The Potential for a Small-Employer Purchasing Pool in Wisconsin:

Issues and Options for Overcoming Barriers to the Development of the Private Employer Health Care Coverage Program (PEHCCP)

Prepared for the Wisconsin Department of Employee Trust Funds
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This chapter focuses on why the private employer purchasing pool program passed in Wisconsin in 1999 has not yet been implemented. This paper explores several options developed specifically for Wisconsin policymakers: (a) reducing adverse selection by adopting rate rules that do not vary based on health status or claims experience; (b) making subsidies available to uninsured, low-income employees of small firms and providing premium assistance for populations otherwise eligible for programs like BadgerCare could reduce state outlays; and (c) designing the small employer pool as the exclusive small employer coverage venue in Wisconsin to achieve large scale purchasing, more stable coverage, and reduced administrative costs.

Overview

The Attraction of Purchasing Pools

Although Wisconsin has one of the highest rates of employer-sponsored coverage in the country, small employers have been increasingly concerned about often unprecedented escalation in their health care premiums. Given these escalating costs and the inherent fragmentation among small employers, the small group market in Wisconsin and other states is increasingly characterized by administrative inefficiencies, wide variation in premium costs, and wildly-fluctuating premium increases.

Policymakers often are drawn to purchasing pools as a potential means to stabilize small employer premiums through increased administrative economies of scale and purchasing clout with health plans. In addition, by aggregating a large number of small firm employees, purchasing pools can offer those employees something not normally available in the small employer market—specifically, choice of competing health plans. Such choice is typically available only to the employees of very large employers, and to state and federal employees.

But to date, voluntary, unsubsidized consumer-choice pools have not gained enough market share to realize lower costs for small employers. And, health plans would generally not be serving their own interests if they were to offer lower rates that

would allow a start-up or small pool to become a larger purchaser. However, the potential for large pools could likely be realized if subsidies or other policies are structured so that health plans could reach an attractive group of enrollees only through such a pool, or if reforms less attractive to health plans are the likely alternative.

To pursue their goals, such purchasing pools have several common characteristics. Particularly to maximize administrative efficiency, pools centralize the administrative functions of enrollment, premium collection, and customer service. Also, to minimize adverse selection (i.e., disproportionate enrollment of high-cost individuals for the pool overall or for individual plans participating in a pool), pools create participation rules, benefit plans, and premium rating methodologies that are relatively uniform across all participating plans. In addition, pools often consolidate and perform communication activities on behalf of the participating health plans.

The passage of 1999 Wisconsin Act 9 charged the Department of Employee Trust Funds to develop the Private Employer Health Care Coverage Program (PEHCCP) and to have this program operational by January 1, 2001. Unfortunately, several aspects of this authorizing legislation inhibited the development of the program. Many of these issues were addressed in subsequent legislation (2001 Wisconsin Act 16), but health plans are highly unlikely to participate in the program unless it is significantly restructured.

Some have suggested that health plans would participate and offer preferable rates if such participation were a condition of state employee plan participation and/or its pool premium rates were tied to those offered to state employees. But this approach alone is of dubious merit. As with most such "painless" ideas, a free lunch is unlikely here. It is likely that, with Wisconsin's existing market, the pool's rates for small employers would be made more affordable only if heavily cross-subsidized.

However, as we discuss later, there are other approaches which have substantial potential to achieve the cost and choice goals stated above.

What Is the Critical Difference Between a Large Employer and a Small Employer Pool with Respect to Adverse Risk Selection Issues?

A large employer group constitutes an attractive pool of people to insure because it is what carriers often refer to as a "natural group"—a group that is constituted for purposes other than health insurance. Such groups reliably include a healthy share of relatively low-risk persons. However, because individual small employers by definition do not have large populations, they are more likely to have a disproportionate concentration of low or high risk employees. Therefore, in this critical sense, an aggregation of small employers that each have unconstrained choices about where, how, and whether they obtain health insurance is not a "natural group."

Only 5% of the population consistently accounts for over half of total health care costs.

Broader risk spreading is important because a large share of health care costs are generated by a relatively small number of persons. As shown in Table 1, only 5% of the population consistently accounts for over half of total health care costs.

And the 50% of the population that is most healthy in a given year accounts for a tiny portion of total costs. This pattern holds for the total population and also for HMO enrollees, the privately insured under 65 years of age, and those uninsured under 65.

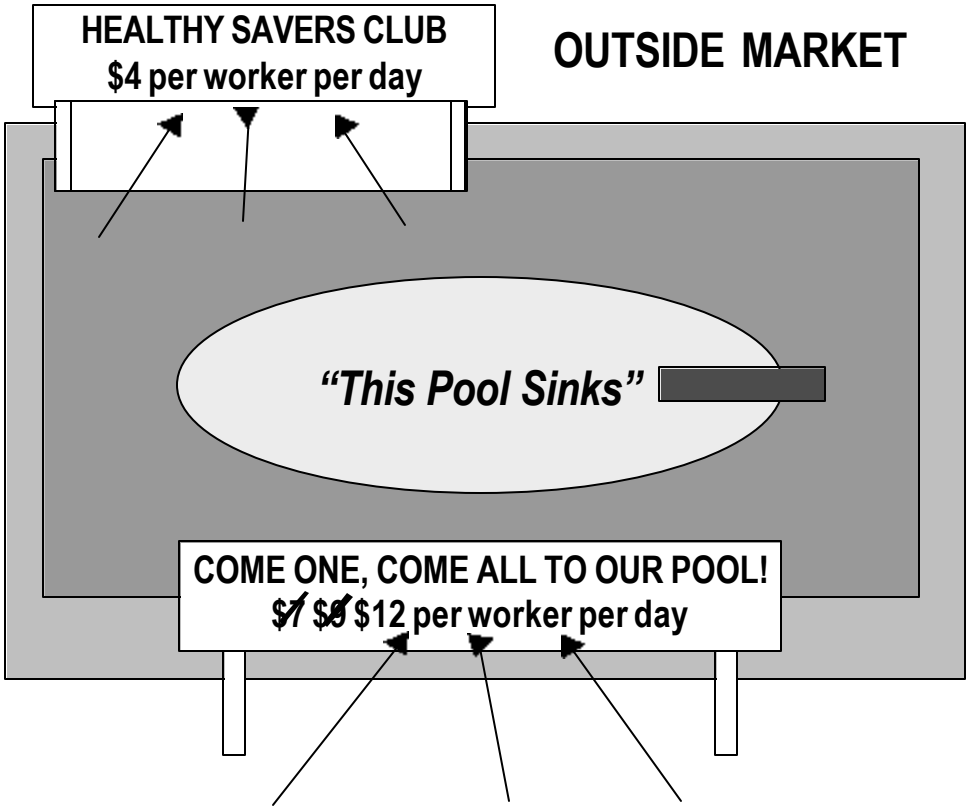
Table 1. The Most Expensive 5% of the Population Accounts for Over Half of Total Health Care Costs (Percent of Total Expenditures Incurred by Top x% of Population, Ranked by Total Payments for Health Services)[1]

Percentile	Total Population, 1987	Total Population, 1996	HMO Enrollees, 1996*	Privately Insured All Year <65	Uninsured All Year <65
Top 5%	56%	55%	51%	51%	60%
Top 10%	70%	69%	64%	65%	75%
Top 50%	97%	97%	95%	95%	99%

**Includes only HMO enrollees under age 65 with employment-based coverage.*

To assure at least some spreading of risks across the small employers a given carrier insures, states have established small employer market rating rules (i.e., constraints on how much insurers can vary premiums for the same health plan across individual small employers). However, those rules in Wisconsin (and a number of other states) allow substantial variation in rates based on the risk profile of a given small employer. Whereas such policies can attract many carriers to participate in the market, they also mean that relatively low premium prices will be available to a small employer pool participant when its members are healthy. So if the pool has rating policies that spread costs more broadly within the pool than health plans spread risks in the outside market, it is likely to attract only firms with a disproportionate share of high-cost individuals which will increase the daily cost per worker. Consequently, the pool is likely to suffer an adverse selection "death spiral" and, as illustrated in Figure 1, "sink."

Figure 1. Avoid "Poolish" Pricing Policies: Pooled Rates Won't Work If Healthy People Can Get Preferred Rates Elsewhere.



Similarly, the pool would be put at an inherent disadvantage if it is required to accept some applicants on more preferential terms than carriers in the rest of the market. For example, if the pool and only the pool is required either to accept self-employed individuals on the same terms as employer groups, or to give the same rates to all participating employers, it will inevitably be what is sometimes referred to as a "risk magnet." Those who are healthy and can obtain a lower price elsewhere will do so. Those who present higher risks and would be charged more elsewhere would come to (and often be aggressively referred to) the pool. As a result, the pool's costs will be higher, not lower, than those in the open market. This dynamic has played out due to such well-intentioned, but unrealistic, policy constructs in a number of states.

In the Eyes of Health Plans, What Would It Take to Make a Small Employer Pool More Like a Very Large Employer's Health Plan Choice Program?

Some observers like to cite the Federal Employees Health Benefits Program (FEHBP) experience or the Wisconsin State Employee Group Health Insurance Program experience as proof that voluntary small employer or individual pools offering a broad choice of competing health plans and benefit designs would be

viable. In fact, many health plans are very concerned about the risk selection problems experienced in FEHBP, which does not have standardized benefit plans to temper such selection problems. But federal employees represent a huge source of enrollment and premium revenue that plans cannot reach through any other means; if health plans want access to that population, they must participate in FEHBP—so many do. Similarly, if changes can be structured so that health plans would view the Private Employer Health Care Coverage Program (or similar purchasing pools) as the sponsors of a significant "natural group" that can only be reached through the pool, then that pool should be relatively attractive.

If health plans view purchasing pools as the only way to reach a "natural group," then the pool should be relatively attractive.

More generally, employer groups are attractive to health plans for the simple reason that workers receive substantial "subsidies" (employer contributions) that they cannot use to buy insurance elsewhere. If premium assistance, tax-credit, or other public-subsidy amounts were sufficiently large, and if a sizable small-firm worker population could only use those subsidies towards coverage purchased through the pool, then plans would be motivated to participate.

Why Do Health Plans Prefer Direct Employer Contracts Over Pools? Why Can't Pools Underwrite As Effectively As a Single Plan?

Most health plans would far prefer exclusive direct contracts with employers over small employer pools which allow workers choice of competing plans. Also, the higher the proportion of a "natural group" covered, the more certain a health plan is of its ability to spread high-cost claims over lower cost members of a group.

- It should be noted that, while less controllable by a given health plan, a pool can achieve this risk-spreading objective through risk adjustment (i.e., techniques that adjust the net payment rates based on the risk profiles of enrollees in each plan). One example has evolved in California's PacAdvantage.
- Another rationale health plans often give for direct, exclusive contracts with employers is that the higher the proportion of a given employer group that a health plan enrolls, the lower its administrative and marketing costs due to economies of scale. But a choice pool can also achieve scale economies by behaving more like one, large employer.

Concerns can be greatly exacerbated where small employer pools have fewer limitations on access, or less aggressive health rating than carriers in the open market. Again, experience in a number of states underscores the legitimacy of these concerns.

Further, most health plans understandably have little interest in helping to create larger purchasers with more bargaining clout out of smaller, weaker groups. Moreover, they do not want to cede control over marketing or administrative functions to a pool. By doing so, health plans lose control over which employers and employees enroll, the accuracy—and potential associated liability—of premium collection and enrollment activities, and a key component of their resource base and administrative role.

In addition, health plans are extremely reluctant to give up control over the medical underwriting process that is an (economic) necessity in the current Wisconsin small employer market where carriers can and do vary rates based on the health status or claims experience of a given small employer. A pool could allow each plan to underwrite and rate each enrollee from the pool. But this would in effect emulate the individual market, and thus involve high administrative costs and individual selection-based competition among the participating plans.

However, the prospect of the pool performing underwriting functions is fraught with difficulties as well. In particular, health plans would have difficulty cooperating with each other, let alone agreeing on a common system, given differences in their provider contracts, networks, base experience, and business philosophy. Moreover, health plans are wary of training or transferring such critical trade secrets to their competitors through a collaborative design process.

The end result for such a small employer pool under Wisconsin's current market rules is two undesirable options. One option would be to adopt the high road and utilize less stringent underwriting practices (which some former, and no longer operational, pools have done). But a pool doing so would be unlikely to attract health plan participation and, even if it did, the ultimate, and potentially quick, result would be significant adverse selection from the market. The other option would be to adopt the most comprehensive medical underwriting process possible that is acceptable across participating carriers. But because such a process would very likely represent a "least common denominator" combination of the participating health plans' approaches, it would be less effective than most individual carriers' underwriting practices. The end result—adverse selection—might take longer to occur but undoubtedly would be the same. Choice pools that have attempted either approach have generally failed.

Are There Alternative Policy Approaches That Might Work in Wisconsin? Three Alternative Scenarios

A. Small Group Market Rating Reforms

If the state were to adopt rating rules that did not allow rates to vary based on the health status or claims experience of a given employer group (but still allowed some adjustment for "case characteristics" such as age and geography), then the pool would be much less likely to experience adverse selection at the hands of the open market. This change would also substantially reduce the maximum premium costs or the volatility in rates a given small employer might experience in the open market. It would also increase rates for those employers who currently present the lowest risks.

Some advocates claim such market rules greatly reduce coverage rates, while others claim they increase coverage rates. Well-documented and peer-reviewed research studies, however, generally find no or very little effect. The reader may wish to refer to one thorough, recently-published study that finds no effect on overall coverage rates or costs and that includes a careful review of other previ-

ous research on this issue.[2] It should be noted, however, that most of the research covered periods when average premiums were more stable than the current environment.

Such rating reforms could greatly diminish the degree of exposure to adverse selection for a pool. But it is still unlikely that more than a few (if any) Wisconsin health plans would be willing to participate on a voluntary basis in a pool that largely competes against the plan's own direct contracting with small employers. Some plans with small market shares or with limited numbers of participating physicians or hospitals (who might be more attractive as an individual employee choice) might be willing to participate. But even with such state market rules, if federal legislation is enacted allowing "Association Plans" to operate outside of state market rules, the pool as well as traditional health plans would be at a disadvantage.

B. Subsidies for Low Income Employees of Small Firms Exclusively Through the Pool

If significant subsidies for uninsured small firm workers were made available exclusively through the pool, a sizable and attractive pool of people could be uniquely reached through the pool. In effect, the subsidies would play the role that large employer contributions play for their employee plans. They would create cohesion similar to that which a "natural" group enjoys and presents to a health plan. (If health plans nevertheless refused to participate, in an effort to avoid "building" a sizable pool, the state could establish linkages to participation in other state programs without significant risk of expensive cross-subsidies.)

"Premium assistance" subsidies for populations eligible for public programs like BadgerCare could reduce state outlays.

Such "premium assistance" subsidies for populations otherwise eligible for public programs like BadgerCare could reduce rather than increase state outlays. Employer coverage with premium assistance for the employee share, combined with employer contributions and federal tax subsidies, would cost the state less than enrolling those families in the public BadgerCare program. But such savings would likely be realized only if those eligible for such employer coverage were required to take it as a condition of receiving subsidies (i.e., in lieu of direct BadgerCare enrollment).

It should be noted that when BadgerCare was designed, the state's intent was that low-income working families should rely on employer coverage whenever possible. This advances two goals: to encourage career development and increase low-income workers' attachment to work (rather than welfare), and to strengthen, rather than undermine, employment-based coverage generally. But this intent has not been realized due to other BadgerCare policies. Information about employer coverage is not obtained for almost half of employed BadgerCare applicants. For applicants for whom the necessary information is obtained, about half are found to have employer coverage available; however, only a tiny fraction ever become enrolled in that coverage and receive premium assistance. (This is because several program policies, some reflecting previous federal constraints under which the state had to operate in designing and implementing the program, have the effect of significantly reducing the number of BadgerCare eligibles who can qualify for premium assistance.)

Under a revised policy context, premium assistance could do a much better job of accessing employer coverage that is available, or could be available to people who are otherwise eligible for BadgerCare. One way to simplify and encourage this would be to make the pool the sole venue through which low-income small-firm workers and their families can receive premium assistance.

Using the pool to manage the flow of subsidy dollars on behalf of small-firm workers and their families would be administratively efficient. And working with such a pool rather than with a myriad of individual small employers and associated health benefit plans could make it much easier to meet federal and state requirements regarding premium assistance (e.g., verification of enrollment and use of funds, reviewing and approving benefit structures, etc.).

Making premium assistance available to low-income, small-firm workers through the pool could also encourage more uninsured small employers to offer coverage.

Making premium assistance available to low-income, small-firm workers through the pool could also encourage more uninsured small employers to begin offering coverage—by allowing them to make a smaller employer contribution than would usually be required. This could be a very cost-effective way of expanding coverage to the low-income working population. But, since most small firms have childless workers as well as parents in their employ, arranging subsidies for low-wage childless workers would need to be addressed.

The potential new enrollment represented by people receiving public subsidies should help to overcome the chief obstacle to the growth of consumer-choice pools in the current marketplace—the reluctance of health plans to participate in them (discussed above).

We would note one significant design issue here. If a substantial number of employers participate because of premium assistance available to eligible low-income employees and their dependents, would this create a "critical mass" that could extend benefits to other small employers and employees? This potential would be limited by small employer market rules. To the extent existing rules continue to allow rates to vary substantially by health status in the outside market, the pool would, at minimum, still need to underwrite unsubsidized applicants for purposes of health rating.

C. The Pool IS the Small Employer Health Insurance Market

Some have suggested a more sweeping option: that the "pool" be constituted as the exclusive small employer coverage venue in Wisconsin. While quite controversial, some have observed that this approach would be more effective than rating reforms in protecting the pool, its health plans, and its enrollees from a systemic adverse selection spiral. And this approach could almost certainly achieve economies associated with large scale purchasing, with more stable coverage, and with substantial administrative economies of scale. (While turnover in small businesses, their workers, and their coverage status is higher than for local governments, administrative costs might be more like the Wisconsin Public Employers' Group Health Insurance Program than to the existing small employer market.)

But unless such an approach were tied to broader health insurance financing and coverage policies, it should be recognized that a number of lower risk small employers might choose the option to "self-insure" under either existing federal law (i.e., Employee Retirement Income Security Act preemption of state regulation of employee benefit plans) or pending federal proposals (i.e., Association Plan proposals).

There are a range of challenging policy design options associated with this general approach, including the appropriate organizational and governance structure for such a pool. One key issue would be the purchasing role of such a pool. In general terms the pool might be:

1. Given authority to aggressively negotiate rates—in which case it would effectively be a price regulator for the small-employer market, or
2. Expected to dictate a highly structured marketplace—e.g., have plans bid on several specified benefit packages, limit and/or have approval authority over marketing materials and approaches, or
3. Given more of a "clearinghouse" function which achieves administrative economies (e.g., through centralized electronic enrollment and premium collection) and establishes guidelines to preclude abuse (e.g., minimum benefit and direct marketing guidelines).

Conclusion

While a small employer purchasing pool might improve health insurance cost, coverage rates, and choice for small firms and their workers, it would require state policy changes. Options include market rating rules, premium assistance, and exclusive venue approaches. A carefully crafted combination of some of these concepts would have substantial potential to meet these goals.

References

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