

Caroliance

North Carolina's Health Insurance Cooperative for Small Businesses Needs a Doctor

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In North Carolina and the rest of the country over the last decade, lack of health insurance has been a large—and growing—problem. Lack of health insurance translates into delayed health care, higher costs of treating more advanced disease, poorer health outcomes, and higher out-of-pocket costs for patients and their families. Nationwide, the vast majority (83%) of the uninsured have a job or someone in the family does.¹ The working uninsured are especially prevalent in small firms and among the self-employed (60% of uninsured workers are self-employed or work for firms with fewer than 100 employees).¹

Because of the disproportionate distribution of uninsured workers in small businesses, federal and state governments have recently focused on making health insurance available and affordable to these firms. North Carolina has been a leader in this movement. In 1992, it became one of the first states to guarantee small companies (presently defined as comprising 1-50 employees) access to health insurance coverage at near-average rates. In 1993, North Carolina became one of the first states to create a state-supported health insurance purchasing cooperative. The intent is to help small groups to obtain better health insurance packages, comparable to those generally available only to larger groups because of their economies of scale and balanced risk pools. North Carolina's purchasing cooperative program is called Caroliance. In this article we report the findings of a case study of the Caroliance program and its effects on the small-group market in North Carolina.²

Background and Methods

The information reported here was derived from an intensive seven-state study, funded by the Robert Wood Johnson Foundation, of various insurance market reforms.³ Data for North Carolina were obtained in two rounds of interviews

with representatives of the insurance industry and state regulatory agencies (conducted in 1997 and 1998, with follow-up in 1999). Caroliance was discussed at 14 interviews with two representatives of the state Department of Insurance, four representatives of two insurers, a Caroliance representative, two independent insurance agents, one benefits administrator, and one insurance industry consultant. Discussions were based on an interview guide; subjects were apprised of the purpose of the study and promised anonymity to the extent feasible. Data were analyzed using both qualitative and quantitative techniques.

In 1993, North Carolina enacted legislation creating a system of regional alliances, which small groups could join on a voluntary basis in order to purchase health insurance. In late 1993, the North Carolina General Assembly appointed an 11-member State Health Plan Purchasing Alliance Board (consisting of the lieutenant governor, the state insurance commissioner and nine other members, six of whom represent small business) to develop and oversee the alliance system. An executive director, appointed in January 1994, hired three other staff members over the following year. The State Alliance Board was charged with setting up 4 to 12 non-competing regional purchasing alliances, which were expected eventually to become self-supporting. Six alliances were incorporated initially, each with a governing board of local small-business owners, and an executive director and support staff. A benefits administration company was hired to help the regional alliances with marketing their products to small groups, enrollment, premium billing and collection, payment of agent commissions, and database maintenance. Insurers were recruited to offer a variety of standardized health insurance products through independent health insurance agents. Caroliance began selling its products in late 1995.

Our evaluation of Caroliance is structured according to its intended purposes. The main idea behind Caroliance was

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that it would allow small groups to pool their purchasing power efficiently and thereby reduce health insurance premiums. It was also intended to offer employees a wide choice of benefit plans and insurers, and to streamline the process of quoting premiums. Finally, Caroliance was designed to make competition among insurers in the small-group market more equitable by requiring the sale of standardized benefit plans in the alliances, by monitoring clinical outcomes and customer satisfaction, and by using a risk-adjustment mechanism to spread the risk evenly among participating insurers.⁴ It was reasoned that having all participating insurers sell standardized benefit packages would make it easier for purchasers to compare products, and more difficult for insurers to select only “good risk clients” through benefit designs that would discourage subscribers with existing health problems. Assessment of customer satisfaction and other measures of quality would permit evaluation of the insurers’ performance. Risk adjustment would help spread subscriber health risk evenly among insurers and thus encourage them to concentrate their energies on administrative efficiency and care management instead of trying to avoid high-risk subscribers.

Consideration of the purposes behind Caroliance suggested the following aspects of evaluation: (1) impact on enrollment and product choice; (2) impact on premiums; (3) participation by and competition among insurers; and (4) the views of insurance agents.

Findings

Enrollment and Product Choice. Caroliance has struggled to gain market share. Its enrollment has never amounted to more than about 1% of the total small-group market (Table 1), and enrollment has declined substantially from its peak in 1997. Despite the disappointing performance, Caroliance has offered a number of important advantages in terms of availability of and choice in products for hard-to-insure groups. Insurers are leery of covering groups of five or fewer employees because small groups tend to be less profitable (they often put off purchase of health insurance until an expensive health care need is imminent, and the per-person cost of administration and marketing is higher). Table 2 shows that groups purchasing through Caroliance have been primarily in this underserved market segment, and that group size has decreased significantly in recent years.

Groups purchasing new coverage through Caroliance are more likely to have previously been uninsured than groups purchasing new coverage in the outside market. In 1996, 1997, and 1998, more than 50% of new business in Caroliance was with the uninsured (those who had no group coverage in the prior 30 days); this is twice the rate (20–25%) in the outside market. A Caroliance representative suggested

Table 1. Comparison of enrollment through Caroliance or outside market insurers

	1996	1997	1998*	1999*
Caroliance				
Groups	453	1,150	900	913
Lives	1,616	4,300	4,000	2,500
Outside market				
Groups	63,933	66,784	71,049	NA
Lives	689,297	552,853	627,647	NA

*As of mid-year for Caroliance; all other enrollment totals are as of year-end.

Lives = Employees plus dependents; NA = Not available

Source: Caroliance enrollment data provided by the State Health Plan Purchasing Alliance Board; outside market enrollment data from the North Carolina Small Employer Group Health Insurance Annual Activity Report 1992–1998, North Carolina Department of Insurance, Life and Health Division.

that this represented an entry point into the health insurance system for new businesses, since Caroliance was more lenient about how long a business had to be in operation to qualify for coverage. This same representative thought that, once groups have initial coverage, they leave Caroliance for the outside market.

Another notable characteristic of Caroliance is its large proportion of guaranteed-issue business (coverage an insurer must offer to any small group regardless of the group’s health status). During its first year, Caroliance reported that 75% of its groups were classified as guaranteed-issue, in contrast to only 4% for the outside market. Since 1997, Caroliance continued to report that 65–70% of its groups were guaranteed-issue, compared to 3% for outside insurers.

Table 2. Comparison of average group size

	1996	1998/99*
Caroliance		
Employees	2.2	1.7
Lives	3.6	2.7
Outside Market		
Employees	5.7	5.1
Lives	10.8	8.8

*As of 8/99 for Caroliance and 12/98 for the outside market; 1996 is as of 12/96

Lives = Employees plus dependents

Source: Caroliance data provided by the State Health Plan Purchasing Alliance Board; outside market enrollment data from the North Carolina Small Employer Group Health Insurance Annual Activity Report 1992–1998, North Carolina Department of Insurance, Life and Health Division.

Caroliance has been able to offer better selections to high-risk groups. North Carolina's original small-group law required that insurers offer two health insurance products to all small groups that applied, regardless of health status. The state-mandated benefits consisted of a basic plan (with minimum benefits) and a standard plan (with benefits approximating traditional indemnity coverage). Premiums were subject to state rating restrictions. When it began operation, Caroliance was allowed to offer only these so-called statutory products, even though they had not been popular because of high cost and a perception of inferior benefits. But Caroliance soon added a "select" product that was comparable to the comprehensive coverage available in the outside market.

Caroliance was required to offer its products to any group interested in buying, although rates for less healthy groups were higher; insurers selling in the outside market had to offer higher-risk groups only the statutory plans. Caroliance thus offered less healthy groups a more attractive benefit package than they could find in the outside market. Caroliance also was more active in marketing its guaranteed-issue products.

Caroliance's advantage largely disappeared in July 1997 with enactment of the Health Insurance Portability and Accountability Act (HIPAA). This federal law requires that insurers offer all their plans, on a guaranteed-issue basis, to groups with 2-50 workers. Thus, some groups who previously were only offered statutory plans could find other plans instead. Indeed, the total number of groups buying statutory plans in the regular market dropped by 22% between 1996 and 1998, and the number of groups buying non-statutory plans rose by 12%.

Caroliance still offers greater choice for the self-employed (also called "groups of one"), who are not covered by the new federal law. North Carolina law requires only that insurers offer the two statutory plans to groups of one, but Caroliance offers the more comprehensive plan as well. However, even this advantage is lessened by the fact that Blue Cross, now the primary insurer in Caroliance, voluntarily issues additional plans to the self-employed purchasing in the outside market.

Caroliance allows individual employees to choose among different insurers and plans, in contrast to the outside market where insurers require small employers to give them all or none of their business. This advantage is diminished, however, by four factors: (1) The employee-choice feature is much less significant to companies with 1-3 workers where there is little distinction between the employer's and the employees' choices (employer and employees may well be part of the same family). (2) Caroliance now has only one insurer operating statewide (Blue Cross). Thus, only the largest cities offer the possibility of a selection of insurers, and even then the selection is very small. (3) Employers can opt

out of the employee-choice feature if they pay 70% or more of the premium. And (4) some of the smallest employers find the choice feature burdensome. The Caroliance benefits administrator does not handle claims problems, so this task often falls to the business owner. Having to understand and negotiate the claims systems of multiple carriers can be time-consuming. It has been reported that some very small employers pressure all their employees to choose the same plan for this reason. These four factors have resulted in fewer than 5% of Caroliance groups enroll with more than one insurer.

A final notable characteristic of Caroliance is that its subscribers have overwhelmingly chosen fee-for-service plans—indemnity and preferred provider arrangements—over managed health care plans (health-maintenance or point-of-service). In sharp contrast to purchasing cooperatives in other states, where enrollment is overwhelmingly in health-maintenance organizations, more than 80% of

Caroliance enrollment has been in indemnity or preferred provider options. This is true for both healthy and sick groups and may reflect the weakness of health maintenance organization provider networks in rural areas. Low enrollment in managed care also may reflect a relatively sicker health status of Caroliance groups, although there is disagreement on this point. Less restrictive fee-for-service plans may attract sicker subscribers, who are more attached to their doctors and are less willing to switch to a new provider in a managed care network.⁵

Premiums. Insurance agents in North Carolina and around the country have told us that small groups are very price-sensitive, and will often switch carriers to save just a few dollars per employee. This is particularly true because of the portability of coverage resulting from state and federal reforms. This puts Caroliance at a clear disadvantage because of its higher rates. Agents say that Caroliance is usually more expensive than outside options, even for policies issued by the same insurer. Some states do not allow insurers to charge more for the same coverage sold through the state's purchasing alliance than through the outside market, but this is not the case in North Carolina. There are occasional reports of favorable prices through Caroliance (one subject told of a 17% discount), but the prevailing opinion is that, more often than not, healthy groups get better prices in the outside market. This was confirmed by an internal study by Caroliance.

The price differential is driven by the health status of the enrolled population. If Caroliance is to be successful, it needs a strong base of healthy groups who will contribute premiums but not add substantially to medical costs. When there is an imbalance between healthy and less healthy groups, the healthier groups purchase outside because prices are lower;

"Having to understand and negotiate the claims systems of multiple carriers can be time-consuming. It has been reported that some very small employers pressure all their employees to choose the same plan for this reason."

this causes prices for those remaining to escalate, driving even more healthy groups away. As mentioned previously, Caroliance has appealed to groups that pose higher financial risks for the insurers. These groups are attracted by the select products and the more welcoming response they receive from Caroliance. Some subjects also say these groups are steered to Caroliance by agents trying to protect favored insurers in the outside market from high-cost business, an illegal practice called field underwriting.

Caroliance has been notably unsuccessful in attracting healthy groups. One important reason is the pricing system used by the benefits administrator. Insurers in the outside market use at least three tiers of rates (guaranteed issue, standard, and low risk), and many use five or six tiers, but Caroliance has generally used only two rates (guaranteed issue and standard). This simplifies the underwriting process so that quotes can be provided more quickly, but the negative effect of making fewer risk distinctions is to drive the healthiest groups to the outside market where "preferred" rates may be 20% less than standard rates. Similarly, Caroliance has until recently used blended family rates, which make no distinction based on the number of children in a family. As a result, smaller families have found it cheaper to purchase coverage in the outside market.

The problem of competitive rates is exaggerated by the fees added to the premiums paid by Caroliance subscribers. Each employer group that joins Caroliance must pay an annual membership fee, as well as a monthly administrative fee according to group size. The fees are a revenue source for the regional alliances, but they increase the effective market price at a time when Caroliance is already at a relative disadvantage in the market.

Insurer Participation and Competition. Health insurance purchasing cooperatives became prominent during the early 1990s, at a time of intense discussion about health care reform at the federal and state levels. Many stakeholders and public policy analysts saw alliances as market-based solutions to the growing numbers of uninsured, particularly among employees of small businesses. Alliances were more palatable to various special interests than a government insurance system, which appeared likely if nothing else were done. In North Carolina, as in many other states, the idea of insurance purchasing alliances for small businesses gained bipartisan support among elected officials, and the backing of insurance industry and business groups. Lt. Governor Dennis Wicker championed the idea in Raleigh.

Several major commercial insurers and nonprofit Blue Cross and Blue Shield were involved in early discussions about the design of this new entity. Several for-profit managed care companies publicly supported the alliance concept as it was being formulated. In 1995, 14 health plans requested applications to sign up as "accountable health carriers." However, only six insurers actually completed the

enrollment process when Caroliance started selling to small employers in November 1995, and only two offered their products in all six regions of the state. The number of participating insurers subsequently dwindled, so that by mid-1999 only Blue Cross was selling statewide and one other company was selling in a limited region. Only two health maintenance organizations have participated in Caroliance and neither across the whole state.

Various explanations have been offered to explain the low rate of participation by insurers. On the political front, the national push for comprehensive health care reform lost steam with the failure of the Clinton reform plan, so insurers no longer felt compelled to support the alliance as an alternative to government insurance. Blue Cross has continued to participate, perhaps because of its special ties to state government and its history as an institution with a broader social mission. On the business front, insurers have viewed the alliance system with skepticism. They complain that, contrary to predictions, Caroliance has not streamlined the process of enrolling and administering small groups and thus reduced administrative costs. Signing up business through the alliances actually takes more work since the Caroliance products do not mesh well with existing administrative systems. The size of the Caroliance book of business is too small to justify changing the internal systems of insurance companies. They are reluctant to sign up Caroliance business because they see it as high-risk and unprofitable. Some companies do not trust the delegated underwriting decisions made by the Caroliance benefits administrator. Others complain that, despite the attempts of Caroliance to identify an existing risk-adjustment methodology that would satisfy insurers' concerns, no suitable mechanism has been implemented. Companies say that Caroliance discourages healthy customers from purchasing because its underwriting system keeps this segment from getting the fullest allowable discount. Moreover, some insurers see the employee-choice feature as an invitation to adverse selection, since in theory an insurer can be left with the sicker members of a group if the healthier members choose a competing plan.

Marketing and publicity during the startup phase of Caroliance may have scared away some insurers and created the self-fulfilling impression that it has largely high-risk customers. News articles based on press releases emphasized the fact that Caroliance was available for employers who had difficulty finding coverage elsewhere, implying that Caroliance was targeted at high-risk groups. At the same time, the benefits administrator never fully developed a marketing plan that would attract a balanced complement of risks to Caroliance, although this was initially envisioned. Instead, fragmented marketing was carried out by the regional offices. Finally, some insurers reportedly left Caroliance because of unrelated changes in their business strategies. Others, namely managed care plans, say that the lack of physician networks in rural North Carolina is one reason they do not participate.

Health Insurance Agents' Participation. Caroliance has had a mixed reception from health insurance agents. Its relationship with agents got off to a rocky start because Caroliance planners initially considered direct sales. Even after Caroliance made it clear that it welcomed rank-and-file agents and that it would sell only through independent agents, there was strong opposition by managing general agents, who are influential professional leaders. Managing general agents opposed Caroliance because it does not pay them "override" commissions for recruiting and supervising field agents. There also is a perception that state funding gave Caroliance an unfair advantage over the private sector, and that the purchasing cooperative creates more complication and expense by introducing an unnecessary intermediary between insurers and purchasers. Some agents have been afraid that Caroliance would cut them out of the sales loop since nothing in the legislation requires their participation. Agents say that Caroliance premiums are too high, blaming the two-tier rating system mentioned above. One source noted that, even when Caroliance prices are competitive, employers have been swayed toward outside policies by added "perks," such as a small amount of term life insurance thrown in "for free." By law, Caroliance cannot add such incentives to its products or sell anything other than health insurance.

Another deterrent to agents is that, for several years, Caroliance paid commissions of only about 5%, compared to the 8-10% available elsewhere. One observer noted that selling Caroliance policies requires a change in business philosophy from what most agents are used to; money can be made, but it is "fast nickels, rather than slow dimes." Insurers generally view Caroliance business as guaranteed-issue business (even though a portion of it does pass underwriting), so they set their Caroliance commissions at the 5% level to reflect the expected lower profitability of guaranteed-issue products. Insurers also justify lower commissions by saying that it is less work for agents to sell through Caroliance, although some agents disagree, saying that the employee-choice feature confuses employers and employees, and requires agents to spend more time explaining the Caroliance system and handling claims and billing disputes.

Other agents have found Caroliance useful. Many hesitate to bring high-risk business to their favored insurers, and Caroliance provides an easy, alternative coverage for these groups. Agents have found that Caroliance is one of the few places where the self-employed can purchase comprehensive group coverage. Other beneficial aspects are fast rate quotes, easy comparison of products, and the availability of comprehensive, "select" products for higher risk clients. Because of its relative simplicity, Caroliance is reportedly more successful with agents who sell health coverage only occasionally, and so are less knowledgeable about all of the offerings in the market. Also, Caroliance allows agents who are not otherwise registered with an insurer to sell its products.

Discussion

Caroliance's most notable advantage is that, prior to HIPAA, it was the only way that high-risk small groups could get comprehensive coverage. Following enactment of HIPAA, this remains true for the self-employed. Caroliance provides easy comparison shopping, because it sells standardized products and it provides quick quotes through its simplified underwriting system. But Caroliance has not succeeded in attracting a large enrollment, offering lower prices, providing a broad selection of insurers, or providing quality-based comparison measures. Instead it has functioned as a *de facto* high-risk pool for groups that the outside market wants to avoid: the sick, very small groups, and new businesses.

In its fifth year of sales, Caroliance is struggling to survive. It has made significant changes in its operations in order to be more efficient, enhance its revenue (it is no longer subsidized by the state) and appeal more to insurers, agents and the healthier groups it needs. It has consolidated the regional alliances into one statewide alliance. It has raised administrative fees charged to member small employers. It has implemented a five-tier underwriting/rating system that recognizes more gradations of health status and thus gives lower rates to healthier groups. (Some informed observers speculate that Caroliance will never be able to offer quotes for prime business as low as the outside market, because insurers, leery of getting too many less-healthy clients through Caroliance, inflate their Caroliance rates to account for the expected higher costs. This practice is of questionable legality, since rating rules require insurers to use the same rating structure for all of their small-group business.) Rates for families are now tiered to account for differences in family size. Caroliance has agreed to allow Blue Cross to sell not only the standardized products but also some custom Blue Cross products, which the insurer says will be more administratively efficient for it to sell.

In making concessions about rates and product lines, Caroliance has reluctantly given up some of its distinctive features and succumbed to the realities of the market's current structure. Instead of reforming the market, Caroliance has largely come to mimic the market. But even with these adjustments, a large increase in enrollment seems unlikely as long as the basic market rules remain unchanged. National observers of health insurance purchasing cooperatives have noted that there is no inherent advantage to insurers to "put themselves in the kind of direct head-to-head competition" that participation in a purchasing cooperative involves. Until market rules mandate the sale of small-group insurance through a collective arrangement,⁶ it is unlikely that Caroliance will have the clout to attract more insurers. In the current environment, insurers can influence healthier groups to purchase products outside Caroliance because flexible rating rules allow lower rates for comparable products purchased

outside the alliance, and because of allowed variations such as commissions and product selection.

Conclusion

Caroliance has improved and made accessible the health insurance packages offered to high-risk small groups. However, North Carolina's health insurance purchasing cooperative has not harnessed the power of group purchasing to bring down premiums or to effect other improvements for all small-group purchasers. The rate of non-insurance among small-group workers in North Carolina has not dropped since Caroliance began operating. The challenge is to find ways to make coverage more affordable for all small-group workers and their families, especially those who have been priced out of the market.

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Note: Since this article was prepared for publication, the authors have been informed that the Caroliance operation will be closing as of December 31, 2000.