What Health Insurance Exchanges or Choice Pools Can and Can't Do About Risks and Costs*

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Introduction

Policymakers are often attracted to purchasing pools or exchanges as a way to make health insurance less expensive for individuals and small employers. A common assumption is that they could aggregate a large number of small purchasers and thus realize administrative economies of scale and negotiate favorable rates with health plans. For small-firm workers, an exchange or choice pool could also offer something not normally available in the small-employer market—choice of competing health plans. For individual purchasers, who already can choose among health plans, pools could help to simplify comparison shopping.

Unfortunately, establishing a purchasing pool or exchange does not automatically produce the same "market clout" as a large employer. RAND studied the three largest small-group health insurance worker choice pools begun in the mid-1990s and found that they did not reduce small-group market health insurance premiums, nor did they raise small-business health insurance offer rates.[1] Other kinds of voluntary "pools" are more prevalent, but they generally have not functioned as assertive purchasers and have not reduced costs. In 1997, one out of three small employers reported they participated in some type of (voluntary) pool, such as an association plan arrangement, business coalition or other multiple employer arrangement. But their costs and coverage rates were no different than comparable employers who purchased coverage directly.[2] For example, the Health Insurance Plan of California (the HIPC, later operated by the Pacific Business Group on Health as "PacAdvantage"), which offered individual workers choice of competing health plans, negotiated and offered lower rates than had been available in the outside market at its inception in the early 1990s. Yet by 1998, analysts found no evidence that its rates were still lower than the outside market. Rather, the data suggested they were slightly higher.[3] This was perhaps inevitable given that group health insurers offered health rating discounts to lower risk groups while the HIPC did not. Due to declines in enrollment and the risk profile of the original PacAdvantage pool, PBGH/PacAdvantage established a separate new small-employer pool, "Paired Choice," and adopted (limited) health rating. The goal was to gain new enrollment of a normal risk-profile population.[4] However, that attempt ultimately was not adequate to overcome the adverse-risk death spiral of its existing enrollment, and PacAdvantage ceased all operations in December 2006.[5]

This issue brief begins by explaining why pools are not the same as large employer groups and then goes on to explore the risks any voluntary purchasing pool faces and the conditions necessary for a pool to overcome those obstacles and succeed.

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Anatomy of a Pool

Many policymakers would like to give little purchasers—individuals and small employers—the same market advantages that large employers have. But merely establishing a pool or exchange does not automatically make it a big purchaser. Understanding why requires exploring the two key differences between a large employer and a pool composed of small employers or individuals: the stability of the group, and its expected risk profile.

Group Stability

As known as cohesion, group stability is what keeps a group together and forces a health plan to negotiate with the group as a whole, rather than offer separate deals to selected members (or potential members) of the group. A group has cohesion if its members have strong incentives to remain part of the group. With respect to employer-sponsored health plans, group stability and cohesion result from the fact that the employer's contribution is generally not available unless a worker participates in that employer's plan. Buying coverage elsewhere means foregoing a significant benefit and, most likely, paying a considerably higher price.

Similarly, when government programs, like state S-CHIP programs or Commonwealth Care in Massachusetts, offer coverage by contracting with health plans, they present a large group that the health plans have no other way to reach, because recipients cannot use their large public subsidy to buy coverage elsewhere.

Choice pool/exchange participation, on the other hand, has usually been voluntary. That is, individuals and small employers have the option of purchasing coverage either through the pool or directly from a health plan. Further, they can change their decision at any time. Obviously, they are likely to buy where they can get the best value.

To maintain stability and cohesion in this voluntary environment, and in the absence of other incentives, a pool would ideally be able to offer its members a lower price than the outside market.[6] If it cannot do so, and if lower risk groups and individuals can obtain a better deal in the outside market, they will do so.[7] The pool will be left with a higher-risk population than the outside market and, therefore, will be more expensive than the outside market, if it is able to operate at all. (This phenomenon is discussed in detail later in this brief.)

Even very large group purchasers cannot ignore the outside market if they allow any of their members to buy coverage there. For example, CalPERS (California's state employee plan) is the only choice for state employees but is available on an optional basis to local government entities. Until a few years ago, it offered the same premium prices in both northern and southern California localities, despite the fact that premiums in the outside market had risen less in the south. As a result, CalPERS was losing participation among the state's southern localities and was eventually forced to establish separate premium rates for the two regions.

Proponents generally assume that pools will be able to negotiate more favorable prices from health plans than are otherwise available, and that these lower prices will allow pools to attract and retain members. But there is a chicken-and-egg problem here. A pool cannot use market clout to negotiate lower prices from health plans unless it is large and cohesive, and no pool can

become large unless there is some compelling reason for people to obtain and retain health insurance through the pool rather than purchase it directly from health plans.

Further, most established health plans are unlikely to cooperate in helping a pool to become large. Why should they want to create a larger purchaser with more bargaining clout out of smaller, weaker employer groups or individuals? In general, health plans can better control their own enrollment and are in a better position to realize higher profits by dealing directly with small employers or individuals, particularly if the plan is already well established in those markets.

As a result of all these factors, voluntary pools/exchanges do not inherently or automatically result in the creation of strong, cohesive large groups.

Risk Profile

A group's risk profile is another factor affecting its ability to offer favorable health insurance prices. The risk profile is important because a large share of health care costs are generated by a relatively small number of people. As shown in Exhibit 1, only 5 percent of the population accounts for about half of total health care costs in any given year. And the 50 percent of the population that is most healthy accounts for a tiny portion of total costs.

Exhibit 1: Distribution of Health Care Expenditures Ranked by Total Payments for Health Services

Percentile	Total Population, 2002	Privately Insured and Younger than 65, 2002
Top 5 percent	49 percent	49 percent
Bottom 50 percent	3 percent	n/a

Source: William W. Yu and Trena M. Ezzati-Rice. *Concentration of Health Care Expenditures in the U.S. Civilian Noninstitutionalized Population.* Statistical Brief #81. May 2005. Agency for Healthcare Research and Quality, Rockville, MD. (http://www.meps.ahrq.gov/papers/st81/stat81.pdf)

Because health care spending is so skewed, the average health insurance cost for a group depends more on who joins the group than on any other factor. As a result, health plans generally do not view groups that are formed for the purpose of purchasing health insurance as attractive customers. Absent other incentives, such groups are more likely to attract people who know that they need health care or who face higher prices elsewhere. They are also likely to have higher average costs than a group drawn randomly from the population.

Health plans offer better rates to "natural groups"—those that are constituted for purposes other than health insurance. If people's reasons for joining a group have nothing to do with health insurance or their perceived need for health care, and if the group is large enough, then health plans can be relatively confident that it will include a substantial share of low-risk individuals to balance out the expected costs of high-risk members.

A single large employer is a natural group and constitutes an attractive pool of people for a health plan to insure because employees are by definition healthy enough to work and because the employer's contribution is generally large enough to motivate almost all employees to participate in the health plan, even if they are in perfect health.[8]

By contrast, individuals are not groups at all, and any given small employer is much more likely than a large employer to have a disproportionate share of low or high risks. Further, their reasons for seeking health coverage may have something to do with their expected health care costs.

More importantly, any aggregation of small employers or individuals, each of whom have choices about where, how, and whether they obtain health insurance, is not a natural group if it was formed for the purpose of purchasing health insurance and does not offer other inherent advantages to its members.

Challenges Purchasing Pools Face

Market Rules and Risk Selection

The market environment within which an exchange or pool operates helps to define the challenges it faces. Where a state's insurance market rules allow health plans to deny individuals coverage, as most states do, or individuals or small groups to be charged more due to health status, as most states allow (though only to a limited extent for small employers),[9,10] policymakers have been tempted to establish purchasing pools that are required to accept all applicants and not consider health status or claims experience in setting premium rates.

But requiring an exchange or pool to accept some applicants on more preferential terms than health plans in the rest of the market puts the exchange/pool at an inherent disadvantage. For example, if the exchange and only the exchange is required to charge the same rates to all participants, regardless of their risk profile, then the exchange will inevitably be what is sometimes referred to as a "risk magnet." Those who are healthy and can obtain a lower price for comparable coverage elsewhere will do so, as illustrated in Exhibit 2. Those who present higher risks and would be charged more elsewhere will come to (and often be aggressively referred to) the exchange. This phenomenon is referred to as adverse selection. As a result, the exchange's costs will be higher, not lower, than those in the open market; and the exchange will enter a classic death spiral[11] and eventually fail—if it is able to begin operation at all. Due to this and similar well-intentioned, but unrealistic, policy constructs, this dynamic has played out many times in a number of states.[12,13]

The bottom line is that no exchange or pool can succeed unless it lives by the same rules as the outside market or unless the pool/exchange, like a large employer, is endowed with compensating characteristics.

Underwriting and Exchanges or Choice Pools

Underwriting is the process of deciding what premium rate to charge an applicant (and, in the case of individuals only, whether to accept the applicant for coverage at all). In states where health plans can now use health status as part of their underwriting, one way to level the playing field between pools and the outside market would be to eliminate use of health status underwriting both in the pool and in the outside market. Another, discussed later in this brief, would be to make subsidies available to the pool or to its members. A third would be to allow pools to underwrite to the same extent as health plans in the outside market. This last approach would not meet a policy goal of lowering the differential prices that high-risk groups must pay for coverage, but it could make the pool viable.

Where a pool contracts with a single health plan, allowing the pool to use health underwriting could be workable—the contracting health plan would simply apply its own health-underwriting methodology. Where a pool offers its members a choice among competing health plans, however, the situation becomes more complex. A choice pool or exchange that competes with health plans that can underwrite or selectively market has three dubious choices:

- *Do not underwrite at all*. Absent other compensating advantages (such as outside subsidies), a pool that does not underwrite at all will suffer severe adverse selection as outlined above. Such a pool may not even be able to begin offering coverage in the first place, because health plans will recognize what is going to happen and simply refuse to contract with the pool.

- *Self-underwrite*. Alternatively, a pool could carry out underwriting itself. Because health plans would be unwilling to share their best underwriting insights with their competitors, this underwriting process would inevitably be a sort of compromise (or lowest common denominator) approach among the several contracting health plans. Though better than nothing, such a do-it-yourself solution would likely not be good enough to compete with outside-market competitors who are more adroit and aggressive at risk selection. Adverse selection leading to a death spiral would remain the likely outcome, though perhaps at a slower pace than if the pool did not underwrite at all.

- *Let each participating health plan underwrite each individual applicant*. Under this approach, the pool would allow each participating health plan to underwrite each individual applicant. This would mean that pool members would not know up front the premium prices they would be charged by each of the participating health plans. Instead, they would have to provide personal health information in order to receive a premium quote from each plan they were interested in. Thus, consumers could not readily compare prices among competing health plans, defeating one of the basic purposes of choice pools. In effect, this approach would recreate the dynamics of the individual market, including its administrative costs and consumer information problems, with the added costs of pool administration.

Previous examples of worker-choice pools (for small employers) that failed in environments in which health plans serving the outside market were allowed to vary rates based on health underwriting include:

- The Texas Insurance Purchasing Alliance, a private non-profit authorized by the state in 1993 that operated until July 1999;
- Caroliance, which was essentially run by the State of North Carolina with local business association sponsors and enrollment and which operated from 1995 to September 2001;[14] and
- A pool in the Chicago, Illinois area launched by the Illinois Manufacturers' Association in late 1998 that operated for only a short time.[15]

A small-employer worker-choice pool has done very well over time in Connecticut, which does not allow health rating in that market. The Health Connections program offered by the Connecticut Business and Industry Association has the highest small-employer-market penetration percentage (over 10 percent) of any worker-choice pool.[16] By contrast, California's small-group market rules allow +/- 10 percent rating flexibility for health status, which means that plans can change more than 20% more for high-risk groups than for other employer groups.[17] Despite significant last-ditch efforts to adjust its policies, including (a simplified version of) health rating, PacAdvantage closed at the end of 2006, largely due to the high cost profile of its enrollees from previous years.[18]

Health Plan Participation and Perspectives

Where health insurance pools or exchanges are an optional coverage venue, and there are no incentives or requirements for their use, exchanges that are expected to offer licensed health insurance plans need those plans more than the health plans need the exchange. Without health plans, pools/exchanges have no coverage to offer. Without pools/exchanges, most health plans serving the individual or small-group markets already know how to reach their target customers. (An exception would be new health plans or plans trying to serve these markets for the first time, such as provider-system-based plans, that do not have established marketing arrangements.)

When a number of purchasing pools were established in the early 1990s, some (such as the Health Insurance Plan of California, later PacAdvantage) had little trouble attracting health plan participation. Some health plans saw such pools as having the potential to bring large-employer attributes to small employers. More generally, reform was in the air, purchasing pools looked like they might be the wave of the future, and health plans did not want to be left out or appear to be against even relatively market-oriented reforms. And some wanted to demonstrate that an optional small-employer pool would work in lieu of proposals for mandatory alliances or a single-payer system. After health reform died, however, basic business considerations once again became primary for health plans.

Most health plans strongly prefer direct contracts with whole employer groups over enrollment through such purchasing pools. Their reasons include:

- *Maintaining their business role*. Many plans do not want to cede—to pools or to anyone else—administrative functions such as premium collection and enrollment. Partly, they are concerned about accuracy and losing control where they are potentially liable. But they are also concerned about losing revenues and functions that are a key component of their resource base and their value-added role as a business. Also, health plans want to retain control of any aspect of the insurance relationship that directly affects their finances, particularly rating and underwriting. When plans do participate in optional smaller pools, these business motives lead them to maintain all or most of these functions. As a result, pool administration becomes duplicative rather than cheaper.

  Moreover, from a strategic standpoint, some large health plans would like to be viewed as offering choice themselves and do not want to cede this role to purchasing pools.

- *Resistance to being "commoditized."* Health plans generally do not like competing head-to-head on price for the same benefit package—a kind of competition some large employers and purchasing pools seek to foster. Instead, plans prefer to focus customers' attention on what they hope are unique and attractive aspects of their own benefit package.

- *Fear of adverse selection* where the pool, rather than the plan, controls marketing, eligibility, rating, enrollment, etc. This is a particular concern where the pool allows worker choice among multiple plans. Outside such a pool, the health plan knows that it will enroll all (or most) members of a given group, the healthy along with the less healthy, so that it can spread high-cost claims over lower-cost members of a group. In a worker-choice pool, the plan is much less certain about the risk distribution of the individuals who will actually choose that plan. Plans also fear that, overall, purchasing pools will attract less healthy groups that can't get coverage elsewhere—at least not as easily.

For these reasons, health plans are reluctant to participate in a pool or exchange that largely competes against plans' own direct contracting with small employers or individuals. If they agree to participate, they likely will not offer lower prices to the pool/exchange than they charge for their outside business. Further, the general point made earlier is worth repeating: *Most established health plans are unlikely to cooperate in helping a pool that competes for their direct enrollment. They generally have no desire to create a larger purchaser with more bargaining clout out of smaller, weaker employer groups or individuals.*

To attract health plan participation, and to be in a position to negotiate with them, a pool or exchange has to be able to offer health plans a large, attractive and cohesive population—that is, a population with a relatively normal risk profile that the plans cannot access in any other way. The following sections explore when and how pools/exchanges could (or could not) attain the necessary market clout to succeed.

The Practical Role for Pools/Exchanges

Policymakers may want health insurance pools or exchanges to play a number of roles. They may be looked to as a vehicle to reach currently uninsured people; reduce premiums for current purchasers of insurance; offer a choice of health plans to workers in small businesses; make comparison shopping for coverage easier for individual purchasers; or some combination of these goals.

Even in a context of mandatory coverage, a pool that is an optional coverage alternative and has no inherent "glue" faces the same fundamental problems: an inability to offer health plans a large and cohesive population and the threat of unsustainable adverse selection. SB2, California's Health Insurance Act of 2003, would have required medium and large employers to either pay the state a fee or "play" by providing coverage directly. It would have created a purchasing pool as an access mechanism for workers and dependents of employers that chose to pay the required fee. However, analysis showed that the SB2 pool could not have survived on its fees alone unless those fees were based on the health status of each employer group's workers—an approach which seemed impractical in a pay-or-play environment.[19] Otherwise, additional funds would have been required.

State high-risk pools make coverage available to high-risk individuals who cannot obtain coverage in the individual market, *to the extent that* outside subsidies are made available to cover most of the excess costs.

The PacAdvantage small-employer choice-pool experience showed that, over time, such an exchange or pool is unlikely to survive where health rating is allowed in the outside market.

As this brief suggests, it seems highly unlikely that optional pools or exchanges, by themselves, can do much to reduce health insurance premiums. Some form of cohesion that makes the exchange or pool a viable group would be needed to give it sufficient bargaining power vis-à-vis health plans.

That cohesion could come in the form of public subsidies that are only available through the purchasing pool. The subsidy would serve as the glue that keeps the pool together. Just as large employer groups and public employee programs work because their employer contributions cannot be used to buy insurance elsewhere, a choice pool or exchange can work if a significant public subsidy is available only through the pool. The subsidy creates a sizable new group that health plans cannot reach in any other way, making the pool an attractive competitive opportunity for health plans.

The Massachusetts Connector's "Commonwealth Care" program for people under 300% of poverty has demonstrated how successfully this subsidy approach can be applied where there is no health rating (and an individual mandate). (This approach was also envisioned in California's 2007 reform legislation.[20]) It is also worth observing that the Massachusetts Connector's "Commonwealth Choice" exchange for higher income individuals and unsubsidized small employers—which does not offer subsidies or lower-than-market prices)—has thus far realized only very modest enrollment.

Few if any policymakers would support spending significant public funds solely to make exchanges viable health insurance venues. But, where the policy goal is to cover uninsured low-income populations, and policymakers are willing to fund subsidies for this purpose, exchanges could serve as an efficient and effective coverage vehicle.

Detailed consideration of how such subsidies might be structured is beyond the scope of this brief. The focus here is on the alternative roles pools or exchanges could be asked to play, assuming they have sufficient cohesion. The most important considerations include the extent of their purchasing role, including their ability to contract selectively, and whether the pool/exchange offers its members a choice among competing health plans. Related factors include what rating rules and limitations apply, how large the pool/exchange is, and how many are permitted to serve each geographic area. These design dimensions interact and affect each other.

Extent of purchasing role

The argument that an exchange or pool has greater purchasing power than individuals or small employers, and thus should be able to obtain more affordable health coverage than their members could attain on their own, presumes that the pool will act as an *active purchaser*, by negotiating the best possible value for its members. (As discussed earlier, a pool can feasibly play this role only if it has strong cohesion.)

But that is just one end of a continuum of possible purchasing roles for pools/exchanges. At the other end is the neutral "*clearinghouse*," which simply makes available information on participating health plans' rates and benefits and does not negotiate with health plans in any way. (For examples, Florida's failed Community Health Purchasing Alliances were set up in this way.) A *clearinghouse* simply aims to make it easy for individuals or small-firm workers to obtain information about the coverage choices available to them and to select and enroll in their preferred plan. Aside from some possible administrative economies from centralized electronic enrollment and premium collection, any savings under this approach will derive from more price competition among health plans resulting from better consumer information.

In the middle of the purchasing-role continuum are pools that act to establish a marketplace structure for the benefit of their members, without actually negotiating premium rates. They might be called "*market organizers*." Many variations are possible, but one example would be a pool that specified several benefit packages it wished to offer its members and solicited prices from health plans for those packages. The pool would not negotiate with health plans, but simply post each participating plan's premium price for each package. However, the pool would establish other guidelines that health plans would have to comply with in order to be offered through the pool. Such guidelines might, for example, limit health plans' marketing approaches to pool members or give the pool approval authority over health plans' marketing materials. Both *market organizer* and *active purchaser* pools might also operate a risk-adjustment mechanism for participating health plans, as PacAdvantage does.[21]

Selective contracting

To be an *active purchaser*, a pool must have the authority to contract selectively—to refuse to contract with any particular health plan and cancel or terminate health plan contracts. The goal

of a *clearinghouse*, on the other hand, is to make it easy for individuals to choose among all the health plans available, so it does not need or want the ability to exclude health plans based on price. *Market organizers* are in between. They clearly need the authority to exclude health plans that refuse to meet their terms, but they may or may not need the ability to exclude health plans on the basis of price.

Most states that have previously authorized purchasing pools have given them the authority to contract selectively. But states with tight rating rules often do not permit health plans to charge pools different prices than they charge in the regular small-group or individual market (as in New York and Connecticut). Colorado allowed price differentials for pools only to the extent they could be justified on the basis of differential administrative costs, which had to be documented by health plans. (Not surprisingly, this requirement resulted in health plans arguing for higher rather than lower rates for the pool.)

Small-employer purchasing pools in California, such as PacAdvantage, were authorized to contract selectively. Because they could offer benefit designs that were not available to small employers outside the pool, they could also negotiate prices.[22] California Choice, the other entity offering a choice of carriers to small employers in California, does not operate under and is not subject to the purchasing alliance statute. Instead, it has special approval from the Department of Managed Health Care to act as a solicitor and third-party administrator with respect to a multiple carrier or health care service plan marketing cooperative in which each carrier or health care service plan contracts directly with subscribing groups or individuals.[23]

Choice of competing health plans

The primary goal of a *clearinghouse* is to provide choice among competing health plans. Without choice, it has no reason to exist. *Active purchasers*, on the other hand, need to limit their number of contracted health plans in order to negotiate affordable prices. Some may prefer to select just one health plan in order to get the best possible price. Informed choice, competition based on consumer choice, and consumer protection are the primary focuses for *market organizers*. Thus, they most likely will prefer to offer their members at least a limited menu of options from which to choose.

Rating rules and limitations

In order to permit pools/exchanges to negotiate rates with health plans, health plans serving pools would have to be exempt from any state law that would prevent a licensed health insurer from offering a pool a different rate than it offers in the direct market. Within the exchange, health plans could not use rating factors that are disallowed in the regular (non-pool) insurance market and, with respect to allowable factors, could not vary premiums by more than is permitted in the outside market. However, exchanges would be free to establish more restrictive rules internal governing premium variation, if desired.

For example, in a state that permitted health rating, an exchange that was the exclusive venue for substantial public subsidies (and thereby had a source of cohesion) might decide not to use health rating for that population. Doing so could greatly simplify administration, make it easier for members to compare health plan prices (i.e., prices could be readily published and compared),

and make coverage more affordable for members with existing health conditions. A pool offering worker choice of competing plans could use a risk-adjustment mechanism to compensate plans that enrolled more expensive populations, as PacAdvantage did.[24]

Number of Pools

In terms of administrative costs, a single, exclusive exchange (nationally or in each state) would likely be the most efficient solution. But the narrower the choice of health plans the exchange offers, the harder it is not to allow an outside market or competing exchanges. Assuming the exchange is the exclusive venue for subsidies, health plans will argue they have been denied access to subsidy recipients unreasonably, and the subsidy recipients themselves may feel their choices have been unnecessarily restricted.

The administrative-cost argument for a single pool is easier to sustain when the pool is a *clearinghouse* that offers access to all, or most, of the health plans serving the geographic area that meet qualifying conditions.

Other Key Factors for Success

The selection and cohesion issues discussed above are essential and interrelated factors that affect any exchange's chances for success. If there is a strong source of cohesion for the pool, such as a subsidy for low-income participation, selection concerns are greatly reduced, at least for the subsidized population. But selection problems and issues will emerge when employees can choose among competing plans or benefit levels. Therefore, it is vitally important that any exchange have the latitude to develop and modify at least some pertinent program rules.

It is equally essential that the exchange be able to use the same factors in establishing premium rates for any unsubsidized participants as health plans in the outside market. That is, there needs to be a level playing field with respect to rating of unsubsidized people, both inside and outside the exchange.

Though issues affecting selection and cohesion are the most crucial, other factors are also important in determining a pool's chances for successful operation. These include a sensible and workable target population; the credibility of the pool's sponsoring organization to its target population;[25] both the reality and the appearance of stability; and competent, responsive operations, without which no program will survive for very long.

Conclusion

Health insurance choice pools or exchanges can be useful as venues to help achieve coverage and cost goals. Yet merely establishing or designating them holds no hope for reducing the number of uninsured or the costs of coverage available to individuals or small employers. If the goal is for the exchange to achieve economies of scale and/or to negotiate or select plans for better value, it will need the "glue" or cohesion to attract and retain a large enrollment base.

Such goals can be achieved if the pool represents a large natural group that health plans can effectively reach only through the pool, making it similar to a very large employer. One way to

create such a group would be to channel subsidies for low-income workers and families, or low-wage employer groups, exclusively into coverage through the pool. In turn, a stable exchange can, if desired, efficiently perform a number of administrative roles that meet the needs of both its participants and the state.

Endnotes

[1] Stephen H. Long and M. Susan Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20:1 (January/February 2001), pp. 154-163.

[2] Stephen H. Long and M. Susan Marquis, "Pooled Purchasing: Who Are The Players?" *Health Affairs* 18:4 (July/August 1999), pp. 105-111. (Exhibit 1)

[3] Jill Mathews Yegian, Thomas C. Buchmueller, Mark D. Smith, and Ann F. Monroe, "The Health Insurance Plan Of California: The First Five Years," *Health Affairs* 19:5 (September/October 2000), pp. 158-165.

[4] Personal communications with PacAdvantage managers.

[5] PacAdvantage press release, August 11, 2006.

[6] A pool that offers other desirable features, such as worker choice of competing health plans and good customer service, should be able to maintain stability and cohesion even if its prices are only comparable to (rather than lower than) prices in the outside market. The Health Connections program offered by the Connecticut Business and Industry Association is one example. But, if its prices are higher than the outside market, such a pool will suffer adverse selection as described here.

[7] Most States allow health plans to consider health status in setting premium rates for individual purchasers; and many, including California, allow health plans to do so in the small-group market, although the extent of variation may be restricted (as it is in California). Where such "health rating" is allowed, healthy people and healthy groups are offered lower rates.

[8] Particularly for smaller employers, health plans can and do protect themselves by requiring that a specified percentage of an employer's workers (who are not covered elsewhere, such as through a spouse's employer) must participate in the plan. If that participation percentage is not reached, a group plan will not be issued.

[9] For example, California allows health plans to deny coverage to an individual based on the applicant's health status unless the applicant has recent qualifying group coverage. California also does not limit how much a health plan can vary premiums for such individuals based on health status. California HealthCare Foundation, *Insurance Markets: Rules Governing California's Individual Insurance Market*. Revised April 2005. (http://www.chcf.org/topics/view.cfm?itemID=20739)

[10] Under both federal and state law, small-employer groups cannot be denied coverage due to health status, but the premiums they are charged can vary. For example, California limits premium variation for small employers to at most 10 percent above or below a health plan's "standard employee risk rate," which can be based only on age, family size and geographic location. Other rating factors can be used but cannot result in a premium that is more than 10 percent above or below the standard rate. California HealthCare Foundation, *Insurance Markets: Rules Governing California's Small Group Health Insurance Market*. June 2003. (http://www.chcf.org/topics/view.cfm?itemID=20740)

[11] A "death spiral" begins with adverse selection, which leads to premium increases, which drive away the healthiest remaining pool members, leading to more premium increases. Eventually, only the high-risk,

high-cost subscribers remain in the pool, at unsustainably high premiums, and the pool fails unless it has access to funds other than premiums.

[12] Elliot K. Wicks, Mark A. Hall and Jack A. Meyer, *Barriers to Small-Group Purchasing Cooperatives*, Economic and Social Research Institute, March 2000.

[13] Another example of unsustainable preferential terms would be requiring pools, but not the outside market, to accept self-employed individuals on the same terms as employer groups.

[14] Wicks et al., *op.cit.*, contains detailed information about the operations of the Texas Insurance Purchasing Alliance and Caroliance. The termination date for Caroliance was found in: BlueCross BlueShield of North Carolina, "Submission of Information Pursuant to N.C. Gen. Stat. §58-65-131(h), For the Public Record Related to Conversion," September 30, 2002 (http://www.ncdoi.com/BCBSNCPublicRecordsSubmission.pdf).

[15] Launched in October 1998, IMA Health Options had enrolled only 3 employers with 20 employees and 30 total covered lives by November 1999. It went out of business as a choice pool shortly thereafter. Unpublished data from the Institute for Health Policy Solutions periodic survey of Consumer-Choice Health Purchasing Groups.

[16] Market share data is difficult to obtain. We compared enrollment figures provided by CBIA "Health Connections" managers (33,000 primary workers covered, personal communication, September 21, 2005) to total enrollment of small-firm workers in Connecticut (181,000 in 2005) from Agency for Healthcare Research and Quality, *Number of private-sector employees by firm size and State: United States, 2005* (Table II.B.1) <http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiib1.pdf> and *Percent of private-sector employees that are enrolled in health insurance at establishments that offer health insurance by firm size and State: United States, 2005* (Table II.B.2.b.(2)) <http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiib2b.pdf>. These figures suggest a CBIA "market share" (percent of covered small-firm workers) of over 18 percent. But the AHRQ data are subject to sampling error (the 2004 figure was 205,000), and CBIA managers thought 18 percent seemed high. Nonetheless, it is clear that the CBIA "Health Connections" purchasing pool is a major player in Connecticut's small-group market.

[17] California's ±10 percent rating band applies to any rating factor that may not be used in establishing the "standard employee risk rate (SERR)," that is, any factor other than age, family size and geographic location. See note 10.

[18] PacAdvantage press release, August 11, 2006.

[19] Institute for Health Policy Solutions, *Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2)*, prepared for the California HealthCare Foundation and the California Managed Risk Medical Insurance Board, March 2005, (http://www.ihps.org/pubs/2005_SB2.shtm) or (http://www.chcf.org/topics/healthinsurance/coverageexpansion/index.cfm?itemID=109984). Hereafter cited as the "*SB2 Report*." Several "Supplements" to the main report, dealing with particular topics, may also be found at these Web addresses.

[20] Rick Curtis and Ed Neuschler, "Designing Health Insurance Market Constructs For Shared Responsibility: Insights From California," Health Affairs 28, no. 3 (2009): w431–w445 (published online 24 March 2009; 10.1377/hlthaff.28.3.w431)]

[21] With respect to risk adjustment in the Health Insurance Plan of California (PacAdvantage's predecessor), see Yegian et al., *op.cit*. Supplement E to the *SB2 Report* discusses risk adjustment in general and gives a brief overview of currently available risk-adjustment mechanisms.

[22] See §§10730 -10749 of the California Insurance Code for PacAdvantage, the successor to the Health insurance Plan of California, which was originally operated by the California Managed Risk Medical Insurance Board. Private voluntary purchasing alliances are authorized by §§10800-10887 of the California Insurance Code, but to date no entity has been certified by the Commissioner of Insurance to act as a purchasing alliance.

Technically, health plans must adhere to the ±10 percent rating bands across any product they sell, regardless of how it is sold. But since the pools can specify unique benefit packages, as a practical matter the rating bands do not affect the pools' ability to negotiate on price. (The rating bands do apply within the pool, of course.) On the other hand, the legal authority to negotiate price does not, by itself, convey the practical ability to obtain a favorable price through negotiations. As noted earlier, since the pools are voluntary and carriers can sell to the same small employers directly, carriers have little incentive to give the pools a favorable price.

[23] Section 10820(i) of the California Insurance Code—part of the Private Health care Voluntary Purchasing Alliance Act—specifically exempts such entities from the requirements of that Act.

[24] See note 21.

[25] For example, if the target population is small businesses, the sponsoring organization should be perceived favorably by small businesses.