Chapter 9.
Insuring Small Groups in Texas: Obstacles and Potential Solutions

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In Texas, small businesses employing fewer than 50 employees comprise more than 40 percent of the group market.[1] Historically, these groups have had the most difficulty accessing affordable health insurance because insurers do not readily target clients whom they feel are potentially risky or who incur relatively higher administrative expenses.[2]

Dr. Rogers Coleman, of Texas Blue Cross Blue Shield, suggests that these smaller groups inherently have the hardest time obtaining affordable health insurance for three primary reasons: high acquisition cost per member, stronger burden of sickness or morbidity index, and the general affordability of expenses peripheral to the actual costs of running the businesses.[3] First, smaller groups have higher acquisition costs because of the expenses involved in administering health insurance to these groups. A small business generally has one agent process the paperwork for all of its employees manually. Applications for insurance as well as claims are hand-written forms that are processed for each employee individually. On the other hand, large businesses are able to input the applications of hundreds of employees electronically, therefore cutting down on the time and cost of administering health insurance to these groups. The overall outcome is that the administrative costs are proportionately much higher for smaller groups than for larger groups, and this cost is written into the cost of insuring the employees of a small business. This in large part contributes to the high cost of insuring employees of small businesses.

Another primary reason that smaller groups are harder to insure is their high morbidity index, or rather the burden of sickness within the group. In essence, the risk of insuring a small group is much higher than that of insuring a larger group because a small group will not be able to spread the risk of any one individual falling ill, thereby increasing the cost of insuring the whole group. For example, Humana's groups of 2 to 3 lives run about 20 percent more in claim costs than their groups of 4 to 9 lives.[4] One sick or elderly person in a group can drastically affect the morbidity index and therefore the cost of insurance for the group. On the other hand, a large business with hundreds of employees can spread the risk of any one employee falling ill over a very large group, thereby lowering the cost of insuring the entire group.[5]

Finally, the most obvious reason that small groups are difficult to insure is that small businesses have less flexibility in their cash flow and often health insurance is a benefit many fledging businesses cannot afford. This lack of operating income of most small businesses keeps many members of the group from being able to afford basic health insurance rates that are regularly subject to change.[6]

Legislative History

Legislators have recently become aware of the obstacles that small businesses have to endure when trying to insure their employees. Several legislative efforts have been made to enable small groups to have access to affordable health insurance. Beginning with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), an insurer in any state is required to offer insurance to all small groups in that state if they wish to insure any single small group. Section 2711 of the HIPAA requires insurers to sell health insurance to any small group of 2 to 50 people that applies for such coverage. Under this act, even groups with members who have pre-existing major medical problems are guaranteed to receive coverage. The only way a carrier may seek exception to this rule is not to sell insurance to any small group at all.

State laws, as well as HIPAA, are geared towards getting small groups of 2 to 50 employees easy and affordable access to health insurance. HB 2055, passed in 1993, was the first time the Texas Legislature dealt with guaranteed issue. Under this law, all carriers that choose to insure within a certain market are forced to accept any group within that market defined as a legitimate business. They cannot refuse to take a group based on health conditions, industry, size of group, or any other factor that would increase the risk to the carrier. In Texas, HB 2055 provided guaranteed issue for groups of 3 to 50. Subsequently, in 1997, HB 1212 brought Texas into compliance with HIPAA regulations regarding guaranteed issue, specifically bringing the minimum group size requirement from three to two employees for small groups.[7]

There were several problems with this law that were not seen at the time, however. At the outset, then-Governor Ann Richards' plan mandated that there would be only three plans that could be sold to small employers.[8] Many groups disputed this requirement because this severely limited the choice of plans available to employees. This left inadequate flexibility for the employers to choose a plan that best suited the needs of that group. This clause in HB 2055 was amended to allow carriers to include their normal range of plans along with the basic three plans and no longer so severely limited the choice of plans available to employers and clients.

Clauses within HB 2055 also made it difficult for employers to insure even their healthiest employees adequately. HB 2055 disallowed employers from insuring only part of a group. For instance, if a business employed seasonal workers that the employer was not willing to insure, that employer would not be allowed to insure any of his full-time employees separately. Furthermore, any employee working more than 30 hours a week is considered full-time, so restaurants are under pressure to keep wait staff working less than 30 hours a week in order to insure only full-time, permanent management. This provision may have actually increased the number of uninsured in the state because many businesses with part-time or seasonal employees chose not to insure any of their employees rather than insure their entire workforce, including the part-time and seasonal help.[9]

Texas House Bill 369 in 1997 eliminated some of the problems in the original legislation. Also in 1997, HIPAA was enacted at the federal level. By this point, however, several interested carriers had already dropped out of the market. Many carriers found that the only way to stay in the market was to raise the rates to three or four times the normal rate if they were no longer allowed to decline a particularly risky individual or group.[10]

Obstacles Faced by Small Businesses

Given all these regulations guaranteeing insurance availability to all groups regardless of size or risk, carriers have still managed to deny certain small groups access to health insurance. An obstacle many small businesses have to face when trying to find health insurance for their employees is searching for an agent to market insurance to their group. Since the paperwork and personnel time invested are proportionately higher for these small groups, agents' commissions when marketing to small businesses are sometimes higher than they would otherwise be for large businesses. For example, some agents require a commission of up to 12 percent on smaller groups, although the same agent may only make a commission of 6 percent on a much larger group.[11] This disparity causes many carriers to provide disincentives to agents who market health insurance to small groups, thereby cutting the overhead that they will have to pay agents. Some carriers have employed techniques to discourage agents from selling insurance to small groups by setting agents' commissions for these groups so low that agents have little or no incentive to target these groups.[12]

Carriers have found that another effective way to bypass guaranteed issue laws is to provide a disincentive to agents who sell health insurance policies to small businesses. Carriers ceased to pay adequate commissions to agents in order to discourage them from marketing policies to these groups of 2 to 50, specifically the "baby groups" of 2 to 5. Agents simply inform the carrier that a particular group is eligible for coverage but the agents themselves do not actively pursue small groups. The group therefore does not have a representative and is quoted a rate determined by the carrier. Some carriers have also stopped renewing the licensing appointments of agents who have brought in unhealthy business. Carriers have chosen not to renew an agent's license with that particular carrier if the agent sells to particularly small and therefore riskier groups. The consequence of this is that many small businesses do not benefit from fair marketing practices and therefore do not receive adequate information on how to insure their employees.[13]

Another way insurers discourage agents from marketing policies to potentially risky groups is by setting high premiums that agents will not be able to market. Carriers in Texas have a 25 percent rate band between what the high-risk and low-risk groups are quoted as their premium rates. In other words, a carrier can charge a low-risk group 25 percent less than its standard rate for a product and charge a high-risk group 25 percent more than the standard rate. Consequently, a carrier that decreases the index rate below the market rate will be reducing the premiums for both of these groups. Agents marketing these plans will target high-risk groups that will readily change plans due to any change in premium rates. However, since agents receive a percentage of what the

employer is charged as their commission, they have little incentive to market these plans to low-risk groups that already have low-cost plans. A plan that costs less than the index rate will therefore reduce agents' commissions and will most likely not be marketed as aggressively by agents. Alternatively, carriers who price their index rates higher than the market will avoid getting high-risk groups who will not enroll in the program due to the disparity in pricing between carriers. Agents will also market these policies more aggressively because as premiums increase, agents' commissions also increase proportionally.[14] Ultimately, all of these targeting schemes allow carriers to increase their premiums by the allowable rate and still be able to promote their policies aggressively to stay competitive in the market.

Using reduced compensation schedules as well as providing other disincentives to agents selling to small employers is a direct violation of the state's Unfair Trade Practices Act.[15] Under this act, any action taken by a carrier to deflect business from high-risk groups is prohibited. Also, premium rates are calculated using agents' commissions as a factor in the final quote. Therefore, any carrier that abandons its normal marketing policies to divert business from small groups is using inaccurate premium quotes in its normal marketing system. This is also a circumvention of insurance reform legislation as stated in HIPAA. However, these tactics are still employed by many insurance carriers to avoid providing coverage to the small group market. In order to reform the treatment of small groups effectively, these insurance practices will need to be monitored adequately and appropriate reminders legislated. Both the Texas Department of Insurance (TDI) and the Health Care Financing Administration (HCFA) have acknowledged these practices to be inconsistent with the guaranteed availability provisions of HIPAA and the Texas Insurance Code.[16] However, carriers can continue to avoid these HIPAA reforms despite these laws and codes.

Texas Small Group Rating

The rates that many small business owners are quoted when applying for health insurance vary drastically from group to group and may depend on the health status of the entire group. Agents that market to small businesses generally assess the health status of individuals and then proceed to quote several rates from different carriers. The rates may also vary depending upon the characteristics of the individual such as age, sex, and whether the employee will be applying for family coverage (see Appendix I). Carriers are required to set a minimum index rate that will be the basis for applying the rate band that is dependent on the risk of the group. Carriers in Texas must file their index rates, along with the variability in rates dependent upon health risk, with the Texas Department of Insurance. Carriers, not TDI, determine these index rates, but most rates are determined by competition with other insurers and therefore do not vary much between carriers. Once the rate has been filed and approved, that index is fixed in reference to the rate bands that are specified by TDI (see Appendix I).

A particularly healthy low-risk group will be quoted the index rate or the "street rate," as agents refer to it. These stripped-down numbers are the advertised amounts that are not rated to include risk factors. Once an agent evaluates a certain group and sends the

assessment to the carrier, a proposed rate specifically for that group will be returned to the agent, who will then quote this rate to the client. This "underwritten rate," which is no longer the bare-bones advertised amount, can sometimes cost twice as much as the base rate for a healthy group.[17] Many employers, seeing this drastic change in the cost of insuring their employees, decline participation in the health plan at this point, leaving the employees without health insurance. Underwritten rates are also subject to increase due to poor participation or reassessment. The carrier only needs to adhere to this underwritten rate as originally proposed if the group has 75 percent participation. This is meant to protect the carrier in case only the sickest individuals sign up, for example.[18]

Chapter 26 of the Texas Insurance Code specifies a certain range or band within a carrier's rates that a group can be charged, dependent upon age, gender, and medical conditions, in order to maintain some control over the rates charged by carriers. TAC 26.32(c) specifies that this band has a 25 percent range on each side of the average allowed rate ("index rate"), therefore permitting the charged rates to vary legally from 75 to 125 percent of the index. The rates for a small group may vary from 75 to 125 percent of the index rate, incurring TDI's maximum allowed rate increase of 67 percent. However, most small business employers experiencing a 67 percent increase in premium rates decline renewal of their coverage, once again leaving their employees without health insurance.[19]

Certain restrictions exist regarding rate increases. For example, carriers currently can increase the rate by 15 percent annually due to any changes in medical conditions or industry safety factors. However, insurers can permissibly increase rates, citing many factors unrelated to medical history, and up to 67 percent, regardless of whether the group has any individuals with pre-existing medical conditions. In increasing small groups' rates so drastically, carriers are hoping that small employers will not renew their suddenly expensive plans and therefore reduce the carrier's risk.[20] The Blue Ribbon Task Force suggests that a public record of these rates and bands would reduce the competitive and deceptive nature of the field and open up possibilities for small employers. One of their recommendations for insuring more Texans is to, "[r]equire TDI to develop a rate guide for employers to use in comparing health insurance plans. Employers trying to shop around for the best price are often overwhelmed by the plan variations and cost differences among insurers."[21]

Many states bypass the obscurity caused by employing rate bands by using community rating. Community rating provides an average rate that is applied to the entire community regardless of health or risk. This form of rating bypasses the process of underwriting because it does not allow for any variability from the mean rate, despite the characteristics of the individual or group purchasing the insurance. In states that do not apply community rating to the entire market, groups become segmented according to risk. Principally, people with low-risk profiles find that their mean premium rate of health insurance goes up due to community rating. This increase in expense causes many of these individuals to abandon the group market and seek individual coverage. The net effect of this is that high-risk groups who benefit from the lowered mean rate that community rating provides will be the only groups remaining in the market. In order for

community rating to be effective, the whole market will have to abide by these rates so that the incentive for risk-segmentation is eliminated.[22]

Options for Small Businesses

Pooling Small Groups

One method of assuring that carriers include small groups in the market is to band groups of 2 to 50 together in an effort to attain economies of scale. Historically the most effective way to minimize costs to carriers as well as to small business employers is to pool small groups together to spread risk over the entire group. Purchasing cooperatives, as these pooling entities have come to be known, have taken many forms. In the late 1970s, Multiple Employer Trusts, administered by the insurer, pooled groups of fewer than 10 lives together. This method effectively reduced the cost of coverage for the whole group.

In Texas, the Texas Insurance Purchasing Alliance (TIPA) was set up by the state and administered by Blue Cross Blue Shield (BCBS). Although TIPA paid better commissions than any of the other carriers, it eventually failed to attract adequate participation to achieve economies of scale. TIPA failed for several reasons, one of which was that administration of this cooperative was very difficult. For example, individuals within a group were allowed to pick a plan from eight different carriers. A certain group could have eight different employees with eight different plans. Administration of TIPA was therefore difficult for both agents and carriers because the agent would have to quote 64 different rates for an eight-person group.[23]

TIPA and other state-sponsored cooperatives also did not receive adequate funding from the state to continue their efforts at pooling the small group market. Some individual business owners have also recently started administering co-ops, unfortunately without backing from insurance companies, and have been largely unsuccessful in finding and maintaining participation in the cooperatives.[24]

Carriers, most notably Blue Cross Blue Shield of Texas, attempt to use the same means to solve the problem by pooling their smaller groups together. A group will be quoted an initial rate based solely upon how it fits the rate band criteria, but the carrier will then pool that group with the rest of its small groups, reassessing the new group's burden within the whole pool of small groups at renewal. Seventy-five percent of the reassessed rate is based upon the entire small groups' pooled burden of sickness, and 25 percent is determined by that one individual group's index of morbidity. Hence, a healthy small group is still subject to drastic rate increases once it becomes a carrier's client.[25] If a mandate were passed for all carriers to pool all small groups, there would still be considerable "cherry-picking," in which carriers shop for the healthiest groups in order to keep their rates lowest.[26]

Ultimately, no efforts to protect small employers from rate discrimination have stemmed the tide of rate increases and risk profiling. Current law allows "a small employer carrier [to] use the group size of a small employer as a case characteristic in establishing

premium rates for a group."[27] Insurers can legitimately abuse this clause in order to quote a two-person group a premium much higher than a 20-person group, irrespective of the group's medical condition or history.

Purchasing Alliances

Over the last decade or so, small businesses have been a primary focus of insurance reform. Smaller firms are generally faced with higher premiums and more fluctuations in premiums than are larger firms. Insurance companies work under the premise that many individuals can enter into a mutual agreement to accrue a small loss in the amount they pay in premiums in order to avoid incurring a large loss due to a serious illness. The purpose is to spread risk so that a large number of healthy people can basically subsidize the medical costs of a smaller group of people who become ill in any given year. The more employees a firm has, the more the medical costs of a few sick people can be spread over the entire group. Large businesses have the advantage of spreading risk among a large number of employees since the proportion of people experiencing serious illnesses is small and will remain roughly constant from year to year. Small businesses cannot spread risk as thin because there are simply not enough employees. Small businesses also generally have higher employee turnover rates than do large businesses and therefore, the health profiles of their employees may change from year to year. A typical business of less than 50 employees can go from a low-risk group one year to being a high-risk group in the next with the addition of a just one or a few employees with serious medical problems. Therefore the insurers' costs of selling insurance to this market are relatively high, even for low-risk groups. High-risk groups are often not even offered coverage. All these factors led to some small employers trying to find ways to reduce their health insurance costs.

The primary reason for the disparity in health insurance costs between small and large firms is in the firm's capability in spreading risk. Small businesses found ways to aggregate their purchases of health insurance in order to reap the purchasing advantages that larger firms have. The objective of purchasing collectively is to pool risk and therefore dissolve the cost of insuring high-risk individuals within the cost of insuring a larger group of low-risk individuals.[28]

There are several benefits of collective purchasing besides risk-sharing. Through participation in a purchasing cooperative, a small business can experience what is referred to as an economy of scale. When a number of small firms act as one large firm, the administrative costs of offering coverage are reduced in that it is less costly to sell coverage to many employers at once than to each employer individually. Therefore, small employers can have access to multiple insurers' plans instead of having to negotiate with individual agents and insurers. The association handles negotiations through a centralized process, thereby eliminating the need for the small employer having to haggle with insurers individually over options and prices.

A purchasing cooperative also allows the small business employer to have greater negotiating power. Insurance companies are less willing to lose the business of an entity that represents many small firms than a single small buyer. A cooperative represents a

large market share with which insurers will be more careful in negotiating, in order to ensure that the business of the entire group is not lost to a competitor. Ideally, by purchasing collectively, small employers can negotiate for lower premiums and better quality of care standards.

Another incentive for joining a purchasing cooperative is that the employees of a small firm can choose their health plans. As a collective purchasing entity, these purchasing cooperatives can have contracts with several health plans. Through the realization of economies of scale, administrative expenses are reduced and the purchasing cooperative can therefore afford to negotiate with several health plans simultaneously. Employers then have the ability to offer their employees the opportunity to choose a health plan that is best suited to their needs.

Collective purchasing alliances can have many forms. These include multiple-employer welfare associations (MEWAs), Health Purchasing Cooperatives, Health Marts, and Association Health Plans. The subsequent discussion is a description of the advantages and disadvantages of these types of plans. Although many states have experimented with the concept of providing insurance to employees of small businesses by employing the use of purchasing alliances, few have succeeded in significantly reducing the levels of uninsurance in the state. This paper will attempt to examine the reason for the success or failure of existing purchasing cooperatives as well as discuss the proposed reforms to these alliances.

Association Plans and MEWAs

Employers have long been searching for ways to band together to form associations with which to buy affordable health insurance. In the 1970s and 80s, many such associations were formed for the purpose of spreading risk among the participants so as to increase their negotiating power, thereby establishing economies of scale. Many of these association plans also had the alternative motive of amassing groups with low-risk profiles in order to negotiate lower prices that reflected their low risk. In addition, these particular association plans also formed self-insured associations in order to be exempt from state regulation and enforcement of mandated benefits and premium taxes.

Under the Employee Retirement and Income Security Act of 1974 (ERISA), state insurance regulators did not have the jurisdiction to regulate health coverage provided by self-insured employers.[29] ERISA provided that states were only given the authority to protect members of associations that buy health coverage from risk-bearing entities. In this sense, state regulators can ensure that licensed insurance providers will be able to pay promised health care claims and not leave enrollees without health insurance when a serious illness occurs. However, they cannot regulate the activities of non-risk bearing entities such as association plans that are self-insured. Small business employers, however, found it to be beneficial to be exempt from the scrutiny of state insurance regulators so that they would not have to conform to state-mandated benefits and contributions to risk pools, thereby drastically reducing the amount they pay in premiums. This freedom from regulation led to the formation of several bogus and

mismanaged self-insured associations that later became insolvent, leaving thousands of people without health insurance in the late 1970s and early '80s.[30]

The vast number of failures in association plans led to an amendment to ERISA in 1983.[31] The amendment gave states the right to regulate self-insured associations. As defined in the ERISA amendment, any association, whether self-insured or fully insured, was labeled as a MEWA. MEWAs thus became subject to state regulation under this legislation. However, simply defining association plans as MEWAs did not prevent some associations from finding loopholes in the 1983 ERISA amendment. Some tried to escape state regulation by falsely claiming that they were established and maintained by unions or employer associations. These two groups were the only ones that remained exempt from the ERISA legislation that enforced state regulation of groups providing insurance to employers.[32]

Another problem in the ERISA legislation arose from the fact that states differed in their interpretation of ERISA. In some states, including Texas, employers' plans are regulated by both ERISA and state regulations. Generally, state insurance laws preempt ERISA.[33] Texas laws regulating MEWAs are similar to federal ERISA legislation in that "they establish minimum standards for coverage, limitations on cancellation and conversion, and procedures to follow upon termination of employment."[34] However, some states have also permitted association plans from being exempt from market reforms. This means that businesses that employ people with low-risk profiles can band together to negotiate lower premiums. This in effect creates a segregated market in which those who fit into low-risk profiles are drawn away from the market. The result is rising insurance premiums for all who remain in the larger insurance pool.[35]

Due to the disparities in regulation of MEWAs as well as the loopholes built into them, initiatives were taken in the late 1980s to reform purchasing alliances. The result was the formation of Health Purchasing Cooperatives (HPCs).

Health Purchasing Cooperatives

There is one fundamental difference between MEWAs and HPCs. HPCs, unlike MEWAs, are subject to small-group market reforms and are therefore required to provide coverage to any small employer applicant. HPCs also do not assume any risk themselves and only offer fully insured health plans. The HPC market is therefore open to any employer of fewer than 50 people, irrespective of the risk profiles of the employees of the firm. This was made possible through small-group insurance reform. Without these regulations, insurers would be able to drain all of the low-risk firms from the larger market through premium incentives, as was the case with MEWAs, leaving HPCs to provide coverage to the remaining high-risk entities.

The move to include HPCs in the infrastructure of the states was made in the early 1990s as part of various proposals to reform the health care system. The central motive for promoting HPCs as part of health care reform was to emphasize the need for increased competition in the health care market. Because HPCs offered the same standardized benefits packages that all health care plans were required to offer, consumers found it

easier to make price-value comparisons between plans. As a result, health plans were under pressure to increase levels of efficiency and service to remain competitive in the market. Supporters of the move to adopt HPCs cite several other advantages of promoting cooperative health care alliances. These include the following.

- HPCs are required to accept any small employer joining the cooperative. This provision was in large part set by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- The governing board of HPCs is made up of both employer and employee participants.
- Health Purchasing Cooperatives are prohibited from assuming risk themselves. They are therefore subject to state regulation as part of the ERISA legislation.
- Employees are allowed to enroll in any plan offered through the cooperative.

What makes HPCs appealing is that they represent the employers and employees rather than insurers. Although HPCs differ in how they negotiate with health care providers, they all have one thing in common: they are open to any small employer. This presumes that HPCs are not driven by favorable risk selection but rather through the establishment of economies of scale, whereby there is a reduction in premium costs to participants.

There are, however, many issues that relate to HPCs that may inhibit their success in the long run. First is the issue of whether participation in an HPC should be voluntary or mandatory. Under Clinton's health care reform proposal of 1993-1994, all firms with fewer than 5,000 employees were required to purchase insurance for their employees through an HPC or similar entity. However, after being faced with much opposition, this proposal was modified to voluntary participation in HPCs. Supporters of mandatory participation, however, argue that it would ensure that HPCs would attain economies of scale and prevent risk segmentation, which would eventually work to reduce the number of uninsured in the country.[36]

Another issue was whether HPCs should compete with each other within a given market. If there were only one HPC in an area, there would be exclusive participation by all small employers in the market, thereby reducing the opportunities for risk segmentation. However, as is the case with any monopoly, having only one supplier tends to reduce the level of efficiency and service. Moreover, there is a debate over whether HPCs should accept all health plans offered to them or actively negotiate with providers for the lowest premiums. By accepting all health plans, participants would have the choice of many health plans but with aggressive negotiations, HPCs would be able to be selective in choosing the plans with the best value. Many of the pros and cons of participation in purchasing alliances are exemplified in the state of Texas' experiment in implementing HPCs.

Current Plans in Texas

The same legislation that provided for the establishment of the Texas Insurance Purchasing Alliance (TIPA) also allowed for the organization of nonprofit private purchasing cooperatives (article 26.14). Although TIPA was the only statewide purchasing cooperative, many cooperatives were set up in the state after the legislation went into effect. Three alliances still exist in Texas: Lone Star Health Alliance in Ft. Worth, Small Business United of Texas in Austin, and Texas Health Care Purchasing Alliance in Houston. Although all three entities still operate as private firms, none account for any income or expenses related to their affiliation as a cooperative. In other words, these organizations exist as cooperatives in name only and do not function in any way to pool small business employees together for the purpose of reducing insurance premiums.[37]

Initially, many consumer groups opposed the formation of these private cooperatives, arguing that anyone could thereby form a purchasing alliance as a marketing gimmick for agents to sell health insurance. Another fault in the legislation lies in the fact that the law may be interpreted in several ways. Although purchasing cooperatives are set up as nonprofit entities serving small businesses of 50 or fewer employees, some individual groups may interpret this differently. Certain alliances have interpreted the law to mean that businesses with as few as three to four employees can be pooled together to form groups of 50. Each pool of 50 employees can be assigned a particular company name. These alliances therefore can form several of these groups of 50 (or several different companies), thereby getting a better rate by achieving economies of scale. However, when insurance companies discovered that these so-called companies did not actually exist, they quickly dropped participation in the plan.[38] For this reason, purchasing cooperatives even in large metropolitan areas, such as Dallas and Houston, have found it difficult to maintain their status as legitimate purchasing alliances.

Many carriers were also hesitant to be associated with so-called purchasing cooperatives after the demise of TIPA. In the early 1990s, purchasing cooperatives were labeled as the wave of the future and many insurers participated in these plans thinking that they would be missing out on a large part of the market if they failed to participate. However, after faith in TIPA dwindled and many carriers rescinded their participation in the cooperative, participation in other cooperatives also waned. For this reason, any and all cooperatives that were in operation in the early 1990s are now either closed or do not report any earnings as a purchasing cooperative. These plans do not seem to be a viable alternative for Texas because insurers and small business employers alike are unwilling to take the risk of investing time and money in cooperatives when they have had experience witnessing the failure of many of these programs.

Health Marts and Association Health Plans

Recent congressional proposals have created two new options for small employers seeking health insurance coverage. These come in the form of Health Marts and Association Health Plans, as outlined in HR 4250, the house-passed version of the Patients Protection Bill of 1998 (US Code, Subtitle G, Title III).

Health Marts

In many ways, Health Marts are very similar to existing pooled purchasing alliances. Like HPCs, Health Marts would accept all small employers and would offer multiple health plans. They must also comply with state laws on administering the entity, as they cannot be risk-bearing entities themselves. However, Health Marts do differ in several ways from traditional HPCs. Unlike HPCs that claim responsibility only to the purchasers, Health Marts will represent employers, employees, and insurers equally. These new entities will also not have to offer standardized benefits packages, or have employee-choice models. Under the proposed legislation, Health Marts may be free from state mandates and therefore do not have to cover certain benefits. Many states also have legislation to protect small business employers from groups that are formed specifically to buy health insurance. These state laws will be superseded by the federal government legislation in the case of Health Marts. However, state patient protection laws concerning licensure, solvency, and fair marketing practices will still apply to Health Marts.

Several things must be considered when assessing how much more effective Health Marts will be in reducing the number of uninsured in the state than existing HPCs are. If by not covering mandated benefits Health Marts are able to cut the cost of health insurance, they are offering what HPCs do but at the cost of offering less comprehensive benefits. Also, by overturning mandated benefits, Health Marts will appeal mainly to low-risk groups for whom the cost of health insurance is already low. Therefore, they do not offer any real benefit over HPCs towards reducing the level of uninsured, since these low-risk groups already have many avenues through which they can get affordable coverage.

There is also a potential for risk segmentation associated with Health Marts. Although Health Marts are subject to state regulations considering the area they are required to cover, i.e., they must cover at least an entire county, there are ways for these groups to avoid high-risk areas.[39] A Health Mart could choose to operate in an area where the small businesses are mainly low-risk businesses such as high-tech companies. They will therefore have an advantage over a group that operates in a county with a relatively high percentage of people working in high-risk industries. In this sense, they can lower the cost of insuring people through their plans but will also practice the same method of risk segmentation that many private insurance companies have been accused of, thereby contributing to the high cost of health insurance for the uninsured.

Another potential problem with Health Marts is that by representing all stakeholders in the entity, mainly employees and employers as well as some insurers, there is a potential for conflicts of interest between these groups. Providers may not be aggressive in attaining the level of insurance that employees may demand when it would mean less income for the providers of insurance.[40] Health Marts may also have the same problem HPCs did in finding funding to operate the organization efficiently. Since Health Marts will be set up as nonprofit organizations, without state help they may find it difficult to continue operations because arguably many entrepreneurs are not willing to invest their

time and money in a nonprofit entity.[41] Considering all these problems, it remains to be seen whether Health Marts will be truly an effective alternative to HPCs in reducing the number of uninsured in the state.

Association Health Plans

Association Health Plans (AHPs) are another reform effort proposed in HR 4250.[42] In essence they would function toward the same goal of insuring small business employees as do existing HPCs and Health Marts. However, they differ from all other purchasing alliances in that they would be able to self-insure and thus may be exempt from state insurance regulations. Amendments to ERISA would be enacted to allow AHPs the same privilege many large insurance providers have and enable them to register as self-insured groups. Therefore, AHPs will not have to provide mandated benefits nor would they be subject to state insurance regulators. The benefit of being self-insured is that by not being under state regulation, AHPs are exempt from paying premium taxes and many other charges associated with complying with state regulations. These exemptions, along with providing less-comprehensive coverage, would in turn reduce the cost of purchasing insurance through this plan.[43] However, without state regulation, and through self-insuring, AHPs have more of a possibility of bringing together mainly low-risk groups and therefore pose a significant threat to the segmentation of the small group risk pool.

Another issue concerning AHPs' immunity from state regulation is that there would be greater incidence of low-risk groups banding together through risk-segmentation to buy less expensive insurance. Those who oppose Association Health Plans argue that it will attract groups that already have insurance but who are trying to escape mandated benefits that raise the cost of insurance. Consequently, the price of insurance for those remaining in the pool will increase and those who are the focus of the uninsured problem will remain uninsured due to the high cost of health insurance.[44]

Under current legislation, however, provisions have been included to limit the possibility of bringing together only low-risk employers who then self-insure. Like previous purchasing alliances, AHPs cannot deny membership to any group interested in participating in the plan. Unlike Health Marts, however, they cannot be formed specifically for the purpose of buying health insurance and any association interested in being classified as an AHP must have been in existence for three years prior to being eligible. This is done in order to prevent the formation of groups that are solely set up to provide health insurance and are therefore more prone to making a quick buck at the expense of small businesses, as was the case with association plans in the 1970s and '80s. However, these efforts at controlling AHPs are easily bypassed. Without state regulation, it will be difficult to monitor these entities in order to enforce these rules. The provisions against risk-selection are also easily bypassed because the law requires that AHPs not set premiums based on health profiles in cross industries. Some may interpret this as not being applicable to associations within industries, which may still choose clients based on risk. The monetary benefits that can be had from risk selection in an unregulated industry may promote the creation of associations solely for the purpose of making immediate profits. AHPs have the potential of repeating the past mistakes of MEWAs, which were

mismanaged or become insolvent, leaving thousands without coverage and with mounting medical expenses.[45]

If the purpose of congressional legislation proposing Health Marts and Association Health Plans is to attract the uninsured who were not previously attracted by HPCs, it is hard to imagine that the benefits of these two plans would truly serve this purpose. In addition, these two plans would threaten what has been achieved in reforming the health care industry in the last decade. These new entities do not have the legislative restriction that HPCs have had in the past and therefore have more of an opportunity to risk-segment the existing pool. This would be a throwback to the segregated market that existed prior to reforms in which those with above-average risk could not afford insurance coverage. Moreover, the cost-benefits of enrolling in these programs would not be enough to attract the uninsured, but are low enough to attract those who already have health insurance and are seeking to lower their costs even further. This will cause insurance reforms to regress and "restart the vicious cycle of ever increasing risk-segmentation."[46]

Texas Insurance Purchasing Alliance

On July 31, 1999, the Texas Insurance Purchasing Alliance was permanently closed due to lack of funding and adequate participation. Although TIPA enjoyed initial success when it was established in 1993, it was never able to secure enough of the market share to establish itself as an alternative to the private market. The failure of TIPA was due in large part to insurance carriers skimming away the small business employers with low-risk profiles for their own plans.[47] Remaining as candidates for participation in TIPA were mainly high-risk businesses that were unable to get affordable insurance in the group market.

TIPA was initially set up as a nonprofit organization funded by the state. It was part of the insurance reform platform of then-Governor Ann Richards, who proposed TIPA as an alternative to the private market. Being part of the state reform package, TIPA was widely anticipated as the wave of the future. For this reason, TIPA experienced initial success and enrolled as many as 20 carriers offering different plans through its run. Blue Cross Blue Shield of Texas administered the plan. TIPA was seen as a unique part of the small group market because it offered a choice of carriers to employees of small businesses. Participants could chose from HMO, PPO, and indemnity plans.[48] TIPA was also a convenient way for small business employers to insure their employees without going through the hassles of negotiating with insurance carriers.

Despite all the benefits of having a system like TIPA administering insurance to small business employees, it never achieved adequate levels of enrollment to capture a strong hold on the group market. Even at its peak in 1997, TIPA only covered 13,000 lives, which was less than 1 percent of the small business market.[49] Over time, it became characterized as mainly insuring those that could not get insurance elsewhere due to costly health care needs. By 1998, most of the 20 plans that were initially offered withdrew participation, as did enrollees in the program.

Several reasons can be cited as to why TIPA ultimately failed to capture its share of the small business insurance market. Most importantly, under the legislation by which it was established, TIPA was forced to accept any small business employer that chose to participate. However, TIPA was practicing community rating in a market that was not, and consequently other plans were able to insure low-risk groups at a much lower rate than TIPA could offer. As mentioned, TIPA was particularly attractive to high-risk groups that had trouble obtaining insurance previously, and thus were also costly to insure. The high cost of insuring participants in TIPA therefore made many small employers decline coverage, which consequently made insurers enrolled in the program withdraw participation in the plan.

Another problem TIPA had during its run was that initially the plan boycotted insurance agents and offered policies to employers directly. This was done to reduce the overall cost of insurance by bypassing the 10 percent commission that agents make on selling policies.[50] This alienated many agents, who as TIPA would learn later, were essential to reaching the vast population of small business employers. TIPA also did not have the means to market the policies on its own as could agents who were experienced in the market. Moreover, TIPA only received $250,000 in start-up funds from the state and later $2.3 million from BCBS. This was an insufficient amount with which to develop a marketing effort that would appeal to such a large population. Consequently, TIPA experienced low participation and did not have the negotiating power to offer competitive rates.

At its inception, Blue Cross Blue Shield administered TIPA under a five-year contract. Many other insurers were wary of being part of the alliance because they felt that BCBS would have an unfair advantage in choosing the low-risk participants for its own plan. This is a charge BCBS has denied, but which still caused a rift between insurers and TIPA. This distrust of the administrators of the plan caused many insurers to withdraw from the plan. Another problem with the administration of TIPA was that BCBS initially agreed to forego administrative expenses since it was expected to make up for this loss due to anticipated high enrollment. However, when it became apparent that TIPA was not going to have the success in mass participation that was anticipated, BCBS more than tripled its regular administration fees, an expense that TIPA could not afford.[51]

All of these factors finally contributed to TIPA lacking the funds and the participation necessary to make it a successful alternative to the private health insurance market. Although the option of purchasing cooperatives is a viable alternative for reducing the number of uninsured workers in Texas, TIPA was poorly administered and planned from the start and therefore did not have the chance to win a fair share of the insurance market. Plans in other states such as Florida and California have had much more success than did the Texas plan due to a variety of factors. Through funding and special initiatives, purchasing cooperatives in other states have been successfully offered as alternatives to private health insurance.

The California and Florida Plans

Two states that are seen as being effective in initiating HPCs into the infrastructure of the private market are California and Florida. Both are said to have been successful in reducing the number of uninsured in the state. Unlike TIPA, a primary reason for the prolonged success of these HPCs is due to the funding provided to these groups at their inception. The Florida plan received $8 million in start-up funds and the California plan obtained $5.5 million.[52] Providing these HPCs with this funding allowed the plans to develop and foster their growth from the start. However, there do exist many differences in the ways HPCs are run in these two states that could either threaten or contribute to their prolonged success.

In Florida, the Community Health Purchasing Alliances (CHPAs) work as nonprofit organizations with representation from both state and local governments on the board.[53] On the other hand, the California HPCs, which were run by board representatives of government, have recently been transferred to Pacific Health Group, a private entity. There are also differences in how the groups negotiate price differences with providers. The Florida CHPAs accept any health plan that meets the minimum requirements for coverage, in which case it is left up to providers to offer competitive prices. HPCs in California, on the other hand, actively negotiate with insurers to attain the lowest premiums. Participants in the plan therefore receive discount premiums due to bulk purchasing. Opponents of this method fear that this practice will pose a threat to modified community rating and say that participants will have fewer plans to choose from. Florida, however, only offers plans from eight different providers whereas California HPCs offer 18 different plans.[54] Ultimately, California allows employees choosing from these plans to have a greater opportunity of choosing the plan that is most suited to their needs.

Opponents of HPCs cite these two states as cases in which implementation of these programs has not led to a significant decrease in the levels of uninsured in the state. In California for instance, 144,000 lives and 3,500 groups are covered in the plan. This is less than 2 percent of the market share. The Florida HPCs only cover 75,000 lives and 920 groups, which is also considered by many to be a small share of the market.[55] A recent report issued by the GAO indicates that premiums within the HPCs are not considerably different from what similar plans offer outside the cooperative. In Florida, a 25-year-old can get coverage through an HPC for $108 per month, whereas a similar plan through a non-participating plan would cost $101 per month. Similarly in California, a 25-year-old employee will be offered a premium rate of $127 within the HPC as well as outside the HPC.[56] However, this similarity in premium prices can be attributed to the fact that many HPCs, even the most successful as in California and Florida, are unable to achieve economies of scale through which to offer more competitive prices than those offered in the overall market.

Increasing Participation in Purchasing Cooperatives

Health purchasing cooperatives like TIPA primarily fail due to lack of participation and cannot achieve the economies of scale that would ensure their success. Several measures can be taken through legislation to lessen the chances of HPCs and other alliances failing. One such initiative should be that states should foster the growth of purchasing cooperatives through funding. As nonprofit entities, HPCs are at a disadvantage over private insurers in the amount of capital they can accrue to fund efforts to increase participation in the cooperative. Consequently, they cannot compete with private insurers effectively enough to win a considerable share of the large group market. States such as California and Florida initially provided sufficient funds to HPCs, thereby giving them the support to ensure their long-run success in the market.

A more comprehensive but controversial way of increasing participation in HPCs is to make participation mandatory. A proposal was made in Clinton's 1993 health reform package to make participation mandatory for all businesses, small and large. A more feasible approach would be to make participation mandatory for small businesses, since these groups are more prone to not issuing coverage to their employees. This would ensure that cooperatives get the participation necessary to achieve economies of scale through which business spending on health insurance would be lowered in the long run.

Finally, as part of federal legislation on Health Marts and Association Health Plans, all groups should be forced to comply with mandated benefits laws. This would in essence prevent the formation of companies that cater strictly to low-risk groups that result in an increase in premiums for those remaining in the pool. Association Plans should also be monitored by the state to prevent the formation of self-insured groups, because as with Health Marts, there will be a tendency towards the banding together of low-risk groups into the plans, resulting in higher premiums for those with high-risk profiles.

Significantly reducing the number of uninsured in the state will take time and investment on the part of governments, employers, and providers. In order to reach all small business employers, changes can be made in the current system to foster the growth of small business purchasing cooperatives. However, the portrait of the current profit-driven insurance market paints a grim picture of what's ahead for purchasing cooperatives. HPCs and other plans, if administered properly, are efficient avenues through which to insure the millions of Texans who cannot otherwise afford individual insurance coverage. Without proper cooperation by carriers and employers, as well as legislators, however, purchasing alliances cannot achieve a stronghold in the group market.

Reform Possibilities

Some have suggested that in order to prevent rate discrimination by carriers, legislation should be amended to prohibit group size from being used as a case characteristic all together. House Bill 949 of the 77th Texas Legislature, sponsored by Representatives Kip Averitt and Ann Kitchen, addresses this issue. Under this proposed legislation, "a

small employer carrier may not directly or indirectly use as a criteria for establishing a separate class of business: 1) the group size or 2) the trade or occupation of the employees of a small employer or the industry or occupation of business of the small employer."[57]

Blue Cross Blue Shield estimates that this method would create a 10 percent rate reduction for groups of 2 to 50 employees. Removing this size criterion could effectively pool all groups of 2 to 50, thereby preventing any discrimination using group size as a case characteristic.[58]

HB 949 will actually enforce the already codified Texas Administrative Code Rule 26.11(d), which permits only a 20 percent corridor between groups of different size if the carrier continues to use group size as a characteristic.[59]

In addition to filing HB 949 to disallow carriers using group size as criterion in determining rates for small groups, Representative Averitt has also filed HB 471, disallowing carriers from implementing "agent commission schedules that vary the level of agent commissions based on the size of the group, or otherwise reduce access to small employer health benefit plans." Both bills are strongly supported by the Texas Association of Health Underwriters. The Blue Ribbon Task Force on the Uninsured recommends legislation similar to HB 471 in its report: "preclude insurance agent commissions from being calculated in such a way as to preclude Texas small employers from having full access to the small employer health insurance market."[60]

A final reform method would be to enact further medical savings account options, described in Appendix J.

Notes

[1] National Center for Policy Analysis, "Brief No. 224: An Easy Way to Make Health Insurance More Expensive" (February 21, 1997). Online. Available: http://www.ncpa.org/ba/ba224.html. Accessed: January 31, 2001.

[2] Interview with Leah Rummel, Director, Texas Association of Health Plans, by David Warner, Katy Fallon, and Sam Miller, Austin, Texas, February 9, 2001.

[3] Telephone interview by Katy Fallon with Dr. Rogers Coleman, Blue Cross Blue Shield, Fort Worth, Texas, March 2, 2001.

[4] Email from Jim Smith, Director of Sales, Small Group Humana, "Humana's perspectives and practices regarding community rating, the uninsured, and agent commissions," to Katy Fallon, March 5, 2001.

[5] Coleman interview.

[6] Ibid.

[7] U.S. Congress, *Health Insurance Portability and Accountability Act, 1996*. Online. Available: http://www.hcfa.gov/hipaa/hipaahm.htm. Accessed: May 9, 2001.

[8] Interview by Katy Fallon and Vidhya Sriram with Shirley Hutzler, Lobbyist, and Lee Manross, Assistant, Texas Association of Health Underwriters, Austin, Texas, January 30, 2001.

[9] Hutzler interview.

[10] Interview by Katy Fallon and Vidhya Sriram with Clark Jobe, Director, Texas Healthy Kids Corporation, Austin, Texas, March 1, 2001.

[11] Jobe interview, March 1, 2001.

[12] U.S. Congress, *Health Insurance Portability and Accountability Act,1996*.

[13] Hutzler interview.

[14] Jobe interview, March 1, 2001.

[15] National Center for Policy Analysis, "Brief No. 224: An Easy Way to Make Health Insurance More Expensive" (February 21, 1997). Online. Available: http://www.ncpa.org/ba/ba224.html. Accessed: January 31, 2001.

[16] Ibid.

[17] Jobe interview, March 1, 2001.

[18] Texas Administrative Code, Title28: Insurance, Part 1: Texas Department of Insurance, Chapter 26: Small Insurer Health Insurance Regulations, Sub-Chapter A: "Small Employer Health Insurance Portability and Availability Act, Regulations, Rules."

[19] Jobe interview, March 1, 2001.

[20] Health Care Financing Administration, *Bulletin: Agent Commissions and Processing Delays*. Online. Available: http://www.hcfa.gov/medicaid/hipaa/content/HIP98-1.asp. Accessed: January 29, 2001.

[21] Texas Blue Ribbon Task Force on the Uninsured, *Report to the 77th Legislature* (Austin, Texas: February 2001), p. 40.

[22] Jobe interview, March 1, 2001.

[23] Hutzler interview.

[24] Jobe interview, March 1, 2001.

[25] Coleman interview.

[26] Jobe interview, March 1, 2001.

[27] Texas Administrative Code, Rule §26.25, Article 21.21.

[28] Eliot K. Wicks and Jack A. Meyer, *Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?* (Washington, D.C.: New Directions for Policy, May 1999, p. 4). Online. Available: http://www.nchc.org/1999PolicyStudies/SmallEmployerHIPurchasingArrangements.html. Accessed: May 10, 2001.

[29] Wicks and Meyer, *Small Employer Health Insurance Purchasing Arrangements,* p. 8.

[30] Ibid.

[31] "Employee Retirement and Income Security Act," U.S. Code, Title 29, Section Ch 18.

[32] Wicks and Meyer, *Small Employer Health Insurance Purchasing Arrangements,* p. 8.

[33] Jinny St. Goar, *The MEWA Muddle: Self-insured pools seek freedom from state regulation.* Online. Available: http://www.assetpub.com/archive/ps/95-06psjune/june95PS58.html. Accessed: October 22, 2000.

[34] Ibid.

[35] Wicks and Meyer, *Small Employer Health Insurance Purchasing Arrangements,* p. 9.

[36] Ibid., p. 11.

[37] Jobe interview, December 8, 2000.

[38] Jobe interview, December 8, 2000.

[39] Wicks and Meyer, *Small Employer Health Insurance Purchasing Arrangements,* p. 20.

[40] Ibid., p. 17.

[41] Ibid., p. 19.

[42] Tom Daschle, Senate Democratic Leader, "Introduction of Patient Protection Bill, Subtitle G-Title III" (March 31, 1998). Online. Available: http://thomas.loc.gov/cgi-bin/query. Accessed: December 9, 2000.

[43] Wicks and Meyer, *Small Employer Health Insurance Purchasing Arrangements,* p. 13.

[44] Ibid., p. 16.

[45] Ibid., p. 22

[46] Ibid., p. 21.

[47] Robert Elger Jr., "The Downfall of TIPA," *Texas Journal* (April 21, 1999), p. T1.

[48] Interview by Vidhya Sriram with Clark Jobe, Director Texas Healthy Kids Corporation, Austin, Texas, December 8, 2000.

[49] Elger, "The Downfall of TIPA," p. T1.

[50] Ibid.

[51] Jobe interview, December 8, 2000.

[52] Jobe interview, December 8, 2000.

[53] Jobe interview, December 8, 2000.

[54] General Accounting Office, Health and Human Services Division, *Private Health Insurance: Cooperatives Offer Small Employers Plan Choice and Market Prices* (report no. GAO-HHES-00-49) (Washington, D.C., March 31, 2000), p. 9.

[55] General Accounting Office, *Private Health Insurance,* p. 6.

[56] Ibid., p. 50.

[57] Texas House Bill 949, 77th Legislature, regular session (2001).

[58] Hutzler interview.

[59] Kip Averitt, Texas State Representative, "House Bill 949 Bill Analysis: Fair Marketing of Health Plans to Small Employers in Texas" (Bill Analysis for 77th Legislature), Austin, Texas, February 19, 2001.

[60] Texas Blue Ribbon Task Force, *Report to the 77th Legislature*, p. 40.