Implementing a Health Plan Purchasing Pool

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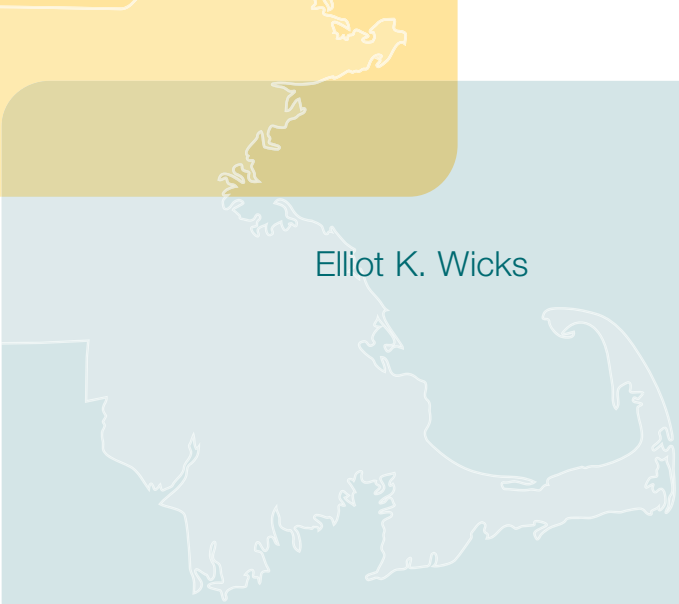

roadmap
TO COVERAGE

Contents

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Introduction

The *Roadmap* to Coverage is designed to achieve universal coverage in Massachusetts by building on four key elements:

1. **MassHealth expansions** to 200% of the federal poverty level for children and their parents and to 133% for childless adults.

2. **Tax credits for individuals** for the difference between premiums and a specified percentage of income (sliding from 6% to 12% of income) for those up to 400% of the FPL.

3. **A voluntary purchasing pool** open to all that would ease access to an increased choice of plans for small firms and low-income individuals.

4. **Government funded reinsurance** that would pay 75% of individual costs incurred above $35,000 in the nongroup market and for firms with fewer than 100 workers.

So that all residents would indeed acquire health insurance, the *Roadmap* adds to these building blocks one of three mandate alternatives:

An individual mandate—a legal requirement that that all individuals obtain coverage for themselves and their families.

An individual mandate combined with a broad employer mandate—a requirement that employers either provide coverage for their employees and their dependents or pay a tax that would help fund coverage for them.

An individual mandate combined with a narrow employer mandate—a requirement that large employers (500 employees or more) either provide coverage for their employees and dependents or pay a tax that would help fund coverage for them.

This paper focuses on the issues involved in implementing the third building block of this reform package—the purchasing pool. The purchasing pool would perform key functions in the reformed health care system. Any individual, family, or employer could buy coverage through the pool but participation would be voluntary. However, people who receive tax credits could use those credits only by purchasing coverage through the pool, and the pool would have responsibility for administering the tax credits, including making the initial determination of the credit amount to which people would be entitled under the law. The pool would solicit bids from, and then contract with, health plans to provide a defined package of benefits. The pool would have responsibility for enrolling people in the health plans they choose, collecting premiums from employers and individuals purchasing coverage on their own and from government for people whose coverage is subsidized, and distributing those monies to

the participating health plans. The pool itself would not bear any risk for medical expenses. Insurers would bear risk, of course, but a portion of the risk would be borne by the state-funded reinsurance system (discussed in detail in another paper).[1]

Although the main focus of this paper is to lay out steps required to implement a purchasing pool, there is a close connection between certain kinds of design decisions and implementation. Thus, in the material that follows, certain design issues are also discussed.

Organizational Issues

Given the far-reaching nature of the *Roadmap's* reform proposal and the crucial role that the purchasing pool would play, it is obviously important to structure a purchasing pool in a way that is likely to make it most effective. The reform's enabling legislation should address key issues regarding the nature of the pool and the process for establishing it.

Pool Size

Experience with past pooling efforts offers some guidance about the issues that need concentrated attention and about which there is some evidence. Probably the most important lesson is that size matters. Pools that are larger have many advantages. They can more readily attract and retain health plans, because there is enough business to make it worth insurers' while to participate. They have enough visibility and market presence to make them an attractive option for small employers. They can realize economies of scale. And with significant market share, they can negotiate more effectively with insurers, if they choose to take that approach.

The size problem is something of a dilemma. Without large size—that is, many enrollees—pools cannot realize many of their potential advantages. But it is difficult to attract many enrollees unless the pool already offers those advantages. Of course, one way to ensure large size is to make the pool the prescribed source of coverage for some significant population group (as the *Roadmap* reform would do).

Probably the most successful examples of large pools are government purchasers. Government pools have a unique advantage in reaching critical mass size: because they have a "captive audience," they don't have to attract customers. Prime examples are the Federal Employees Health Benefit Plan (FEHBP) and CalPERS, the public employees plan in California, which serves not only state employees but municipalities as well. Because of their size, these pools have no trouble recruiting health plans, and they use their market power to influence the levels of service, the kinds of products insurers offer, the prices at which they offer those products, and even the nature of the medical care delivery.

Private pools have fewer records of long-term success—at least if success is measured in terms of attracting many customers and having a favorable effect on price and the

delivery of medical care. Three examples that can at least claim relatively long life and a significant number of enrollees are COSE, a Chamber of Commerce plan in Cleveland that accounts for a very large share of the local small-group market; PACAdvantage, now operated by the Pacific Business Group on Health but which started out as the state-operated Health Insurance Plan of California and has about 140,000 to 150,000 enrollees from small firms; and the pool offered by the Connecticut Business and Industry Association, which has a long record of serving the small-group market. The number of failed pools is a longer list. With one exception (Florida's Alliances), they never had large numbers of enrollees, they had difficulty attracting any but the very smallest employers, and they had trouble recruiting and retaining prestigious health plans.

If a pool is established in Massachusetts in conjunction with the other elements of the *Roadmap*, it would have the advantages of reaching a reasonable size, for several reasons. First, the people eligible for the tax credits could apply them only for coverage purchased through the pool. Second, small employers who do not now offer coverage would be required under the *Roadmap* to either offer coverage or pay a tax. These employers would find the pool a convenient source of coverage if they choose to "play." If they choose to "pay" instead, most of their employees would likely choose the pool as the source of coverage to meet the individual mandate requirement, since they could buy coverage at a discount (to compensate for the fact that their employer is paying the tax).

Price Taker or Negotiator?

Another organizational issue is what relationship pools should have with health plans. One approach is for the pool to simply solicit bids, accept whatever price is offered, and let competition for enrollees be the disciplining force to ensure that prices are reasonable. The other approach is for the pool to actively negotiate with health plans, aggressively seeking to attain more favorable conditions. In other words, the pool would negotiate with potential suppliers in the way most large buyers do, including large employers buying health coverage. It is not entirely clear based on past evidence which approach produces more favorable results for the participants in the pool. But what can be said is that most of the large pools are not simply "price takers"; they actively negotiate, sometimes after soliciting competitive bids. This has been the case with FEHBP, CalPers, the California HIPC, and COSE. The Florida Alliances took the opposite approach, and their inability to negotiate, combined with the fact that the contract was between the health plans and the employer rather than with the Alliances, was seen by a number of observers as a design deficiency that made the Alliances less effective than they could have been.

Selective Contracting or Every Willing Health Plan?

A related question is whether the pool should accept all health plans that wish to participate or instead retain the choice to reject plans. The first approach assumes that the ability of pool participants to choose any plan (maximum competition)—will reward health plans that provide the best value and thus force health plans to offer cost-effective, high-value products. Plans not offering high value would attract few

enrollees. Within the context of the *Roadmap*, this approach has implications for the total cost to the state, however. Allowing higher priced plans to participate would raise the subsidy cost, because the subsidy is tied to the average-cost plan in the pool.

The selective contracting approach is based on the judgment that the best way to ensure high-value offerings is to give the pool the option to allow some plans in and keep others out. The thought is that this approach would strengthen the pool's hand in negotiating, for two reasons: insurers not making an acceptable offer would have no chance at any of the business, and the pool could promise a larger market share to the selected plans in exchange for more favorable offerings.

Public or Private?

Another key issue is whether the pool would be a private or a public agency. Both approaches have worked well. In California, the successful purchasing cooperative for small employers was initially established by an agency within state government, although one with an unusual degree of decision-making flexibility. However, that California cooperative is now operated by a private entity (the Pacific Business Group on Health). In Connecticut (Connecticut Business and Industry Association) and New York (HealthPass) the purchasing pools are private, although in the latter case the initial work was done under the auspices of the mayor.

If the pool is private

The case for having a purchasing pool that is a private entity separate from government rests in part on its greater flexibility and enhanced ability to perform the entrepreneurial functions of the pool. Private agencies generally have greater latitude in hiring and terminating personnel and, in general, are able to react with greater speed to changing conditions. For example, hiring an executive director and initial staff could probably be done more quickly by a nongovernmental agency. A private pool may have another advantage: given their wariness of government, employers may hesitate to acquire coverage from a government entity—a significant issue, because the pool will need to attract large numbers of employers if it is to achieve economies of scale in administration. A private entity is also likely to face less skepticism and wariness from agents and brokers. Public organizations may also have a harder time justifying expenditures for marketing, including payment of sales commissions. Nevertheless, it is important to recognize that public purchasing pools, such as the California HIPC, have successfully dealt with these issues.

A private pool could be either a for-profit or a nonprofit organization, with the nonprofit approach perhaps the more common model. Several pools are operated by "business groups on health," business coalitions that serve the broader function of furthering the business community's common interest in improving health care delivery and quality and moderating costs. Even in instances where pools have been sanctioned by state legislation, they have often been private nonprofit organizations.

If the pool is to be a private entity, state government could still retain considerable control. It could issue an RFP to select a contractor, or it could certify an entity to serve as the pool. In either case, the state could require that the pool have a governing

board that would ensure accountability to the people the pool is designed to serve. This would give the state some of the advantages of both a private and a public entity.

If the pool is to be a private entity, then someone within either the governor's office or an executive branch agency would need to be responsible for starting the process of establishing it. Whichever choice is made, it is important that the people responsible have considerable flexibility and not be unduly hampered by bureaucratic restrictions. Criteria would need to be developed as a basis for choosing the organization to operate the pool. Then it might be necessary to prepare and issue an RFP to elicit responses from parties willing to serve the function. Someone within government would have to be assigned the initial tasks related to choosing an organization to be the pool. One of the issues to be concerned about with this approach is that there may not be any existing entity that is appropriate or willing to perform the functions of the pool, either because none is prepared to take on the task or because qualified entities (like insurers or brokers) have a conflict of interest. (It is important to make the distinction between the pool being a private entity itself and having the pool contract with a private entity for certain nonpolicy functions, such as administration of premium collection and distribution, and maintaining eligibility files. This issue is discussed below.)

If the pool is public

The case for having the purchasing pool be a public entity is related to issues of coordination and control, confidentiality, accountability, and the capacity to serve the public interest. The reform process of which the *Roadmap's* purchasing pool is be a crucial part would involve a variety of new policies undertaken by state government. The functions assigned to the purchasing pool would be integral to the whole reform and interwoven with other processes and policies that are under state control. For example, the pool would determine on a case-by-case basis the amount of the credit that an applying individual would receive given the eligibility specifications in the law. This process would involve gathering confidential information on income, family size, etc., and ultimately cross checking records and subsidy dispersements with the Department of Revenue, which would have responsibility for determining at year end whether the credit amount was correct given the final income reported on tax returns. The pool would also be receiving and dispersing revenue from the Department of Revenue to cover the premium subsidies.

Especially if the pool is not a public entity, great care would be needed in structuring safeguards to ensure that confidentiality is protected and that the pool is acting responsibly, efficiently, and effectively in handling large sums of government money. Ensuring that the pool's activities are consistent with and further the total system reform goals would probably be easier if the pool were a government entity, or at least an entity that is clearly accountable to serving the public interest and subject to government oversight.

If the purchasing pool is to operate within the government sector, the next question is whether it should be assigned to an existing agency or operate as a separate entity. On the one hand, if it operates within an existing agency there would probably be

some staff on board who could be assigned to begin work immediately after approval of the reform, and not all procedures would need to be invented anew. On the other hand, the association with an existing agency might carry negative baggage for some people and organizations with which the pool must interact, as well as limiting flexibility. An independent government entity governed by a board representing the interests of the people the pool serves—perhaps something like the Federal Reserve at the national level—would help give the pool an identity separate from existing institutions and provide a more flexible structure for moving quickly and being able to adapt to changing circumstances. It would also be desirable to give the entity wide latitude and maximum flexibility in the way it carries out everyday procedures, free of some of the civil service and procurement procedures usually required of government agencies, though always subject to the approval of its governing board.

Whether or not the pool is private or public, it would need a governing board. The temptation might be to include all the major stakeholders on the board, including providers and insurers. The counter argument is that the pool should mainly represent the buyers of health care. If the pool is to be able to bargain effectively with health plans to get the lowest possible price given a defined set of needs and standards, it cannot represent the sellers, that is, insurers, agents, and providers. It should represent employers, employees, and individual health insurance purchasers, as well as health policy experts, perhaps including state officials, who are knowledgeable about and sympathetic to the overall objectives of the reform. The board should also be somewhat removed from short-term political influence, which suggests the need for relatively long terms that are staggered so as to maintain policy continuity through changes in political control of the governor's office or the legislature.

Startup Issues

The legislation would clearly need to appropriate money for the pool to begin implementation. Experience with other purchasing pools suggests that several millions would be necessary to fund the startup. In the most recent case of a private pool, HealthPass of New York, the organization began with a grant of $1 million from the mayor's office, which was later increased to $4 million. But the functions that the proposed *Roadmap* pool would undertake are substantially more varied than those of typical pools, which do not do anything related to administering subsidies or reinsurance (the latter function might or might not be assigned to the pool in Massachusetts). Moreover, the size of that pool is expected to be substantially larger than typical private pools. Perhaps a better point of comparison would be the public pools, like CalPERS or other state employees' plans. Of course, once operations are fully underway, it would be possible to finance operations through an administrative fee added to the premiums, if this is thought desirable.

Once enabling legislation is in place and funds are available, the first task would be to identify the entity that is to be the pool if not specified in the legislation. If this is to be a private entity, criteria would need to be developed to choose an organization, and someone would have to be assigned responsibility to research possible candidates

and make the selection. This is likely to be a several-month process.

The second step would be to appoint a governing board, the composition of which would presumably be specified in the enabling legislation.

The third step would be to develop a job description for an executive director, do an executive search, and then hire the person. This responsibility would most logically be lodged in the governing board. But the actual day-to-day activities related to preparing to hire an executive director would probably need to be done by someone within state government. If the decision is made to have the pool be a government entity, especially within an existing government agency or department, assigning this task should be relatively straightforward. Otherwise, the governor's office should probably decide who takes initial responsibility for hiring the executive director. Supporting staff would need to be hired or transferred as well, although the executive director would be expected to take primary responsibility for this task.

Once the initial staff is in place, a first order of business would be to prepare a work plan and spending plan for the first year and ideally a tentative budget plan for the second and third years. The *Roadmap* implementation schedule calls for pool enrollment to begin with the third year. Thereafter, some if not all of the pool's revenue would presumably come from the premium charged to those who buy coverage through the pool.

The pool would also probably need to seek legal advice about a number of issues, including indemnification of staff and board members, especially since the pool would be at least indirectly responsible for very large money flows. If the pool is to be a newly formed private organization, it would need to incorporate.

Major Tasks

The previous discussion covers organizational steps preliminary to the actual work of beginning the purchasing pool. What follows is a discussion of the major tasks the pool would have to perform before it could begin enrolling people. Although they are listed in roughly the order in which they would have to be undertaken, a number of the tasks would have to be performed simultaneously, and some would need to be repeated periodically during the operation of the pool in future years. The general experience of those who have been through the task of beginning a pool is that once the pool is formed, if all goes very smoothly, it generally takes at least a year of intense work to accomplish the tasks that have to be completed before the pool can start enrolling people. The Massachusetts pool includes more functions than the typical pool and thus requires developing and making operational more mechanisms and procedures. The pool must also closely coordinate its procedures with those of the Department of Revenue. These extra tasks are what lead to the expectation that the pool would begin enrolling people at the end of the second year.

Choosing a Plan Administrator and Defining its Tasks

Plan administration refers to a specific subset of tasks the pool must perform—

specifically those that involve enrolling people in health plans, collecting premiums from employers and individuals (and, for those eligible, subsidies from the Department of Revenue), transmitting payments to appropriate health plans, providing customer service to employers and individual enrollees, and coordinating functions with insurers. The plan administrator (if a separate organization) would not be a policy-making entity but instead would do the routine but very important tasks just enumerated. The administrator's role is similar in many ways to the role third-party administrators (TPAs) play in administering self-insured employer health plans.

Insurers themselves, aided by agents and brokers, currently perform many of these functions, but under the *Roadmap* arrangement the pool or its contractor would be responsible for most of them, although some might be shared. The process is complicated by the fact that individual employees, not the employers, would be choosing from multiple health plans. Thus, it is possible that a firm composed of five people might have employees enrolled with five different carriers. This would complicate the premium determination process for each employer[1] as well as the process of maintaining eligibility files and distributing premiums to health plans.

Most purchasing cooperatives and pools that offer individual employee choice have initially chosen to contract for administrative services with firms that specialize in this kind of administration. (An exception is the Connecticut Business and Industry Association plan.) Such pools have determined that it was not practical or cost-effective to try to develop the required expertise in-house, especially today, given the need for sophisticated computer technology and web-based access for enrollees, employers, insurers, and the pool itself. Developing reliable and user-friendly computer systems is difficult, expensive, and time-consuming, and there are substantial economies of scale to such systems. There is also great value in having an experienced administrator used to working with insurers to implement the individual choice system, since insurers may have little experience with this model—especially in the context of the small-group market. Smaller employers seldom offer multiple health options. The experience of other purchasing pools suggests that it is important that the plan administrator have a cooperative relationship with health plans and that the administrator be able to listen to the problems raised by health plans and work to accommodate them whenever possible. Retaining the good will of health plans is very important to the success of the total effort, since they tend to be wary of dealing with purchasing pools. Insurers need to view the pool administrator as a partner rather than an adversary, according to people involved in past pool startups.

Since insurers already perform many of these plan administration functions, would it be appropriate to consider contracting with an insurer? Such a solution should be approached with caution. At least one experience with a failed purchasing pool that tried

[1] The premium would be different for each health plan, and even if the employer pays a fixed dollar amount regardless of the plan the employee chooses, the employee share (which the employer collects and sends to the pool) would vary for each health plan and change every time an employee chooses a different plan. When employers offer just one plan, as is often the case now, they typically contribute the same percentage of the premium for every employee regardless of age, etc. But under the multiple-choice option, the premium would vary based on the employee's age and based on the employee's plan choice. So the employer might not be willing to pay a fixed percentage of an uncapped amount. In any case, the employer would probably need more information than is typical when one insurer covers all employees. Of course, a number of pools have successfully administered a system that includes such complexities.

this approach (in Texas) suggests that other insurers are likely to look unfavorably on having a competitor serve this function. They worry that the competitor will gain access to information that gives it an unfair advantage, and they are not entirely trusting that the administering insurer will be fair in making decisions that have financial repercussions. At the very least, such an approach creates the perception of a conflict of interest.

An obvious question is whether the state employee's health plan might serve as the pool's administrator. The state employees' health plan performs many, though by no means all, of the functions that would be required to administer the new purchasing pool. The unique aspect of the pool involves collecting premiums from many people enrolling on an individual basis and from multiple employers, each of whom may have employees enrolled in several health plans. Maintaining eligibility rolls for such a system is obviously more difficult than for the present state employee system. These functions require mechanisms, processes, and computer technologies that the state probably does not have, and developing them and interfacing that system with insurers' systems would likely be expensive and time-consuming and could be difficult to do in a timely way.

The advantages of using the state employees' plan as the administrator are the usual advantages of doing something in-house. The state develops expertise, retains the institutional memory, and thus does not become captive to an outside vendor. If an outside vendor proves less than fully satisfactory, it is not a trivial or easy task to switch to a new vendor. There are bound to be major transition problems in making such switches. And, of course, part of what the state is paying for is profit for the administrator, although the hope would be that the economies of scale realized by a vendor specializing in the function would result in a cost no greater than the state would incur if it were performing the function in-house.

Past experience shows that it is important to have the plan administrator on board before trying to recruit health plans, to help to sell the idea to insurers. Health plans have generally not been eager to participate in purchasing pools, as noted, and one thing they are concerned about is the administrative aspects of the new program. They have to be convinced that they can trust the plan administrator to properly maintain eligibility files and properly allocate premium revenues. Otherwise, they cannot be assured that they are getting paid what they are due and that they are not paying invalid claims. Trust has to be established between the insurers and the administrator if health plans are to be willing to participate. Thus the decision about who is to administer these functions needs to be made before approaching health plans to seek their participation.

If an administrator is to be chosen from outside state government, it would be necessary at a minimum to identify possible vendors (perhaps by conferring with other pools) and to develop criteria for making a selection. The process can be formal or less formal. The formal approach would be to issue an RFP and to choose a vendor based on the responses. Another approach would be to ask potential vendors to submit a letter of interest along with their general qualifications and then meet with the most promising of the candidates that respond, and finally to make a

selection on the basis of the total available information and negotiate a contract. A person involved in a formal RFP selection process for engaging an administrator in one pool has suggested that the more informal process would have worked well and could have been completed more quickly.

Getting Participation of Health Plans

Recruiting health plans and maintaining their participation has proved to be a challenge for previous purchasing pools. It is not surprising that health plans may be less than enthusiastic about an arrangement that gives their customers increased bargaining power. They also worry about being victims of adverse selection, especially when the pool allows individual employee choice. Insurers feel better protected against adverse selection when they can be assured of getting whole groups rather than just some individuals within the group, since there is some spreading of risk even within small groups. The particular structure envisioned in the *Roadmap* is designed to relieve insurers' worries about the dangers of adverse selection. They are protected against the most expensive risks by the reinsurance arrangement, under which the government pays 75% of the costs above $35,000 that a patient incurs in a year. In addition, a risk adjustment mechanism is planned within the pool to neutralize the effects that an insurer might otherwise experience by attracting a group of enrollees with either substantially above—or substantially below-average risk.

Insurers will participate in the pool if they think it is in their self-interest to do so, and they are more likely to come to that conclusion the larger the market share accounted for by the pool. The *Roadmap* proposal would likely result in large numbers of people buying coverage through the pool. So the incentives to participate may be strong. Even so, it would be important to create a hospitable environment for health plans so that they are willing participants.

Experience with other purchasing pools indicates that it would be highly desirable to approach and consult with health plans early in the process. They would have concerns about the new system and how it meshes with their normal way of doing business—for example, what changes in their administrative processes will be required and at what cost. They are especially likely to be worried about adverse selection, as noted above. The risk adjustment process, which is designed to alleviate some of those concerns, would require some explanation—with insurers likely to have questions about the way the process would work and perhaps some skepticism about its adequacy to protect against adverse selection. They may have reservations about having to offer a new benefit package, especially since that normally requires a filing with the regulatory authorities. In short, health plans would need to be reassured that they can profitably participate in the new system.

If the decision is to selectively contract rather than admit all health plans, the pool would have to decide how many plans should be included in the pool and what characteristics they should have. If past experience applies in Massachusetts, getting desirable, prestigious plans in the pool may be more of a problem than keeping unwanted plans out. But if the number of plans wanting to participate is large, how many should be selected? The number should be large enough to ensure real choice,

especially if some of the health plans do not have broadly overlapping provider networks. People understandably do not like to be forced to change providers, so it is desirable to offer enough choices that relatively few people are forced to change providers in order to purchase through the pool. In addition, there would need to be sufficient numbers to provide an incentive for plans to compete on the basis of price. When there are more plans, there is likely to be greater price variation and more intense price competition. Because people weigh price heavily in making choices, plans have strong incentives to compete on the basis of price. A good example of a purchasing pool that offers many carrier choices is the Federal Employees Health Benefits plan, although the benefits are not standardized to the degree envisioned in the *Roadmap*, making cost-benefit calculations more difficult for people trying to decide among plans.

A case could be made for limiting the number of plans, however. Too many choices may be confusing to potential enrollees and complex for agents. And administration and customer service obviously become more complicated for the pool if there are many plans. Moreover, limiting the number of plans to a relatively small group would make it more likely that each participating plan will enroll a relatively large number of people. That should make the plans more eager to offer an attractive price, because they are competing for a significant share of the market.

Some observers may be concerned that if the number of participating plans is limited the opportunity is created for plans to enter the state, underbid to gain market share, and then, having knocked out competitors, raise rates. The first thing to note is that this could happen even if the number of plans is not limited. Underpricing to gain market share is not a new problem, and many health plans have engaged in it in the past without purchasing pools being part of the environment. But one way to reduce the danger would be for the pool to contract with several reputable plans (without going to the extreme of accepting any willing plan) and not to base the decision about which plans to include solely on the basis of price. (Part of the negotiation process should be to determine that offered prices are not unreasonably and unsustainably low.) This would help ensure that the pool does not become captive to one or two plans. Moreover, there would be a market outside the pool, and the plans that serve that market are potential competitors. Even if not initially included in the pool or not competitive because of underpricing by other plans, these plans would likely be willing to participate if the existing pool plans start price gouging once they capture a large share of the pool business. High prices and high profits always attract competitors.

Even if the pool chooses to limit the number of participating health plans, it should always keep open the option of allowing other plans in. In fact, this should be the expectation, and whenever rebidding is done, non-participating plans should be encouraged to bid.

Designing Benefit Packages

The expectation is that the reform design and the enabling legislation would give considerable guidance about the services to be included in the coverage offered through the pool, as well as the cost sharing provisions. But some of the details would

still need to be worked out. Specifying these in legislation in the detail needed would seem an unwise choice. Changes in technologies and preferences could quickly render some of the details obsolete, making some flexibility desirable. On the assumption that flexibility exists, the exact services to be covered under what conditions, exact cost sharing provisions, limitations on services, etc., would all need to be specified and agreed to by the insurers.

The advice from pool officials who have been through this process, as noted repeatedly, is to involve the health plans in the process at early stages. They will have ideas about the specifics of plan design. It would also be important to know the directions the market as a whole is going with respect to benefits, even if the pool should decide to set its own course, and the health plans can provide that context. The insurers would also need time to adapt to the pool's requirements; doing so may involve some administrative burdens for the insurers, and they would probably, as noted, need to file their plans with insurance regulators.

A strong case can be made for having the pool offer a very limited number of benefit options, with each insurer offering the same standardized plan(s). One of the objectives of allowing individual employees to choose different insurers from those participating in the pool is to put the insurers in direct competition with one another. If the system works as intended, each year each individual would be able to compare all the plan offerings and choose the one that offers the best value. So insurers would have strong incentives to compete on price, service levels, and quality. But this works well only if individuals assessing the options can easily and meaningfully compare the various offerings. If the benefit packages are not standardized, on the one hand, the task of comparing the value of the different plans is much more difficult; there are just too many variables to keep in mind. On the other hand, people do value some degree of choice, and some variation in benefits may be desirable. One way to achieve elements of both objectives is to have every insurer offer the standard set(s) of benefits, but then allow them to offer add-ons—for example, dental or vision coverage—that are priced separately from the main benefit plan. It is important that such "riders" be separately priced, so that potential enrollees are still able to compare a standardized benefits base without the riders.

Even if the pool offers standardized benefit packages, past experience suggests that changes would be needed over time, if only because the products offered in the rest of the market will change. One example is the recent emergence of Health Savings Account (HSA) plans and other "consumer-driven health plans." Because cost-sharing would be limited under the *Roadmap*, HSAs would not be an option within the pool. But the point remains that market forces, along with changes in medical technology, are likely to alter preferences and views about what belongs in the standard benefit packages. So the pool and the health plans need to be prepared to revise the benefit package over time. One pool official cautioned that it is important for the pool to get participating insurers to commit at the beginning to changing the benefit package over time as the pool determines changes are needed.

Recruiting Agents and Brokers

Experience with previous efforts to initiate purchasing pools shows that agents and brokers play a crucial role. Because small employers do not have specialized personnel assigned to negotiating and administering a health insurance plan, they depend heavily on the advice and expertise of their insurance agents and brokers. If agents and brokers do not bring the pool's plan to an employer's attention, the employer is unlikely to buy coverage from the pool. And if agents and brokers are not part of the pool's marketing plan, they are likely to be hostile to the pool, which will hurt the pool's ability to attract small employers. They could even steer higher-risk people to the pool, which would exacerbate any adverse selection the pool might experience.

The pool has some attractive features for agents and brokers. An important selling feature would be that employers buying pool coverage could permit individual employees to choose different health plans. This feature of pool coverage would also make it easier for employers to contribute to employee health premiums on a defined-contribution basis, thereby making it somewhat easier for employers to limit their cost exposure as premiums rise. Partly for these reasons, employers would be less likely to switch to some new carrier at the end of a plan year, which means that the agent would enjoy higher retention rates and lower servicing costs.

Pool coverage would differ in important ways from what agents typically offer employers, most notably because employees would be able to choose from a variety of insurers. Thus, it would be important to begin early to recruit agents and brokers—to sell them on the idea and to educate them about the product and the potential markets. The pool would also need to make software available to the agents, so they can easily and quickly provide price quotations to employers.

Marketing and Education of Employers, Employees, and other Consumers

Past experience shows that even though the pool would be offering a new kind of coverage with important advantages for employers and employees, this is no guarantee that large numbers of employers would take up the offer. Of course, the *Roadmap* pool would have a key advantage because the tax credits would be available only through the pool, giving all who are eligible for tax credits strong incentives to seek out pool coverage. Moreover, part of the reform package is a requirement that all employers either offer coverage or pay a fee, and all individuals would be mandated to have coverage. Buying coverage through the pool would be a relatively easy way for employers and individuals to comply with the mandates. While attracting employers and individuals would obviously be easier if the mandates are in place, efforts would still need to be made to attract people to the pool. If the mandates are not in place, the pool would clearly need a marketing strategy to bring in as many employers as possible—to ensure the administrative economies of scale and bargaining power with health plans that would be required.

Past pools have tried a variety of marketing approaches, and there is no clear evidence that a particular approach is most effective. Some of the more successful pools have had relationships with organizations already known and trusted by

business, such as Chambers of Commerce. In Massachusetts, Chambers have already helped publicize the premium assistance that is available to small employers under MassHealth's Insurance Partnership, so they could be helpful. The pool would probably need to hire a marketing firm to develop a strategy that suits the particular environment in Massachusetts. The general conclusion of other pools is that a really effective marketing campaign requires more money than they have had for the purpose.

An important marketing issue that is different from those discussed above is how to communicate effectively with people who may be eligible for tax credits. A common problem with public subsidy programs is that many eligible people do not take advantage of them. The state's experience with Medicaid and SCHIP outreach will be instructive here, although the audience for tax credits would be somewhat different, since many will be higher in the income scale than those eligible for current public programs. Reaching them may require identifying different information sources and somewhat different tactics. Of course, the presence of the individual mandate should make people more than usually receptive to receiving information about strategies that help them comply.

Determining Eligibility for and Administering Tax Credits

As proposed, the pool would have responsibility for making the initial determination of who is eligible for tax credits and for transferring the credit amount along with each enrollee's and employer's portion of the premium to the health plans. The tax credits are designed so that a family's cost for buying the median-priced plan offered through the pool does not exceed a specified percentage of income. (A family could buy a more expensive plan, but the credit would not increase.)

Some entity would need to take responsibility for publicizing the availability of tax credits, providing information about the eligibility requirements, and answering questions that would surely arise. This task would not be trivial and could require a substantial budget and personnel. Whether it should be assigned to the purchasing pool is an open question. The magnitude of the challenge and the need for resources would be greatest when people first become eligible. But some of the functions would be ongoing, and it seems sensible to place these ongoing information-providing functions with the pool.

Apart from publicizing the program, the initial task would be to accept applications from potential recipients and determine the size of the credit to which they are entitled under the law. To carry out this task requires preparing an application form and establishing a process and the capacity for reviewing applications. Since the state already performs a similar function for people who apply for Medicaid and SCHIP, the pool should exploit that experience. In fact, a strong case could be made for out-sourcing the process to the agency that determines eligibility for these programs.

What should serve as documentation for income and how can lags be avoided? One approach would be to use the previous year's income as reported on tax returns. A problem is that income tax returns for, say 2006, will not all be filed until April 15, 2007. So people seeking to qualify for the credits in 2007 might not be able to

provide documentation until well into the year, even though they would have been eligible starting in January. If the plan year begins in January, as is common, people who are enrolled on an ongoing basis would be receiving credits for a plan year based on income information a whole year old. This delay would increases the probability of a discrepancy between a recipient's actual income and the income figures on which the credit amount is based. One way to lessen this problem would be to have the open enrollment period be shortly after April 15, perhaps beginning May 1. A second approach would be to rely on documents that are more up to date than income tax returns. In the case of most lower income people, wage stubs would be a reasonably accurate reflection of their true income, since few of these people would have significant nonwage income. But documentation might be needed for several wage earners in the family, and in some cases, nonwage income could make a difference in determining eligibility. Provisions would also need to be made for people who experience significant mid-year changes in income to submit documentation so that their tax credit amounts could be changed to reflect their new economic circumstances on a timely basis.

These issues arise, of course, in any need-based program where documentation of income is required, and the solutions that have been used in other income-based subsidy programs in the state could be applicable in this situation. The pool could, for example, adapt some of the processes and mechanisms already created in Massachusetts to verify income eligibility for the Free-Care Pool, the Insurance Partnership, or other programs.

The funds for the payments the pool would make each month to insurers would come not only from employer and individual premium payments but also from tax credits. The pool would need to develop a mechanism for getting the tax credit funds from the Department of Revenue. The amount would vary depending upon who qualifies for tax credits each month. In essence, the pool would have to invoice the Department of Revenue for the appropriate amount. This assumes the tax credit funds go directly through the pool to the insurers. Instead, the Department of Revenue could send a voucher in the amount of the tax credit to recipients, who would send the voucher to the pool along with any additional premium payment they owe. The pool would then submit the vouchers to the Department of Revenue for payment.

The *Roadmap* includes a reconciliation process to be completed at year end to determine whether the amount of the tax credit a household receives based on income expectations for the year equals the amount they are entitled to based on their actual income. The pool would have to provide the Department of Revenue with a list of every person receiving a credit for every month along with the amount they received and how the eligibility amount was determined—that is, what income was used to document eligibility. But apart from this, the reconciliation process need not involve the pool; it would between the credit recipient and the Department of Revenue. Whether or not the insured person was actually entitled to the credit they received is not relevant to the amount of funds the pool should receive from the Department of

Revenue. Even if the person is not eligible for any credit, the plans would have covered the person and thus would be entitled to the full premium payment, which the pool would have paid. The Department of Revenue would make up any shortfall by collecting the money from the credit recipient, not the pool.

One issue to be considered in designing the reconciliation process is whether it would be useful to require people to "pay back" small overpayments. Some mismatch between the "right" tax credit amount and the actual credit amount is likely to be common. Requiring people to pay back amounts that are less than, say, $200, may pose a significant administrative burden on the state and create a financial burden for credit recipients when there was no intent on their part to get a greater credit than due. On the one hand, the administrative costs in collecting the overpayment could be significant, making the net revenue recovery quite small. And fear of having to pay back something could also deter some low-income people from applying for the credit. On the other hand, requiring full reconciliation has the appeal of complete accuracy and would avoid the inequities of differential treatment of people in similar economic circumstances.

Enrolling People in the Pool

If the pool has the role envisioned for it, it would have a large enrollment, from four sources:

1. Tax credit recipients would be enrolled in the pool, including those whose employers offer their own non-pool coverage.

2. Many employers, especially smaller employers and low-wage employers, would find it advantageous to meet their play-or-pay requirement by offering coverage through the pool (since the cost will often be less than buying coverage outside the pool and the administrative burden for the employer will be minimized).

3. Employees of firms that meet their play-or-pay requirement by paying the tax rather than offering coverage would presumably enroll in the pool, because they would be eligible for premium discounts to reflect the fact that their employer has paid into the pool on their behalf. The hope would be that these employers would encourage and facilitate such enrollment, which would make the pool's task easier.

4. People getting coverage on their own who would currently buy coverage in the individual market are likely to find that the pool offers less expensive equivalent coverage (because of lower administrative costs).

Given the large numbers and differing populations buying through the pool, the process of enrolling people deserves attention.

From the pool's standpoint, the easiest situation would be when employers choose the pool as the source of coverage for all their employees. The employer would need to supply the pool with a list of employees and dependents. The pool administrator would then be responsible for enrolling people in the plan of their choice and ensuring that the information is transmitted to the health plans to complete the

enrollment process. Some employers, especially small firms, would be using the services of insurance agents, who could help employers through this process, relieving the pool of some elements of the task.

A somewhat more complex situation would occur for employees of firms that choose the pay option. If these employers take the initiative to facilitate the enrollment process, it would be similar to the previous situation, although the pool would face the additional task of determining the size of the discount each employee is eligible for (if the discount is based on income, as proposed). If the employer chooses not to become involved in helping employees enroll in the pool, then the pool would face a situation similar to having people enroll as individuals outside the employer system.

The most complicated situation would occur when an employer offers coverage outside the pool but some employees qualify for the credits and would thus need to enroll in one of the pool plans. The initiative for such enrollment must come from the employee who thinks he or she is eligible for a credit, but employers should certainly be encouraged to inform their employees of the eligibility standards and how to apply for the credit and pool-based coverage.

The last case would be people enrolling as individuals completely apart from the workplace. This is probably the most costly form of enrollment from the pool's standpoint, since the pool would have to assume all elements of the enrollment task unless insurance agents are part of the transaction.

For people enrolling through the workplace, the pool's work would be greatly simplified if employers were required to withhold premium contributions from employees' wages and transmit the withheld amounts to the pool.

In any of these situations, the pool or its administrator would need to be prepared to provide information about how the process works and to answer questions that new enrollees would have. Since the number of initial enrollees would be quite large because of all the people eligible for tax credits, it would be important to have the capacity and tested processes to handle all these people from the beginning.

Rating Practices

An important issue for the pool would be the degree to which it restricts insurers' ability to vary premium rates based on past history or characteristics of insured individuals and groups. The safe rule to follow to minimize adverse selection would be that, in determining the conditions under which people would be allowed into the pool, the pool insurers follow the same rating rules as those that apply outside the pool. If the insurers outside the pool rate on the basis of age, location, and prior claims experience, the pool insurers would do the same. The reason for adopting this rule is that if the pool adopts more lenient rules—for example, using community rating while the rest of the market rates on the basis of individual or group risk—the pool insurers would be sure to end up with a disproportionate share of high-risk enrollees. High-risk people would get a better deal by buying pool-based coverage because they would not be penalized for being higher risk. Under these conditions,

the pool would become a victim of adverse selection: its claims costs and thus its premiums would rise, the lower-risk people would leave to get a better deal outside the pool, and the pool could become financially unviable.

Similarly, if those buying coverage outside the pool are subject to exclusions and waiting periods for prior conditions, the pool should follow the same practices. However, in a system in which everyone is mandated to have coverage, as proposed in the *Roadmap*, there would be no need to have pre-existing condition exclusions or waiting periods inside or outside the pool. These are in place at present to prevent people from waiting until they become ill or know they need expensive services to enroll in a health plan. Under a mandate, people could not delay getting coverage in this way; they would normally have continuous coverage. So it would be appropriate to change state law to prohibit these rating practices regarding pre-existing conditions and waiting periods, and also to mandate guaranteed-issue not only in the small-group market, as now, but also in the individual market.

Even if the pool uses the same rules for accepting and pricing applications as the zoutside market, it still could experience some adverse selection. As noted earlier, however, if the reinsurance program protects insurers both inside and outside the pool against much of the expense of high-cost cases, as proposed, the negative effects of adverse selection would be reduced. In addition to reinsurance, a risk-adjustment mechanism is planned for the pool to protect insurers operating inside the pool from adverse selection relative to other health plans within the pool. But that does not address adverse selection against the pool as a whole. If the risk-adjustment mechanism were applicable both inside and outside the pool, the impact of adverse selection against the pool would be mitigated. If all three of these policies were in place—reinsurance, risk-adjustment within the pool, and risk-adjustment between the pool and nonpool markets—the pool could probably adopt at least somewhat more lenient risk-rating rules.

Even without the protections of risk adjustment and reinsurance, however, the pool might be able to adopt more lenient rules for one population that buys coverage through the pool—the people receiving tax credits. The reason community rating does not work within a pool for most populations is that individuals always have the option to go outside the pool if coverage is cheaper. But credit recipients would not be able to go outside the pool unless they are willing to give up the credit. For those who receive generous tax credits, going outside the pool would seldom be less expensive. The conclusion is that for credit recipients, the pool might be able to move further toward community rating than is the standard used in the individual market generally. Doing so would help to ensure that higher-risk credit recipients would find the pool insurance to be affordable. For example, if the pool adopted rating rules that used a somewhat narrower rate band for age, an older enrollee might pay less than they would for the same coverage outside the pool (before application of the tax credit), making coverage more affordable. Younger workers would, of course, pay more inside than outside the pool in that circumstance. But since they could not use their credit outside the pool they would likely stay in it. Of course, some young

people receiving very small tax credits might find a better deal outside the pool. So a small amount of adverse selection might still occur within this population.

The pool would be an option available to all employers. But the state's small-group rating laws do not apply to those firms with more than 50 employees, which is typically the upper limit for defining small employers. They are either self-insured or are insured based on their expected and experienced risk. Since the pool would accept such larger firms, it might need to protect itself against adverse selection: the firms most likely to join would the higher-risk firms that find it difficult to find affordable coverage elsewhere. To prevent attracting just such firms, the pool might need to risk-rate these firms, apply medical underwriting, etc., just as any other insurer would do.

Conclusion

The role envisioned for the *Roadmap* purchasing pool bears a strong resemblance to the role played by other large pools. But it goes beyond that because of the pool's responsibility to serve as the source of coverage for tax credit recipients and to administer those tax credits. The nature of the pool's operations would also be different because no other pool functions as part of a financing system that includes an employer play-or-pay requirement and an individual mandate. Thus, while some lessons can be learned about how to implement a pool from the experience of other pools, the *Roadmap* pool would be plowing some new ground and providing new lessons for other pools that might follow.

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