BUSINESS INITIATIVES TO EXPAND HEALTH COVERAGE FOR WORKERS IN SMALL FIRMS

VOLUME II: CASE STUDIES OF FOUR INITIATIVES

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This report is available only on the Fund's website at **www.cmwf.org.** Volume I of this study, which contains an overview and summary of lessons learned, is available from the Fund by calling our toll-free publications line at **1-888-777-2744** and ordering publication number **475.** Volume I can also be downloaded from the Fund's website.

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INTRODUCTION

Today's health insurance market tends to favor large employers with negotiating clout and technical expertise. In contrast, small businesses struggle to offer employees affordable health care coverage. Therefore, it seems reasonable to expect that small companies would benefit when larger buyers help develop and manage insurance products designed to meet small firms' needs. As we report in Volume I of this study, small businesses do gain when more experienced parties intervene in the market on their behalf. Economic and Social Research Institute (ESRI) research suggests that while programs sponsored by large employers can do little to influence the rates paid by small businesses, these initiatives have succeeded in providing small firms with more choices than they would have had on their own.

What is the exact nature of such initiatives? In what ways are they succeeding? And what stops them from accomplishing more? Volume II presents four case studies of programs intended to make health care coverage more easily accessible and affordable for small firms. Table II-A summarizes the four programs we examine in this volume.

Table II-A. A Summary of Four Small-Group Programs

Name of Program	Sponsors	Location	Contact	Date Founded	Covered Lives	Offerings
HealthPass	New York Business Group on Health and the City of New York	New York, New York	Laurel Pickering Executive Director NYBGH 212-252-7440 laurel@nybgh.org	December 1999	4,800 (as of June 2001)	20 HMO and POS plans from four health insurers
PacAdvantage	Pacific Business Group on Health	San Francisco, California	Chuck Kiskaden Director of Marketing PacAdvantage 949-766-1905 chuck.kiskaden@pacadvantage.org	July 1993; (PBGH took over in 1999)	140,000 (as of May 2001)	HMO, POS, and PPO plans from 13 health plans
Cooperative for Health Insurance Purchasing (CHIP)	The Alliance	Denver, Colorado	Tom Rockers CEO The Alliance 303-333-6767 trockers@alliance-ppo.com	1994	30,000 (as of May 2001)	16 HMOs through three plans; 5 PPOs through one insurer
The Alliance–Chamber Health Insurance Plan (A-CHIP)	The Alliance	Madison, Wisconsin	Cathy Mahaffey Manager, Member Services and New Business The Alliance 608-210-6638 cmahaffey@alliancehealthcoop.com	1994	3,000 (as of March 2001)	HMO and POS plans through one managed care plan

A brief overview of each program follows, along with a discussion of its origins and goals, how it works, its results, and key issues and challenges. We also assess important lessons drawn from each program's experience to date.

Methodology

Our research began with the mailing of a brief survey to 24 business coalitions and large employers that had either been involved in or had expressed interest in health care-related initiatives to benefit small employers. The survey was designed to capture basic information about health insurance buying practices and to identify any level of activity related to assisting small firms. Our mailing list was based on ESRI staff's knowledge of large-purchaser activities as well as information gleaned from experts in this area. We received 17 responses—eight from coalitions and nine from individual employers. Using the survey responses, as well as new leads from knowledgeable sources, we conducted

follow-up interviews with 10 coalitions that appeared to have some level of activity involving smaller companies.

The goal of these interviews was to identify five sites for more extensive study. In choosing the programs to profile in this volume, we had hoped to be able to present a variety of strategies that large employers are implementing to assist smaller firms in the insurance market. However, our research uncovered fewer examples of business-sponsored insurance programs than we had anticipated. As a result, we honed in fairly quickly on four programs—all sponsored by business coalitions—whose activities are extensive enough to merit full case studies. ESRI staff visited each of the four sites, where we conducted extensive interviews with coalition staff, board members, health plans associated with the program, and other relevant parties.

All of the programs profiled in this volume use the cooperative model, in which small firms gain access to a choice of health plans by becoming part of a larger group. Our research also identified three coalitions that have pursued a "network access" model, in which large employers make their provider networks (and associated discounts) available to small firms. While we give brief descriptions of such initiatives in Volume I, we did not include any case studies because the model is fairly straightforward and generally requires little strategic involvement from coalitions once they have negotiated access to the network. Since one or more insurers market the network and sell the coverage, small businesses may not even be aware that a coalition plays a role in making the insurance available. Our research also yielded three employer groups whose efforts to assist small businesses with coverage either did not get off the ground or were short-lived. Brief profiles of these efforts are included in Volume I. Table II-B gives basic information about these groups.

Table II-B. A Summary of Other Employer Initiatives

Coalition Name	Location	Dates of Operation	Comments
Coalitions that use the Network Access model			
Buyers Health Care Action Group	Minneapolis, Minnesota	January 2001	Offers access to provider-based care systems developed for large employers
Health Care Network of Wisconsin	Milwaukee, Wisconsin	1991	Offers access to provider network through local insurance company
Small Employer Initiative of The Alliance	Madison, Wisconsin	1994	Offers access to provider network through two insurers serving small group market
Coalitions that considered/attempted small-group programs			
Memphis Business Group on Health	Memphis, Tennessee	1994–2000	Offered access to provider network; failed due to spiraling costs
Southwest Michigan Healthcare Coalition	Kalamazoo, Michigan	1999–2000	Implemented a purchasing group with a mix of employer sizes; deactivated after 1.5 years because of lack of commitment from large employers
Midwest Business Group on Health	Chicago, Illinois	N/A	Pursued several efforts that struggled to get beyond planning stage in mid-1990s; Chicago chapter currently evaluating new effort to expand HMO contract to smaller firms

THE NEW YORK BUSINESS GROUP ON HEALTH'S HEALTHPASS PROGRAM

OVERVIEW

HealthPass is a public-private effort to develop and market health care insurance that addresses the needs and budgets of small businesses and their employees in New York City. The public part of the partnership is the Mayor's Office of Health Insurance Access of the City of New York. The private partner is the New York Business Group on Health (NYBGH), a coalition of large employers and representatives of the health care industry.

The City of New York

New York City's population exceeds 8 million. More than one million, or 28 percent, of the city's adults ages 18 to 64 are uninsured. This compares to about 19 percent nationwide. Of the nation's 85 largest urban areas, New York has the seventh largest percentage of uninsured non-elderly residents.[1] A major contributing factor to this lack of coverage is the number of people who work for small businesses that do not offer health insurance. Currently, the city has about 200,000 small businesses (those with between two and 50 employees) and roughly half of those businesses do not provide insurance benefits. The decision to create a purchasing alliance to meet small businesses' need for access to quality health care coverage was part of a multi-pronged effort to attack the problem of the uninsured and to support a larger strategy to improve the competitiveness of small businesses.

Having determined that a partnership with a private entity would be the most appropriate and effective strategy, the Mayor's Office of Health Insurance Access signed a two-year, $1 million contract in July 1998 with the New York Business Group on Health to guide, and eventually to manage the development and implementation of HealthPass. Subsequently, the contract was extended for one year, with nearly $1 million in additional funding, because the December 1999 launch of HealthPass was later than anticipated. Set to expire at the end of June 2001, the contract has again been extended, this time through June 2002. When the contract is complete, the city hopes that HealthPass will be able to function independently.

The New York Business Group on Health

The New York Business Group on Health is a mixed-model coalition (employers plus other health care stakeholders in the community). The coalition has 150 members, only

[1] D. Sandman and E. Simantov. *Five Boroughs, Common Problems: The Uninsured in New York City* (New York: The Commonwealth Fund, February 2000), fact sheet.

about one-third of which are large employers. The rest of the members include health plans, pharmaceutical companies, hospitals, consultants, and brokers. The City of New York is also a member.

The group's principal mission is to serve as a nexus for all players in the industry to come together to address issues that affect them all. Initially, execution of this mission was limited to sponsoring speakers at breakfast meetings for employers, sending news updates to members, conducting conferences for the entire health care community, and attending national meetings and conferences. In the past three years, however, the group has become more assertive. In 1997–98, NYBGH began a joint venture with IPRO called the New York State Health Accountability Foundation, which produces an annual report card for employers on the quality of HMOs in the state of New York. The partnership with the city to produce a useful insurance product for small businesses presented another opportunity to take a major leap forward.

The coalition formed a subsidiary, the New York Health Purchasing Alliance (NYHPA), to create and launch HealthPass. NYHPA has its own staff, although its executive director is a city employee. The head of the Mayor's Office of Health Insurance Access and the executive director of NYBGH also contribute significant amounts of time to the project.

Status

Launched in December 1999, HealthPass has not been operational long enough for a serious evaluation, but it is generally regarded as a well-designed start-up. The key question for the alliance's board, staff, the city, and NYBGH is whether the program can attract enough small business groups to become financially self-sustaining before the contract with the city ends. The HealthPass staff and board estimate that this will require 5,500 employee members. The staff initially set monthly membership and financial targets that the program would have to meet in order to achieve that number. Over time, they have revised those projections as they have developed a better understanding of the market and the potential for HealthPass. So far, program participation is less than halfway toward the ultimate goal, but the sales staff believes that it can reach the target, with its associated income, by the time the contract expires in June 2002.

BACKGROUND

Impetus for a Small Business Product

The city's push for an insurance product for small businesses reflects Mayor Rudolph Giuliani's growing concern about the plight of New York City's uninsured. Over the last

several years, he has become increasingly aware of the pressures on the public hospital system and primary care facilities, as well as of the problems of uninsured citizens. At least some of these pressures and problems arose because many small businesses do not offer coverage to employees and many employees who have access to coverage do not buy the insurance. Therefore, the city decided to investigate the potential of a small-business purchasing alliance. (City government has also been involved in other initiatives to improve access to care for the uninsured, including the citywide HealthStat program to enroll people in existing public health insurance programs.)

Why an alliance?

The Mayor's staff looked at the experiences of several purchasing alliances around the country to help determine the appropriateness of this model for New York City. Several factors contributed to the decision to support the development of a purchasing alliance that could offer access to multiple health plans. One was the desire to address the small business community's need for flexibility. Market research revealed that cost was not the only issue driving the coverage decisions of small businesses. The inability to offer a *choice* of health plans was forcing some employers to choose unnecessarily expensive plans (e.g., those with out-of-network options or relatively richer benefits) for everyone in order to meet the needs of a few. Thus, the city identified a demand for a flexible insurance product that would enable small businesses to offer coverage to employees with different needs.

A second consideration was that this strategy be compatible with the goals of the city's economic development program. The ability to offer the same kinds of choices as large employers offer could help make small businesses more economically competitive by improving their ability to attract and retain employees. Finally, a private organization rather than the public sector could run a purchasing alliance, which was important to the small businesses that would be its target. Market research had confirmed that small businesses felt more comfortable with a public-private partnership than with an entity completely under the city's control. This model was also consistent with the city's desire to provide seed money and management assistance, rather than a permanent commitment.

How the Business Group Came on Board

These considerations meant that the city needed to collaborate with a local organization that small businesses would perceive as neutral. Moreover, this group must have demonstrated a commitment to health care and the access issues of concern to the city. At the time, very few organizations were focused on both community-wide health care issues and the business community. The New York Business Group on Health was clearly the

best candidate. Since the group did not represent any particular segment of the health care industry, it did not present the risk of conflict of interests. Also, the city was intrigued by NYBGH's efforts to develop quality-oriented health-plan report cards for employers.

The city approached the NYBGH in late 1997 about the possibility of creating a partnership to develop a health insurance system for small businesses. Although the coalition had not previously been involved with small businesses, its diverse membership was well aware of the problems of access and cost and was concerned about the large number of uninsured people in the city. However, the group did not have sufficient resources to address these issues independently. Also, the coalition's experience with developing or marketing an insurance product was limited to a carve-out pharmaceutical benefit management plan offered to members through the National Business Coalition on Health.

NYBGH's board was quickly convinced of the merits of this initiative with the city. HealthPass would cause the group's level of activity and visibility to grow. It would also help to round out the coalition's mission. Finally, the board was intrigued by the idea of a program that not only provided a choice of plans but would attract employers that had not offered coverage in the past. On the other hand, the board was especially concerned about what resources the start-up would need to become viable, how long it would take to become self-sustaining, and the consequences if it failed. Board members were aware of other purchasing alliances that had not succeeded. Further investigation, including a look at similar programs in Connecticut (CBIA) and California (HIPC, now called PacAdvantage), reassured them that the program could work.

Once they had agreed to proceed and NYBGH had received the city's grant, board members—especially the executive committee—were very active with this project. They exchanged ideas with the staff and shared their experiences in the market. However, while the board was receptive to the idea of an alliance, it is important to note that it was not proactive—there is no question that this project would not have happened without the city's initiative and funding.

The Funding

In addition to nearly $2 million in grant money, the city loaned the coalition a full-time staff person to run the program as well as staff to provide administrative help. This in-kind contribution was critical to completing the planning, launch, and implementation of the purchasing alliance. This included getting the health plans on board, finding an administrator, and figuring out how to deal with the brokers and general agents who

would actually sell the insurance. Given its small budget—about $425,000 per year—the coalition could not afford to provide financial support to HealthPass. However, while neither the coalition nor its members invested money directly in the NYHPA, it did offer in-kind and indirect support. For example, the coalition's executive director devoted a significant amount of her time to the program's development.

PROGRAM DESCRIPTION

The Product

HealthPass is based on a defined-contribution model in which the employer sets the level of contribution to coverage and each employee gets to choose among several health plans and insurance products. Employees of small businesses that pick HealthPass may choose from 20 options—four health plans offer five standard benefit options (two in-network plans and three plans that offer access to providers both in and out of the network, like point-of-service (POS) plans). The only choice left to the employer is which of four levels of prescription-drug benefits to offer. The chosen benefit then applies to whatever choices the employees make. Each of the five benefit options has the same co-payments and deductibles—e.g., employees who select one of the three POS products pay the same copayment no matter which of the four health plans they choose.

Employers are not required to offer HealthPass exclusively. Businesses that want to provide richer benefit packages to executives may offer other commercial plans as well. Also, employers are not required to pay a minimum dollar amount or percentage of premium. To help reduce the likelihood of enrolling only high-risk people, NYHPA requires that at least 75 percent of eligible employees enroll in a health plan, and at least two full-time employees must enroll in HealthPass.

Eligibility and Enrollment

As of June 2001, HealthPass had 2,800 employee members from 490 companies, for a total of 4,800 covered lives. It is available to all groups with two to 50 employees operating in the five boroughs of New York City and Westchester and Rockland counties. There are about 200,000 to 250,000 such groups in the market, although not all are eligible (ineligible groups include the self-employed and companies with 1099 employees, like real estate companies). Roughly 50 to 60 percent of these groups currently offer health care coverage of some kind.

The following statistics reflect HealthPass's progress to date:

- **Reaching the uninsured:** The percentage of groups indicating that the health care benefit is a new offering is an impressive 52 percent. Some of these are established companies that had not offered insurance before, and some are start-ups. Among health plan members, 28 percent report that they did not have coverage previously.
- **Average group size:** Average group size has been about six employees and 10 covered lives, which is relatively high for small businesses. According NYHPA statistics, 60 percent of the groups in this market have between two and five employees. HealthPass's average group size implies that it is attracting slightly larger groups from the eligible segment of small employers.
- **Demographics:** Enrollees are relatively young (72% are 44 or younger) and the majority (75%) are male.

Key Selling Points

The primary benefit of HealthPass is that it gives employees the same kinds of choices that large employers offer with no additional cost or administrative burden. It is very difficult, although not impossible, for small employers to offer choices on their own. The problem is not a lack of plans in New York, but the existence of legal restrictions and administrative challenges to offering multiple options. For example, a small business that wants to offer several health plans would have to handle multiple enrollment forms and monthly bills. NYHPA issues one monthly bill regardless of how many different plans enrollees choose. The alliance's third-party administrator (TPA) then distributes the payments to the health plans as appropriate.

NYHPA also emphasizes that HealthPass can help employers manage, and even contain, their costs more effectively. Marketing materials encourage employers to adopt a version of a defined contribution model in which the employer sets an amount to contribute to coverage and employees pick up the cost of a richer plan if they want it. This enables the employer to predict and budget for health care expenses, typically a major burden for small businesses. It also lets employers give employees the ability to buy up if they choose. Finally, the defined contribution model allows the alliance to demonstrate that employers can offer choice without contributing any more than they are already putting towards health care coverage.

A third selling point is that HealthPass enables employers to offer employees and dependents access to a large network of providers. Employers can let each employee pick the network that suits his or her needs best. This is particularly valuable in New York—while HealthPass is available only to businesses in the five boroughs of New York and

Westchester and Rockland counties, employees may reside anywhere in the tri-state area (New York, New Jersey, and Connecticut).

Marketing and Administration

HealthPass is managed from NYBGH's offices in mid-town Manhattan. A TPA in Florida handles enrollment, does billing and collecting, distributes funds to the health plans, and pays commissions to the brokers. Claims are administered by the plans themselves. The alliance receives a percentage of the premiums to cover the management expenses, and part of that goes towards the fees of the TPA.

To date, NYHPA's biggest expenses have been staffing and marketing. Marketing has been a particular challenge because HealthPass competes with all other health plans in the city's small-business market. To build awareness and stimulate demand, HealthPass initially advertised in subways, with the intent of reaching employees and possibly some employers. The alliance then initiated a direct-marketing campaign targeting decision-makers at small companies. A telemarketer follows up to determine the level of interest, forwarding leads to a core group of committed brokers. NYHPA has also contracted with a direct-marketing consultant to help build enrollment as well as with public relations and advertising firms. Recently, it launched a targeted mass-media strategy, including advertisements in local business publications.

The alliance also markets directly to local brokers and general agents—they hold the key to selling HealthPass—with educational seminars and personal meetings. In addition, it gives brokers packets that contain all the materials they need to explain the product and sign up employers.

KEY ISSUES AND CHALLENGES

Those responsible for planning, launching, and managing the purchasing alliance say every aspect of it has been more challenging than anticipated. For example, it was surprisingly difficult and time-consuming to find a TPA that could be flexible in adapting to different health plans' systems and handle accounting at the level of employees rather than employers (necessary since each employee picks his or her own plan). Major challenges the alliance faces at this time include:

Achieving Sustainability

NYHPA must become self-sustaining before its contract with the city ends in 2002. The staff says 5,500 members are required to generate income sufficient to cover expenses. The staff's ability to achieve adequate sales rides on several factors, including the brokers'

willingness to push HealthPass aggressively and marketing's effectiveness in building greater awareness and stimulating word-of-mouth among small businesses. Retention of members over time is also critical. So far, HealthPass has done well in this area, with a retention rate of more than 90 percent. As with any start-up, staff and board members say they remain confident but wary. Expressing concern that HealthPass may be a niche product with limited appeal in the larger market, one board member suggested that membership might hit a threshold level that it will not be able to exceed. If only a segment of small businesses can afford any coverage, the potential market may not be as big as it seemed. If HealthPass cannot support itself, the program may have to disband.

Earning Broker Loyalty

Like all small-business insurance systems, the success of HealthPass is dependent upon the willingness and ability of brokers to push the product. Some purchasing alliances have tried to cut expenses by working around the local brokers, but that approach has met with little, if any, success. Most have had to revamp sales strategies to incorporate the broker distribution system.

HealthPass has encountered some challenges in the broker community. Many were selling HealthPass just like any other health plan because they did not understand the program's unique features. In particular, they did not appreciate or market the appeal of offering choice to employees. The alliance has also had to explain the idea of a defined contribution and how employers can benefit from this approach.

A complication in the New York market is the prominent role of general agents, who control 90 percent of small-business coverage, including health care, dental, life, and other forms of insurance. In New York, more than 7,000 brokers can sell group health products. General agents provide marketing and administrative service—i.e., these agents serve as a go-between for the carriers and the brokers. A broker may make the sale, but an agent might serve as the benefits manager for the group. General agents also perform marketing and back-room services for carriers, which saves the health plans money because they do not need a direct sales force. Therefore, the alliance has had to cultivate relationships with general agents in addition to educating and meeting the needs of the brokers.

To make these challenges manageable, the alliance decided to focus relationship-building on the fairly small subset of brokers who appear to be responsible for the lion's share of the business, as well as the agents who were willing to commit themselves to HealthPass. To find them, NYHPA took the unusual step of issuing a request for

proposals (RFP) to general agents, which allowed it to be selective about who participated in the program. Since the agents were not accustomed to RFPs, those who bothered to respond were truly interested in representing the product; this helped the alliance identify those most likely to push HealthPass.

The current strategy is to cater to a small group of brokers and agents and include them in planning. For example, NYHPA introduced a continuing education credit program in the fall of 2000 to develop loyalty among the brokers. Not only does this program create a way to build relationships with brokers, it also helps to position the alliance as a partner who is aware of and responsive to their needs. The general agents have helped by hosting the educational meetings with brokers and handling direct mailings.

While NYHPA cannot increase brokers' financial incentives (which are competitive with those for other products), it has taken steps to decrease expenses associated with selling HealthPass. One example of this is the information packet that the alliance gives brokers to use with their clients. Another is the software developed for their use. Having learned that the software brokers used to present options to employers was not compatible with HealthPass's options, NYHPA created and distributed separate software that enabled the brokers to present HealthPass in a similar way. However, HealthPass still cannot be compared directly to the products of other health plans.

Getting Health Plans to Participate

NYHPA has had mixed success in convincing health plans to participate in HealthPass. It has not yet been able to convince any of the better-known national plans to participate. However, it did attract several plans whose networks complement one another, so businesses can offer employees a choice of networks that together cover the entire tri-state area.

Health plans' skepticism about purchasing alliances—especially that of national plans that had bad experiences with other alliances—was a big stumbling block. Some purchasing alliances in other parts of the country had had limited success in attracting enrollment. Also, health plans were concerned that the alliance plan would compete with their own small-group business. Another issue was the fear of adverse risk selection. Therefore, NYHPA emphasized HealthPass's potential to get plans a bigger piece of the small business pie, rather than to take business away from their existing products. Since the employee chooses the plan, the HealthPass model offers the opportunity to capture some lives from many employers, rather than lose an entire firm's business to a competitor. The

alliance also focused on ways to mitigate the risk-selection issues, primarily by establishing and enforcing rules to prevent health plans from becoming a dumping ground for poor risks. NYHPA requires that at least 75 percent of eligible employees participate in a health plan, whether or not it is one of HealthPass's. This reduces the risk of adverse selection. In addition, the alliance is diligent about limiting enrollment to people who are eligible for benefits—e.g., it monitors enrollment to ensure that member groups are not suddenly adding older, uninsured relatives to their employee rosters. Unlike other alliances that set unilateral guidelines for what the plans must do, NYHPA is committed to working in partnership with the plans to make risk-related decisions. To the extent it was feasible, the alliance's policies mirror those common in the small-business market, so HealthPass is no more susceptible to risk selection than any other product the plans may offer. While it is still too early for the participating plans to provide conclusive data, initial information (such as the age and gender of enrollees) suggests that risk selection is not occurring.

A representative of HealthNet (formerly PHS Health Plans), one of the four participating plans, indicated that their positive experience with a Connecticut purchasing alliance (CBIA) encouraged them to take part in HealthPass. HealthNet also saw HealthPass as an opportunity to enhance its visibility and brand recognition in the New York market. While there was initial concern over potential replacement, the HealthNet representative is not aware of any significant impact on existing business so far. The health plan was pleased that the development and implementation of HealthPass was very careful and deliberate, and that program planners took the time to learn from other alliances' experiences. Finally, HealthNet suggested that the health plans appreciate their ability to retain a sense of control since the alliance involves them in design decisions and makes sure that all participating plans agree on any changes to the program.

Keeping Large Employers Involved

We had hoped our research would reveal whether or not a business coalition's decision to sponsor a product for small employers reflected an explicit desire to help address the needs of that segment of the market. If that was the case, we further hoped to learn what was driving that desire. We found that the problem of unaffordable health care coverage for small companies and their workers does not capture the attention of the top management of New York's large employers, although they may certainly be aware of and sympathetic to the issue. As one board member noted about his superiors, "health care is not relevant to their bottom line." Rather, the involvement of large employers results from the benevolence of specific executives who participate on the board of the business group. Their interest in being part of the solution to this societal problem is largely a function of their personal commitment to and concerns about health-care coverage issues. In some cases, their ability to act upon those concerns also reflects the cultures of the corporations

for which they work. Two of the three board members interviewed for this study indicated that their companies fully supported their involvement in activities that would benefit the community, and that their involvement was consistent with the company's ethos. However, none were specifically directed by their managers to pursue a project that would benefit either the uninsured or small businesses. Moreover, all noted that should they leave or move into a different position in the company, their successors would not necessarily support the program.

If the NYBGH's current level of support and enthusiasm for NYHPA truly depends on the commitment of individuals rather than organizations, this may pose a challenge when those individuals move on. How can the alliance cultivate other individuals to take the place of its current board members? The current plan is to change the composition of the HealthPass board so that it better represents the interests of small businesses, but the board will still need large-employer representatives to share their perspective, their experience, and presumably, their clout.

Working with Regulators

During the planning stages, the HealthPass staff invested a lot of time and resources in dealing with the New York State Department of Insurance, primarily to determine how NYHPA would be classified for regulatory purposes. In the end, it was deemed a health insurance trust, which allows it to be considered a group for the purpose of buying insurance. However, state regulations prevent the alliance from offering the product that the staff believes would be best for the small-business market. With one of the strictest approaches in the nation, New York law requires insurers to use community rating for groups with 50 or fewer employees; larger groups can be experience-rated. This means that health plans cannot offer a less expensive product through NYHPA than they offer directly to small businesses. To qualify for experience rating, the alliance would have had to represent 10,000 lives on the date that HealthPass was issued.

Meeting the Needs of Small Employers and Their Employees

HealthPass does not pose a barrier for employers already committed to offering coverage because they do not have to make a bigger financial commitment to HealthPass than they do to any other product they could offer. Still, cost remains the biggest barrier to coverage for many employers and employees (especially for families), and HealthPass is no *less* expensive than comparable commercial products. This problem is compounded in New York because the basic benefit package that the state mandates is very rich. Further, New York's requirements for community rating for small groups leads some younger and healthier people to stay out of the small-group market. Those with household incomes

between $18,000 and $40,000 are hardest hit because they are not eligible for government assistance but usually cannot afford the coverage on their own. Over the past year, HealthPass worked with its carriers to develop lower-cost products that will become available this fall. However, NYHPA anticipates that affordability will be a continuing problem as rates continue to rise.

Building Awareness, Generating Interest

Marketing has been and continues to be a huge challenge for NYHPA, which must compete with large health plans with much greater resources. Looking back, the alliance is unsure about the effectiveness of its initial mass-marketing plan, although results of recent focus groups suggest that the subway advertisements may have helped to build awareness and to set the stage for the direct-marketing campaign. The alliance also tried a radio campaign early on, but did not have the money to buy enough spots to make an impact. The direct-marketing campaign has been more promising: its response rate has hovered in the .5 percent to .6 percent range, which is typical for this kind of solicitation. It is too soon to predict the effectiveness of the targeted mass media, but the staff is optimistic.

Competing with Health Plans

The alliance has found that it cannot afford to compete with health plans for high-level staff. It has had to be creative and patient in its staff recruitment efforts in order to attract high-level staff members who prefer the rewards that HealthPass can offer, such as entrepreneurial opportunity and a social mission.

Incorporating Information on Quality

A remaining challenge involves incorporating quality information into the program. The RFP that went out to the health plans in 1999 requested information on financial stability and set some specific standards for other aspects of performance, but it did not emphasize the use of quality measures for monitoring or reporting purposes. However, NYHPA staffers say that they clearly signaled the health plans that an eventual program goal would be to provide information on quality to employers and consumers. First, the alliance wants to enroll enough covered lives to enable it to have some leverage over the plans. The small size of HealthPass could be a stumbling block, but one board member noted that because it is a subsidiary of NYBGH, the alliance will not be alone in its negotiations for quality information—it will have the combined leverage of the more than one millions lives represented by the large employers and the city. A second and equally important reason for the delay is the need to focus the small staff on immediate concerns. While NYHPA may want the information on quality, there is a limit to how much its staff can handle during the start-up phase.

LESSONS LEARNED

- **Secure a solid source of start-up funding.** There was broad agreement that this program could not have happened without the city's financial support. One board member noted that corporations may chip in $5,000 to $25,000 at best—and most grants are at the lower end. Therefore it would take a large number of companies to match the support from the public coffers. In this case, the city clearly regards HealthPass as a good use of public seed money—it allowed the city to do a lot with a limited investment.

- **Focus relationship-building on the subset of brokers that really matters.** Rather than trying to market to everyone, NYHPA made a point of identifying and cultivating a small number of brokers and agents who demonstrated an affinity for the product and were willing to explain it to their clients. In addition to educating them about HealthPass, the alliance supports brokers by generating leads, working with them to develop useful materials, and helping them reduce the time and effort required to sell HealthPass.

- **Be a big fish in a small pond.** The alliance purposely chose a TPA that would allow it to be a big fish in small pond. The staff believes that this decision resulted in a level of personalized attention that the alliance would not have received had it contracted for administrative services with a larger, more rigid organization.

- **Target marketing dollars to get the greatest bang for the buck.** NYHPA learned the hard way that it could not afford a mass-marketing strategy, and it could not compete with larger, richer health plans on that basis. While the current strategy of direct marketing to decision makers at small businesses is still too new to evaluate, it appears to be an effective and efficient use of the alliance's resources as well as a good way to strengthen relationships with brokers.

- **Cultivate board members from companies that value community activities.** A program of this kind is more likely to get support from representatives of companies that are rooted in the community, emphasize being a good corporate citizen, and support employees' efforts to contribute locally. Generally, older, mature companies are more involved in charitable community-oriented activities, but that may not be the case in every community. It is also important to have board members who can make commitments on behalf of their corporations.

- **Don't underestimate the amount of time or money needed to launch a small-business product.** It took two years and significant help from the city for

NYHPA to launch HealthPass. In retrospect, the staffers indicated that they had not anticipated how long it would take to complete each step. Time-consuming activities included negotiating with health plans, setting up administrative systems, developing rules for the program, getting approval from the state insurance department, and setting up an infrastructure (i.e., the office and staff). Similarly, the city did not anticipate the need for money beyond the initial seed money. In addition to its capital investment, the city devoted considerable staff time to program operations.

THE PACIFIC BUSINESS GROUP ON HEALTH'S PACIFIC HEALTH ADVANTAGE (PACADVANTAGE)

OVERVIEW

In 1992, the California legislature passed Assembly Bill 1672 to create the Health Insurance Plan of California (HIPC), the state's voluntary small-employer health-insurance purchasing pool. The HIPC, which became operational in July 1993, was established to make health coverage more accessible and more affordable for small employers. It was privatized in 1999, in accordance with requirements in the authorizing legislation. After two rounds of responses to an RFP and a court challenge to its first award, the Managed Risk Medical Insurance Board, the state agency that had overseen the HPIC, awarded it to the Pacific Business Group on Health (PBGH), an experienced, well-established health-care purchasing coalition of large employers that represents 3 million lives. PBGH's Negotiating Alliance, the purchasing vehicle for the large groups, represents 500,000 lives. Under PBGH's management, the HIPC has been renamed Pacific Health Advantage (or PacAdvantage).

THE IMPETUS FOR PBGH'S INVOLVEMENT

PBGH had several reasons for its interest in taking over the HIPC. First, it represented an opportunity for growth—at the time, PBGH was trying to increase its leverage with health plans, which were themselves consolidating and growing, by representing more lives. By adding the 140,000 lives that the HIPC represented, PBGH hoped to improve its position vis-à-vis the health plans, some of which overlapped with the plans that were already negotiating with PBGH. Other motivating factors included opportunities to:

- introduce PBGH's quality and data initiatives to the small-group market,
- help the small businesses that were customers of many of the companies represented on PBGH's board , and
- learn whether and how PBGH could apply HIPC's small-group risk-adjustment methodology to large groups.

There were also financial benefits. PBGH anticipated that the cash flow generated from the administrative fees for operating PacAdvantage would provide additional funding for its quality initiatives and other value-based purchasing activities, which would benefit both PacAdvantage and the large groups. The 3.5 percent administrative fee that PBGH realizes from the $250 million cash flow of PacAdvantage premiums is expected to generate approximately $875,000 in annual revenue. Also, because its new role with small employers would be an extension of its established role with large employers, PBGH

expected that it would be able to take advantage of shared efficiencies in administrative and negotiating processes.

The only drawback to taking on the HIPC was that it was likely to divert staff and resources from PBGH's core mission, which is to serve the interests of its large employer members. Survey respondents noted that the first year of operating PacAdvantage was difficult because PBGH had to choose a TPA, negotiate with new, small health plans, and fight legal challenges when the award was contested.

PROGRAM DESCRIPTION

As of the end of 2000, PacAdvantage is a separate 501-C-3 company that holds contracts with health plans and with approximately 10,000 small employers representing about 140,000 lives.

The Offering

PacAdvantage currently offers 13 health plans including an indemnity plan with carve-outs, and triple-option managed care plans with HMO, POS, and PPO benefits. The highest enrollment continues to be in HMOs, as it was with the state-run HIPC.

Eligibility Criteria

Eligible firms must have between two and fifty employees. Eligibility applies to full-time employees (30 to 40 hours per week) and part-time employees who work at least 20 hours per week. A minimum of 70 percent of eligible employees in a company must participate. The employer's contribution to premiums must be equal to at least half of the lowest-cost single-coverage age-based premium for the plans that its employees are eligible to join.[1]

Marketing and Administration

Using PBGH employees and California-licensed insurance brokers, PacAdvantage handles all operating, oversight, marketing, and sales. Benefit Partners Inc., a California TPA, does billing and other administrative functions.

Major Changes to the HIPC

Privatization has brought several significant changes to the HIPC. Since taking over, PBGH has taken several steps to make the program more competitive with other small-group products by making it mirror the market. New policies include individual company anniversary dates (the state had a single anniversary date of July 1 for all employers

[2] T. Buchmueller, "Managed Competition in California's Small-Group Insurance Market," *Health Affairs* 16 (March/April 1997): 218–228.

regardless of enrollment date), an updated benefit design, and 12-month premium rate guarantees for employers. The strategy to make PacAdvantage look and behave more like other plans in the market is evident in a more aggressive approach to broker relations. PBGH is dedicating staff to marketing to brokers and making their job easier. It has also developed a relationship with a general agency that can service brokers on PacAdvantage's behalf. Finally, PBGH has introduced a quality initiative that provides participating PacAdvantage health plans with additional payments for achieving specific quality targets in customer service, claims processing, and Health Plan Employer Data and Information Set (HEDIS) measures.[3]

KEY ISSUES AND CHALLENGES

Penetrating the Small-Employer Market

A 1999 survey found that the California small-employer market represents 12 to 13 percent of the entire workforce.[4] The same survey revealed that California's small employers offered health insurance coverage at a lower rate than small employers nationally—41 percent of California firms with 3 to 9 employees and 62 percent of firms with 10 to 50 employees offer health care coverage, compared with 55 percent and 75 percent, respectively, at the national level. A recent Kaiser Family Foundation report says that 64 percent of small employers in California who do not offer health insurance believe premiums are too high.[5] This relatively low level of interest in offering coverage (or the ability to do so) is reflected in the HIPC's progress in meeting its enrollment goals. Initially, HIPC's designers had forecast an enrollment of 250,000 at the end of two years, which would have required 10,000 new members per month. The table below shows that while enrollment has steadily increased (although at a declining rate[6]), the expectations for enrollment were not achieved.

HIPC Enrollment, July 1994–1998

Year	Total Enrollees (employees and dependents)	Annual Percent Change
1994	58,017	N/A
1995	92,064	59%
1996	113,081	23%
1997	132,313	17%
1998	140,740	7%

Source: California Managed Risk Medical Insurance Board.

[3] J. Yegian, T. Buchmueller, M. Smith, and A. Monroe, "The Health Insurance Plan of California: The First Five Years," *Health Affairs* 19 (September/October 2000): 158–165.

[4] Henry J. Kaiser Family Foundation, Health Research and Educational Trust (HRET), Center for Health and Public Policy Studies at the University of California, Berkeley, "1999 California Employer Survey," January 2000.

[5] Ibid.

[6] J. Yegian et al., 2000.

It is unclear how much credit PacAdvantage can take for the improvement in coverage among small employers in California. Compared to the results of a pre-Assembly Bill 1672 survey,[7] a 1995 survey pointed to an increase of 10 percentage points (from 47 percent to 57 percent) in small-employer coverage. These findings are consistent with HIPC enrollment data, which show that 20 percent of new enrollees were previously uninsured. However, there is no evidence to indicate how much of this improvement is attributable to the HIPC. It is difficult to isolate the effects of small-group reform laws (part of AB 1672), the HIPC, the healthy economy in the late 1990s, and competition in the small-group market. For example, some say that increases in small-employer coverage would have occurred with or without the HIPC. A 1997 survey supports this view, finding that new offerers (small employers who had been offering insurance two years or less) were no more likely to participate in the HIPC than employers who had been offering insurance for more than two years.[8] These findings support one respondent's comment that any increase in coverage uptake "may be likened to taking a portion of the insured market out of the left pocket and putting it into the right one." Others believe that the HIPC is one of the factors that contributed to the increase in coverage.

Building Relationships with Brokers

"Brokers are the small employer's health insurance consultant—they do it all," an industry representative stated. Initially, the HIPC did not recognize the brokers' value, seeing them purely as a middleman, a part of the process that could be eliminated to save money for small employers. Consequently, its stance toward the California broker community was unprecedented. First, small employers could enroll directly through the HIPC commission-free and thus bypass the broker (and the broker's fees). (Nevertheless, 70 percent of firms joining the HIPC during its first three years enrolled via brokers, which shows employers' attachment to them.) Second, the HIPC itemized broker commissions on the employers' bills, which, intentionally or not, reminded the employer how much the broker charged. Third, the HIPC paid brokers less than market rates for their services. These policies engendered animosity[9]—many brokers refused to promote the HIPC[10] and, say interview respondents, may have shifted higher-risk groups to the HIPC.

The HIPC later reversed these policies by raising broker commissions (sometimes higher than rates in the rest of the market), charging small employers a fee similar to a broker's commission for enrolling directly, and rolling broker commissions into the

[7] T. Buchmueller, 1997.

[8] S. Long and M. Marquis, "Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs* 20 (January/February 2001): 154–162.

[9] J. Yegian et al., 2000.

[10] S. Long and M. Marquis, 2001.

premium rather than itemizing them. Although all three reversals were clearly intended to heal broker relations, one respondent suggested that the decision to impose a fee for direct enrollment might have also signaled that the HIPC had begun to experience higher administrative costs. In addition, some respondents suggested that the broker friendly policies might have been implemented too late to fully counter the damaging effects of earlier policies.

PBGH is actively marketing to brokers and implementing services to address their needs. In addition to a staff of four marketing people who work with brokers full-time, the coalition has contracted with a general agency that puts about 15 people at PacAdvantage's disposal to serve brokers. The state had not worked with general agencies or provided overrides (fees paid to the agencies for servicing the brokers). PBGH has also developed an on-line quote system that allows brokers to get immediate information. This system has been getting 1,000 requests per month, and, says PBGH, has had a significant impact on sales.

It will be interesting to see what effect the effort to cultivate relationships with broker s has on small employers' awareness of PacAdvantage. In 1997, only 40 percent of employers offering insurance were aware of the HIPC.[11]

Negotiating Lower Costs for Small Employers

Initially, HIPC premiums were 10 to 15 percent lower than those of the outside market.[12] More recently, rates have been comparable to those available in the outside market.[13] Another report finds that the HIPC's 1997–98 HMO premiums were slightly higher than those available in the outside market for comparable plans, adjusting for differences in benefit design.[14]

It remains to be seen whether PBGH can have an impact on lowering the premiums for small employers enrolled in PacAdvantage. Prior to becoming PacAdvantage, the HIPC had not achieved an enrollment base large enough to offer lower prices than the outside market. This inability to negotiate lower rates has been cited as the principal cause of HIPC's low market penetration. However, while its large enrollee base may give PBGH more negotiating clout with the plans, it is not clear whether or not the coalition will be able to overcome the obstacles that undermine other small-business purchasing

[11] Ibid.

[12] T. Buchmueller, 1997.

[13] E.K. Wicks, M.A. Hall, and J.A. Meyer, *Barriers to Small-Group Purchasing Cooperatives* (Washington, D.C.: Economic and Social Research Institute, March 2000).

[14] J. Yegian et al., 2000.

alliances. A recent report concludes that purchasing pools achieve little, if any, economies of scale.[15] As health economist Mark Pauly puts it, "You cannot make a giant just by rounding up a passel of midgets."[16]

The HIPC had expected insurers to have lower administrative costs because it was performing some of the functions (e.g., enrollment and premium collection) that health plans would normally have handled themselves. However, most insurers did not experience administrative cost savings—the amount of business HPIC generated for the plans was not enough for insurers to justify changing their administrative procedures to take advantage of the work the HIPC was doing. Thus plans were duplicating some of the work done by the HIPC, and the HIPC's administrative costs became an add-on. This suggests that PBGH will have to lower its own administrative costs or work with the plans to ensure that employer groups are not paying twice for the same functions.

Managing the Risks of Small Employers

The HIPC employed two strategies to combat risk selection—benefit standardization and risk-adjusted payments to plans. Participating plans were required to offer two standard benefit options, differing only in the amount of patient cost-sharing (the two options were slightly different for HMOs and PPOs because PPOs offer patients the option of choosing providers from outside their network). The decision to limit benefit options had two purposes. First, it made it easier for consumers to compare plans on the basis of cost and quality without the complication of wide variation in benefits. Second, it reduced the risk segmentation that occurs because people with different levels of risk tend to divide themselves systematically among plans on the basis of benefit differences.

While standardization did succeed in reducing the likelihood that any single PPO would be adversely selected relative to another PPO, it did not eliminate the likelihood that PPOs as a whole would be adversely selected relative to HMOs. (Less healthy people tend to like the greater freedom of provider choice.) To compensate for the limits in benefit standardization, a risk-adjustment process became effective in July 1996. The mechanism provided additional payments to plans that had a disproportionate share of high-risk enrollees. These payments were negligible when compared to the high risk and costs the HIPC's PPOs experienced. An HIPC report concludes that its PPOs incurred a 20- to 34 percent higher prevalence of specific high-cost diagnoses when compared to the average for all plans. Also, in 1995–96, the PPOs' premiums were on average 37 percent higher than HMO premiums. This premium differential shifted 90 percent of enrollees to

[15] E.K. Wicks et al., 2000.
[16] J. Yegian, et al., 2000.

HMOs, leaving PPOs adversely selected.[17] Further aggravating the PPOs' situation was a clause in HIPC contracts that prohibited any plan from selling its HIPC product at a lower price in the outside market. This clause tied the hands of PPOs that needed to sell their services for a given amount in the outside market to remain competitive but could not stay solvent if they offered those lower rates inside the HIPC, where the enrollees were comprised a higher-risk population.

Ultimately, risk-adjustment payments were not sufficient to support PPOs' high costs. The payments seem to have been too little too late: PPO plans fell victim to "the death spiral" and eventually withdrew from the HIPC. Some HIPC staff argue that the problem was more than just inadequate risk adjustment—they believe that PPOs were at a competitive disadvantage relative to HMOs because they exerted less control over costs, in part because PPO patients can choose care from non-network providers whom the plans cannot influence. It is also possible that the PPOs were more costly because they were less efficient managers of care. Risk adjustment is not designed to, and should not offset, higher costs due to inefficiency. The market is supposed to penalize inefficiency.

Today, nearly 40 percent of small-employers health benefit programs include a PPO option.[18] Not surprisingly, the HIPC's difficulties in persuading PPOs to continue participating hampered its ability to sign up employers. PacAdvantage now has two PPOs through HealthNet. If they attract a large number of enrollees, they may have enough lives to spread risk and stabilize. On the other hand, it may not be feasible to allow individual employees to choose between a PPO and an HMO within such a small pool.

Maintaining Affordable Choices

The HIPC's most notable achievement was expansion of health-plan choice for small employers. The pre-HIPC market was characterized by a single plan option for most small employers—a 1993 survey showed that 86 percent of small businesses that offered health benefits had only one plan. During this period, small employers could not afford to offer employees choice because of the administrative burdens and costs. HIPC offered a choice of 20 plans at its inception. This may have spurred the outside market to begin offering more choice to small employers. Blue Cross/ Blue Shield, for example, now sells multiple benefit packages in the small-employer market. Even with choice, however, a 1998–1999 report shows that 92 percent of HIPC's enrollees were in HMOs.[19] During the same period, six plans accounted for 80 percent of enrollment, leaving the 10 other carriers to divide 20 percent of enrollment. This could be interpreted to mean that workers in small

[17] T. Buchmueller, 1997.
[18] J. Yegian, et al., 2000.
[19] Ibid.

firms have limited interest in plan choice. If nothing else, HIPC does give them a choice of multiple HMOs— more than many such workers enjoy. However, the high HMO enrollment probably is at least partly the result of HIPC's limited choice of PPOs and their higher prices. The California market has a high degree of provider panel overlap (apart from Kaiser Permanente, which is a closed-panel HMO). This may explain why enrollment is concentrated—because an employee can often see his or her provider regardless of plan or benefit choice, price becomes the deciding factor.[20]

The HIPC's two-percent market share makes it obvious that choice is not overwhelmingly important to most small employers in California[21]. If it were, HIPC's market share would be larger. Still, agents say that choice is the most important selling point for those small employers who do choose the HIPC. Employers are attracted to the cost savings they can realize by offering HMO coverage, but they are often reluctant to force all their employees, whom they often know personally, into a single HMO; also, the owner-employers often prefer a PPO option for themselves. Offering the HIPC allows small employers to realize the cost savings of HMO coverage without forcing everybody into a single HMO.[22] Employers can also tie their contribution to the cost of the least expensive HIPC plan, realizing savings while allowing employees to choose another plan and pay the premium difference out of pocket. The fact that a few plans sign up most of the enrollees even when workers have several choices may simply mean that employees are price-sensitive. It probably also reflects the importance of Kaiser Permanente, which accounts for a large portion of total California enrollment.

Dealing with the Competition

In 1996, California Choice (known as CalChoice), a subsidiary of the Southern California insurance broker Word and Brown, became the first *private* multi-plan small-group health insurance program in California. CalChoice contracts with nine health plans that include HMO and PPO options. Its stated mission is to allow small employers to choose the health carrier they want and the benefit levels they need at a price they can afford.

The CalChoice model is similar to the HIPC in some ways and different in others. Brokers created it, whereas the HIPC was instituted by legislation with a board of directors that saw itself as a buyer representing small-employers in negotiations with health plans. The brokers who run CalChoice do not have such an arm's-length relationship with health plans and do not negotiate over price. Its marketing approach is to make small

[20] Ibid.

[21] E.K. Wicks et al., 2000. Data obtained more recently from PacAdvantage indicate that it has 1 percent of eligible employees and 5 percent of groups.

[22] Ibid.

employers think of their health insurance expense as a defined contribution that still offers employees choice. This has apparently been a relatively successful marketing strategy—as of October 2000, CalChoice had 128,000 enrollees with about 8,400 employers. Taken together, PacAdvantage and CalChoice account for nearly 270,000 covered lives, or almost 4 percent of the potential small-employer market.

LESSONS LEARNED

Since PBGH has not had a great deal of experience with PacAdvantage yet, it remains to be seen whether this group of large purchasers will be able to attract more businesses and significantly affect the level of coverage in California. However, there are still lessons to be learned from the program's recent history.

- **The state can create a product with market value.** The story of the HIPC shows that a state agency can build something substantial that can later be privatized. While PBGH's motivation includes a desire to reform the broader health care market, there is little question that it saw the HIPC as an attractive entity with the potential to grow and to generate income.
- **Competition may be a plus.** Combined, PacAdvantage and CalChoice serve a reasonable chunk of the small-employer market. Competition may help to keep each program attuned to the needs of the small firms.
- **To give small businesses what they really want, coalition-sponsored programs will have to find ways to manage risk.** Employees of small firms tend to want the same kinds of provider choices that employees of large firms prefer, which helps to explain the resurgence in popularity of PPOs. PBGH regards the recent re-entry of PPOs to PacAdvantage as a major marketing coup. But as the HIPC's experience shows, PPOs' attractiveness to employees makes it that much more important that small-group programs either develop a risk-adjustment mechanism to ensure that PPOs are not penalized or design the benefits in a way that mitigates risk selection.

THE ALLIANCE'S
COOPERATIVE FOR HEALTH INSURANCE PURCHASING (CHIP)

THE PROGRAM

CHIP is an array of fully-insured health insurance plans offered primarily to small businesses in the Denver area by The Alliance, an organization created in 1988 to allow businesses to consolidate their health-insurance purchasing power. The Alliance offers a self-insured PPO to medium- and large-sized employers; CHIP is open to smaller employers. As of May 2001, the group served about 2,000 employers (160 in the self-insured PPO and 1,840 in the CHIP). This year, employers who sign up for the CHIP can offer employees a choice of 12 HMOs from three health plans or five PPOs from one insurance carrier. (Prior to January 2001, four health plans were participating.[23]) The Alliance handles all administrative activities, including marketing, billing and collection of premiums, payments to health plans, and monitoring and reporting on selected quality measures for each of the plans.

ORIGINS AND OBJECTIVES

The Primary Impetus: No Clinton Health Plan Here

CHIP's roots go back to 1993–94, when President Bill Clinton was actively promoting his health-care reform package, which was designed to decrease the number of uninsured workers and to enhance choice of health plans. At the same time, some members of the Colorado legislature were pushing a similar initiative called Colorado Care. A number of Colorado business leaders (including Alliance board members) felt these proposals involved the government too much in the health care industry. CHIP was designed as an alternative to a government-led initiative to broaden coverage among workers and their dependents.

A Secondary Factor: Reducing Cost-Shifting

Along with a philosophical bias against more government involvement in health care, large Colorado employers had a financial interest in expanding coverage to small employers. Because many small companies did not offer insurance, large employers ended up financing care for small businesses' employees—at least partially—through higher health insurance premiums.

[23] On December 31, 2000, PacifiCare pulled out of the CHIP program, leaving three health plans from which to choose. Alliance management does not believe that PacifiCare's withdrawal will have a meaningful impact on employee choice, since there was significant overlap between the provider networks of PacifiCare and the other two IPA-model plans, Anthem Blue Cross and Aetna US Healthcare.

The Alternative: Group Purchasing for Small Employers

Large employers in the Denver area began promoting changes in legislation that would allow small employers to enjoy some of the same benefits as larger buyers. They pushed for legislation that would allow the formation of purchasing cooperatives that could aggregate small employers for the purpose of buying a fully insured plan. (At this time, such cooperatives were illegal in Colorado.) They also favored allowing some form of community rating for small employers to prevent insurers from rate banding, which effectively gave younger, healthier employees access to affordable coverage, while higher-risk populations were either unable to obtain insurance or unable to afford whatever insurance was available.

The result was the passage of two bills in 1994. House Bill 1210 allowed modified community rating for groups of one to 50. Under this law, insurers had to guarantee the issuance of insurance for any small employer, with prices based on community rates that were formula-driven and consistent—they could be modified only on the basis of the age profile and geographic distribution of the company's employees. House Bill 1193 was a companion law that allowed for the creation of an organization that pooled small employers and negotiated with health plans on their behalf.

The Alliance launched CHIP shortly after these bills passed. Some financing came from the large-employer community, which donated approximately $750,000 that had accumulated as surplus from The Alliance's self-insured PPO. The John A. Hartford Foundation contributed another $1 million. In 1995, the Alliance issued an RFP to health plans operating in the state. Eight plans responded, and four were chosen: Kaiser Permanente, FHP of Colorado (later acquired by PacifiCare), Frontier Community Health Plan (later acquired by Aetna US Healthcare), and HMO Colorado, the Blue Cross and Blue Shield plan now known as Anthem Blue Cross. In 1995, each plan signed a contract that committed it to participate for three years. The contracts placed no limits on price levels or future increases.

Goals: Promote Access to Insurance, Broaden Choice

The goals of the state legislature and The Alliance in promoting the development of small-group buying cooperatives were to encourage small businesses that could not afford insurance to take advantage of group purchasing and community rating and to offer employees a choice of health plans.

HOW CHIP WORKS

Operating Environment

The state of Colorado and the Denver metropolitan area are home to many small businesses. In fact, companies with less than 100 employees account for approximately 98 percent of the state's 245,000 businesses. More than six in 10 are owned and operated as sole proprietorships. Of businesses with non-owner employees, nearly 60 percent have fewer than five employees, 78 percent have fewer than 10 employees, and 96 percent have fewer than 100 employees. Companies with fewer than 100 employees created three out of every four net new jobs in the area during the first half of the 1990s.

According to a survey of Colorado members of the National Federation of Independent Businesses (NFIB), six out of 10 small businesses do not offer health insurance, a figure greater than the national average. The primary reason is straightforward—company executives do not believe they can afford to offer it. The same survey found that health care costs were the second most important issue for small businesses, right behind recruiting and retaining employees. The problem has only gotten worse over the last few years, as a cycle of aggressive pricing by health plans (to gain market share) ended, and was followed by double-digit increases in health insurance premiums. In addition to the insurance market cycle, the increases are the result of rising medical costs and increased demand for medical services. It is in this environment that CHIP has been marketed to small employers from interviews on site visits.

The Program Today

Businesses that want to sign up for CHIP must get at least 75 percent of their employees to participate. In addition, the employer must cover at least 50 percent of the cost of the lowest-priced plan. Employees may choose from 12 health plans—four from each of the three participating insurers. The "Basic" and "Standard" plans have state-mandated benefits. CHIP defines the benefits for two more comprehensive plans—Plus HMO and a POS version of Plus HMO. In the beginning, employees were free to choose either the HMO or POS version of Plus HMO, but objections from the participating plans (primarily related to administrative issues and concerns about potential adverse selection into the POS plan) led to a change in the 1998 renewal contract. Now, employers decide up front to offer employees either the HMO or POS option. In spring 2000, The Alliance also began offering fully insured PPOs (five options from Blue Cross) to small employers.

The Alliance handles all marketing and administration for the program. This includes developing advertising materials and campaigns, supporting the broker community, paying broker commissions, billing and collecting premiums from employers,

paying health plans, and monitoring and reporting on selected clinical and service quality measures (e.g., member satisfaction, phone response time and abandonment rates, mammography screening rates, and pediatric immunization rates).

RESULTS

Reasonably Strong Growth

The CHIP has enjoyed strong growth throughout most of its existence. After signing up nearly 9,000 lives in its first 15 months and 17,000 in the first two years, growth slowed in late 1997 when health plans began aggressively competing for business by offering low rates. Some small employers began to bypass the CHIP because they could get better rates directly from the insurance companies. By 1999 rates began increasing at a rapid pace (20% or more). At that point, the prospect of broader choice at reasonable prices through the CHIP became attractive again, and rapid enrollment growth resumed. As of May 2001, roughly 1,840 companies had signed up for the CHIP. Together, these companies cover 30,000 employees and dependents, representing roughly three to four percent of the small-group market in the metropolitan area.

Main Benefit: Broader Choice

The results to date would suggest that the CHIP has been quite successful in achieving its objective of offering broader choice to employees of small companies. In fact, surveys of companies that sign up for the CHIP suggest that approximately nine in 10 previously offered health insurance. The majority of these employers had offered only one health plan. In such instances, CHIP did not provide access to insurance per se, but an opportunity for employees to choose among a number of plans. No hard data are available, but Alliance and health plan representatives suspect that rapidly growing companies that have a hard time attracting and retaining workers use the CHIP as a way to enhance their benefit packages and become more attractive to hard-to-find workers.

Some companies attracted to the CHIP's greater choice are medium-sized employers with more than 50 workers. In fact, while companies with fewer than 50 workers/dependents account for just over 90 percent of enrollment, they represent only half of the 27,000 enrollees. Companies with more than 50 employees/dependents represent 8 percent of CHIP employers and 52 percent of enrollment.

Secondary Benefit: Access to Insurance

The CHIP is making only a minor contribution toward reducing the number of uninsured workers in the Denver area. Surveys show that roughly 10 to 12 percent of CHIP companies did not offer insurance previously. Therefore, perhaps 2,500 to 3,000

people have so far gained access to health insurance because of the CHIP. More small companies have not gravitated toward the CHIP because its prices are slightly higher than those most small employers could get by buying directly from an insurance carrier. So most employers who did not offer coverage before the CHIP came along are unlikely to see its availability as a compelling reason to start doing so.

KEY ISSUES AND CHALLENGES TO DATE

Attracting Employers Who Don't Offer Insurance

When the CHIP was launched in the mid-1990s, Alliance management was convinced that the group-purchasing model could result in administrative cost savings that could be passed on to small employers in the form of lower premiums. It was hoped that these lower premiums, in turn, would encourage some small employers who did not offer insurance to do so. This expectation has not panned out. The plans' prices for CHIP options, combined with the additional fees that the Alliance charges to cover administration, are typically a little higher than a small employer could get by buying directly from one of the carriers. The root causes of CHIP's higher prices (and thus its lack of appeal to small employers who do not offer insurance) are not completely clear. A variety of potential explanations exist:

- Economies of scale for administrative expenses have not yet materialized. Problems with outsourcing administration of the CHIP have led to inefficiencies at The Alliance and the health plans. The Alliance believes that its administrative expenses have historically been too high, and that they can be brought down significantly. The health plans believe they are incurring additional administrative costs for CHIP plans—expenses that they would not have with their own direct-to-small-employer offerings. For example, the health plans absorb significant costs associated with reconciling their books for CHIP members, in part because the CHIP has not provided the plans with employer-specific codes. (Even though all employers have the same plan design, they each have different rates based on the age profile and geographic distribution of their employees.) This problem is being addressed, which should reduce future plan administrative costs.

  In addition, some plan representatives feel that CHIP members require more education about the product. While some of these problems can be addressed, it is conceivable that the complexity that comes with broader choice, multiple products for each plan, and the existence of a third-party intermediary (The Alliance) makes the CHIP inherently prone to redundancies and thus more costly to operate. One example of this inherent inefficiency involves the collection and distribution of basic information on CHIP enrollees. The Alliance collects this information and

turns it over in paper format to the plans, which then have to re-enter it into their computer systems. The CHIP is currently trying to implement a system that allows for electronic transfer to reduce the duplication of effort. But even in a world with electronic transfer of all data, the need for so many parties to have access to the same information creates additional complexity and costs.

- Colorado law prevents the CHIP from negotiating on the medical-cost component of the premium dollar. The goal of this legislation was to prevent the CHIP from gaining an unfair advantage due to its size. Therefore the cooperative can negotiate only on administrative costs, which represent only a small portion of the total premium dollar. Even if administrative costs were lowered and the savings were passed on to small employers, it is unlikely that they would have a significant effect on premiums.

- Health-plan pricing policies keep prices higher than direct-to-employer offerings. Even if economies of scale could lower administrative costs and the law on negotiating was changed, it is not clear that CHIP's prices would fall below those of competing small-group offerings. Denver health plans seem to be firmly committed to the idea that CHIP plans should cost more than any direct-to-employer offering because the cooperative offers a higher value to employers and employees in the form of broader choice. Plans also feel they give something up by participating in the CHIP, since the broader choice translates into fewer enrollees per employer group. In addition, some plan representatives believe that dividing a given company's employees among multiple plans creates a greater chance of adverse selection, thus justifying a higher price to account for this risk.

  At this point, Alliance management seems resigned to the situation. They are no longer trying to position it as a low-cost arrangement for employers who do not offer insurance. Instead they market it as a product that can offer small employers and their employees greater choice.

Managing the Administration

Until recently, The Alliance outsourced administration for CHIP. Two different firms have handled the task over the years, and unfortunately, says The Alliance, neither did a particularly good job, resulting in both service-quality and cost problems. Service problems include the timeliness of billing employers, the complexity of those bills, the speed with which changes in employment status have been recognized, and the speed and ease with which accounts can be reconciled. On the cost side, the companies have failed to take advantage of automation and other technologies to the extent that they could have, resulting in unnecessarily high expenses. While these problems do not appear to

have had a meaningful effect on overall enrollment, they reflected badly on the CHIP within the health plan and small employer communities. Consequently, Alliance management recently decided to bring administration in-house. While this will require the purchase of a variety of new hardware and software systems, The Alliance hopes that these investments, combined with better management, will reduce administrative costs and alleviate the service problems.

Measuring and Rewarding Quality

The CHIP was conceived as a way to promote quality improvement in the market. In fact, the legislation that allowed its creation requires The Alliance to publish annual reports that compare plan performance. The Alliance decided to report three service measures (identification card turnaround time, telephone response time, and abandonment/disconnect rates) as well as plan-specific scores on patient satisfaction, access to primary care physicians, pediatric immunization rates, and mammography screening rates and service measures. However, the group had hoped to go well beyond that. It wanted to create financial incentives for improvement. To that end, the original contracts contained provisions that penalized plans that did not meet agreed-upon benchmarks, while simultaneously rewarding strong-performing plans with bonuses. (Penalties and bonuses were paid at the end of the fiscal year out a pool—two percent of premiums that were withheld from the plans). While the penalties and bonuses were fairly small initially, they became large as the CHIP grew. Over time, the health plans became very unhappy with the system, because they strongly disliked the idea of money being transferred from one plan to another. Some observers believe that the plans were gaming the system by building the penalties into their pricing, thus raising the cost to employers. By the time the 1998 contract period rolled around, the plans clearly wanted a change. After a compromise solution also met with resistance, the financial incentive program was dropped. While CHIP report cards are still produced, the impact (if any) they have on promoting quality improvement within the plans is unclear.

Marketing Through Brokers

Without question, brokers are the dominant distribution channels for selling to small employers in Colorado. In fact, the majority of small employers rely on brokers as their primary source of information about health insurance. However, many brokers were negative toward CHIP when it was launched, primarily because they saw it as a competitive threat, and feared that small employers could bypass them and buy directly from The Alliance. Many brokers also found CHIP's system to be more complicated than others in the market, since it offered multiple health plans and multiple options within each plan.

Recognizing that they were the keys to sales growth, CHIP's management has made every effort to recruit and work with brokers. Practically speaking, this commitment has translated into competitive financial terms and superior service. The CHIP pays brokers the full market rate and commits to payments that are "certain and timely." To alleviate fears of being cut out of the equation, the CHIP pays the broker his or her full fee even if the broker is not involved in the transaction. In addition, the cooperative recently dedicated two full-time sales people who are given incentives to sell and service the broker community. (Previously, four salespeople divided their time between the CHIP and the Alliance's self-insured PPO, but Alliance management felt that a dedicated sales force would work better for both products.) These salespeople target brokers active in catering to the small employer market. They spend much of their time explaining the product to the brokers and ensuring that they have the ammunition they need to sell to the employers. The agents also intervene to resolve issues between participating plans and brokers in a timely manner. Finally, the CHIP is arming brokers with a unique Internet tool that gives them instantaneous price quotes for every CHIP product when the broker enters employer-specific information (e.g., age distribution of employees). Only a few competitors offer instant quotes over the Internet, and the CHIP is alone in its ability to give quotes from multiple plans simultaneously. Practically speaking, it is much easier and faster for a broker to give quotes for CHIP products than for those of the competition.

Maintaining Health Plan Participation

The CHIP has generally been quite successful in keeping health plans interested in participating. Eight plans responded to the initial RFP in the mid-1990s. These plans generally felt that the CHIP served an important, growing niche in the market—i.e., small employers who wanted to offer a choice of health plans (which the plans could not offer on their own). Four plans were selected, and all stayed with the program through the first six years. Three of the four have signed on for a third three-year period.

The primary reason for health plan participation was that the CHIP was a way to capture new lives. In fact, the first several years of the CHIP's operation coincided with a highly competitive period in the Denver health plan market when most plans sought to aggressively grow share through competitive pricing. Some also saw participation as the right thing to do, given the push for health care reform to broaden choice and reduce the number of uninsured.

Keeping the health plans on board has not been easy, particularly as the market has shifted away from a "buy-share-at-all-costs" mentality. As this shift has occurred, some of the health plans have raised concerns about how cumbersome it is to participate in the

CHIP. The Alliance was forced to abandon its financial incentive program designed to promote quality improvement because of plan resistance. In addition, several administrative issues have created unrest among the plans, and forced changes. The first involved eliminating the option for employees to choose either the HMO or POS. Now the employer decides this up front. A second problem involved providing plans with a group identifier code that allows them to trace employees to their firms. Now that The Alliance has brought CHIP administration in-house, it has committed to providing this information. Administrative issues were clearly a consideration in PacifiCare's decision to pull out of the CHIP. (That said, company-specific issues, including financial problems that led to a company-wide restructuring, likely played a bigger role in the decision.) And for at least one of the other health plans, the employer identifier code had become a make-or- break issue—had the CHIP not committed to addressing the situation, the plan was seriously considering terminating its relationship.

FUTURE CHALLENGES AND ISSUES

Legislative Changes on the Horizon?

The Colorado legislature appears poised to revisit a couple of issues that are relevant to the CHIP's operations, including modified community rating and inclusion of the approximately 150,000 employers in the state with only one employee ("groups of one") in the community rating plan. Some forces within the state would like to eliminate or at least change the provisions of modified community rating for small employers so as to allow for greater differentiation in pricing based on the underlying risk of an individual employer's employees and dependents. At present, pricing can only be adjusted on the basis of age of the population and geography. Some would like to allow for adjustments based on other risk factors. On the other hand, powerful interests, including the local chapter of the NFIB, are strong supporters of the current version of modified community rating.

There appears to be a great deal of interest in changing the law to exclude groups of one from the modified rating system. Insurers are pushing hard for the change, claiming that these sole proprietors have a tendency to take advantage of the guaranteed-issue provision by jumping in and out of insurance coverage depending on their need for health care services. Even small-business advocates recognize that there is something fundamentally different about the behavior of an employer buying on behalf of other employees and the owner of a one-person shop. Recent legislative changes have attempted to address insurer concerns by placing limits on the ability of sole proprietors to jump in and out of coverage, but it remains to be seen whether the legislature will take further action on this issue.

Offering More Choice While Keeping Plans Interested

The Alliance's senior management believes that the future of health insurance will see consumers take charge of buying their own health plans. They envision consumers being able to choose among a wide variety of health insurance offerings, with add-on products that can be selected to customize plans. Under this scenario, employers would continue to finance a portion of health insurance, although their financial contribution will be fixed, and employees would pay the difference if they opt for a higher-priced plan or optional features such as open access or more comprehensive coverage. Alliance management has tried to modify CHIP to offer consumers this kind of choice—this includes the health plan offerings of today, and the recently introduced self-insured PPO products.

Yet, with only 30,000 lives spread out over three different health plans and a PPO, the CHIP lacks the market clout to make a real difference in price negotiation or quality improvement. Without a massive influx of new enrollees, this market clout may actually decrease as new offerings come on board. Some of the participating health plans already believe that current CHIP volume is spread too thin. It is conceivable that further erosion in the volume that each plan receives from CHIP could mean additional health plans will re-evaluate their commitments to it.

This, the CHIP finds itself at a crossroads. Believing firmly that the entire marketplace is moving toward broad choice of health insurance plans at the level of the individual consumer, the CHIP is striving to become the vehicle to offer that choice to small employers. Yet a proliferation of new products could mean that health plan participants find that the volume of business coming through the CHIP erodes further. The only way to make the model work, therefore, is for CHIP to grow to the point that the proliferation of plan offerings is more than offset by growth in enrollment. Alliance management estimates that the plan needs to grow to 150,000 to 200,000 members to make the model work. It remains to be seen whether the small employer marketplace in the Denver area will embrace CHIP to that extent.

LESSONS LEARNED

The CHIP program in Denver offers a number of lessons. The first set has to do with the market for a choice-oriented product for small employers, including those that do not offer insurance. The second set has to do with operating this type of product in the marketplace:

Lessons on the Market

- **There appears to be a real market for choice among small employers.** Many CHIP employers are actually paying a premium for choice.
- **CHIP does not appear to be an attractive first product for employers who did not previously offer insurance.** Only about one in 10 CHIP companies did not offer health insurance to employees before joining.
- **Health plans appear reluctant to offer their best pricing to a choice product.** Plan representatives clearly believe they are giving something up to CHIP, since volume is divided among different plans. To compensate for lost volume and greater perceived risk of adverse selection, they charge a higher premium, believing that at least some segment of the small employer market is willing to pay it.

Lessons on Operations

- **Start-up funding is critical to the success of this type of program.** Without the commitment of $750,000 from large employers and the $1 million Hartford Foundation grant, the CHIP likely would never have gotten off the ground.
- **Marketing and service activities should be targeted at those who influence the small employers' buying decision.** Brokers are king with the small employers in Denver. The Alliance was wise to focus resources on the broker community, including education, competitive commissions, and timely, responsive service, as well as services that help differentiate the offering, such as the instant Internet quotations.
- **Purchasing alliances should work closely with health plans, and respond to legitimate concerns.** By quickly addressing problems, the Alliance kept all four plans in the program for the first six years.
- **Economies of scale for administration may be a myth—at the very least, they are difficult to realize in practice.**

THE EMPLOYER HEALTH CARE ALLIANCE'S A-CHIP PROGRAM

OVERVIEW

The Employer Health Care Alliance, known as "The Alliance," is a health care purchasing cooperative in Madison, Wisconsin. It began in 1990 as a vehicle for mid-sized and large self-insured employers to engage in direct contracting with providers. In 1993 and 1994, The Alliance developed two fully insured products in an effort to facilitate access to low-cost, high-quality health insurance for small employers:

- The Alliance-Chamber Health Insurance Plan (A-CHIP) improves access to affordable, fully insured managed care plans using local chambers of commerce to pool the lives represented by small businesses.
- The Small Employer Initiative (SEI) offers small groups access to The Alliance's network.

The Alliance

The Alliance was founded in 1990 by seven of the Madison area's largest employers. Facing escalating health care costs, the self-insured employers joined forces in an effort to attain the same kind of discounts that managed care plans were getting from providers in the Madison market. Currently, The Alliance has 175 members, most of which have fewer than 1,000 employees in the coalition's service area. The A-CHIP program represents the interests of more than 300 small employers. Its three programs mean that The Alliance represents about 100,000 covered lives, roughly 5,500 of which are enrolled in the small-group program. The coalition is a non-profit cooperative owned by the member companies. Its board includes nine representatives from the self-insured companies, one voting representative from a small company that uses A-CHIP, and the Alliance CEO. Only self-funded employers can be equity members of the cooperative with voting privileges. Insured employers are non-voting affiliates.

Advantages for Large Employer Members: Discounts and Political Presence

The self-insured employers were successful in leveraging their combined negotiating influence. As a single entity, they contract directly with a large and well-regarded network of providers in south central Wisconsin. The Alliance staff negotiates with and maintains the contracts with the provider network;, processes and re-prices claims for members, and assesses and monitors the quality of network providers. The Alliance also offers a preferred vendor for pharmaceutical and dental benefits.

In addition, the group is involved in health care access and policy issues. The Alliance lobbies on health care issues at the state level, and its CEO sits on a state committee to evaluate access to insurance for small employers. At the national level, The Alliance is a member of the National Business Coalition on Health, which lobbies the federal government, and participates in a national forum on quality measurement and reporting.

Products for Small Employers: The A-CHIP and SEI

While The Alliance's business model is not designed primarily to serve small employers, the organization has attempted to meet the needs of this group as part of its mission to improve access to health care coverage for all employers. Rather than simply generating savings for themselves at a cost to those with less clout in the market, its members like to have a community-wide perspective on health care reform. For example, many of the companies are supporting area health-care improvement initiatives that benefit people other than their own employees. Sponsorship of products for small businesses helps to fulfill their interest in being good corporate citizens, and demonstrates that The Alliance can provide a service that goes beyond the business interests of the individual members.

- **A-CHIP:** The A-CHIP provides access to health insurance coverage for small groups (less than 100 employees) that are members of local chambers of commerce. Since 1994, this coverage has been available in Dane County (where Madison is located) and outlying areas through one managed care plan, Group Health Cooperative (GHC), which offers HMO and POS options. (See below for more detail on this program.)
- **The Small Employer Initiative (SEI):** In 1993, The Alliance began allowing access to its provider network in order to give small employers the cost controls and inflationary protections available to its self-insured members. Under the SEI, two insurers—Blue Cross and Blue Shield of Wisconsin and Midwest Security Insurance Companies—offer small groups (2 to 99 employees) a fully insured product that uses the network that The Alliance negotiates and manages. Currently, the SEI plans cover about 300 employers representing 2,270 lives.

The Alliance regards this initiative as a win-win—small employers benefit from the purchasing power wielded by the large groups as well as from The Alliance's careful selection and monitoring of providers in the network. The Alliance gains by bringing a little more business to its providers, which strengthens its leverage in negotiations. In addition, the arrangement with the insurers provides The Alliance with a small but steady

income. As a result, The Alliance expects to continue supporting SEI for the foreseeable future.

Funding

Members of The Alliance pay a one-time start-up fee as well as monthly access fees. In addition, The Alliance retains a small share of each of its members' claims savings—13 percent for new members; and 10 percent for members of at least four years. These savings are defined as the difference between the providers' charges and the discounted rates that employers actually pay. The SEI also contributes to Alliance coffers, but the A-CHIP does not provide it with any financial benefit.

PROGRAM BACKGROUND

Impetus: Chambers Identified Problem, Approached Alliance

A 1994 survey conducted by the Greater Madison Chamber of Commerce (GMCC) confirmed what other local chambers were finding—access to affordable health insurance was a major concern for their members. In particular, small employers were worried about competing for new hires and losing employees to larger firms that offered generous health benefits. At the time, the Madison area economy was thriving and the labor market was tight. Small employers also expressed concern for their employees' well being and productivity. On behalf of a group of four chambers, GMCC approached The Alliance to discuss ways to help the small-business community.

Designing the New Product

The four chambers and The Alliance created a joint task force that developed a plan for the A-CHIP. Their goals were to:

- provide employers and employees with access to multiple plans with comprehensive benefits,
- stabilize premium increases through administrative accountabilities and efficiencies, and
- minimize the barriers to accessing quality, cost-effective health insurance.

The program was originally designed to ensure availability of coverage to all employers with few than 100 employees, including groups of one. It also aimed to offer a range of coverage options through varying levels of co-payments; rate stability, addressed with a three-year premium structure; competitive premiums (although few plans offered insurance to small groups), and "reasonable" underwriting that would allow the small

employers to be treated like a large group. The structure of the program also included the use of local insurance agents in the sales and underwriting process. The task force put these components into an RFP and sent it to several commercial and managed care health plans.

PROGRAM DESCRIPTION

Group Health Cooperative was the only health plan to respond to the RFP. After negotiations with The Alliance, GHC began offering a plan with the following features:

- A choice of benefit options for employers—three HMOs with different co-pays and a POS. (As of January 1, 2001, the POS option is no longer available.)
- A guarantee that rates will grow no more than 6 percent annually for the first three years.
- Simplified underwriting for groups with more than 10 employees (a policy that has undergone recent changes).
- An open enrollment process once a year.
- Rates that do not vary across geographic regions and are not adjusted for age or gender. (This feature has not been sustainable; rates are now modified for both age and gender.)

Eligibility and Enrollment

The A-CHIP is available only to members of chambers of commerce that have agreed to let The Alliance negotiate on their behalf. Chamber members who choose to enroll must use the A-CHIP as a total replacement for other insurance. At this time, groups of two to 99 employees are eligible to join the A-CHIP. For several years, groups of one (i.e., self-employed individuals) were also able to join—at one point, in fact, groups of one comprised half of the A-CHIP's employer members. However, concerns about adverse selection led GHC to freeze enrollment of these groups in late 1999. A-CHIP's peak membership was about 5,000 members; it now covers about 3,000 lives. It is unclear whether or not changes in the program to bolster GHC's financial situation will enable the plan to boost enrollment.

Key Selling Points

To some extent, the A-CHIP's strongest selling point has been its availability and affordability in a market where few plans are willing to provide coverage to small groups, let alone at a reasonable price. This is especially true for the groups of one who had access to the product until last year. While it had some competition, the A-CHIP's loose

underwriting rules and its use of community rating ensured that it would be attractive to any small business interested in offering health benefits.

Marketing and Administration

Until very recently, The Alliance has played a large role in managing the A-CHIP program. The staff negotiated with the insurer, supported plan administration, and helped train the local chambers and insurance brokers to present the product. That role is changing as GHC takes on greater responsibility for broker relations, chamber relations, and other aspects of marketing.

STATUS

The good news is that the A-CHIP program has been well received by the local chambers of commerce. Owners of small businesses have embraced this opportunity to get insurance for themselves and to offer a decent benefit that can help them attract and retain workers in a competitive labor market. The A-CHIP is being studied by the Wisconsin governor's Small Employer Health Insurance Task Force as a potential model for improving access to coverage in the state.

The Bad News: Withdrawal from Outlying Markets

While the program has had some success in expanding access, recent modifications have had a major impact on enrollment. Serious financial losses led GHC to reconfigure the product offering as of early 2001. These losses were a result of the higher costs of maintaining the network in outlying counties and of adverse selection, particularly by groups of one. To stem the losses, GHC recently decided to restrict the range of the A-CHIP service area, especially in rural areas beyond Dane County, where GHC has to reimburse providers on a fee-for-service basis. (Within Dane County, GHC operates as a staff-model plan.) This change has meant that approximately 40 percent of the A-CHIP's enrollees have lost their health care coverage. At its peak in early 2000, the A-CHIP had 928 employers and roughly 1,900 employees, representing about 5,000 lives. As of March 2001, enrollment is 312 employers and about 1,500 employees, for a total of about 3,000 lives. The number of chambers of commerce offering the A-CHIP program to members fell from 27 in November 2000 to 17 in spring 2001.

Small employers, local chambers, and The Alliance are distressed by GHC's decision, which leaves small businesses outside of Dane County with few affordable options for coverage, but they are powerless to change the situation. While The Alliance remains committed to the A-CHIP, it does not know what, if anything, it can do to make the program work better for both the health plan and the small employers.

Impact of Market Withdrawal on Key Players

GHC's decision to cease offering A-CHIP in outlying counties has been challenged by another insurer. Because of the HIPAA portability laws, insurers must offer coverage to former A-CHIP members (although not necessarily at a price they can afford). Concerned about having to absorb bad risks, Blue Cross of Wisconsin filed a lawsuit in 2000 to stop GHC from terminating some of its groups. The suit created a slight delay in GHC's implementation of the change, but the terminations took place as scheduled in early 2001 after a Circuit Court judge ruled in favor of GHC.

Had Blue Cross succeeded in obtaining an injunction against GHC, the health plan (and The Alliance) could have been forced to find a way to make the A-CHIP financially sustainable in the outlying counties, perhaps by changing the rate structure and underwriting rules. While some employers in that area may have had to drop out as a result, at least not all of them would have lost coverage. However, an injunction could also have had a chilling effect nationwide on the willingness of already reluctant health plans to enter the small-group market.

The loss of a reasonable health insurance option after several years of coverage may be devastating for many small employers, especially if it causes them to lose employees. Other coverage options are not as comprehensive or loosely rated as the A-CHIP. A recent Alliance survey found that about two-thirds of the dropped employers have already obtained commercial coverage, most likely at higher rates. The rest are either turning to expensive, state-sponsored high-risk coverage or rejoining the ranks of those priced out of the market. As a result, many employees will have to fend for themselves in the individual insurance market—while some may be eligible for Badger Care, the state's program for low-income parents and children, most are likely to be uninsured.

In part, the A-CHIP program was designed to meet the needs and interests of the founding chambers. Not surprisingly, the opportunity to participate in the A-CHIP succeeded in drawing many new members to the local chambers of commerce. By joining the chambers and enrolling in A-CHIP, small employers could take advantage of the group rates, the uniform benefit design, and the reasonable underwriting standards. However, what was good news for the chambers may have been bad news for GHC, since the A-CHIP was especially attractive to very small businesses, including groups of one. To the extent that some of these businesses may have joined specifically to get needed health care coverage, this behavior contributed to the adverse selection that bears some of the blame for GHC's substantial losses.

The chambers in the outlying counties have been very concerned about the termination of A-CHIP in their areas. They have held several meetings to develop alternative plans, including one where the State Insurance Commissioner was invited to hear firsthand the distress of the employers. That said, these chambers do not appear to be bitter about the change. One reason was that GHC gave sufficient notice to The Alliance and to the affected employers. Given the scarcity of comparable options, the overwhelming attitude seemed to be that "it was good while it lasted."

KEY ISSUES AND CHALLENGES

In light of the recent changes, the primary challenges facing the A-CHIP concern its ability to recover from the losses and fulfill its original goals in the small-group market.

Improving Access to Coverage

The Alliance has not surveyed the A-CHIP employers to determine whether they are offering coverage for the first time, but estimates that, at best, 25 percent of them did not previously offer insurance. With only 312 employer members and a couple of thousand members, it is unlikely that the product has made a significant dent in the number of the area's uninsured. While The Alliance, the chambers, and GHC are resuming marketing efforts, it remains to be seen whether the A-CHIP can capture more than its current one-percent share of the small group market in Dane County.

Addressing Financial Losses

The news of GHC's financial losses with the A-CHIP did not surprise either The Alliance or the chamber directors. GHC had made them aware of the costs of the plan from the beginning,. The biggest issue was that the plan incurred unexpected costs related to uneven utilization patterns across the network. Staff-model providers in the core GHC area closely monitored and clearly established referral patterns and use of services. Non-staff physicians in the outlying areas were paid on a fee-for-service basis—referrals by these doctors were costly and hard to control. The positive income from Dane County at first made up for the losses GHC experienced in the outlying counties but this approach was not sustainable. After nearly six years, cumulative losses were estimated at more than $1 million—too much for a small plan to absorb. While the fee-for-service payments in the outlying areas were the primary problem, some sources faulted GHC for being "too nice" by offering lenient standards in underwriting and rating. Some also suggested that the incentive system for local insurance agents, who were paid six percent of premiums, may have encouraged them to sell the program to groups that were not necessarily in the plan's best interests. The Alliance and GHC are now making some changes to the program to reduce the risk of the original plan.

Getting Health Plans to Participate

When the original RFP was sent to local insurers, only GHC wanted to participate. Other plans told The Alliance that the A-CHIP was not consistent with their strategic plan with respect to small groups. For some, this seemed to be a way to say that they simply did not want to enter this market; for others, it most likely indicated a reluctance to compete against their existing products for small employers. The plans also were concerned that the program's requirements (such as the inclusion of very small groups and the use of community rating) would invite adverse selection.

With a history of working with some small employers, GHC was not afraid of bidding on a proposal for small groups. A small, primary care staff-model HMO with health centers in Dane County, GHC had a good reputation among its 25,000 members, but was seen primarily as a niche player in the HMO market. When the RFP for the A-CHIP was issued, GHC was looking to augment its reputation and to expand its network to outlying counties. These strategic objectives fit well with the A-CHIP interests.

As hoped, the A-CHIP program has enabled GHC to expand outside its existing service area and to establish relationships with local chambers and local insurance agents. Moving beyond its staff model, the health plan negotiated discounted fee-for-service contracts with providers in the new coverage area. By developing a broader service area to accommodate the chambers, the plan could also sell its products to other employers who were looking for a network beyond the staff-model boundaries. GHC's total membership was more than 50,000 by late 2000. This helped GHC in its negotiations with the hospitals and specialty providers in its original service area. However, the plan's recent decision to limit its service area means that it has also had to terminate coverage for employer groups in the outlying areas that were not purchasing through the chambers, so its membership has decreased accordingly. While the A-CHIP program did help GHC grow, its financial experience has confirmed the suspicions of the other health plans about the riskiness of the benefit design. When The Alliance and the chambers issued a second RFP to six health plans in December 1999, none responded. However, it is possible that other plans will reconsider participating if the employers succeed in making the product less risky.

Paying the Costs of Administration and Marketing

The Alliance has played a large role in developing and supporting the A-CHIP. Its leaders negotiated the original contract and The Alliance continues to hold the contract with GHC. A few Alliance staffers have also devoted a great deal of time to educating local chamber directors on the basics of insurance and on the A-CHIP plan.

Initially, GHC paid The Alliance a small fee per member for marketing and administration. However, since the fee generated little income, The Alliance eliminated it fairly quickly and chose to administer the plan pro bono. Surprisingly, there does not appear to be any resentment on the part of The Alliance staff or board members regarding the costs of supporting A-CHIP. That said, they seem to be in the process of reducing their responsibilities; GHC is now taking over much of the marketing and training work that The Alliance had been doing. Also, while The Alliance's willingness to bear these costs is certainly admirable, and speaks highly of its dedication to this product, other large employer groups are unlikely to adopt this model.

LESSONS LEARNED

- **Take steps to anticipate, modify, and possibly eliminate policies that create additional risk.** Concern about adverse selection stopped some plans from responding to the original A-CHIP RFP, and eventually contributed to GHC's decision to tighten its service area and its policies. As suggested above, one issue is that employers may be joining only when they know they will need care—this was a particular concern when self-employed individuals could enroll. Another problem is that, while participating employers offered their workers the A-CHIP only, they cannot force everyone to join. There is no minimum participation rate. While there are no plans right now to change the rules for A-CHIP groups, Alliance leaders suggest that it may be possible to balance the effects of adverse selection by encouraging (or requiring) greater participation, which creates a wider range of risks. Other small-employer purchasing groups require employees to take up the insurance unless they are covered under another plan. Local insurance agents who handle A-CHIP sales may also have exacerbated underwriting risk. Some observers suspect that eligibility requirements have not been tightly enforced at the local level. For example, some employers may have included non-employee friends or family in their groups so that these people could have access to the plan. The commission arrangement may also have fostered loose underwriting.
- **Be prepared to invest time in the education and training of small employers.** The Alliance director noted that management of the distribution channel is important. However, because most small employers and chambers of commerce have little experience with health insurance, the learning curve is steep. The Alliance invested a lot of time and money in teaching insurance brokers, chamber staff, and small employers how to handle this new insurance option. The chambers of commerce needed to be trained to promote the health insurance options to new and existing business members. Many of their employer members had to be educated on the basic concepts of insurance and eligibility. They also

had to be taught how to structure the benefits and how to present the plan to their employees.

- **Expertise and commitment are good, but clout is better.** Small employers clearly benefited from Alliance support throughout the development and administration of the A-CHIP. The donated time and expertise allowed the A-CHIP to operate at a low cost, and the knowledge and the health benefits experience of The Alliance members helped shape the product. However, while The Alliance remains involved and committed to the A-CHIP's success, the employer group has not been able to solve problems arising from GHC's market losses. Because The Alliance's members generally do not use GHC's network in their own self-insured plans, they cannot exert much influence on GHC or its providers. Short of directly subsidizing the plan, The Alliance cannot keep it the way it was. At best, the large employers can try to use their influence in the community and their relationships with policy makers to help bring attention to the needs of the small employers.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org.** Other items are available from the authors and/or publishers.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms. Volume I: Overview and Lessons Learned* (October 2001). Jack A. Meyer and Lise S. Rybowski. In this report, the authors weigh the potential of purchasing coalitions formed by larger businesses to help small firms offer health insurance to employees. To be effective, the authors say these programs must do more to market to small firms, work with insurance brokers, and collaborate with the public sector.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children's Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation's 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#457 *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* (July 2001). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, The Pennsylvania State University. The authors conclude that the loss of employer insurance should not be used as the primary justification for implementing Medicare buy-in or other reforms for over-55 and over-62 age groups, but instead propose that the better justification for such reforms is the poorer average health status of those nearing age 65.

#468 *Market Failure? Individual Insurance Markets for Older Americans* (July/August 2001). Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman. *Health Affairs,* vol. 20, no. 4. This new study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

#469 *Embraceable You: How Employers Influence Health Plan Enrollment* (July/August 2001). Jon Gabel, Jeremy Pickreign, Heidi Whitmore, and Cathy Schoen. *Health Affairs,* vol. 20, no. 4. In this article, the authors reveal that high employee contributions for health insurance often deter low-income workers from signing up for coverage, even when they are eligible.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs,* vol. 20, no. 4. The author explains that the Medicare+Choice options available to beneficiaries have diminished: existing plans have withdrawn from M+C, few new plans have entered the program, greater choice has not developed in areas that lacked it, and

the inequities in benefits and offerings between higher- and lower-paid areas of the country have widened rather than narrowed.

#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine,* vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

#441 *Medicare Buy-In Options: Estimating Coverage and Costs* (March 2001). John Sheils and Ying-Jun Chen, The Lewin Group, Inc. This paper examines the need for insurance expansions for Americans approaching retirement age and analyzes the likely impact of Medicare buy-in options on program costs and their effectiveness in reducing the numbers of uninsured.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001).

Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication **#415,** presents a detailed side-by-side look at the 10 option papers in the series Strategies to Expand Health Insurance for Working Americans.

#459 *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare* (January/February 2001). Dennis G. Shea, Pamela Farley Short, and M. Paige Powell. *Health Affairs,* vol. 20, no. 1. The article examines whether eligibility for a Medicare buy-in should be based on age or ability to pay.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs,* vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs,* vol. 20, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

Tracking Health Care Costs: Inflation Returns (November/December 2000). Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel. *Health Affairs,* vol. 19, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine.* Available online at www.medscape.com/ Medscape/GeneralMedicine/journal/public/mgm.journal.html.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70,* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 *Current Population Survey* and *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this report examines reasons why 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance,* this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age

Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.