

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)

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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

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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 and rating rules, 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.”

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%

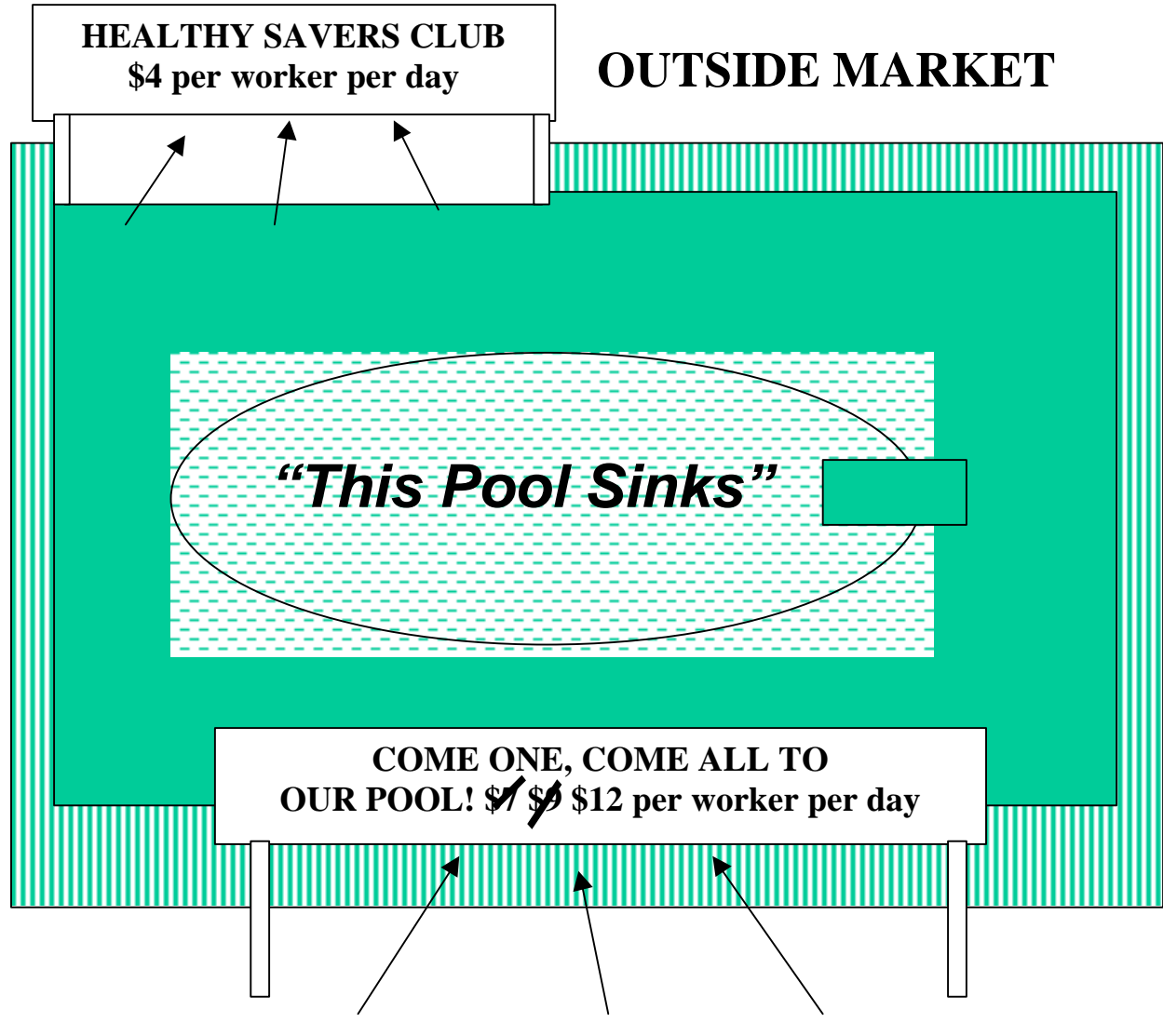
* Includes only HMO enrollees under age 65 with employment-based coverage.

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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 below in Figure 1, “sink.”

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



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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 PEHCCP (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.

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

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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 one of three undesirable options. One option would be to adopt the high road and utilize less stringent or no health underwriting (which some former, and no longer operational, pools have done in a similar market). 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.

A second option would be to let each participating carrier underwrite and rate each potential applicant. But this approach recreates the dynamics of the individual market and therefore its administrative costs and consumer information problems. (E.g., consumers can't compare prices unless they go through the separate underwriting processes of multiple carriers.)

The third 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 carrier's 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.

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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.

While many such employers might experience rate increases in the transition, those increases would be modest, compared to the reductions some high-cost employers would realize, and could be phased in to temper negative effects. It should also be noted that many employer groups that are currently low risk would benefit, because in the future their rates would not escalate because some employee(s) developed high-cost conditions. But rating rules may have limited effect if health plans and their distribution agents do not, when selling to a customer, affirmatively disclose all products available. If higher-risk groups cannot easily find out what plans are available to them, they may be persuaded to buy a plan that is less desirable and/or more expensive (thus allowing the health plans to “reserve” certain plans for low-risk groups). If only lower-risk groups are made aware of certain plans, only they will buy them.

To solve this problem, states such as California have required that health plans and/or their distribution agents make readily accessible information affirmatively disclosing all products that are available to small employers. If such disclosure includes premium prices (which can be prospectively known if based only on objective demographic factors and not on health underwriting), it will help avoid intentional risk selection through carriers’ pricing and marketing practices.

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 of tighter rating rules versus looser rating rules for the average small employer. (Findings differ, of course, for the unsubsidized individual market.) The reader may wish to refer to one thorough, recently published study that finds no effect on overall coverage rates or average costs in the small-employer group market and that includes a careful review of other previous 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. In this sense, such reforms are a necessary condition for a pool to serve “mainstream” small employers (i.e., those with mostly higher wage employees who would therefore not qualify for the lower premium contribution requirements discussed in the next section). 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

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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. Extending Coverage to the Uninsured and Making Coverage More Affordable for Small Employers

The PEHCCP has great promise as a cost-effective mechanism for reaching uninsured workers and their families if subsidy funds are made available through coordination with the state’s BadgerCare program. As envisioned here, the PEHCCP could be an adjunct of broader BadgerCare policy changes to encourage and build on employer coverage and contributions and to stem escalating BadgerCare enrollment and costs.

This approach, along with the basic thrust and functions of the PEHCCP, could also greatly enhance Wisconsin’s qualifications for a possible federally funded demonstration project opportunity. The Institute of Medicine’s health reform demonstration recommendations to U.S. Health and Human Services Secretary Tommy Thompson (in response to his request to identify possible demonstration projects) include state health insurance coverage demonstration goals and attributes that are consonant with those sought for the PEHCCP. Significant among those are a source of stable health insurance coverage which offers consumer choice of health plans informed by comparative data, and which affords working parents and their children coverage under the same plan

The PEHCCP would also carry out enrollment and related functions that could enhance the state’s ability to compete for one of these demonstration projects. Those functions would provide a foundation for the electronic enrollment clearinghouse for eligibility verification and insurance program enrollment that the IOM recommends as integral to these federally funded state demonstrations. Although it would not include all aspects of the envisioned clearinghouse, the PEHCCP would entail a range of applicable administrative functions and would maintain applicable electronic and data sharing linkages. For instance, the PEHCCP would conduct eligibility determinations; maintain enrollment databases; bill, disburse, and reconcile funds; provide quality and other related information to inform the choices of individual workers; and share different degrees of electronic eligibility and payment data with health plans, employers, agents, employees, and governmental agencies. These functions are largely parallel to those described for clearinghouses in the IOM recommendations.

Of course, the principal purpose of the demonstration would be coverage of the uninsured. The approaches recommended below would help stretch available state funds toward that end. Specific measures to parlay financing sources for coverage of the uninsured, and to reduce health insurance costs for small employers follow.

1. 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

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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.)

Such “premium assistance” subsidies for populations otherwise income-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, which is the backbone of Wisconsin’s relatively high coverage rate for working families. This policy direction was well-advised, given recent research findings (based on demonstrations in other states) that half of the public-program enrollment of adults between 100% and 200% of poverty represented “crowd-out” of employment-based coverage rather than expansion of coverage to the uninsured.³

Unfortunately, in actual operation, this intent has not been realized. The availability of BadgerCare to low-income working families at very low cost creates strong incentives for employers with a number of such workers to stop contributing toward health benefits entirely and encourages low-income working parents to enroll in BadgerCare rather than make the contributions required to enroll in their employer’s plan. Although BadgerCare theoretically requires workers with access to employer coverage to enroll in it (with state assistance if the employer pays less than 80% of the premium), in practice avoiding this requirement is quite easy. Information about employer coverage is requested for all employed BadgerCare applicants, but there are no consequences for non-response, so the information simply is not obtained for almost half of 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.)

A revised policy context would invert the current paradigm to return to the program’s original intent and to send clearly the message that employment-based coverage is expected to be the primary source of health coverage for full-time workers, even for those who are low income. Significant changes in BadgerCare’s eligibility and recipient contribution policies and in its application and eligibility determination procedures would be necessary to make this paradigm shift. A reformed BadgerCare program would emphasize providing premium assistance to enable low-income workers to enroll in their employer’s plan, and to make affordable coverage available through low-wage small firms, rather than providing coverage outside the employment

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context. (Under this approach, the public program would remain readily available for families headed by non-workers or part-time and temporary workers who are not normally eligible for employer coverage.)

The pool would play a key role in this reformed approach to public subsidies for health coverage of low-income working families. 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 myriad individual small employers and associated health benefit plans could make it much easier to meet otherwise burdensome federal and state requirements regarding premium assistance (e.g., verification of enrollment and use of funds, reviewing and approving benefit structures, etc.). For example, the pool could:

- Specify benefit packages its health plans are to offer that include options that meet the state's policy goals (and any applicable federal requirements) for the low-income working population with respect to covered services and cost-sharing levels;
- Collect data about employer contribution amounts at initial enrollment and track changes in those amounts over time through re-enrollment forms;
- Combine premium payments from multiple sources (employer, worker, state subsidy) and route them to the health plan chosen by the enrollee; and
- Verify that subsidized families have in fact enrolled and remain enrolled in a plan.
- In addition, the process of evaluating cost-effectiveness would be much simpler because there would be only one (or a few) benefit package designs to be evaluated, and employer contribution information would be readily available in one centralized location.

These capabilities of the pool would make it much easier for the state to provide premium assistance to enable low-income workers who would otherwise decline their small employer's offer of coverage (presumably because of the cost to them) to enroll in that coverage. As a practical matter, only about one-third of workers who declined their employer's offer of coverage work for small firms,⁴ and many of these workers obtained coverage through a spouse's employer. But the state might want to give large employers the option of using and contributing toward pool coverage as an easy way for them to allow their low-income "decliners" to access premium assistance.

Perhaps more importantly, 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 those with mostly low-wage workforces to make a smaller employer contribution than would usually be required. Experience from several local pilot programs in Michigan and California indicates that many small employers with mostly low-wage workers will participate in offering health insurance if they feel the amount they must contribute is affordable and predictable and will remain so over time; if their contribution reduces the costs their workers face; if their workers can afford what they are asked to contribute; and if the coverage source is reliable and sustainable and minimizes the employer's administrative burden.⁵

Because most Wisconsin workers whose employers do not offer health insurance at all are employed by firms with mostly low-wage workforces and fewer than 50 workers—between

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120,000 and 140,000 workers out of 235,000 whose employer does not offer coverage at all⁶—this could be a very cost-effective and well-targeted 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, as discussed above, the pool would be hard-pressed to avoid adverse selection with respect to mainstream employers, at minimum.

2. More Affordable Health Insurance Packages

Finding a means to control health care costs for private employers is a paramount rationale for the development of the PEHCCP. Requirements that health insurance policies cover specified health services or services provided by certain non-physician providers’ services are a source of intense debate regarding their value relative to their cost. Proponents, who often include the provider groups included by such mandates, insist that such requirements ensure that policyholders have access to specific providers or receive coverage for certain conditions that insurers might otherwise preclude or withhold. It is also noted that some such requirements, particularly preventive services, provide equal access to necessary services and may pay for themselves over time. Employer representatives point out that such requirements result from political pressure, increase the cost of insurance, and create administrative burdens for insurers and costs for small employers that large, self-insured employers can avoid.

Small employer representatives in Wisconsin have indicated that more affordable coverage could in part be achieved if the PEHCCP, like a large employer, could design and offer benefit packages that do not include all the state’s treatment and provider mandates. To the extent that this is true, such affordable benefit packages could enhance health plan and employer interest and participation in the pool, thus helping to create the critical mass important to achieving broader objectives of the PEHCCP. (It should be noted that at this point it is unclear how significant the costs associated with such mandates are. One example given is that the Office of the Commissioner of Insurance estimated that, in 2001, the cost of the state’s mandated mental health and other drug abuse services was about 3 percent of premium.)

In addition, the PEHCCP would be an appropriate forum for designing benefit packages that are not in full compliance with all state mandates. Because the PEHCCP would be highly visible, and its board consists of well-respected individuals, state policy makers could be comfortable that the board would make sensible and responsible decisions regarding mandates to retain and

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others to exclude. For instance, the PEHCCP would undoubtedly choose to retain priority and preventive services such as immunizations and maternity coverage.

C. The Pool IS the Small Employer Health Insurance Market

Some, including some health plan executives, 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 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 some 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.

A specific set of approaches that can achieve current policy goals in Wisconsin follow.

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- One important condition for the PEHCCP to serve “mainstream” small employers who do not have many low-wage workers eligible for subsidies will be modified community rating rules for Wisconsin’s small employer market. Such rules do not permit the use of health status or claims experience in establishing small employer premium rates. Without such rating rules, the PEHCCP could not successfully serve this population. If it attempted to do so, it would experience high risk of adverse selection from the market. Similarly, rules should require each carrier to provide information and referral to readily accessible data giving full disclosure of all its products and associated prices for the small employer market. This will help prevent the PEHCCP from suffering from intentional risk selective marketing practices.

To minimize disruptions within the market, it would be sensible to phase in these rating policies for currently insured and low-risk small employers, but it would be important to have reforms largely in effect at the point the PEHCCP began offering coverage to mainstream employers.

- To both (a) offer affordable coverage to uninsured small firms with a majority of low-wage (e.g., \$10 per hour or less) workers and (b) expedite premium assistance for uninsured, low-income workers in firms offering coverage, the PEHCCP should be structured to coordinate BadgerCare subsidy funds. This would extend employment-based coverage to working families consonant with Wisconsin policy objectives. It could also encourage uninsured small employers with low-wage workers to initiate coverage and thus would build toward coverage of Wisconsin’s uninsured.
 - To better meet state budget constraints, this initiative could be an adjunct of a paradigm shift in BadgerCare eligibility, premium contribution, and premium assistance policies. BadgerCare policy changes would be designed to encourage and coordinate with employer contributions and coverage, rather than encourage shifts to BadgerCare. This would help the state avoid continued escalation in BadgerCare enrollment costs.
 - Furthermore, the pool and associated structures would develop a platform that would put Wisconsin in a better position to qualify for potential federally funded demonstration projects to cover the uninsured as recommended by the Institute of Medicine to U.S. HHS Secretary Thompson.
- The ability of the PEHCCP to attract the interest and participation of health plans and small employers—and thus build critical mass—would be enhanced if the program were permitted to offer benefit plans that are not in full compliance with the state’s provider and treatment mandates. Given the pool’s visibility and high degree of public accountability, policy makers could be assured that the pool would make sensible and responsible decisions about the benefits offered.

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³ A study of four state expansions that included low-income adults found that, among adults between 100 and 200 percent of poverty, approximately 55 percent of the increase in public program enrollment resulted from a reduction in the number of uninsured, while 45 percent was associated with a decline in private insurance coverage. Richard Kronick and Todd Gilmer, “Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?” *Health Affairs* 21:1 (January/February 2002), pp. 225-239.

⁴ Institute for Health Policy Solutions analysis based on data for Wisconsin from the U.S. Agency for Healthcare Research and Quality, *Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics* (1996-2000), Rockville, MD: September 2002 (http://www.meps.ahrq.gov/data_pub/ic_tables.htm).

⁵ One such local pilot program is the FOCUS (Financially Obtainable Coverage for Uninsured San Diegans) program, run by Sharp Health Plan. It offered heavily subsidized coverage to about 2,000 workers and dependents through previously uninsured small employers in San Diego County. See the presentation by Kathlyn Mead, CEO of Sharp Health Plan, in Institute for Health Policy Solutions, *Effective Coverage Expansions for Uninsured Kids and Their Working Parents: Links to Job-Based Coverage*, transcript of a policy conference on coordinating with employment-based health coverage to cover uninsured working families held in Washington, DC: May 18, 2001. (Available at www.ihps.org.) Additional information is available at Sharp Health Plan’s website: <http://www.sharp.com/HealthPlan/>. Also, two local projects in Michigan—Access Health in Muskegon County and HealthChoice in Wayne County—have also had success in covering workers in previously uninsured small businesses with mostly low-wage workers by asking employers and workers each to pay about one-third (or a little less) of the cost of coverage through a network of local providers. Information about the Access Health program is available from the Project’s website, <http://www.mchp.org/html/pahealth1.html>. Limited information about Wayne County’s HealthChoice program (22,000) is contained in the 2000 Annual Report of the Wayne County Department of Public Health, available at <http://www.waynecounty.com/hcs/phealth/annual.htm>.

⁶ Institute for Health Policy Solutions analysis based on data for Wisconsin from the U.S. Agency for Healthcare Research and Quality, *Employer-Sponsored Health Insurance Data. Private-Sector Data by Firm Size, Industry Group, Ownership, Age of Firm, and Other Characteristics* (2000), Rockville, MD: September 2002 (http://www.meps.ahrq.gov/data_pub/ic_tables.htm).