative; however, healthy individuals could pay up to 30 percent more for coverage within the cooperative. Because this practice caused the cooperative to attract a disproportionate share of high-risk groups, beginning in January 1997 it revised its rating practices to become more comparable to rates available in the small group market.

Cooperatives' Potential for Obtaining Lower Premiums Is Limited

Three factors appear to explain why cooperatives have not typically achieved greater overall premium reductions. These factors are a small market share, minimal administrative savings, and state rating requirements.

First, despite their efforts to leverage market share, the cooperatives we reviewed were limited in their ability to do so. In part, this was a function of their relatively small size. Three of the cooperatives—California, North Carolina, and Texas—each represented 2 percent or less of the small group market in their states, while Florida and Connecticut represented about 5 and 10 percent, respectively, of market share. In some cases, a cooperative's bargaining leverage was impeded by legal and practical constraints that largely prevented it from selectively contracting with only

²²See Long and Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs* (July/Aug. 1999). This study did not report premiums for specific small employer purchasing cooperatives. Nonetheless, it found that individuals participating in the California, Connecticut, and Florida cooperatives were no different for selected risk factors—age, sex, and earnings—than those who purchased insurance outside of the cooperative.

a few insurers, thereby fragmenting an already limited pooled market strength. For example, some of the cooperatives we examined experienced difficulty in leveraging their market share because they were required to contract with all qualified health plans, as in Florida, or they had difficulty attracting and retaining insurers, as in Texas. To avoid a threatened boycott by agents and brokers, the California cooperative initially accepted all plans that met its terms; however, the cooperative has subsequently been able to be more selective in admitting new plans. In contrast, the Connecticut cooperative—a privately sponsored entity—faced neither legal nor business impediments and therefore had more flexibility in limiting participation to four insurers. It cannot, however, pass any savings it may achieve to its members in the form of lower premiums because the state Department of Insurance interprets the state's community rating statute to prohibit insurers from adjusting their rates as a result of administrative savings.

Insurers' perceptions of risk also limit a cooperative's abilities to use its pool of small employers to obtain lower premiums. Specifically, actuaries and insurers reported that the risk of insuring a large employer is perceived to be more favorable than that of a small employer, even when the small employer participates in a purchasing cooperative. Insurers reportedly anticipate a greater chance for adverse selection within a purchasing pool composed of several small employers than for a comparably sized pool created by one large employer. In addition, some insurers believe that some small business owners are inclined to purchase health insurance only when they or an employee imminently needs coverage.

Second, while the cooperatives tried to obtain premium reductions by assuming some of the administrative responsibilities of insurers, the anticipated administrative savings either never materialized or were not valued by insurers. According to some cooperative officials, administrative savings are inherently limited because cooperatives can relieve insurers of only a fraction of their costs. Moreover, when assuming responsibility for an administrative task, such as marketing, a cooperative generates its own costs that must be covered, typically by a fee to members. Administrative costs can be higher for insurers selling insurance to a cooperative of small employers than for a single large employer. This is due, in part, to insurers facing an increased need to create name recognition and product differentiation when employees in cooperatives can choose among competing plans. One insurer also reported that its administrative costs actually increased because it had to modify its computer programs in order

to accommodate the information requirements for business obtained through the cooperative.

Third, cooperatives were limited in their ability to offer significantly lower premiums to firms with high-risk employees because state laws, to varying degrees, already restrict premium variation allowed in the small group market. For example, the premiums within the Florida cooperative are essentially based on the same rating factors that can be used outside—age, gender, family composition, geography, and tobacco use. As a result, most groups could obtain similar premium prices from an insurer whether they purchased a plan through this cooperative or on their own. The California cooperative based its premiums on three rating factors—age, geography, and family size. Outside of the cooperative, state insurance laws and regulation allowed insurers to vary premium rates by plus or minus 10 percent from their base rate for additional factors such as health status. Therefore, if insurers applied these additional underwriting standards,²³ premiums outside the cooperative could be as much as 10 percent higher or lower for some groups.

In addition, cooperatives were concerned that offering lower premiums to firms with high-risk employees could attract too many high-risk individuals, a phenomenon called “adverse selection.” As mentioned earlier, the Texas cooperative was able to temporarily offer significantly lower rates to high-risk employers by imposing greater restrictions on insurers’ ability to set premiums than the restrictions allowed by state laws and regulations for all insurers in the small group market. By doing so, however, the cooperative produced the classic “death spiral” by charging relatively higher rates to those who were healthier, leading to an increase in average premiums as more high-cost individuals enrolled in the cooperative and the low-cost individuals left. While the cooperative eventually adopted rating practices similar to those used by insurers outside, insurers withdrew their participation anyway and the cooperative ceased operation in July 1999.

²³The American Academy of Actuaries defines underwriting as “the process of identifying and classifying the potential degree of risk represented by a proposed insured or group of insured. Medical underwriting is sometimes used to identify risks which are expected to incur high medical costs.”

Cooperatives Take a Variety of Actions to Maintain Their Viability

To remain viable, cooperatives have to attract a sufficient number of insurers and employers interested in participating. Key to this effort is maintaining both the perception and the reality that the participating employer groups do not include disproportionate numbers of high-risk individuals. To accomplish this, cooperatives used a variety of strategies to protect individual insurers from receiving a disproportionate share of high-risk enrollees, including establishing standardized benefit packages and formal risk-adjustment mechanisms. Furthermore, the cooperatives have learned that they need to maintain close working relationships with insurance agents in the small group market to increase participation of employers.

Small employer cooperatives have had varied success in maintaining their viability. The cooperatives in Connecticut and California have generally enjoyed stable—even growing—employer participation. However, participating PPO plans withdrew from the California cooperative because of adverse selection by high-risk groups. In contrast, cooperatives in Texas, Iowa, and Kentucky have discontinued operation. Other cooperatives, including those in Florida and North Carolina, have struggled with declining participation by insurers and employers. Several insurers have withdrawn from both the Florida and the North Carolina cooperatives, some citing high administrative costs and the risk perceived to be associated with the cooperatives.

Cooperatives Use Varying Approaches to Manage Risk Selection Among Insurers

The cooperatives we examined used various approaches to manage potential risk selection—adverse or favorable—among insurers, including establishing standard benefit packages, requiring all participating insurers to offer both an HMO and a POS option, establishing employer participation requirements, and establishing formal mechanisms to adjust payments for instances where adverse selection had occurred. Because cooperatives allow employees to choose directly among competing plans, the potential for selection bias may be compounded, since employees have more information about their own likelihood of using services than do their insurers or employers. To preserve and enhance a broad choice of plans for their members, cooperatives instituted approaches to mitigate the potential for adverse selection affecting insurers that offered out-of-network options such as PPOs and POSs that might be attractive to high-risk individuals.

Each of the cooperatives we reviewed made standardized benefit packages available to limit the potential for risk selection. By requiring all

participating insurers to offer similar benefit packages, the cooperatives try to minimize attempts by insurers to attract only lower-risk groups by excluding benefits particularly valued by high-risk individuals. This was echoed by a cooperative official and an insurer we interviewed who indicated that the cooperatives designed their benefit packages to closely match those offered in the small group market so that they would not attract an undue proportion of low- or high-risk groups seeking coverage.

Beyond standardizing benefits, all participating insurers in the Connecticut cooperative offered the same two types of managed care plans—HMO and POS. The cooperative deliberately designed its plan offering to reduce risk selection that might develop for insurers if they offered only a POS option. The goal was to minimize the likelihood that any one participating insurer would find itself with an undue proportion of higher- or lower-risk individuals because of the type of plan that it offered.

The California cooperative implemented a risk-adjustment system that retrospectively redistributes funds to insurers who attract a disproportionately sick population. California's risk-adjustment model is designed to redistribute funds from plans that enroll a population with expected costs at least 5 percent less than the cooperative's average to plans with costs expected to be at least 5 percent greater. Plans with lower-risk enrollees pay a portion of their revenues to plans with higher-risk enrollees.²⁴ Even with this risk-adjustment mechanism, however, insurers no longer offer a PPO option, considered too high-cost, through the California cooperative.

²⁴As discussed in John Bertko, *Health Based Payments—What Do We Know About Risk Adjusted Payments?* (Jan. 1998) and Jill Yegian and others, *Health Insurance Purchasing Alliances for Small Firms: Lessons From the California Experience* (May 1998). The California cooperative's risk adjustment process involves identifying individual enrollees who have been hospitalized in a previous period with a "marker diagnosis"—that is, one of approximately 120 diagnoses with high costs, all requiring inpatient admission. Each individual with one of these diagnoses is assigned a weight based on average costs derived from California health care experience in managed care plans during the period 1992 to 1994. All other enrollees receive an "average weight." An individual insurer's average weight for all enrollees then determines a risk assessment score that is used to calculate proposed risk-adjustment amounts. In 1996, the plan that received the most favorable selection paid \$11.80 per contract per month into the pool, and the plan that received the most adverse selection received \$46.04 per contract per month. In 1997, four plans paid out a maximum of \$8 per contract per month, and one PPO received \$16 per contract per month. In 1997, 1998, and 1999, the percentage of premiums transferred was 1.14 percent, 0.04 percent, and 0.11 percent, respectively. Pacific Health Advantage is in the process of converting to a new risk-adjustment method.

The North Carolina cooperative explored two alternative risk-sharing mechanisms but did not implement either. Officials of the cooperative reported that they considered a risk-adjustment system and a reinsurance mechanism providing stop-loss protection to insurers for individual claims exceeding \$150,000. The cooperative explored financing these mechanisms with funds contributed to a pool by insurers or with funds from the state for the purpose of creating a high-risk pool. The cooperative did not implement either mechanism because the expected costs would have obviated potential premium reductions sought by the cooperative from participating insurers.

Agents Retain Important Role in Employer Participation in Cooperatives

Officials of the cooperatives we examined indicated that working collaboratively with insurance agents and obtaining their support is essential to success. Typically, small employers rely on agents to assist them in procuring health insurance. Specifically, agents assist small employers in identifying plans, completing applications, and obtaining premium quotations. Without the cooperation of agents, a cooperative is likely to face difficulty identifying small employers interested in offering health insurance and in enrolling those employers, and may experience adverse selection.

Cooperatives fulfill many of the functions that insurance agents traditionally have performed for small employers. In recognizing this, the California cooperative reported taking actions that made optional the use of agents and, for those using agents, limited the commissions paid to agents, thereby alienating many of them. These actions included paying agents a set fee per employer instead of a percentage of premiums; listing the amount of the agent's commission on the employer's bill; and enrolling employers directly, thus bypassing agents. As a result, agents were less likely to market the cooperative to small employers who initially contacted agents. The state board overseeing the cooperative discontinued these practices because it realized agents are needed to enroll small employers; currently, 77 percent of employers in the California cooperative use agents or brokers. A North Carolina cooperative official stated that the cooperative attempted to work more collaboratively with agents as a result of hearing about the California experience.

The commissions paid to the agent by the cooperative and insurer, and the agent's relationship with insurers, can also influence which groups an agent will enroll in the cooperative. When the cooperatives and insurers set different agent commissions for the same groups, agents have a financial

incentive to enroll their groups where the commission is highest. While cooperatives offering higher commissions than insurers outside the cooperative may increase employer referrals by agents, it does not guarantee that agents will not tend to direct higher-risk groups to the cooperative. Cooperative officials reported that agents are sometimes reluctant to enroll higher-risk groups directly with insurers in order to protect existing financial relationships. Instead, such groups may be steered toward the cooperative, since some cooperatives are sometimes viewed as de facto high-risk pools. For example, after raising commissions to 10 percent to enhance its competitive position and broaden its agent base, the Texas cooperative reported that agents still tended to enroll groups with high-risk individuals in the cooperative, rather than enroll them directly with insurers. In this way, agents could receive a relatively higher commission for high-risk groups while maintaining positive relations with insurers that provide the bulk of their compensation by continuing to enroll low-risk groups with them outside of the cooperative.

Concluding Observations

The experience of existing cooperatives—based on our analysis of 5 cooperatives, as well as other recent research—demonstrates that they can provide employees of small employers with an enhanced choice of health plans offering standardized benefits. In addition, a cooperative can offer employers fewer administrative hurdles to obtaining health insurance. However, in general, existing cooperatives have not realized any potential to significantly reduce premiums for employers or employees. Additionally, not all of the cooperatives have been successful in attracting and retaining insurers willing to participate within the constraints of the cooperative or in avoiding enrolling a disproportionate share of firms with higher-risk individuals.

Key to the cooperatives' ongoing viability is how practices such as benefit offerings, premiums, and requirements for insurers affect the distribution of risk among enrollees—that is, the extent to which the cooperative and the insurers within it disproportionately attract and retain healthy, low-cost enrollees or less healthy, higher-cost enrollees. Several cooperatives established in the early to mid-1990s have either ceased operation or faced declining participation by insurers and employers, and even the largest small employer cooperatives have attained only a small share of the health insurance market for small employers. As new forms of pooled purchasing arrangements designed for small employers are proposed that operate under different regulatory and market conditions, the experiences of existing small employer purchasing cooperatives can provide meaningful

insights. However, differences in the design and regulatory environment of the proposed Healthmarts and the existing cooperatives mean that their experiences may not be fully generalizable for new pooled purchasing arrangements.


External Comments

Officials from the cooperatives we examined as well as expert reviewers from two organizations provided comments on a draft of this report. In general, they concurred with our findings and made technical comments, which we incorporated where appropriate. In their comments, several reviewers highlighted specific design features that they believe could enhance or impede cooperatives' viability as more effective purchasers for small employers. In particular, they emphasized the importance of the ability to negotiate rates, selectively contract with insurers, and maintain comparability in benefits and rating practices with the small group market. As discussed in our report, the cooperatives we examined demonstrated these characteristics to varying degrees but were constrained in their ability to selectively contract and negotiate rates. All of them eventually established benefits and rating practices that were generally comparable to the small group market, and the existing ones remain a small part of that market. One reviewer also noted that the design and operation of some more recently established, privately sponsored cooperatives—such as those in Colorado, New York, Oregon, and Washington—reflect these design features. Because these cooperatives have only recently come into existence, have very few participants, serve employers with more than 50 employees, or operate in limited geographic areas, we did not include them in our review and cannot comment on their operations.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. We will then make copies available to appropriate congressional committees and others upon request.

Please call me at (202) 512-7118 if you have any questions about this report. The information presented here was developed by N. Rotimi Adebajo, JoAnne Bailey, and Mark Vinkenes, under the direction of John Dicken.

Sincerely yours,

A handwritten signature in black ink that reads "Kathryn G. Allen". The signature is written in a cursive style with a large initial 'K' and a distinct 'G'.

Kathryn G. Allen
Associate Director, Health Financing and
Public Health Issues

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