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Small-Employer Health Insurance Purchasing Alliances

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Moderator: JAMES T. O'CONNOR

Panelists: RICHARD FIGUEROA†

HARVEY SOBEL

JIM H. SRITE

Recorder: SUSAN A. JACKSON

Summary: Several states, notably California, Florida, and Kentucky, have created small-employer health insurance purchasing alliances. They differ somewhat from one another in terms of their structures and rules. This session provides a description of the purchasing alliances and their experience to date.

Mr. James T. O'Connor: Several states, notably California, Florida, and Kentucky, have created small-employer health insurance purchasing alliances. While they have much in common, they differ somewhat from one another in structure, plan availability, and participation rules. In addition and in contrast to the state organized alliances, employers in various areas of the country have banded together voluntarily to form alliances.

We have three distinguished panel members who are going to be talking about both the state-sponsored and voluntary alliances.

Our first panel member is Richard Figueroa. Mr. Figueroa is the deputy director for eligibility and enrollment for the California Managed Risk Medical Reinsurance Board. In his capacity he's responsible for the operation of the state's

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†Mr. Figueroa, not a member of the sponsoring organizations, is Deputy Director, Eligibility Enrollment of California Managed Risk Medical Insurance Board in Sacramento, CA.

small-employee purchasing cooperative, the state's high-risk pool for individuals, and an insurance program for non-Medicaid eligible pregnant women. Previous to this position, Richard was the chief budget consultant for the California State Senate on health and welfare issues. He has a B.A. from University of California-Davis and an MBA from UCLA. Rich will compare and contrast the organization and experience of the Health Insurance Plan of California (HIPC) with the Florida and Kentucky alliances.

Our second speaker is Jim Srite. Jim is the vice president and group actuary for John Alden Life. He has had significant involvement in small-group reform and has been a member of two reinsurance boards and three state design committees. John Alden was one of the original participating carriers in the HIPC and has since withdrawn. The company has decided not to participate in the Kentucky Alliance and has decided to not participate in the Florida Alliance for its indemnity plans. The company is participating in Florida for its health maintenance organization (HMO) plans. Jim will discuss the advantages and disadvantages of participation, and some of the strategies and issues that carriers can consider when deciding whether or not they should participate in these alliances.

Our third speaker is Harvey Sobel. Harvey is a principal and consulting actuary in the Buck New Jersey office. He consults for insurers, providers, employees, and alliances. A number of years ago he was the actuary in *The Wall Street Journal* radio ad that was broadcast. Harvey will share with us his experience with working with a Michigan voluntary alliance. Then perhaps we'll see some contrasts between that and the state-sponsored alliances.

Susan Jackson is an actuary with Washington National. She has graciously agreed to act as our recorder for this session.

Mr. Richard Figueroa: As was mentioned I'm going to talk about three states' approaches: the California, Florida, and Kentucky publicly sponsored health alliances. These three states have distinguished themselves among other states by establishing these relatively early on. All feature some form of the managed competition model, where you have a standard benefit package and employee choice with appropriate incentives for employees, over time, to gravitate toward more efficient and high-quality plans. This in turn gives incentive to participating health plans to compete over price and quality and not over cost avoidance.

I'll be discussing some of the characteristics of these cooperatives, emerging trends, and drawing conclusions as appropriate. Given the really young nature of these alliances—they're all very young—I'm going to draw things as I can given the first few years of their operation. I'm going to also refer to them as alliances. Whether

you want to call them alliances or co-ops or pools or HIPCs, they're all kind of the same thing. So if I tend to mix my synonyms here, you'll excuse me.

An appropriate quote from Machiavelli says basically, "There's nothing more difficult to plan or doubtful at success, no more dangerous to manage than the creation of a new system, for the initiator has the enmity of all who profit from the preservation of the old and merely lukewarm defenders in those who would gain by the new." That has been definitely the experience in all three states. The plans were very controversial when they were put together. And in the most recent case of Kentucky they tend to be very controversial, and they've gone through some very dramatic changes in their structure taking place July 15, 1996. So these are very controversial entities, and will continue to evolve over time.

I'm going to start out with some of the implementation features. California's was the first in July 1993 of the three that we're discussing. It's run by a five-person state board with broad authority over the operation of the HIPC. The board is required to privatize the pool by June 1, 1997. We're going through that process. That is one of the negotiation tactics as part of establishing the pool. California's pool is called the HIPC. We thought we were being cute at the time. The coin or the term HIPC isn't quite as popular as it was back when Clinton was first proposing these. It's something that has stuck with us.

Florida started about a year later. It has a very different operational structure. It's run by nine different regional boards, with 17 members each. It's an unwieldy process for the folks in Florida. They had a little bit different vision about how these ought to be run, much more community-oriented with local community boards. Their cooperatives are called community health purchasing alliances (CHIPAs). I'll refer to them as CHIPAs as we go through. These boards are monitored by the state and really share operational responsibility for the CHIPAs with the state.

Kentucky is the most recent, and it has just been around for about a year now. Their coop is called Plan Source. It is operated by a state board. It really works more like California, the board has broad operational responsibilities. Their board sunsets after a certain period of time. I think it's another year or two and then the board actually sunsets.

Let's move onto eligibility. There are some big differences in who can join, and it reflects the different politics of the state. California has the most restrictive rules about who can join, mostly due to concern over the allowance of individuals to participate. In California, you have to be a small business with between 3 and 50 employees. Seventy percent of eligible employees must join. To be eligible to be considered a full-time employee you have to work 30 or more hours. Again, that's

the most restrictive. The legislature didn't want to get into covering part-time employees. It didn't want to have anything to do with individuals, even though we wanted it to. But, again, it's a very controversial feature that was discussed.

Florida is the least restrictive in terms of group size. Florida will take the self-employed, the onesies and twosies as they're called, as well as more traditional small groups of 3–50. Much like California, Florida has the same requirement in terms of what percentage have to be covered as eligible employees, and allow a little broader coverage in terms of part-time employees. If you work 25 or more hours, you're eligible for Florida's co-op.

Kentucky is the most broad in its reach. It not only encompasses employers with between 2 and 50 employees, but also includes public employees. All the state and school district employees are mandatory enrollees in the HIPC. There are a number of other groups that are voluntary including other educational institutions, colleges, as well as cities and counties. Originally it should also be noted that when Kentucky first started a year ago, it was able to cover groups up to 100. But as of July 15, 1996, it can only cover groups up to 50. It has actually been a retrenchment in their scope. Eighty percent of those eligible must join, and they actually cover even more part-time employees. You only have to be working 20 hours a week to participate.

All of them offer guaranteed issue and guaranteed renewal. These are all operating in a reformed marketplace where guaranteed issue and guaranteed renewal is required of all carriers. This is for the obvious reason that the pools won't be selected against. So they have to operate in a reformed marketplace in order to survive at all.

In terms of health plan contracting, a basic feature of co-ops is their ability to contract with health plans. Both California and Kentucky use a selective contracting process where you don't have to take all comers. You can decide based on rates, or a variety of other factors, whether you want to do a contract with them. Florida takes on all comers that have met a set of published criteria. You are then designated as an accountable health plan and can participate. California has 22 plans participating; Florida has 24; and Kentucky has 12.

As can be seen by the number of plans, however, both of these methods seem to attract a lot of suitors. There really is a wide variety of plans to participate in all three. When I talked about 22 health plans and a large number of benefit options, it's because some of those health plans offer more than one product in that pool. For instance, they offer an HMO or preferred provider organization (PPO), or HMO point of service or indemnity, and that kind of thing. Two of the health plans are

new to California. There will be eight new health plans joining Florida's as of July 1, 1996, as they continue to be vital and growing in the marketplace.

Before we get any further, I wanted to enter into the dynamics or the mechanisms of the pools to give you some idea or some flavor of the volume we're talking about and its relationship to expectations. California, as I mentioned before, only covers small groups. There are about 106,000 individuals representing about 6,000 small employers who are participating. The average group size is ten. So in terms of volume and the size of the group, it's been relatively good for the carriers. But in terms of expectations, legislatures have been very disappointed in the California HIPC in terms of meeting the public policy goal and establishing the co-operative. Unfortunately, only 22% of the groups were uninsured before, and that's just groups. When you actually look at the individuals, about 15% of those in the HIPC were previously uninsured, which is only about one-third of 1% of the total amount of uninsured in the State of California. There are still 6–7 million uninsured in California. So while it has met the volume goals and has been popular among small employers, it has not met the public policy goals for the legislature, given the relatively small amount of previously uninsureds now covered.

Florida is a little bit different. It has enrolled about 77,000 individuals. And it should be noted that individuals are treated as a small group. In Florida there isn't a breakout, even if the states do cover a lot of self-employed. The state doesn't distinguish between small group and individual. In contrast to California, about 52% were previously uninsured. This is treated as a great success by policymakers in Florida. It's one of the things that Florida points to with much pride.

Kentucky again is very different from the other two. It has mandatory enrollment of its public employees. So it's very apparent where the volume is going to be, and it's going to be on the public employee side. Kentucky doesn't seem to think that it's setting the world on fire in the small-group or individual insurance market. There's about 20,000 individuals enrolled at that end. This may look like California Public Employment Retirement System (PERS), where it's just very heavily weighted toward the public employee side. Kentucky, like California, has about 22% who were previously uninsured, which given a relatively small volume may be appropriate for Kentucky's size. But certainly I think the legislators are going to be very pleased if they're able to save them some money in terms of their own premium payments on behalf of state employees.

Moving on to benefit options: What are these folks choosing from? Well, in order to reflect market preferences, attract enrollment, and offer choice, the co-ops all strive to provide a variety of options. Each benefit option, as I mentioned previously, is standardized so that employees can make an apple to apple comparison as

you would expect in co-ops. The benefit packages themselves are fairly comprehensive and include even prescription drugs, mental health benefits, durable medical equipment, to some extent transplant coverage, mental or chemical dependency, and alcoholism benefits depending on the type.

California has never offered a fee for service option, maybe reflecting a more mature managed care market. We do offer 3 PPOs, 22 HMOs, and 3 point of service plans.

Florida did at one time offer fee for service, but it has lost its last indemnity as of July 1, 1996. I think there will be no more indemnity policies offered through Florida. They'll be mostly PPO and HMO. There are about 8 PPO products, and about 26 HMO products offered in Florida as of July 1996.

Kentucky offers the widest variety. They, however, much like Florida and California, have lost their last two private sector indemnity products as of July 15, 1996. Kentucky has 3 PPO products, 12 HMO products, and 8 point of service products. Kentucky is still going to have 1 fee for service product. What the legislature has done since it has had a statutory requirement to offer a fee for service product through its co-op, is it is opening its self-funded public employee fee for service or indemnity product to the commercial market. That's the way the state is going to continue to retain or maintain a fee for service product in Kentucky.

Certainly overall the co-ops seem to be losing their least restrictive service delivery models over time. The managed competition model seems to be more popular, especially among the HMO industry and to a lesser extent among the PPO industry.

Overlaid with all of those, the different service delivery systems, there are a number of copayment and deductible options, mostly along the high/low copayment model. California has the most simplistic approach to this. We have only a standard and a preferred product with the only difference being copayments. The benefits are exactly the same between the two. About 40% of our enrollees are in the standard product, and about 60% are in our preferred product.

Florida has both differences in copayment and some restrictions on benefits. The benefit restrictions are mostly related to contraceptives and transplant services. Florida has a basic, standard, and plus product. The majority of enrollees are in standard, and the second most popular is the plus product.

I've had to divide Kentucky into three different categories. Kentucky offers five different products. These products in particular in Kentucky are the only five products that can be offered outside the co-operative as well. Kentucky is a much

more regulated market. Of the three markets, Kentucky is very different from the other two, because these are the only kind of products that can be offered both inside and outside. There are different relative percentages in terms of popularity among the public enrollees, their small-group enrollees, and their individuals. The thing I guess that's standard or common among all of them is that the more enhanced products seem to be the more popular products. There's very low enrollment in both the basic product in Florida and the budget product in Kentucky. So people, by moving with their feet, are certainly interested in the more enhanced products than anything else.

Who makes these choices among all these different options available to them? Both California and Kentucky employ what's called pure employee choice, where any employee can go to any health plan he or she wants. Florida has kind of a modified employee choice structure. If you're a small employer with less than 30 employees, you have to choose at least two health plans, then let employees choose from those two health plans. If you are an employer that has more than 30 employees, you have to choose at least three health plans from those that are available, and then let the employees choose from there. In reality most of Florida's small employers offer a much wider variety. In fact, a lot of them just opt for pure employee choice among them all. They don't want to have to make that initial whittling down decision for those employees and kind of engender their grief and madness later on.

The one feature that's so distinctive about co-ops is also the most popular among small employers in terms of why they choose to join: it's that choice factor for their employees.

Employer contribution levels are also another factor that distinguishes pools in the managed competition model. A multiple-plan model allows you to set employer contribution standards to give incentive to employees to choose lower cost plans. The volume at the low end in turn provides incentives for health plans to keep their rates in that lower premium tier. Both California and Florida, in order to provide this incentive, have pegged small-employer contribution standards at 50% of the lowest premium available to that employee.

California has the most data on how that has affected choice. Florida and Kentucky don't have that yet. To give you an idea, in the California HIPC, fully one-third of employees pay at that very lowest level. To give you some idea, in the San Diego area, our Kaiser Permanente plan offers a \$68 rate, and that's the lowest one available. So that employer is paying \$34, and that's the minimum it is required to pay. About one-third of all our employees are paying at that level. Fully 60% of all the employees in the HIPC are choosing plans within 10% of the lowest cost plan. When you get within 20% of the lowest cost plan, that number moves up to over

85%. So most of the volume is concentrated at the low end, and this employer contribution standard has a lot to do with it. Again, Florida and Kentucky are still analyzing the data. And I should mention that Kentucky's data will be somewhat skewed because it uses a fixed contribution rate for its public employees, which happens to be high enough that even the fee-for-service option is covered at a relatively low cost to the employee. So Kentucky's numbers are going to be quite skewed when you look at that because they use a very different kind of structure.

When you look at premium rating factors, they vary widely between co-ops. But it should be noted that these rating factors apply across the marketplace. Again it's very difficult to have a HIPC unless you have some kind of standards in a reformed market.

In California they're the most restrictive. We only allow age, area, and family differential, and a plus or minus 10% differential off a standard rate related to medical experience. It should be noted that the HIPC does not use this additional differential. We believe that the risk can be spread far enough in the pool that we don't have to employ this particular factor for the very small percent of employers that would be an unhealthy group, for example.

Florida has a little bit wider band of rating factors, including both gender and tobacco use. Kentucky used to have a much smaller set of factors. As of July 15, 1996, what has just happened in that state is really a carrier revolt as well as a legislative revolt. Kentucky now has a wide variety of things that can be taken into account, including gender, industry, and healthy lifestyle. Outside the pool Kentucky can also use a plus or minus 30% medical experience factor. The state isn't going to allow that for its mandatory population, which is most of the enrollment in that particular HIPC.

Under administrative costs, another feature added to these rates is that they tend to use outside private-sector administrators to run these. All three use private-sector administrators to provide eligibility, premium, and marketing functions. As a percent of premium, the cost ranges from about 1.75 to 2.75% added on to the premium solely due to the administrative costs of running the pool. I've also thrown in agent costs there, because each state varies on how it does the value, added function or includes that in the premium. But just to give you a general sense that as a part of the premium the states are a lot smaller than other outside commercial business, which tends to run more in the 8–12% range.

The pool, of course, endeavors to convince plans to lower their own administrative load as part of the premium since they've taken on a number of functions that those carriers used to do on their own, such as eligibility and premium collection. You

try to make it so that just because they join a pool there aren't more administrative costs. We hope if they're done efficiently, there's even less administrative cost.

When you get to premium experience and you can buy all these features, I'll give you some sense of what that has been so far. In California so far so good, at least we believe that way. There's been generally decreasing HMO premiums. At least in the last year, we've seen the PPOs start to increase. That's masked in the overall much larger HMO increases. In 1993-94 HIPC rates were about 5-15% below the prereform marketplace. In 1994-95 they went down even 6% beyond that. In 1995-96, they went down an additional 3%. And this coming rate year, 1996-97, there is another 1% decrease. Within the HMO/PPO mix, there is a much larger decrease with the HMOs, and we started actually seeing increases in our PPO.

The average premium is about \$108. That has been declining over time. It's also important to note that the lowest cost sales offered in the HIPC, from the very first year to the very last year, declined by about 20%. There was a very dramatic decrease in premium, particularly at the low end to engender volume. Florida has had somewhat of the same experience; the first-year premiums were about 5% below the preregulated, pre-reform marketplace. In 1995-96, there was a relatively large decrease in HMO rates, but we started seeing a relatively large increase in PPO and fee for service. It looks like in 1996-97 there will be an average rate increase over all Florida's products. So Florida, much like California, has started to see a change in the level of decrease.

Very little is known right now about Kentucky. Kentucky wasn't able, since it has very different products available this year than were available in the year before, to give us any kind of a benchmark. Kentucky is currently in its rate negotiations, so it doesn't have any additional information to give us on what next year might look like.

Does the decreasing rate of decrease reflect a maturing book of business for the HIPC? Is it the underlying cycle starting to go up again? Or are HIPCs receiving some sort of adverse selection? It is probably too early to know, given the relatively young experience rate of all three HIPCs. We have to take a little more time to see what happens.

What do we know about loss ratios? We know very little at this point. Most carriers don't report their loss ratios by just the HIPC pool of business. It's usually incorporated in their small-group book or in their overall trend. Information is reported to the department of insurance in the various states. One might have to look at some proxy measures instead. One can argue that more carriers are trying to join. Maybe one measure is that there isn't word on the street that these are bad

books of business. Have rates been relatively stable? On the HMO side they have and in most cases have been decreasing. Does that mean there's a bad book of business? Maybe not. Are carriers that are currently participating in the pools offering more products within those pools? The answer is clearly yes. The carriers that are currently participating are offering more of their products. So, one could say, that's a proxy for the measure that the medical loss ratios aren't too bad. Of course one could argue that maybe carriers are just trying to buy a book of business for the volume side as well. It's very hard to get it in to know.

The other thing I'll mention real quickly is, in an effort to stabilize rates in California, particularly on the PPO side, California has implemented what's called a risk adjustment, risk assessment mechanism. For anyone who is interested in getting this—it's produced by John Bertko, who is a consulting actuary from Coopers and Lybrand—I can provide that to you. It's an attempt to provide a transfer mechanism to transfer some dollars to plans which have an inordinate amount of adverse risk, from plans that have an inordinate amount of healthy risk. This is mostly an attempt to not only keep our PPOs but also to make sure plans aren't just by the luck of the draw getting much sicker employees than other plans due to the employee choice feature.

What we've learned so far is that reforms must be marketwide. And they are that way for all three states.

Who's choosing whom? In California our PPO has almost never been more than 5%. We did lose a couple PPOs last year as I have indicated. About 95% of our enrollment is now in HMO or point-of-service products. Florida has three quarters of their folks in HMOs or POSs, about 74% through the HMO and about 24% in their PPOs. And the remaining 2% obviously will go to zero because they've lost their last fee-for-service option. Kentucky has a little broader distribution. HMOs and point of service are still vastly the most popular, with about two-thirds of their folks involved. It is interesting in this particular market that individuals are choosing the least restrictive plan, even though they have to pay the most out of pocket. The state employees, who have the largest contributions, have chosen primarily the HMO. So it's an interesting anomaly that bears further review.

We've learned reforms must be marketwide in all three states. If you didn't have that, then there would be adverse selection into these pools of people, the only people doing guaranteed issue, guaranteed renewal, etc. Alliances can be administered inexpensively. The administration load, solely because its small employers joined the HIPC, is about 1.75–2.75%. Again we try to get that back out of the administration loads in the health plan rates. Standard benefits do lead a rational choice. For employees, carriers are willing both to offer and sell standard benefits.

And it is really necessary for employees to make the apples to apples comparisons that allow employee choice to flourish in the marketplace.

Choice sells. This is the number one feature that small employers mention when they talk about why they've joined a purchasing co-op. Managed competition can suppress price. It's more true in the HMO environment than it is in the PPO environment.

Employer contribution does affect selection, at least based on the California experience, very dramatically. And last, as I like to point out to our policymakers and our governor all the time, universal access is not universal coverage. So even if you offer a very comprehensive benefit package that offers great choice and low rates, these products are not overwhelming the marketplace. People are still choosing a lot of things outside of these purchasing pools and certainly, at least in California's experience, aren't really bringing in large amounts of uninsured. So, I think we would say that pools by themselves are not the answer.

Mr. Jim H. Srite: I'll be covering a lot of the same ground that Rich covered, but from different angles. My talk will be filled with blatant assertions, sweeping generalizations, unsubstantiated opinions, and a few facts. I'll try to point out when the facts show up so that you can recognize them. I think giving that type of a talk means that I'll be giving a talk similar to the level of knowledge in the marketplace in general right now. Because I don't think anybody knows much of anything at this point.

This environment, I think, lends itself particularly well to actuaries, whose job I've heard once described as explaining in excruciating detail every aspect of the business problem and then further explaining in excruciating detail why you shouldn't use any of the results. So we'll see how this goes.

The first thing I wanted to talk about is some of the goals in purchasing alliances. These are all from my perspective, and what I've heard of the goals of the purchasing alliances. And the three goals are to pool purchasing power of small groups, to give them easier access to insurance, and to reduce administrative costs. In short, if you sum all of those up, it would be to allow small groups to enjoy the benefits of big groups.

When these purchasing alliances were first coming out and looking at those goals, I felt that was what insurance companies were supposed to do. But I guess we've needed to try another mechanism with HIPCs. And to try and accomplish these things, there are three things that I can think of as potential cost reductions. Obviously, there is the pooling of purchasing power. You can potentially get better

deals on medical costs and lower your cost of services. Two, you can lower distribution costs. There's no doubt that selling particularly to the small-group market has very, very high distribution costs. When you consider the commissions and then your internal marketing, it can easily be 12%, 13%, or 14% of premium just to get the product to the individuals. And then the third thing would be increased competition. If the market is not really competitive, there's a perception that insurance companies are raking in all these wonderful profits. This is an attempt to squeeze out some of those profits. So those are three things that in my mind could reduce costs and help achieve the goals that we just mentioned.

On the other hand, I have a list of things that would increase costs, and from my perspective, I'm going to be focusing a lot more on these than on the other three. Low participation is a problem. One of the concepts of group insurance is that you try to get high participation to make sure that you spread the risk. Well, one of the main concepts, as Rich mentioned, behind HIPCs is employee choice. So we're saying we can't force a pool of people to take your particular product. Now one of the ways around that is the risk adjusters, which we hope would help a little bit. I'm not convinced how good a job we can do on risk adjusters yet. Even though I know there's a lot of work that has been done on the subject. The second concept would be the selection by health status between plans. Most of these issues, by the way, are issues related to the guaranteed issue market in general for small groups, not just for HIPCs. But, in the old days when you could underwrite, you could protect yourself against the unhealthy people picking richer plans. Well, now you can really have an individual who knows he needs services go to the place where those services are most available. It's the basic concept of insurance. It's like the concept that you wouldn't sell homeowners' insurance to someone who is standing outside watching his or her house burn down. If people can choose, knowing what their condition is, the plan that maximizes their value, then there's selection and ultimate cost that gets the carriers. The third concept is exploitation of rate structure weaknesses. I mentioned that five years ago we all worried about irrational competitors. I think in the current market today we're all irrational competitors, because we don't know what we're doing. And when you throw 25 plans together, with all of our own mistakes that we're making, and individuals can choose to find each one of our mistakes, that can have a fairly big cost.

High turnover is a problem. When enrollees have easy access to switch between plans, if you find your mistake in your rate structure and you fix it one year, you don't get to keep that person to recover it. The person just goes on to the next company and finds their mistake in their rate structure.

Selection versus the outside market is true probably originally in California to a larger degree, to maybe a lesser degree and more subtly in Florida. Whereas in the

outside market you had a plus or minus 20% spread around your standard rate, inside the HIPC, you have a standard rate and that's it. So in the outside market we'd rate somebody up 20%, and if they didn't like that, they were sick let's say, they'd just go into the HIPC and buy the plan at a lower rate.

So obviously that's a selection problem. And then selection by plan design is related to something I mentioned earlier that, if you have someone sick and that person can pick the \$100 deductible versus the \$1,000 deductible, you've obviously got high claims by plan design.

Those are really potential cost increases. And I'm going to show you some things later, at least from the PPO side where you see what impact those costs actually have. And not to be totally negative against HIPCs' customer-friendly features, there are many things that HIPCs are trying to do that are very good. If we can figure out ways to do these and control the risk, it would be good to do that.

Regarding individual selection of plan, everybody would like to be able to pick their own plan instead of being forced into a plan by their employer. People want easy switching between carriers. One of the big problems that the insurance industry is taking a beating for is the fact that, when people get sick, they can't transfer to some other plan. Well, if you can switch between carriers, if you've had bad service, or if something happens with your particular carrier, that seems to be a good feature for the customer.

Those two customer features are ones that I think are problematic in terms of controlling risk. The second two features are ones that I think actually could be an advantage and don't necessarily create a problem. And those are consistent marketing, where you don't have this flurry of different brochures from different carriers with all their individual plan features that you have to try and wade through. That could be a real benefit to have one book that tells you what all your options are and you get to pick. And the other item is consistent underwriting. A little later I'm going to talk about what maybe can work in HIPCs. If you have consistent underwriting, then you don't have all the different rules, the different carriers and everybody goes through one process to get in. And I think those would actually be good things in the market.

I'm going to go through a couple of examples. I'll talk about the California HIPC and the Florida HIPC. And then I'll briefly mention one private alliance that we were in for awhile, one of our mistake stories.

I'll try and go through the California HIPC quickly, because Rich already covered a lot of it. First of all, all the things which I'm talking about are the HIPC as I know

that existed at the beginning. So some of the things that he mentioned are changes that have been made in the meantime. First of all the California HIPC was rated at what I call modified community rate, or the standard rate, and it was guaranteed issue. I say one plan of benefits; it really is the two that he talked about, which essentially are the same plan of benefits with just a small option. You have individual selection from approved carriers. So what you essentially have is individuals picking plans and not groups. With the risk adjusters, if they worked appropriately, you'd get back to the group concept more. But again, it's individual selection of plan and not group. The outside market was rated at the modified community rate, plus or minus 20%. That has since dropped down to plus or minus 10% as of July 1, 1996.

At first there were 20 HMO plans and 3 PPO plans that signed up. There was a rule that said that the modified community rate in the HIPC could be no higher than your modified community rate outside the HIPC. I'm not positive of that rule since it has been modified. There is a two-year election. So once you've signed up, you're in for two years.

That's the difference between this plan and Florida. Florida does it actually month by month with a trend factor. There is some agent compensation built in, but there is a provision that, if you want it to pay additional agent compensation, you could, as long as it was disclosed to the group. I'm not sure if that's changed either. Originally, I think we were one of the first that actually paid the additional agent compensation. I think some others followed suit after that, I really didn't keep up with it all that well.

Now let's discuss the Florida CHIPA. We'll talk about it a little bit, just to give you an idea from the risk standpoint what's going on. It's a modified community rate, the same as the outside market. Again it's guaranteed issue. You must offer the basic and standard plans. Florida actually has a provision in its law that says the carrier can offer any other plans that it would like to. But I'm not sure anybody is really doing that. So you could offer your whole portfolio through HIPC if you wanted to.

The rates were encouraged to be lower than the outside market. So there was quite a bit of pressure put on you to make your rates lower, but there was no specific requirement that they had to be lower. Now one of the interesting things there that has played out over time is, since Florida is a community-rated state, could a single company have different rates inside the HIPC and outside the HIPC? The answer in our case as we've tried to actually get out of it, has been yes, as long we could justify it. So they would allow you to have a different community rate inside and outside the HIPC.

I believe there are 11 regions in Florida. There may only be 9 boards, but I'm sure there are 11 districts, each with an administrative board. But at any rate there are a whole lot of boards and a whole lot of districts.

As I mentioned earlier the new business rate can change monthly. There is a fairly elaborate filing process. I think for our three or four plans, Florida has a system that you file under. And I think the filing was quite thick for these three or four plans. In Florida, the plan is required to be sold through an agent. I don't know how much of that was practicality and how much of that was the agent lobby, but there was a provision in there that an agent had to be involved in the sale.

Briefly I wanted to mention one other alliance that we were in and this was a private alliance in Iowa that was actually put together by insurance agents. It was guaranteed issue only in special plans, the state basic and standard plans. The other plans were actually underwritten. However, for the basic and standard plans, you weren't allowed to use the rating that you could normally use, the extra 50% under the law. I'll talk about the experience in just a second.

We can compare our loss ratios to the national average. The California HIPC loss ratios range anywhere from about 145% of our national average to close to 250% of our national average. And that's on about \$4–5 million in premium at one point in time. One of the nice things about HIPCs as an experiment is that, if you decide you can't participate anymore, you have an easy out. That is pretty dramatic. But if you look at the Florida CHIPA experience, you'll see that the loss ratios are maybe slightly better, but still range from 125% up to 150% or 160% of average. Now one difference there is we were able to raise rates quarterly. And so as we saw experience developing, we raised rates to catch up.

I really wanted to talk about why this is what it is. The bottom line is that insurance is still a risk business. If we take the selection out of the risk business, and say anybody can buy insurance whenever they need to, there's a cost associated with that. When you go to a HIPC, what you're essentially doing is, you're taking a large group of ten people where you have some spread of risk. You're letting each of those people individually choose. There are two factors going on here. In my mind, one of them is guaranteed issue in the small-group market has a huge cost. I think many of us are starting to realize that. And so what you've done with the HIPC in my mind is make large groups smaller groups. So you've made the impact of the guaranteed issue much larger. I think we looked at the things employers would like, and sure there's a lot of features they would like about this, but at what cost? And in my mind that's the key issue here.

Now one thing which is another key issue is that everything we've done with guaranteed issue nationwide is still voluntary where the person can choose whether or not to buy insurance. If you somehow said we're going to make it a mandatory market, then you change all the dynamics of this, and you have a great opportunity to do a lot of really good things.

So the bottom line is, to some degree either we haven't understood or we have forgotten basic insurance principles of risk selection and how that works with small group. There's a mentality out there that says you have individual and you have group and that's just two things. And people forget about this 1-25 or whatever the size is group market.

My conclusions are insuring individuals of very small groups without some risk selection mechanism is costly. Another conclusion in our mind is that the insurance agent is important in accessing small groups. Now whether you could do it differently than that we still think that the insurance agent is important, and that in the Florida example has proven out. I think probably to a lesser degree it is true in California. That is something that might change over time. I think the small businesses are uncomfortable not going to their individual agents to pick. That could change and that might be a good change. I wouldn't necessarily argue that. Increased competitive pressures can lower costs in the short term; the long term is very much less certain. PPO plans and purchasing alliances have not been successful in general.

I wanted to make a couple of comments from the notes I was taking while Rich was talking, and then cover one area that I really left out of this. On the previously uninsured, I think sometimes there are misleading statistics because people don't understand the market. I think the big difference between California and Florida is that Florida insures one- and two-life groups. Our company's average group size is 2.5. And when we study our business, 40% of our normal business that comes in was previously uninsured. So that's not anything unusual. And I think the big difference is the size group you're selling to.

The next thing I haven't really covered is HMOs. If I'm saying these costs are so horrible, how come costs are going down? And I will fully admit that HMOs so far have held their costs down in the HPCs. This is where I really get into my opinion. On the HMOs I have three opinions. Medical management is one; there is something to medical management that HMOs can manage costs better. However, I'm not convinced that, if you take an inherently healthier book of business than a healthier book, HMOs can manage those costs to be the same thing. The costs will still be different. I think selection is a big key. Right or wrong there's a perception about HMOs that, if people are unhealthy, they're going to typically not want to

choose the HMO when they have a wide range of choices. And so I think HMOs by the nature of their product still have risk selection. And of course, that's part of what the risk adjusters are trying to get at. The third is lack of reporting. Do HMOs know what their experience is inside the HIPC, or are they just rolling everything together and they don't really know yet? My personal opinion is that why the HMOs are still doing alright is a combination of these three factors. I wouldn't venture any guess as to what those percentages are. So in closing if you'll allow me a little bit of a corny statement since we're in Colorado, if you're going to climb the mountain of providing risk without selection, you better be prepared for the avalanche of risk.??

Mr. Harvey Sobel: I will discuss a voluntary non-state-sponsored alliance in Michigan called the Health Care Alliance Pool (HCAP). This is going to be a little bit different than the alliances you've heard about, because this is basically a model where we're going out looking for one carrier, because we realized early on that, to open this up to a lot of choice, we're going to get into a lot of selection issues.

What is HCAP? Well, it was formed as a not-for-profit corporation in 1994. But actually the organization had early beginnings going back to 1991, and it took HCAP that long to really get formed. It's a little bit different than some of the other alliances in that it is a joint employer-provider coalition. The employers came together because they obviously wanted lower rates. The providers were concerned about control and where they stand in this whole managed care movement.

Without even having a product, over 100 employers joined. They had to pay some modest dues of \$100–200 to join. The alliance covers 14 counties in east central Michigan, north of Detroit, with the main focus in the Saginaw Bay/Midland area. As I stated, the goal was to both control and lower health care costs, and pass on those savings to the participating employers. The target market was small businesses with under 100 employees, and which we estimated to be about 75,000 target employees in the HCAP area.

One of the first things that we did when Buck Consultants was engaged by the alliance was to do basically a competitive assessment. There had been a great deal of misconceptions that had grown over the four years prior to the forming of HCAP. We got involved with HCAP in the beginning of 1995. And we did an analysis of the marketplace, and confirmed what everybody knew: That Blue Cross/Blue Shield had a very high market share, that they were a major force in the market. And so we knew that we had to have products that were going to be competitive to the Blues. We also would need to achieve fairly low retention levels. There was a misconception on the part of some that there were very high retention levels and all that HCAP had to do was come in and shave 5% or 10% off, just because as you

heard Jim say, insurance companies have these high retention levels and just coming in you could just shave it off the top. But we did our competitive assessment, and we learned that it would not be that easy; we would have to work on the retention.

And we also did an analysis of the cost variations by region. There was some misconception that there were cross-subsidies between Detroit and east central Michigan. We looked at it and found that this really was not the case. It was really a misunderstanding about how insurance companies, HMOs, and the Blues rate their products.

We were in search of a vendor. There's really three stages in the HCAP chronology. We got involved with the second and third. Prior to Buck Consultants being engaged by HCAP, it went through a request for proposal (RFP) process, where it sent out an RFP to a number of insurance companies. The RFP was not received very well. There was not a very high response rate, and that process petered out. It led HCAP to get into sole source negotiations with John Alden. It was not Jim's group. It was actually the Columbus, Ohio, group operation. And after a couple of months of negotiating, that fell through because of differing approaches. I believe it fell through about the time we saw some of those loss ratios take hold. We were really involved very heavily with what I call the second RFP process, which I'll describe in a moment.

Now when we went into this process of looking for a vendor our third and perhaps last time, we wanted to make sure that we were able to find an insurer that would have competitive premium rates: We knew that we would accept some underwriting standards, but we wanted them to be reasonable. We didn't want to have to say to, for example, half our members, you've joined HCAP, but we can't offer you coverage because you don't meet underwriting. We knew we'd have to have some underwriting to be successful in the marketplace. We also wanted a vendor that was going to recognize the alliance as two things. One is it's not only a network of providers, but also a large group. And it's what Jim said that we wanted the large group economies of scale. We also insisted, and this was something that some vendors really didn't want to offer, to do business with one vendor, and have refund accounting as a large employer would. We established that as a criterion going in. A number of vendors said, no, we'll be sponsors, but we want to basically offer small-group coverage through policies to the groups. We said, no, we want to have one master policy, and coverage would be offered to subscribing employers.

This is sort of the chronology of the second RFP process. We went out with a very wide mailing to almost all vendors in the small-group marketplace, asking if they have an interest, describing briefly what HCAP was about to see if there was interest

in it. We got back a lot of thanks but no thanks. United Health Care at the time was still digesting Metra Health—it said no thanks. The Prudentials and Aetnas of the world said they felt this was not the type of alliance they wanted to be involved with because they wanted more control. We did get back six interested vendors that said they had an interest. That led to our sending out a preliminary RFP, which tried to focus in on some of the key areas. We were very aware that many vendors don't like to spend hours filling out massive proposals. We tried to keep it short and hit the high points. That led to three proposals coming back. We conducted interviews in October 1995 of the three vendors. That led to one of the vendors, which we realized had misinterpreted our requirements on refund accounting, dropping out. We were left with two finalists. We conducted site visits of the two finalists. We asked them to resubmit a more expanded proposal. Then in March 1996 the board selected Nationwide as the winning finalist. Right now we're working with Nationwide in terms of watching the product, which I'll talk about shortly.

In terms of the provider network, HCAP did go out, and because of the heavy provider involvement in forming HCAP and funding HCAP, we were able to secure participating provider agreements from 13 out of 17 hospitals, and almost 400 out of 580 physicians in the area. So it's a very broad PPO. We were very aware at this point that we did want to be very inclusive, and we saw that perhaps down the road we might want to whittle the network a little bit, but not at this stage. We also made use of Nationwide's contract with Pharmaceutical Card System (PCS) Drugs to cover pharmacy. We really did not want to reinvent the whole pharmacy network.

I should also mention that, just as we solicited providers, we also solicited brokers and agents. As you've heard our other two speakers indicate, it's very important we felt to have the involvement of the agents and brokers, and not that they would feel threatened. So we settled on a competitive commission scale that we felt would not price us out of the market, but would still offer us the option of getting steerage from the agents and the brokers and them feeling a part of this community-based product.

Briefly, we wanted to keep the plan designs relatively simple but still offer choice. We are pushing three point-of-service plan options: two of them are 90/70, and one is 80/60. But, we do have an 80/20 traditional indemnity plan option for those who want to keep their current arrangements. We offer two drug rider options. And we allow them to purchase dental, life insurance, and other ancillary coverages through Nationwide. And as I mentioned, only the employer has the choice, not the individual. We felt that at this stage we really did not want to get into those selection issues.

All the pieces of the puzzle are put into place. We have vendors lined up. We have the providers under contract in a very short time. The agents are on board, and we're quoting cases. We're slipping a little bit behind our July 1, 1996 effective date, but we think we're going to have business on the books August 1, 1996.

So it has been a rocky road, but we've really come a long way in a short time period. And I'd like to close by my two lessons. One is, and I believe for a consultant this process pointed out the Ruskin motto, "the work of science is to substitute facts for appearances and demonstrations for impressions," because there were many misconceptions that we had to clear up before we really got going. And I think the other thing that this engagement reinforced for me personally was a lesson right out of negotiations 101, which is to try to make sure you maintain your options, and don't close down your options too soon, because it makes it very difficult to select your vendors on the most favorable terms.

Mr. John A. Hartnedy: Has there been an effect on the total number of uninsured in the state? Has it reduced the total number of uninsured? Or is it probably too early to tell? Can anybody comment on that?

Mr. Srite: I think it's difficult to tell because there are so many reforms going on in the market all at the same time. We might be able to answer the question, have the number of uninsured gone down? It would be difficult to answer the question have HIPCs done that? And this is back to opinions, but my opinion is that nothing much that we've done has significantly impacted the number of uninsured. It may have shifted who they are, but I don't think it has impacted the total.

Mr. Figueroa: I share the same feeling. I mean we've only added 15,000 folks in the small-group market. You know California's uninsured rates; people's rates just keep going up and up all the time. So it has really had no measurable impact. There's also quite a significant amount of uninsured in the small group market. In fact some folks think that is where most of the uninsured really are. So I think there was an expectation that we would have had a bigger dent, and it makes all kinds of questions about subsidizing the cost of health insurance and all kinds of things. But clearly what we've got so far hasn't had that kind of an impact.

Mr. Srite: One other thing with respect to Florida, because of the guaranteed issue and community rating all the way down to one, our experience on one- and two-life groups is that the loss ratio is 25–30% higher than our other loss ratios for other sized groups. And what has started to happen in the marketplace is a lot of carriers are putting in reverse graded commission schedules, which pay a very low commission on one and two life groups and pay a higher commission on three plus. We

were forced to do that because the competition was doing it. I think that's going to increase the number of uninsureds in the exact market we're trying to serve.

Mr. John A. Dwyer: Do brokers drive the selection against the alliance?

Mr. Srite: I have a couple of interesting comments on that. I actually have a group I sing with in the church, and one of the guys who sings with me is an insurance agent. So I asked him about this. Why do you like HIPCs? And he went through this whole list of things, and in my mind I was shaking my head. Every one of them was a huge selection problem. It's easier for brokers, but it's a selection problem. The other person I talked to was an insurance agent who didn't really sell health that much, but was looking for insurance for her spouse. I asked her, "Why don't you get a plan from Florida?" She said, "Oh, I don't want one of those CHIPA plans." This is an insurance agent who didn't realize she could get guaranteed insurance through the normal market and thought the HIPC was the only way to get it. In fact the HIPC is advertising, if you're sick, can't get insurance, come see us. The CHIPA in Florida is advertised that way. And one other interesting angle that someone mentioned to me to think about is that agents have a responsibility to their client, and to some degree, if we're making mistakes, agents have an ethical responsibility to find them and get the best deal for their client. There isn't the risk there used to be, that if it doesn't work out, they can't get insurance somewhere else. There used to be a real argument that, yes, you can go with this low rate, but if you get sick, they're going to raise your rate, and you can't get insurance. That argument isn't there anymore. And so agents are almost ethically bound to find our mistakes.

Mr. Figueroa: I would just note that in California part of our reform law made it illegal for agents to steer risk on any product. If we have seen an agent with any kind of published material or find out about it verbally that they have tried to steer totally based on risk, we've gone after them through the Department of Insurance licensing mechanism. But as Jim mentioned, it's very hard to differentiate between what makes good business sense for the client, if it lowers the cost and risk issue because you do not have a medical experience factor that the outside market employs that we don't use.

Mr. Srite: I have one other thing that I think might be interesting to you in terms of loss-ratio types of information since we are real heavy into the small-group market. Back in the days of underwriting we looked at our costs by case size, and of course, we had some plan design features and underwriting features and tried to level that out. But even at that, our medical costs for a one-life group were approximately 10% higher than for a ten-life group.

What we have seen, and we have some reasonable experience on this now, in a guaranteed issue environment down to one life with a modified community rate (and that's very important if you have a rate band that changes dramatically), is that the rates for one-life group will be more like 50% higher than a ten-life group. And I can't believe that's going to help the market in the long run. I was on the bandwagon thinking that would work a couple of years ago. I really made a turnaround when I saw what our experience looked like.

Mr. O'Connor: One question I have is in terms of comparing the rates that are being charged for the alliance plans or the HIPC plans to similar plans outside the alliance, any feel for the different variations that you're seeing?

Mr. Srite: In Florida, my feeling is the HMO plans are generally similar. I don't think there's a lot of difference. When they first came out with the CHIPAs, a lot of plans were generally 5–10% below the outside market. We are in the process of withdrawing from most markets for PPOs with the Florida CHIPA. And at this point, our rates are something like 25% above our outside market rates. That may be more related to the size issue, since we're essentially issuing one-life groups, than it is any particular HIPC selection. I really think that's the big issue, that you're basically selling individuals guaranteed issue coverage.

Mr. Figueroa: In California, there's been a similar experience. On the HMO side, I think our rates are very competitive with those on the outside. For the PPOs, they are higher.

Mr. James E. Carter: Harvey, could Nationwide do the same thing without going through the alliance?

Mr. Sobel: Theoretically, yes. Theoretically, a vendor could come in and go out and do the contracting. However, what I think worked in the favor of this alliance is that there was a sponsorship by the provider community, in particular the hospitals. Some of the hospitals' chief executive officers sat on the board, so there was an easier time in terms of the contracting and getting favorable deals. In terms of the structure, we've set it up that HCAP basically holds a contract with the providers and allows Nationwide access to the deals. So contractually HCAP has the control. Theoretically, Nationwide could have come in and done their own contracting. But that's not the model we went with.