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Health Insurance Purchasing Cooperatives

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Small employers[1] have particular disadvantages as purchasers of health insurance. They often are not well informed about the insurance options available to them because, unlike large employers, they do not have specialized staff to manage their employee benefit programs. Small business owners, who usually make decisions about insurance for their firms, typically have little time or expertise to bring to the task and often must rely on an agent's advice. Even when small employers make informed choices, their health insurance premiums are likely to be substantially higher than what large employers pay for comparable coverage.

One idea for overcoming these disadvantages continues to generate widespread interest—the health insurance purchasing cooperative. People attracted to the idea reason that small employers who join together to purchase health coverage collectively should be able to strike a better deal than they would by acting separately. Acting jointly, it seems that they should be able realize the advantages that large employers enjoy because of their size and bargaining power. If, by aggregating their purchasing power, small employers were able to buy coverage at lower cost, firms not previously offering health coverage might be encouraged to do so, thus reducing the numbers of uninsured. The collective purchasing idea appeals to people of divergent philosophical perspectives because putting it in place does not require major institutional changes or government regulation and does not seem to be very costly.

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This brief compares the expectations of health insurance purchasing cooperatives for small employers with the actual experiences of different co-ops and draws lessons about the potential for similar future purchasing efforts.

The Case for Co-ops

The theory of purchasing cooperatives is straightforward. Acting as a group, small employers should be able to wield the kind of purchasing clout that large employers enjoy in their negotiations with health plans. If they bring many prospective clients to the table, the cooperative should be able to negotiate more favorable prices and to persuade health plans to cater to their particular needs. Collective purchasing might also be expected to reduce administrative diseconomies and thereby reduce the costs of coverage. When insurers serve hundreds of small employers, they incur higher administrative costs than when they serve a single large employer with the same number of employees. It is expensive to send insurance agents to each small employer to explain coverage, handle sales, and service accounts once the coverage is in place. Because each insurer and health plan serving this market has to establish mechanisms and pay people to perform these functions, there is much duplication. If a single purchasing cooperative served small employers, it could presumably consolidate many of the marketing, educating, billing, and servicing tasks under a single roof, thereby realizing economies of scale and lowering the costs of coverage.

The purchasing cooperative approach could potentially bring another advantage to small employers—a choice of health plans for individual employees. Cooperatives typically allow individual employees to choose from the array of plans with which the cooperative has negotiated contracts. Individual employees, rather than their employers, are thus able to decide what kind of health plan best meets their particular needs. If workers leave one job for another position at a firm that buys through the cooperative, they can avoid having to change health plans and therefore avoid changing physicians. Employee choice has particular value in an insurance market dominated by managed care plans, each with different treatment philosophies, expectations of enrollees, and panels of providers. Because of the administrative burdens associated with having health insurance contracts with multiple health plans, few small employers are able to offer individual employee choice except when they participate in a collective purchasing arrangement.

Another advantage often attributed to purchasing cooperatives is risk-pooling. People frequently make the argument that, by joining together, small employers can spread risk by pooling firms of normal risk, higher-than-average risk, and lower-than-average risk. (In this context, "risk" refers to the probability that members of an employer's workforce and their insured dependents will incur medical expenses for which the insurer will have to pay.) The expectation is that coverage would become more affordable for higher-risk groups. Unfortunately, this advantage can seldom be realized in practice. If the legal environment permits insurers to use risk-rating to set premiums for firms that buy coverage outside of the co-op—as is the case in many states—lower-risk employers will typically find it more advantageous to buy coverage in that outside market, since they will be offered a price that reflects their lower risk.[2] If that happens, the average level of risk of the employers remaining in the purchasing cooperative will rise, and the cost of coverage will rise in turn. This will set off a chain reaction of spiraling prices and retreating employers that will destroy the pool's viability. With respect to pooling risks, a purchasing cooperative has to follow essentially the same practices as the outside market when dealing with employers with different levels of risk. If the outside market is permitted to charge higher-risk employers higher premiums, the purchasing cooperative has to do the same to survive—greatly complicating the co-op's pricing and associated administrative tasks. A cooperative can use various forms of community rating—which prohibit basing premium rates on enrollee's health status—only

if the law requires insurers to follow the same community rating rules in pricing *all* of their products sold in the small-group market. (Currently, states vary in their rules on this matter.) But in that case, the cooperative is not the risk-pooling agent; risk-pooling occurs because the law requires insurers to use community rating whether they sell inside or outside the pool.

Measuring Expectations Against Reality

In practice, purchasing cooperatives have not always met expectations. Although there are certainly successful models, there have also been some notable failures.[3]

One of the first successful collective purchasing co-ops was created in Cleveland, Ohio—the Council of Smaller Enterprises, commonly known as COSE. Today, COSE dominates the small-group market in the Cleveland area with an enrollment of about 200,000 people. COSE is not a prototypical purchasing co-op because, for virtually all of its history, a single health plan has accounted for nearly all of its sales. Although COSE now offers a choice of two independent health plans and a number of plan types, the employers, rather than individual employees, choose the health plan. Nevertheless, because it dominates the small-group market in its area, COSE has proven that small employers banding together can be effective purchasers of health coverage.

The best-known purchasing cooperative is the one in California known in its early years as the Health Insurance Plan of California (HIPC). Originally a creation of the state and operated by a state agency, the California co-op is now run by the Pacific Business Group on Health, an organization that during most of its history represented only large employers. Now called PacAdvantage, the co-op provides coverage for approximately 147,000 people and offers about a dozen health plans (not including different plan models offered by the same parent company). Another successful co-op is the Connecticut Business and Industry Association, which enrolls about 10,000. The New York Business Group on Health collaborated with New York City to establish a purchasing cooperative in late 1999, which has a current enrollment of about 7,000 and is growing.

A significant proportion of co-ops have failed. The failures have included co-ops that initially seemed to be quite successful as well as others that never really became viable. The demise of the Florida Community Health Purchasing Alliances was perhaps the most notable failure because the co-op had once seemed quite successful. Originally a state-created consortium of 11 separate alliances, the cooperatives enrolled 92,000 people when enrollment peaked in 1998. But over the years, the Florida alliances had increasing difficulty attracting any but the smallest employers and gradually found themselves losing health plans. As a consequence, enrollment also fell, and the purchasing alliances ceased operations in 2000.

The Texas Insurance Purchasing Alliance, begun in 1994, never reached the enrollment levels of the Florida effort, covering only about 1,000 firms and 13,000 people at its height. Difficulty in attracting employers led to the withdrawal of health plans, and the Alliance governing board ultimately decided that the operation was not viable and closed it down. The North Carolina Purchasing Alliances, which opened for enrollment in 1995, were patterned after the Florida model, but they struggled to attract employers throughout their existence, and the leaders finally admitted defeat in 2000.

The Alliance in Colorado was the most recent failure. Established in 1995, the Alliance closed in the summer of 2002 after one of its three health plans withdrew from the state small-group market, a second capped enrollment, and the last decided to stop participating.

A number of conclusions can be drawn from the experiences of both the successful and unsuccessful purchasing co-ops. The most important is that collective purchasing arrangements are unlikely to succeed unless they can attract large numbers of employers, and not just the smallest of

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employers with only two or three employees. Without large numbers or substantial market share, co-ops cannot exert purchasing power,[4] they cannot achieve economies of scale, and they cannot attract and retain health plans. Health plans have often been hostile to the purchasing co-op model for several reasons. First, they are understandably wary of the model because it gives their customers bargaining clout. Second, they do not like the individual-choice feature of co-ops because it provides enrollees with a ready way of switching to a different health plan during every open enrollment period. Third, they believe that their chances of getting and keeping all of the employees in an employer group—which brings in more revenue and helps to spread risk—are much better when they market to that group outside of the purchasing co-op.[5] Therefore, unless a co-op commands a significant market share that health plans cannot afford to pass up, plans are unlikely to be eager to participate. This creates a "chicken-or-egg" dilemma: without large numbers of enrollees, it is difficult for purchasing cooperatives to attract health plans; but without the ability to offer substantial choice among well-known health plans, it is difficult for co-ops to attract enrollees, who are drawn to co-ops in part because of their ability to offer such choice.[6]

Size is also a prerequisite for purchasing co-ops to achieve economies of scale and to reduce administrative costs. As long as their non–co-op business accounts for the bulk of their revenue, health plans must maintain their existing administrative structures to handle that business. The health plans contend that any savings they might realize as a result of the co-op's assumption of some administrative functions for the relatively small number of co-op enrollees is more than offset by the extra cost the plans incur because they have to change their administrative systems to accommodate the administrative structure of the co-op.[7] In short, health plans believe that dealing with the co-op adds to, rather than reduces, their administrative costs.

It has also become clear that some significant diseconomies of scale are inherent in serving small employers and that these costs cannot be eliminated by centralizing the administration. It will always be more costly to serve 5,000 employers with 10 employees each than to serve a single employer with 50,000 employees.

Early proponents of purchasing co-ops believed that administrative costs could be lowered by reducing or eliminating the role of insurance agents and having the sales activities administered centrally.[8] Proponents sometimes assumed that if a co-op offered a high-quality, high-value product, it would more or less sell itself. That assumption proved to be incorrect. Selling health insurance of any kind in the small-group market is extremely difficult without the cooperation and even enthusiastic support of insurance agents and brokers. Early efforts to save the cost of commissions by diminishing agents' roles or eliminating them altogether backfired. Insurance agents not only did not sell purchasing co-op plans, they also became strong and effective opponents of the concept. Today, co-ops assiduously cultivate the good will of agents as necessary allies.

Early proponents of cooperatives also hoped that these new organizations could offer prices somewhat lower than were generally available in the market. This hope was not fulfilled. With very few exceptions, premiums for employers buying through co-ops have not been lower than those available to small employers elsewhere.[9] This failure to realize the expected price advantage is attributable to several factors. Co-ops have not been able to reduce administrative costs. They have not had enough market share to bargain for discounts. And in many instances state laws have prohibited insurers from offering co-ops premiums lower than those they charge to employers outside the coop, even if the insurers' costs are lower for co-ops.[10]

Many supporters hoped that purchasing co-ops would attract a large number of employers who had not previously offered coverage. The prospects for success in this area were dimmed by

co-ops' inability to offer lower premiums. Even if co-ops had realized price reductions, however, most uninsured small employers would still not have been induced to offer coverage to their employees. The research evidence shows that even a 30 percent reduction in premiums—far more than co-ops could be expected to produce—would cause only 15 percent of currently uninsured small employers to offer coverage.[11]

Though they have failed to generate significant savings, co-ops have succeeded in one important respect: participating employers have been able to offer their employees a choice among health plans. This unique feature has proven to be attractive to employers, but it alone has been insufficient to induce a significant number of employers who had not previously offered coverage to do so. The available evidence, though limited, suggests that purchasing co-ops attracted about the same proportion of newly insuring employers as the non–co-op market.[12]

Summary

An analysis of the efforts to implement the purchasing cooperative model yields the following lessons:

1. **The principal advantage that current co-ops offer to small employers is not lower premiums but the opportunity for individual employees to select different health plans from the variety the co-op offers.**

2. **In the future, co-ops might be able to offer more attractive prices, but that would depend on reaching "critical mass" size.** To offer attractive prices, a co-op has to be able to realize administrative savings and/or have bargaining leverage with health plans. Both these conditions require that co-ops control significant market shares.

3. **Achieving critical mass size is difficult.** To persuade a number of health plans to participate and continue participating, a co-op must have a significant market share. But without the participation of a variety of highly reputable plans, it will be difficult for co-ops to attract the number of employers that would yield a significant market share. Furthermore, co-ops do not sell themselves. Without the support of health plans and insurance agents, small employers will not seek out co-op coverage. But health plans and agents have often been hostile or, at best, indifferent, to the co-op model.

4. **Even if co-ops could offer lower premiums, they could not substantially reduce the number of uninsured because the premium reductions would not be big enough to induce large numbers of uninsured employers and uninsured workers to opt for coverage.**

5. **Co-ops cannot be the vehicle for pooling high-risk, low-risk, and medium-risk employers.** If co-ops follow premium rating rules or rules for accepting applicants that are significantly more permissive than those that apply in the outside market, they will suffer from adverse selection and ultimately fail.

6. **Co-ops are likely to become an important source of health coverage only if some significant change makes them the favored or perhaps the sole source of coverage for particular groups.** This could happen, for example, if employers adopting a defined-benefits approach to health coverage channeled employees to co-ops, or if government offered co-ops as the source of coverage for individuals who receive certain kinds of subsidies. Without a change of this sort, purchasing cooperatives are unlikely to become a major feature on the health care landscape.

Notes

[1] For the purposes of this brief, the term "small employer" refers to firms employing roughly 100 or fewer workers. Most purchasing cooperatives have limited membership to firms with 50 or fewer workers because state insurance laws have typically defined small groups using this cutoff point.

[2] Jill Yegian et al., *Health Insurance Purchasing Alliances for Small Firms: Lessons from the California Experience,* California Health Care Foundation, May 1998, p. 7; U.S. General Accounting Office, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices,* GAO-HEHS-00-49, March 2000, p. 20.

[3] For a detailed discussion of six purchasing cooperatives, including both successful and unsuccessful efforts, see Elliot K. Wicks, Mark A. Hall, and Jack A. Meyer, *Purchasing Health Coverage for Small Employers: Barriers to Small-Group Purchasing Cooperatives,* Economic and Social Research Institute, March 2000.

[4] General Accounting Office, March 2000, p. 18.

[5] Elliot K. Wicks, Mark A. Hall, and Jack A. Meyer, March 2000, pp. 116–17.

[6] Elliot K. Wicks and Mark A. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects," *Milbank Quarterly,* Vol. 78, No. 4, 2000, p. 534.

[7] General Accounting Office, March 2000, p. 22.

[8] Jill Yegian et al., May 1998, p. 8.

[9] General Accounting Office, March 2000, p. 20.

[10] General Accounting Office, March 2000, pp. 21–22.

[11] James D. Reschovsky and Jack Hadley, "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," Issue Brief: Findings from HSC, No. 46, Center for Studying Health Systems Change, December 2001; see also M. Susan Marquis and Stephen H. Long, "To Offer or Not to Offer: The Role of Price in Employers' Health Insurance Decisions," *HSR: Health Services Research,* Vol. 36, No. 5, October 2001, p. 946.

[12] Elliot K. Wicks and Mark A. Hall, 2000, pp. 517–18.

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