The Health Insurance Plan Of California: The First Five Years

The purchasing alliance model holds promise, based on the experience of the nation's first and largest state-run purchasing group.

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COMMENTING ON THE ROLLOUT of the Health Insurance Plan of California (HIPC) in 1993, Governor Pete Wilson said, "The promise is of a new way, a better way, a less expensive way for small business to buy health insurance."[1]

The HIPC was the nation's first and largest state-run purchasing alliance for small firms. Since its creation in 1993, the HIPC has established itself as a stable and experienced player in the competitive market for small-group insurance. Although its existence does not appear to have made a noticeable impact on the number of Californians with insurance, the alliance offers something that previously was quite rare in the small-group market: the freedom for employees to choose their own health plans. In addition, competition from the HIPC appears to have spurred other health plans to innovate in ways that increase the degree of choice available to employees of small firms and to constrain the growth in premiums.

Purchasing alliances continue to be at the forefront of health policy, in California and elsewhere. President Bill Clinton's budget for 1998–1999 included $100 million over five years to aid states in developing alliances for firms with one to fifty employees. The Patients' Bill of Rights Plus Act of 1999 (H.R. 2990) called for the creation of "HealthMarts," to provide multiple options from which employees of small firms could choose; similar programs have been endorsed by presidential candidates from both parties during the 2000 election cycle.[2]

In 1999 the Pacific Business Group on Health (PBGH) took over the HIPC and renamed it Pacific Health Advantage. Here we focus primarily on the HIPC's first five years of operation, prior to its transition to the PBGH. Our analysis is qualitative in nature, based largely on a series of in-depth interviews with key HIPC players—program administrators, health plan representatives, and insurance brokers and consultants.

Background On The HIPC

The HIPC was established in 1992 as part of broader small-group reform legislation, which included guaranteed issue and renewal of coverage for small firms, limits on preexisting condition exclusions, and restrictions on how premiums could vary across small groups.[3] Whereas other reform components were designed to address problems of accessibility, the main goals for the HIPC were to increase coverage by improving affordability and enhancing consumer choice.[4]

Understanding the relationship between the HIPC and the broader market reforms is important both for evaluating the HIPC's performance and for extrapolating from its expe-

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rience to other settings. The fact that it was never intended as a stand-alone reform means not only that is it difficult to distinguish the effects of the HIPC from those of the broader reforms, but that such distinctions may not even be meaningful. At the same time, it is important to identify how the policy context affected the HIPC's experience. Of particular importance is the fact that the marketing and underwriting rules are virtually the same inside and outside the HIPC. This congruence has contributed to the stability of the HIPC, assuring that it did not evolve into a high-risk pool. Although there was adverse selection against certain plans within the HIPC, there is no evidence of adverse selection against the HIPC as a whole.

Between 1994 and 1998 enrollment in the HIPC grew at a fairly steady, though decreasing, rate (Exhibit 1). At the end of its first year of operation, the HIPC's enrollment represented roughly 1 percent of the small-group market.[5] Since that time, the number of small firms in the state also has grown. Our best estimate suggests that the growth in HIPC enrollment has not outstripped the growth in the number of small firms and that the HIPC's share of the small-group market has remained below 5 percent, perhaps as low as 1 percent.[6] Whether such figures should be viewed as large or small is a matter of perspective. More than one health plan representative we interviewed said that they would be pleased if they could increase small-group enrollment by 150,000 lives so quickly. At the same time, the HIPC's growth has fallen short of early expectations. HIPC designers had hoped to enroll 10,000 members per month, which would have yielded an enrollment of 250,000 after only two years.[7]

Benefits And Costs Of Choice

The defining feature of the HIPC is the choice of health plans it makes available to employees of small firms. Data from a 1993 survey of employers indicate that 86 percent of firms with fifty or fewer employees that provide health benefits offer only one plan.[8] In contrast, in 1998–1999 the HIPC offered between eleven and fifteen health maintenance organizations (HMOs) and one or two point-of service (POS) plans, depending on region.[9] Given the evidence that satisfaction is greater among employees offered a choice of plans, this is a valuable benefit.[10]

However, one could argue that the HIPC menu included more than the optimal number of plans. In 1998–1999, when nineteen plans participated in the alliance, six plans accounted for 80 percent of enrollment, while ten others had a combined market share of less than 2 percent. Thus, if the HIPC were to drop plans with very low market shares, the program's administrative cost would fall, but only a small number of enrollees would be adversely affected, particularly since the current California market features a high degree of overlap in the provider panels of competing network-model HMOs.

EXHIBIT 1
Enrollment In The Health Insurance Plan Of California (HIPC), July 1994–July 1998

	Groups		Employees		Enrollees (employees and dependents)	
	Total as of July	Annual percent change	Total as of July	Annual percent change	Total as of July	Annual percent change
1994	3,246	–	32,496	–	58,017	–
1995	4,911	51%	51,801	59%	92,064	59%
1996	6,044	23	63,087	22	113,081	23
1997	6,919	15	73,306	16	132,313	17
1998	7,430	7	78,318	7	140,740	7

SOURCE: California Managed Risk Medical Insurance Board monthly reports.

The number of distinct plans available is not the only, or even perhaps the best, way to measure degree of choice. Many consumers place a high value on being able to choose their own physicians and self-refer to specialists; accordingly, they tend to favor preferred provider organizations (PPOs) over HMOs. Whereas the initial HIPC menu included several PPOs, all subsequently dropped out of the program. In the 1998–1999 benefit year two carriers offered POS plans, but these plans cost much more than competing HMOs; 92 percent of HIPC enrollees were enrolled in HMOs in August 1998. As we discuss below, the main reason that the PPOs exited the HIPC was that they experienced adverse selection. This result, which has occurred in other managed competition settings, suggests a conflict between two aspects of choice: the ability of individuals to choose their own health plans and access to plans that offer greater freedom in choosing one's own providers.[11]

The lack of PPOs is likely one factor that has limited the HIPC's growth. Results from recent surveys of small California employers indicate that nearly 40 percent of those offering health benefits provide their employees with a PPO option.[12] In addition, several plans in California's small-group market, including Blue Cross and Blue Shield, now offer "dual-choice" products, which allow employees of small firms a choice among two (or more) benefit designs. This allows a situation that was initially possible within the HIPC: The owner and high-wage employees of a small firm can choose PPO coverage, while more price-sensitive employees can choose less costly HMO coverage. The disadvantage of dual-choice products relative to the HIPC is that employees still have no choice of carriers. With the high degree of provider panel overlap among network-model HMOs, the key distinction is that the HIPC allows employees a choice between Kaiser and non-Kaiser plans, a choice that is not generally available in the small-group market. At the same time, dual-choice products have one important advantage over the HIPC. Since the same carrier insures all the benefit designs, premiums can be based on the risk characteristics of the entire group, and the cost of adverse selection can be internalized.

Purchasing Alliances And The Cost Of Insurance

The stated intent of the legislation authorizing the HIPC was to "help make coverage more affordable by establishing a purchasing pool for small employers."[13] In the absence of premium subsidies, there are two ways in which a purchasing alliance might achieve this goal. One is by leveraging the size of the alliance to negotiate better rates from plans. For example, the California Public Employees Retirement System (CalPERS) is often cited as using its "purchasing clout" in this manner.[14] In its marketing materials the HIPC touted the "power of the pool," implying that its size translated to lower premiums for participating firms.[15] Second, there may be economies of scale in marketing and administration associated with pooled purchasing.

Surprisingly little evidence is available on the impact of purchasing alliances on premium costs. One recent national analysis found no cost advantage to employers participating in pooled purchasing arrangements but did not control for differences in benefit levels.[16] Similarly, two reports on the potential benefits and costs of HealthMarts and association health plans conclude that the economies of scale from such purchasing pools are likely to be small if they exist at all.[17]

Although a dearth of suitable data precludes a formal quantitative analysis, an examination of the HIPC's experience also raises doubts as to whether pooled purchasing has yielded significant savings relative to options available in the small-group market. It has been reported that the HIPC's initial premiums were lower than those outside the HIPC.[18] More recent data, however, provide no evidence that HIPC rates are still lower. A recent report from the actuarial consulting firm of Reden and Anders compared the 1997–1998 premiums of the HIPC HMOs with the greatest enrollment to premiums for the

same HMOs available in the outside market, adjusting for differences in benefit design.[19] The results indicate that premiums were slightly lower outside the HIPC, a finding that is consistent with what a number of plan representatives and brokers told us.

Two important qualifications apply to this finding. First, the HIPC probably does reduce the cost of offering employees a choice of plans. Employers receive a single monthly bill regardless of how many different plans their workers select, and switching plans by employees generates no additional administrative cost for employers. However, the comparison implied by the Reden and Anders analysis and by the comments of our interview subjects is between the HIPC and the option of purchasing coverage directly from one carrier. Since very few small firms outside the HIPC offer a choice of plans, this is a relevant comparison. As Mark Pauly has pointed out, it is not clear that pooled purchasing can significantly reduce the administrative cost of insurance relative to this alternative:

> The higher per-employee administrative cost in a set of ten 25-employee firms, as compared to a single group of 250, arises because each firm must be sold insurance, each firm must receive a premium bill, and each firm must be serviced...But combining the ten firms into one HIPC does not change the number of sales, bills, or services required; you cannot make a giant just by rounding up a passel of midgets.[20]

One aspect of the HIPC's experience that seems consistent with Pauly's argument is the evolution of its policies on brokers' fees. Initially, firms that enrolled in the HIPC directly (rather than through a broker) were able to avoid paying fees. However, in later years the HIPC began charging fees to such employers. While this policy change may have been partly influenced by a desire to mend relations with the broker community, it also reflects recognition that firms that enrolled directly generated real administrative costs.

A second qualification is that we are not arguing that the HIPC has had no effect on premiums in California's small-group market. In fact, its existence may have contributed to the intensely competitive nature of this market in the 1990s. Early newspaper reports suggest that the HIPC's low initial rates spurred carriers operating outside the alliance to cut their rates to remain competitive.[21] In addition, the HIPC may have contributed to price competition by improving the quality of information given to small employers. The HIPC brochure clearly lays out the premiums charged by each participating carrier by region, age, and family category, making it easy for employers to make "apples-to-apples" price comparisons among its standard benefit designs. This information is a public good that benefits all small employers.

The Reality Of Risk Adjustment

In its third year of operation the HIPC implemented a process for assessing the distribution of risk among plans and, if biased selection was detected, risk-adjusting payments to plans.[22] High-risk enrollees were identified as those who were hospitalized in the prior year with one of a set of costly conditions classified as "marker diagnoses." Since plans that did not report any members with marker diagnoses were assumed not to have had any, there was a financial incentive to collect and report the diagnostic data. Limiting the marker diagnoses to those requiring hospitalization reduced plans' ability to game the system. A disadvantage of this approach, however, was that it penalized the efficient substitution of outpatient care for costly inpatient treatment. The decision to rely exclusively on inpatient data was made for largely practical reasons: Because of the widespread use of capitation, many plans were unable to provide the necessary outpatient data to support more-comprehensive risk assessment measures.

Plans were compared in terms of quantitative "risk assessment values" (RAV), and funds were reallocated among plans if any plan had an RAV that was 5 percent above or below the average for the entire pool. Transfers were determined by an iterative process that continued until all plans had risk-adjusted values falling within the 0.95 to 1.05 range. For most plans, biased risk selection

was neither a problem nor an advantage: In each of the three years the process was in operation, the majority neither made nor received transfer payments (Exhibit 2). By far, the largest transfer occurred in the first year, when one PPO received payments of $46.04 per member per month. However, this transfer was not enough to keep the plan from leaving the HIPC. Similarly, the other PPOs that dropped out would have qualified for transfers from the risk adjustment process. This suggests that even a sophisticated risk adjustment mechanism may be unable to compensate for the effects of biased selection when individuals can choose their own plans.

Two extenuating circumstances hold the potential for the HIPC's risk adjustment process to fare better under different conditions. First, the fact that the PPOs began with a very small share of the HIPC's internal market may have hastened the movement of these plans along the adverse-selection death spiral. In cases where plans receiving a disproportionate share of high-risk enrollees have a larger enrollment base, risk adjustment may be more successful in stabilizing the system. In addition, the HIPC contract includes a provision that prohibits participating plans from underpricing their HIPC products in the outside market. While the PPOs might have been viable in the HIPC at a higher price, increasing premiums within the alliance would have required doing so in the outside market as well. This strategy clearly would not have been in the plans' interests, given that HIPC enrollment represented such a small share of their overall small-group business.

In contrast to the disappointing results with respect to risk adjustment, the HIPC's experience presents a more positive picture of another strategy designed to minimize biased selection: standardization of plan benefits. Full standardization is not possible when a mix of plan types is offered, as HMO and PPO benefit designs differ greatly. After the PPOs left the HIPC, both benefit variation and risk dispersion declined within the HIPC. The risk assessment values for the remaining plans

EXHIBIT 2
Health Insurance Plan Of California (HIPC) Risk Assessment Results, 1996/97–1998/99

	Contract year		
	1996/97	**1997/98**	**1998/99**
Plans participating	24	27	24
Plans affected	8	6	6
Low outliers (RAV < 0.95)			
HMO	2	3	1
PPO/POS	0	0	0
Plan making payments			
HMO	7	3	4
PPO/POS	0	0	0
Monthly risk adjustment (range)	$0.69–$10.70	$0.65–$3.36	$2.00–$5.37
High outliers (RAV > 1.05)			
HMO	0	0	1
PPO/POS	1	0	1
Plans receiving payments			
HMO	0	2	1
PPO/POS	1	1	1
Monthly risk adjustment (range)	$46.04	$0.50–$2.11	$2.73–$9.07
Transfers as percent of premium revenue	1.14%	0.04%	0.11%

SOURCE: California Managed Risk Medical Insurance Board.
NOTES: RAV is risk assessment value. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan.

have generally clustered between 0.95 and 1.05. When there have been outliers, the required transfers have been small: 0.11 percent of total premiums in 1998.

Role Of Agents And Brokers

Insurance agents and brokers are key players in the small-group market as it is now configured. Recent research finds that agents and brokers have had a major influence on how market reforms are implemented.[23] The experience of the HIPC bears this out.

"Pooled purchasing alone cannot sustainably lower the cost of insurance enough to increase its provision among small firms."

The HIPC's initial policies concerning brokers represented a middle ground, neither eliminating the role of brokers nor mandating their involvement. However, they diverged from standard industry practice in three ways. First, employers were allowed to bypass brokers and avoid their fees. Second, brokers' fees were itemized on the employer's HIPC bill rather than being rolled into the premium, serving as a monthly reminder that the broker was receiving compensation regardless of services rendered during that month. Third, brokers' fees paid by the HIPC were low relative to commissions of 8–10 percent offered outside the HIPC.

In considering these policies toward brokers, it is important to keep in mind their historical context as well as the alliance's broader policy objectives. Decisions regarding broker compensation were made in late 1992 and early 1993, a time when comprehensive national health care reform based on the managed competition model appeared imminent. That model emphasizes consumer choice among plans offering standardized benefit packages. Policymakers assumed that providing apples-to-apples comparisons would make it easier for consumers to choose among available options based on price, network, and quality, thereby reducing the need for advice from a broker. On a more practical note, with no state funding for subsidies, reducing or eliminating fees paid to brokers was one of the few concrete ways that the HIPC could lower the cost of insurance to small employers.

Whatever their motivation, our interviews indicated that these policies created animosity in the broker community. Given that small firms rely heavily on brokers for information on their health insurance options, it is likely that this limited the HIPC's growth. Two other factors also provided impetus for changes in the HIPC's broker policies. First, 70 percent of firms joining the HIPC during its first three years came through a broker and voluntarily paid the commission. Second, groups enrolling directly required more time and staff resources than did those enrolling through brokers.

The HIPC responded by altering its enrollment structure and compensation system. Broker compensation was increased on several occasions. The option to bypass brokers and avoid paying their fees was eliminated; although employers could still enroll directly, they paid an equivalent fee to the HIPC rather than to the broker. A new incentive program was created to reward agents selling the HIPC with "lead calls"—cold calls that the HIPC telemarketing staff made to small employers in the ZIP code of the agent's choice. The most important change, however, occurred when the HIPC adopted the convention of the industry by converting the broker fee to 8 percent of premium, automatically included in the rates. This change, implemented in September 1998, eliminated brokers' objections to monthly itemized charges and greatly simplified the process of quoting HIPC rates.[24] The HIPC's administrator reported that agents' requests for quotes of HIPC premiums were up by 30 percent in the months immediately following this policy change.

Privatization

The legislation creating the HIPC mandated that the state establish a process for privatizing the alliance within three years of its crea-

tion. In 1998 the HIPC found a new home at the PBGH, a coalition of thirty-two large purchasers of health care representing three million lives and $3.5 billion in health spending each year. The PBGH took over operations of the HIPC in July 1999, renaming it Pacific Health Advantage, or PacAdvantage.

The change in management brought about several relatively modest changes in the alliance's design and policies. Four health plans exited the alliance, and two others joined for the first time, resulting in a total of fifteen HMOs offered in some or all regions of the state. A new HMO benefit package has been added, expanding options to include a $10 copayment for physician office visits as well as the existing $5 and $15 copayment benefit levels. Although there still are no PPOs available, four carriers now offer POS options. In addition, PacAdvantage has added optional vision and chiropractic coverage, which, like the existing dental benefits, can be purchased separately by firms that purchase health coverage through PacAdvantage.

The risk adjustment process is still in place, with one major change: Medicare diagnostic cost groups (DCGs) have replaced the HIPC's marker diagnoses as the basis for risk adjustment. A key advantage of using DCGs is administrative simplicity: Since health plans already collect these data for Medicare, little added work is required to submit them to PacAdvantage as well. In addition, because they use information on all hospital admissions, risk measures based on DCGs are more comprehensive than are those using the limited set of marker diagnoses. In principle, DCGs also can incorporate data on outpatient costs, although such data remain unavailable. The first risk adjustment results using the new method were due in February 2000, in time to factor into negotiations for July rate changes.

A notable new feature of PacAdvantage has clearly been adopted from the PBGH: performance guarantees. Participating plans put 2 percent of premiums at risk and receive those funds only if they meet a number of targets in areas such as customer service, claims processing, and Health Plan Employer Data and Information Set (HEDIS) measures.

Legacy Of The HIPC

These results illustrate that the managed competition model is a viable means of expanding the health plan choices available to the employees of small firms. At the same time, the HIPC's experience shows that pooled purchasing alone cannot sustainably lower the cost of insurance enough to increase insurance provision among small firms. The relationships among underwriting rules, choice, and adverse selection imply that alliances are best suited to offering broad choice of plans but little variation in benefit design. These factors will likely limit purchasing alliances' role in the commercial health insurance market.

The real potential for the purchasing alliance may lie in efficiently offering publicly funded health insurance. The California Children's Health Insurance Program, Healthy Families, adopted a purchasing alliance structure and now offers more than 290,000 children a choice of health and dental plans that vary by county. Proposals under discussion in San Francisco and San Diego would concentrate public funds from various sources for the purchase of health insurance for uninsured residents.[25] Advantages include relative ease of administering subsidy funds, ability to offer choice among plans, and integration of diverse revenue streams. Whether these public policy objectives can be realized through the alliance model remains to be seen, but there is promise.

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NOTES

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