

## **Group Health Care Plans and Small Business**

Mr. John Polk, Vice President and Executive Director of the Council of Smaller Enterprises (COSE), Cleveland, OH.

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### **Introduction by Mr. Fred Orth, President, Oklahoma Health Underwriters Association**

Mr. John J. Polk is the Vice President and Executive Director of the Council of Smaller Enterprises (COSE). This small division of greater Cleveland Growth Association, Cleveland's Chamber of Commerce with over 7,000 member companies, employing nearly 150,000 greater Clevelanders. That's 150,000 employees under their program.

COSE is the largest local small business organization in the United States. The group's mission is to promote local economic development for the creation and delivery of programs and services designed to promote entrepreneurship and small business development. COSE volunteers lead programs in management education and assistance. Group insurance and other benefits and small business advocacy at the federal, state and local levels of government.

Mr. Polk is a frequent speaker and organization development counselor who has testified before Congress and in the Ohio General Assembly on issues involving tax and regulatory reform, healthcare cost containment, finance and small business development. He is a founding officer and director of COSE's Group Services, Inc., a non-profit benefits management operation run by COSE on behalf of its members and has been a founder and key organizer of other regional and national small business groups including Ohio's Small Business Council and National Small Businesses United.

### **Mr. John Polk**

I can begin by confessing right off that I have an attitude problem. That's because I represent a hitherto unrepresented segment of the healthcare delivery system, and that's the customer. It is my experience that the iron triangle of healthcare delivery represented by government, providers, and conduits, otherwise known as third-party payers in the insurance industry, cloaked in human concern and seeping the milk of human kindness from every pore, are consciously attempting to persuade MY members to pay for what THEY want and my job is to try to keep the process a little bit honest. So, while I may appear to be somewhat aggressive and somewhat arrogant, I guarantee you that I am genuinely aggressive and somewhat arrogant and actually very defensive about what I consider my members' interests.

Let me begin by answering a question that many of you may have asked yourselves already and that is, "What the hell is this guy doing here?" I am not an attorney. I am not a lobbyist. I am not a professor. I am not an economist. I am not a spokesman for the insurance industry nor am I a consultant nor am I a healthcare technician.

I'm just a customer.

I'm the Executive Director of an organization called the Council of Smaller Enterprises affectionately referred to as COSE.

### **What is the Council of Smaller Enterprises?**

COSE is the small business division of the Greater Cleveland Growth Association, Cleveland's local Chamber of Commerce. Our members are about 8,000 small employers that employ now upwards of 180,000 people in the greater Cleveland area as you heard from the introduction.

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We are fairly active in three general areas of assistance for small employers - management education and assistance, small business advocacy, which involves giving our members the opportunity to speak for themselves as their own advocates in the legislative process, federal, state and local, and the management of one of the nation's largest group healthcare plans for small employers; and I think it is for that reason that I am here today.

Let me tell you a little bit about our plans today. Today, out of 8,000 or so member companies, about 5,600 small employers participate in at least one of the group healthcare plans that we offer for our members. (You notice, I will refer to group healthcare primarily group healthcare coverage as opposed to insurance because I believe, as Allen stated earlier on today, that there is no way to insure this type of coverage.) Those 5,600 member companies provide coverage to about 38,000 employees and about 115,000 total lives through our programs.

Through the Council of Smaller Enterprises, a small employer, with as few as one employee, has the option to participate in any one or combination of 14 group healthcare programs available through 6 different carriers operating in Cuyahoga County. The average size of the employer participating in a COSE group healthcare program is a company with seven employees. So, we are talking about the smallest of the small.

We also have the luxury, in the Cleveland area, of operating in an environment which, depending on who counts, includes either the third or the fifth highest level per capita of healthcare costs in the United States, so anything that we do to save our member's money is welcome. But no matter how hard we try to save our members money they are still spending twice the national average for health insurance, so maybe that's why we have a little bit more history in this area than other organizations.

COSE's plans began in 1974, and they began when a group of small business people recognized that as individual small companies it was virtually impossible for them to acquire an adequate level of group healthcare coverage at reasonable costs in the insurance system as it then was organized, and is still organized today. So back then the presidents of a bunch of little companies and the president of a big insurance company, Blue Cross/Blue Shield of Ohio, decided to make a deal. Blue Cross/Blue Shield would provide our members collectively with a discount of about 10% (at that time) off the cost of their regular package of group healthcare benefits and the chamber would assist the local Blue Cross/Blue Shield plan in marketing those programs.

So the plan began in 1974 with about 80 companies and about 1000 employees participating in it. When I joined the staff about 10 years ago, participation in the plan was up to about 1200 small companies and once again today there are about 5,600-5,700 companies participating in our group healthcare program.

Let me give you a little more background on the COSE programs. Between 1978, when I began with the organization, and 1982 our members received for their Blue Cross/Blue Shield plan a group healthcare package that very strongly resembled the type of group healthcare coverage that is incorporated into Senator Kennedy's national mandatory minimum essential healthcare act. A very high level of benefits paid on usual and customary reasonable basis. A community rated product (which for those of you who don't know means that there is one plan priced at one rate), no medical exclusions, a

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guaranteed issue program, no apparent attempts to control the costs of that coverage. And between 1978 and 1982 the prices that our members paid for group healthcare coverage increased a net of about 130% in five years.

### COSE Operating Principles

In the early '80's, a group of COSE volunteers began, literally out of desperation, to try to find some ways to break that upward cycle of inflation in our members' prices and we adopted some philosophies as well as some operating practices which were, and still are apparently, radical in the small business community.

We began by making the decision that an independent entity, divorced from our insurance carriers, needed to be created to change the nature of the relationship between our carriers and our members. We needed to create a single centralized customer to which our insurance carriers would be accountable.

Secondly, we wanted to act like a customer and persuade our carriers to sell us what we wanted to buy as opposed to what the carriers had to sell. To do so required the development of a fairly comprehensive and innovative and management information and data collection system.

We began by focusing not on the risk portion of our members' group health insurance cost but by focusing on the administrative portion of the health care coverage bill. Our idea was that we were at the time offering a number of programs with about six different carriers and we thought that by doing something to centralize the administration of those programs. One independent entity providing centralized management and information services on behalf of all our carriers could provide those services at a substantially reduced cost over the cost of permitting our carriers to provide those services themselves, and we were right.

The administrative entity that we created, COSE Group Services, handles primarily enrollment, billing, and reimbursement functions for us with all our carriers, and we provide all those services to our members at between 10 and 25% of the cost that the carriers provide those services operating themselves. Frankly, insurance carriers are risk managers. They are not administrators. They don't know. So, we have tried to teach them.

Since we have established these programs, centralized administration, some very rudimentary medical underwriting rules, which I will talk about a little bit later, since we have ginned up our marketing efforts and since we have begun to collect data which we can use to keep our members honest and our carriers honest. In the last five years between 1983 and 1988, the costs of the group healthcare programs that COSE offers to its members have increased a cumulative net of 19.3%. That's 130% ten years ago versus 19.3% in the last five years, and we have done it while increasing the availability and affordability of group healthcare coverage to small employers. The experts still tell us that we're not supposed to be able to do that. That's why we don't let experts run our plans.

### Why do the COSE programs work?

There are a number of reasons. First of all, obviously is size. Today those 5,600 COSE member companies and the 38,000 employees that work in them will invest about \$80 million in healthcare premium with our sponsored carriers, and it should stand to reason, even in a regulated marketplace,

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that an \$80 million customer gets a little bit more attention than a \$,2000 per year customer. So, merely our size has given us some basic advantages.

Another advantage of our program which leads from size is negotiating strength. Of that \$80 million in health insurance premium, about \$72 million goes to one carrier - Blue Cross/Blue Shield of Ohio - which provides us with 8 of our 14 different plans: traditional plans, hospital-based PPO's, physician-based PPO and an HMO. When I go into a meeting with the president of our local Blue Cross/Blue Shield plan, I generally go with a \$3 million check in my pocket and we start the meeting by handing the president of Blue Cross/Blue Shield a \$3 million check. That helps the president of our local healthcare provider to remember who his customer is, and that has given us the opportunity to negotiate a little bit more aggressively on behalf of our members than our members could negotiate themselves.

From that negotiating position has evolved the creation of some fairly innovative approaches to product development and pricing. Our programs are priced based solely on the rate of medical inflation in our local community so if the CPI for our region in hospital and medical services says that costs have increased 10%, 10% plus or minus a couple, is what our carrier is going to receive from us. What's the principle? Well, the principle is if you've got an \$80 million program this year and you're going to increase that cash flow by 10%, an additional \$8 million on top of \$80 million, even I could spend that money fairly efficiently and effectively. There is no reason for the small business consumer to conscience perpetual increases of 20%, 25%, 30%, 40% or 50% in health insurance costs. It just isn't necessary.

Another advantage that we have developed is a very acceptable mix of risks. In a group that is composed of 115,000 or so employees and dependents, you've got a universe which I think even an actuary would consider to be fairly credible. Out of a group of 115,000 people you know there are going to about so many normal deliveries, so many appendectomies, about so many cases of AIDS and so many incidences of open heart surgery or coronary bypass surgery. So with a group of our size, it is fairly easy to predict what utilization in our plan is going to be and as long as we can persuade our carriers to treat us as a single customer and not as merely a conglomeration of thousands of tiny little units in our community, we can develop utilization assumptions and from utilization assumptions establish some rates which makes some sense.

Our approach to healthcare management on behalf of our members is also unique in that it is long-term in nature. Our volunteers in their wisdom concluded in the early '80's that anybody can make a little better deal on price this year; but that in order to make certain that our members would continue to enjoy the benefits that were available to them through the organization at reasonable costs, we needed to think about not just what our rates were going to look like next year but also what we needed to do to make certain that we could lend some stability and predictability to our rates five years out.

We don't sign a contract with an insurance carrier that is less than three years in duration. Usually it's a three year contract with a two year re-up at our option; but that long-term commitment provides our carriers with a certain degree of comfort, provides us with the opportunity to plan for the evolution of our program into the future and the combination of all these factors has produced a program, a very innovative program which provides a wide variety of group healthcare options to our members at costs

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which are between 40 and 50% lower than the cost of group healthcare coverage on a retail basis to individual small firms in Cleveland, Ohio.

And, as we get on in the program, I will attempt to offend those of you who are in the insurance industry by saying that the fact that our members' costs are so low relative to the marketplace is not because we are so wonderful; it's because most of the insurance industry runs pretty crappy small group health insurance plans.

### **Relationships with Insurance Carriers**

I should mention one other thing while I am trashing the insurance industry and that is we have a great carrier. About five years ago, after having been ignored for seven or eight years by our local Blue Cross/Blue Shield Plan, the Plan got a new CEO, a guy who most people in the Blue Cross/Blue Shield business don't like, a guy by the name of Jack Burry, President of Blue Cross/Blue Shield of Ohio. He sat down with us one day and said, "You know, I was looking over these numbers and I realize you guys are a pretty big customer." We were astonished because this was literally the first meeting that we had ever had with the chief executive officer of our local Blue Cross/Blue Shield Plan; and at that first meeting, that insurance company's CEO said, "I value you as a big long-term customer and I want to make sure that you are my biggest customer ten years from now and I want to work with you to make sure that happens."

I have yet to find another insurance company's CEO that is willing to take that kind of an entrepreneurial risk and make that kind of a statement. "Entrepreneurial insurance carrier" is as much an oxymoron as "entrepreneurial banker" in our community.

### **Why Mandates Are Not A Long Term Solution**

You want to hear about a second orientation solving small employers group healthcare problems in the next hour or so. You have already heard about the mandate orientation that relies very heavily upon a highly centralized and powerful government bureaucracy which is going to pass laws to make employers do things. I think that our program exists and is successful because of our very strong market orientation, solving members' problems. You have already heard Allan (Dr. Allan Sager; The Massachusetts Health Security Act) talk a little bit about, in specific terms, the problems with mandated benefits. I would like to share my biases with respect to mandates as well. Why mandates in the long-term cannot work?

First, as you have already heard, the answer to our community's, your community's healthcare problems, do not involve an infusion of more cash into the system and that's what mandated benefits provide. Our cash already flows into a system which is receiving too much money and which is not operating efficiently.

In a mandated benefits system, there is no incentive for anybody to control costs. Certainly there is no incentive for providers; certainly there is no incentive for insurance carriers (or conduits, forgive me). and certainly no incentive on state funds which operate in the political environment, and everybody knows how easy it is renege on promises that have been made in a political environment. Allan touched on that briefly during the Q&A session. In that kind of an environment who speaks for the customer.

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I had the opportunity to speak with Senator Kennedy back in February about his mandatory minimum essential healthcare act of 1988; and I asked him if the U.S. Congress passed a law that forced every American in the United States to own a Cadillac, what did he think would happen to the cost of Cadillacs. Well, he did not answer that question; it was complicated, so he turned to his staff and his staff provided the answer that if the Congress were to pass a law that mandated that everybody in the United States had a Cadillac, that the price of the Cadillacs would go down because there would be so many more of them. My rebuttal to the staffer was that if the U.S. Congress passed a law that mandated such a thing, it would no longer matter what Cadillacs cost or how well they worked, because everybody in America would have to have one. Where is the incentive to be sensible in a system that relies on mandated benefits.

A mandated benefit program like the Kennedy program also takes away the small business owner's only opportunity to exercise some control over costs, and that's the ability to shop. Under the terms of Senator Kennedy's proposal, unlike the Massachusetts proposal, if you are a small business owner and you offer a health insurance program, you are not allowed to leave the program that you are in, no matter what it costs. Of course that wouldn't matter because the federal program also provides a fairly specific very detailed and very comprehensive schedule of benefits which every insurance carrier selling in the marketplace must offer; but if everybody is selling the same thing, priced in the same way, and essentially un-managed in the same way, I doubt that there would be much price differentiation among carriers operating in the marketplace. But, when you lock a small employer into a bad deal, it's kind of tough to suggest to him that he should be a good citizen and just quietly pay the prices that he is charged as the price of his good corporate citizenship.

Another problem with mandates is that by and large, especially if enacted on the state level, is that if small employers pay twice, and pay through the nose. The first way they pay, of course, is in the form of this payroll tax, medical security contribution, whatever you want to call it. The second way that small employers pay twice is by picking up their share of the subsidy for so-called uncompensated care which hospitals are permitted to pass back to insurance carriers, and which insurance carriers are permitted to pass along to their customers. The only organizations that buy group healthcare coverage from insurance carriers are small employers. Self-insured entities, at least unless the state of Massachusetts has its way and that ERISA preemption is revoked, are exempt from that portion of state risk pool funding. So, small employers pay through the nose. It is not an equitable distribution of costs. Mandated programs established solely to deal with the needs of the uninsured create an uninsured ghetto in a state. Programs whose purpose is to provide coverage to the uninsured at any cost and which segregate the so-called uninsured from the so-called insured deny the fact that the reasons why that the uninsured are the uninsured are not the same reason. The only thing that these diverse constituencies have in common is that they lack group healthcare coverage. Most of the reasons that the uninsured are uninsured have to do with health. So create a special pool for sick people, make small business people pay for the cost of that pool, don't regulate it, don't underwrite it; the cost of providing healthcare to the uninsured is going to go "kablooie" and there's nothing anybody can do about it because it's going to be the "law".

Finally, mandates are based on a fundamental misassumption which really kind of makes me mad. Mandated benefits for small employers are usually predicated on the misassumption that the reason

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that the working uninsured are uninsured is that employers are greedy, that employers, particularly small employers, who do not provide insurance coverage to their employees do so out of some conscious decision that by not providing coverage to their employees, they are somehow gaining a labor cost-related advantage in the marketplace that enables them to compete more successfully against their competition, and that's just wrong.

We have been providing access to group healthcare coverage for small employers by the thousands for the last fifteen years and our programs are predicated on a very important first assumption, and that is that everybody on earth wants group health insurance coverage because the benefit levels are better, the prices are better and more controllable than the cost of individual coverage and the availability of individual coverage when you can get it and that the reason that small employers don't offer coverage to their employees is not that they're greedy - it's for other reasons.

What are those other reasons? I have already said it. I don't believe that it has to do with lack of demand because everybody wants the coverage. Small employers cannot legally purchase coverage for themselves at the expense of their employees without violating most state insurance laws and many federal healthcare regulations, plus insurance carriers don't write coverage on a group basis for partial groups so an employer that is making the decision not to purchase group healthcare coverage for his employees is normally making the decision to forego coverage for himself and his family. And everybody wants group health insurance coverage, so no small employer in his right mind is going to make that decision. Companies which have uninsured workers are in that position for a reason.

### Why Are Small Businesses Difficult To Insure?

The first reason is that the small employer's work forces are hard to insure because of a lot of part-time workers or a lot of seasonal workers, because there is a very high level of turnover in the small business workplace, and also because small businesses themselves are in and out of existence very rapidly. Fifty percent of the companies that are founded this year are going to be out of business next year, and 80% of the businesses that begin this year are going to close within five years. It's very hard to capture those numbers, particularly at the lowest levels of the marketplace and for sure, government is going to be incapable of micro-managing group healthcare programs down to that level of volatility and fragility in the marketplace.

The next issue, which it pains me to admit, is that there is a lot of, I think the new euphemism is inadvertent non-compliance, among small employers who buy group healthcare coverage. What does that mean? That means that in the small business marketplace there are an awful lot of people who work who should get health insurance coverage but who don't because the employer doesn't know the rules. The employer doesn't know that if he is offering healthcare coverage to one of his part-time workers (usually his son or daughter whose off for the summer) he must offer group health insurance coverage to all his part-time employees. Small employers don't realize that it's not real fair to impose a two-year waiting period for benefits on new employees in the company and then to make those programs available only to management in the firms. There are some rock-headed small employers out there who believe that their small companies are their fiefdoms and can't nobody tell them what to do with their programs, right, wrong or indifferent, cause that's just wrong.

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There are civil penalties that exist when dealing with those kinds of rock heads and it is not fair of me, even as a small business advocate, to talk about this problem without acknowledging the fact that there are some problems with compliance in the small business community. Very few of those compliance problems are conscious in nature and when those problems are conscious in nature there are penalties available to deal with them.

Underwriting rules are another reason that the working uninsured are the working uninsured. Even in our plan where medical underwriting will keep about 5% of the groups that apply for coverage through our plans from getting coverage, our approach is that our insurance carrier, particularly with companies that employ fewer than ten people, can reject an entire group who have applied for group health insurance coverage if even one employee has a serious pre-existing medical condition. Now there are some ways that we have played with that that our federally qualified HMO doesn't like. I mean generally speaking we take that sick person and put him in the HMO. But in a place where a COSE-type program doesn't exist and that coordination isn't possible, there are entire small groups; groups of 5, 6, and 7 employees, who are denied group healthcare coverage because one member of that workforce has a pre-existing medical condition. I'm not saying that's right or wrong. It represents a problem.

The big reason that you hear that small employers don't provide access to healthcare coverage for their workers is price. So, let's pass a law to make health insurance more affordable. Sorry, it doesn't work that way. Because just like trying to pass a law to cover the uninsured is treatment of a symptom at the expense of an analysis of the problem, so is citing price as the primary barrier for group health insurance coverage among small employers. An excellent diagnosis of a symptom which does not provide anybody with a lot of room to explore the underlying problems of which high prices are symptomatic. It is true that in the small business marketplace generally health insurance costs are about 40% higher on the average than the cost of health insurance for larger employers, and significantly higher than the cost of coverage for large self-insured employers.

### Why Are Prices So High For Small Business?

What are the reasons that prices are so high? First, there's a lot of discrimination in the federal tax code against unincorporated companies whereby partnerships and sole proprietorships are denied the ability to write off the cost of their group health coverage as a business expense. That is when sole proprietorships can acquire group coverage which mostly they can't. I'll talk about that later. And so, in areas where we have taken away the tax incentive for sole proprietorships to purchase group healthcare coverage for themselves, the price of that healthcare coverage for that small employer is very significantly higher because it is all after-tax money. That's a really stupid provision of federal tax policy.

A second reason that price is a problem for small employers - state mandated benefits. I'm not real familiar with the state mandated benefit situation in the state of Oklahoma. But, in the state of Ohio we operate our programs under the constraints imposed by fourteen different state mandates, with three more state mandates on the legislative front burner. We believe that each of those mandates adds about 1% to the cost of our member's group health care coverage. I mean to a provider, if it ain't worth at least 1% it ain't worth the special interest trying to get the money. One percent doesn't seem like a lot but in the COSE business and COSE's group healthcare programs, 1% of premium is about \$1 million. One percent here and one percent there does tend to add up, and those state mandates are expenses

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which large self-insured employers don't need to deal with. That's something that healthcare professionals have forgotten to educate legislators about. State mandates don't cover all employers, only people who buy insurance. The only people who buy insurance from insurance companies are small employers.

Now, if we eliminated those state mandates, would our members' costs go down 14%? Probably not. We figure about half - about 7%, because many of those benefits we would negotiate into our contract with our carriers. That's good but that's because COSE exists. In other areas where organizations like ours that have leverage over carriers don't exist, I'm not sure how we deal with issues like state mandates. I can tell you that if we have the opportunity to negotiate those coverages, like our coverages for outpatient psychiatric and substance abuse services which are capped now at a state mandated minimum and which we will not rise above because state has set a minimum, we would probably negotiate a higher level of benefit for those services. But as long as the state has decided that this amount is at least as much as you need to offer and you need not offer more, we are going to follow state's advice.

The biggest reason that prices for small employers are out of whack is what is euphemistically referred to as market forces. By market forces I mean the relationship between the insurance industry and the small group marketplace. Reality: the small group marketplace is the last retail marketplace for group healthcare coverage in the insurance business. A small employer buys a product which comes off the shelf and which has a price. If that price is too high then that small employer goes someplace else. If a small employer buys a retail product from a commercial health carrier or from a Blue Cross/Blue Shield plan and the price goes up too much next year, the small employer has very few choices but to leave.

So, for the insurance industry, small groups have become like buses. There's one coming along every five minutes or so and if you miss one, you'll always catch the next one and if you lose one, there's one coming along soon to take its place. There's a lack of long-term commitment on the part of the insurance industry, both commercial carriers, and increasingly Blue Cross/Blue Shield Plans to servicing the small group marketplace. Well, of course, it's a retail product. The buyer has no particular leverage in the marketplace except to shop elsewhere.

### Selecting Health Care Plans

So, we have in COSE, because we are a very large customer what we call the first meeting (TFM) with this month's newest and most innovative approach to healthcare cost containment in our community. The Prudential comes in and sits down; Travelers comes in and sits down; Cigna comes in and sits down; Equitable comes in and sits down - tries to sell us their newest and low cost group healthcare option. We look at that program; we say thank you very much; come back and see us when you have a couple of other customers. Two years later that program is gone and the people who made the mistake of buying this year's or this month's low cost healthcare option are stuck because their carrier has gone away. The carrier has unilaterally made a decision that they don't want to sell to you anymore so you're stuck.

There is also a certain price that insurance carriers must recoup from turnover, because this is a price-

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oriented market and because small employers have a tendency to buy coverage and then, when coverage gets expensive, tend to leave because there is no long-term commitment to the insurer on behalf of the small employer. That turnover has a price and that price has got to be passed along to small groups.

And employers cheat, (inadvertently non-comply) and the price and that cheating or that inadvertent non-compliance has a price and that price has got to be built into the cost of small group coverage. All these problems have created an enormous risk aversiveness on the part of the insurance industry toward creative solutions to providing access to coverage for small employers.

But all these problems that relate to price are not demand-side problems. They are supply-side problems. They impose barriers to access to coverage for small employers. Now, you listen to a guy from Travelers Insurance talking and he'll say, "Gee, there's no supply problem; there are a million different carriers out there offering a million different plans." Yeah, but if they all underwrite so that if you have five employees and one of them is sick you can't get coverage from any of them, and if their price, the case of Cleveland, Ohio, is about \$2,000 per month for the highest risk cases, there ain't no supply. There represents a fundamental problem of access in the marketplace.

These "market force" issues form the answer to an often-asked question: "If COSE is so wonderful, why aren't there COSE's everywhere in the United States?"

Insurance carriers have reason to be nervous about association plans because generally they are not run very well. The first thing that you will hear from an insurance carrier is a problem with adverse selection. Okay. Adverse selection means different things depending on which side of the table you are sitting on. To the insurance carrier, adverse selection means that people who have problems which your plan will cover and which other plans won't cover, will buy your plan. That means that sick people get into your plan and those sick people drive up the cost of your coverage. What adverse selection means from our side of the table is that companies make the best deals they can for themselves and if your plan is the best deal for them, they will buy your plan. If you take a look at adverse selection in that context, small companies are selecting adversely against carriers all the time because when costs get real expensive they go someplace where costs are less expensive. That's what adverse selection means for us. It's kind of a bogus objection from the insurance industry.

I think the real problem among insurance carriers is that they've got a retail market. They are selling to thousands of little tiny companies on a retail basis. What incentive could they possibly have to back out of a retail arrangement for making coverage available in favor of a lower cost and lower margin wholesale approach to providing coverage to small employers? I mean if you are a retailer, you know what the difference is between retail prices and wholesale prices? Why would you want to offer your commodity at wholesale prices?

### **More On Mandates**

Now, there are solutions to all these problems; but they are largely technical solutions and they don't play well to the political grandstands. Mandates play well. They're great if you're trying to get elected but they don't solve the problems. Mandates do not represent an innovative approach to new healthcare policies. Mandates represent an acknowledgement that policy has failed and a desperate

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acknowledgement that we are unwilling or incapable of developing any more creative solutions. I will say this now because I am a 1,000 miles from home; there may be a time when some kind of mandated health insurance coverage is necessary, but we ain't there yet. Some kind of mandated health insurance coverage may be necessary to deal with those "rock heads" who are cheating their employees, but we should only be considering mandated benefits programs after we have taken every feasible step to make the voluntary marketplace work as well as it can, and as I said, "we ain't there yet."

Some of the issues I discussed can really only be addressed at the federal level; certainly that modification of the tax code is an item that the congress in its wisdom will have to address if it so chooses. I think that with respect to indigent care and part-time workers and this Medicaid buy-in program that Vice-President Bush is talking about, I think that that does seem to portend some kind of increase in federal Medicaid matches which should provide, at least in the short-term, some relief to some state health and welfare programs.

We are also working with a number of members of the U.S. House of Representatives, to move forward enabling legislation which is being referred to as "The Small Employers' Health Insurance Availability and Affordability Act", also known on Capitol Hill as the COSE bill, which is enabling legislation which would make it easier for small employers, through associations, to purchase healthcare coverage more effectively in the voluntary marketplace by taking a look at some ERISA problems, some other problems imposed by the Department of Labor, seek some partial relief from things like the new, soon to be imposed, Section 89, Non-discrimination Rules and other regulatory headaches and hassles that are imposed on small group plans. A key component of that COSE bill involves extending the ERISA pre-emption to association plans like ours that qualify, so that we have the opportunity to negotiate benefit levels and offer standard packages of benefits throughout our state and across state lines if necessary.

But, while we are waiting for Washington to do whatever Washington is going to do, there are many opportunities at state and federal levels of government to be creative. In your state, and with all due apologies to your legislature, many of these activities are activities which do not require legislative activity. In fact, in the short-term future your choice if you're trying to solve the problem may come down to a choice between passing laws and creating a program that solves the problem. One of the things that I wish Vice-President Bush had said in response to Governor Dukakis' statements with respect to universal access to healthcare is that the state of Massachusetts doesn't have a program to guarantee universal access to healthcare to every resident of the state of Massachusetts. They just passed a law, and there's a whole big difference between passing a law and solving a problem.

### **Is it possible to create a COSE-type healthcare program in Oklahoma?**

Sure. I mean it's possible. The fact that COSE's program exists and is measurably successful, means that it's possible. Do you believe that such a program would be helpful? That's a question that you've got to answer yourselves, but I suspect that such a program would be helpful. Do you have the resources at your disposal? Probably. You certainly have the interest. This foundation is a tremendous resource. You certainly have the talent and apparently, at least most of you have the interest, but do you have the will, collectively?

Do you have the will to collectively set aside your old strictures and your old biases and your

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traditional political alliances to create something new? Because, the solution to this problem of the working uninsured ultimately - the real working solution - will result in the formation of partnerships and conceptual frameworks that haven't occurred to you yet. Are you prepared - all of you - insurance industry, business, the hospital industry - to back off an inch or two from your own self-interests, economic and political, to solve this problem? Because there is a way to do it if you have the will to do it.

### Voluntary Private Sector Initiatives

I've told you about all these problems. I guess you have a right to ask the question "What should we do about it?" How do you start establishing a voluntary private sector program? I think you start by making some fundamental agreements and reaching a consensus on a number of fundamental understandings. Now, some of these are going to seem so basic as to appear to be "no brainers", but I think they bear repeating. I don't like to assume anything when we are dealing with a problem as complex and as volatile as this.

#### Understanding No. 1.

We've got to start by understanding mutually that it is impossible to force change and simultaneously protect the status quo. The problems in our healthcare system are systemic. Its like a problem in a family. It is hard to judge who is most to blame. These problems are not attributable to any particular sector or constituency. It's not the hospitals' fault; it's not the doctors' fault; it's not the industry's fault; not the business community's fault; it's everybody's fault. And, to move off dead center. It is going to require an agreement and an understanding that the problems are systemic and cannot be resolved by punishing one sector or rewarding another sector. Solving this problem is going to require cooperation and sacrifice from everyone, including I might add and I can because I'm not a legislator, individual tax-payers.

#### Understanding No. 2.

The uninsured are not a single constituency - it's just a label that we use to identify a bunch of diverse groups who have only one thing in common: they lack access to group health care coverage. Who are some of these groups? The chronically ill is a group among the uninsured, the unemployed, part-time workers and seasonal workers, full-time employees who are working but uninsured, the dependents of full-time, part-time and seasonal workers, the elderly, there are others. But you can't throw a single blanket over all these groups and pretend that you have solved the problem. They require an integrated set of diverse solutions. All of them are in that place, that one place being uninsured for various reasons. The solution to the problem ultimately is going to involve not a single grand slam solution but an integrated set of different solutions that respond to the needs of different segments of the uninsured population.

#### Understanding No. 3

Everybody is going to pay. Everybody is going to pay. Mandated benefits are convenient because they are taxes on employers. Those taxes are imposed because it appears that the money is there. But if we have agreed to Item No. 1, which is we're dealing with a systemic problem and that everybody is going to share in the solution, we must also agree that the funding of these solutions is going to involve participation by every sector and by every individual involved in our society.

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### Understanding No. 4

To reiterate, we must understand that the fundamental problem is not an insufficiency of cash. I've said it before. Once again, it bears repeating: Mandates will raise a lot of money but we already spend in this country more than any other country on earth on access to healthcare and we do a worse job at it than anybody else. Money is not the problem. There are issues of service delivery, quality, benefit design which merely generating cash flow does not address.

### Understanding No. 5

This is very important one. It is an understanding of the difference between insurance and subsidies. The term "health insurance" is bandied about very loosely and too often we start to talk about people who are unemployed and chronically ill and how do we get them health insurance. The unemployed, chronically ill or the employed chronically ill don't need health insurance. They need a cheaper way to finance the treatment that they are already receiving. There is a real big difference between insurance, which is an investment that you make today in the event that you experience an unforeseen and predictable future occurrence, and somebody who is looking for a lower-cost way to pay for benefits other than paying for them out of their pockets.

I think that it is important in designing a solution that you keep in mind the distinction between insurance and subsidies. I think that our goal should be to enable the private insurance system to do as much as it can, and for the public sector to play a lead role in developing community based strategies, preferably managed healthcare systems to meet the healthcare subsidies needs of the ill, the unemployed, and the otherwise medically indigent. Now, I have all kinds of opinion on that public-private partnership subsidy stuff, but I am here to talk primarily about how to help small employers purchase group healthcare coverage more efficiently and cost-effectively in the voluntary marketplace, so that's where I'm going to try to finish up here.

### A Process For Creating Alternatives

Remember once again that the demand for quality care at affordable cost exists. Everybody wants group health insurance coverage so let's figure out what you need to do to get it to them and to do it right.

The first, sounds corny, but first you must achieve a consensus and a basic agreement that we're going to do it cooperatively. Now, here I am talking primarily about government insurers and the business community. Too much provider input is counter-productive to this process because the provider community's agenda is different from the customer community's. And, if they tell you otherwise they are being less than direct. Providers are contractors. They are providers of services. Physicians and hospitals are only now beginning to acknowledge the fact that they are not a holy fraternity of mystical brethren providing some specially protected mystical service. They're in the service business, high tech hotels in many cases. We should try to keep this a market-driven, payer-driven, customer-driven system as much as possible. Keep in mind I'm talking about a new and improved private healthcare plan and I realize I'm not a politician and so I don't have to deal with those interest groups like politicians do. The Bush campaign has suggested that we must agree to deal with this issue not as a political football but as a painful and complex problem that will require cooperative

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solutions implemented over time and as you have heard, even the Massachusetts Health Security Act doesn't take effect until 1992. Once again, passing a law doesn't equal having a program. When I'm trying to deal with this stuff with our carriers, I want to sit down around a table and I want to see everybody look me in the eye and nod their heads, and I want to get their signatures on a letter that says, "Yes, we are going to work together to solve this problem." Unless we can get that kind of consensus, we're fooling ourselves.

Second, you need a sponsoring organization. I would suggest once again - not a hospital or not a health maintenance organization. They should be contractors. You need to create a customer, a buyer organization with strong links to the market place and that's one of the reason that I happen to like chambers of commerce as sponsoring organizations. They are local organizations by and large or at least regional organizations. They are reliant on business for membership dollars. They are visible in their communities. They are committed to economic development and job creation. They have a high level of intense commitment to bringing the business community into community improvement activities. They thrive on service to members and many of them now over the last ten years have developed small business councils which are trying to find ways to get small companies to join. That's one of the reasons why COSE is so famous in the chamber of commerce business. Over the last ten years the mix of membership dues in our chamber has gone from 70% money from big business versus 30% money from small business to the reverse. Seventy percent of our organization's membership dollars come from small companies and 30% from big companies. The reason is our job of providing value-added services to our members so that they voluntarily choose to vote with their dollars by becoming members or staying members of our organization. The only thing that's in it for us is to attract and keep members. Just three or four local chambers with the appropriate information system networking them could regionalize the servicing of a statewide health insurance program. We are working on this type of approach in the state of Ohio right now.

I want to stress here the need for a customer advocate in this process. The way the healthcare system is designed today - nobody, not the insurance industry, not the provider community, certainly not government, has any incentive for controlling small companies' cost. Somebody has to play that role and I believe that chambers, because of their unique ties to their local communities, are in a perfect position to provide their members with these important services. That requires, of course, on the part of chambers or your sponsoring organization a certain degree of active management advocating constantly on behalf of the customer/member.

That requires the right kind of talent, not always volunteer talent, usually professional talent. When we began the design of our programs in the early '80's I had to spend time talking with six of the best law firms in Cleveland, trying to find an attorney who believed that it was possible for us to design this kind of a program. It is going to be difficult to find a technician who is willing to be creative. Finally, I found a brilliant young woman who works with one of our larger law firms who when she heard the story said, "Gee, that sounds like fun. I think I would like to try that." The firm worked as a volunteer which, for us, was an extremely generous contribution.

The third thing you need is a sense of the market and the product mix in the environment. We're not talking about something out there to provide coverage to the uninsured. You're talking about designing a product, and it's got to be a product that people want to buy. You don't start developing a product by

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looking at who the uninsured are. You start that process by looking at what products people are buying today. What are the benefit levels that are offered? What do the plans look like? What do the plans cost? In the Cleveland area, 80% of the companies that participated in our group health care plans buy Blue Cross/Blue Shield coverage at the highest level of benefits available because that's the way health insurance has been in Cleveland, Ohio, for the last 40 years. A UCR program may be unheard of in this state, at least in the small business market. How is that plan designed, what are the benefit levels? When an international benefits consulting firm conducted a survey of 200 large company group benefit plans to enable them to get some idea of whether Senator Kennedy's "Minimum Package of Benefits" was indeed a minimum package of benefits, they found that nearly 70% of the companies that they surveyed would be required to upgrade their plans to meet the minimum specifications imposed by Senator Kennedy's legislation.

We shouldn't be trying to design a plan that is so rich that nobody is going to be able to afford it. One of the things that I see, especially with chamber programs, is that you can always find plans that are great. I mean they are real cheap. They're very cost effective, but they don't provide any benefits. Only by determining what it is that people in your community are buying, do you have a hope of being able to design a product which will be saleable in your communities or across your state. I suggest designing a plan that people who have bought insurance would like to buy and can afford. Once again, we don't want to take this group called the "uninsured" and establish a ghetto and design a program that is only for them. You want to try to integrate the uninsured, as much as you can, into the existing system of private insurance. That means designing a product which people who are already purchasing insurance would find attractive, then mixing uninsured people into that mix.

### Plan Design and Pricing

Based on your plan design specifications and a sense of your potential customers, you can then make some assumptions that will help you create, design, and price a product. There are four components to that: plan design, of course, the appropriate mix of conventional insurance coverage and HMO's or PPO's. Most of you know about UCR plans, comp major medical plans and others. Whatever it is that is most popular in this part of the country will provide you a good analog around which to develop a program.

Here's a very interesting fact. Most HMO's and PPO's don't sell to small employers. If you are a company that employs fewer than 25 people, try to find an HMO or PPO that will voluntarily offer you coverage. You can't. That's interesting, considering that HMO's and PPO's are being heralded as a cost-effective way to make coverage available to employers in the workplace. Now HMO's and PPO's will tell you that one of the reasons their costs are lower is they don't sell to small employers. So, maybe it will take some intervention by government to figure that one out.

Second, is underwriting as it is absolutely critical to mention. Got to have some kind of underwriting rules; and we have designed ours to be as inclusive as possible. Our job is to make certain in COSE that as many companies as possible that wish to are able to participate in our plans. If you leave the insurance carrier to design the underwriting specs, they will design the underwriting specs to be as exclusive as possible, to keep as many people out as they can possibly keep out. That's the reason to have an advocate for the customer in the mix. We try to develop our programs, our underwriting rules in a loose-tight way. The programs are liberal enough to make it as easy as possible for as many

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individuals and as many companies as possible to participate, while at the same time being tight enough to screen out those people who don't need insurance, but who require a subsidy. A good goal to assume in developing your underwriting specifications is to assume that as much as 10%, as many as 10% of the companies that apply for coverage through this sponsoring organization won't be able to get it. Our rate of underwriting turndowns is about 5%, but I think that 10% is a good goal. Underwriting rules raise the question of what to do about exceptions.

Third, eligibility rules. It is so dumb when state mandated programs get established and exempt companies with fewer than five employees because that's where the need is in the marketplace. I mean I have no objection to exempting companies from regulatory burdens but the vast majority, more than 2/3's of the working uninsured, are working in companies with fewer than 25 employees and the majority of those are working in companies with fewer than 10. If you are going to design a program that won't accept companies with five employees, what good is it? The eligibility rules for our program are such that any company of any size with as few as one employee, properly underwritten, can participate in our program. Got to be open to under 10's.

Set a flexible definition of what type of employees are eligible. In our contract we set a minimum of 17-1/2 hours per week and employers can choose their own definition above 17-1/2 hours per week and below 30 hours per week as to what constitutes a full-time employee. As long as the employers follow the rules consistently, they should have the flexibility to define for themselves what constitutes full-time employment. Set participation minimums to avoid inadvertent non-compliance. In our plan if you have six or fewer employees, all six have to be enrolled in the program. Beyond ten employees, you have to have 85% participation so if you have 12 employees, you have to have 11 people on the plan. We also have several eligibility exceptions. If you have an employee in your company who is the working spouse of someone who has family coverage provided by his or her employer, that working spouse is exempt from our eligibility rules. Ask an insurance carrier why they would require you to provide duplicate coverage to a single employee who is covered on a family plan someplace else. Want to know the answer? Money. They want the money.

Finally, enforcement - a very important party of plan design. To protect from inadvertent non-compliance and to punish the evil-doers. Your rules need to be simple but they need to be consistently applied and applied like crazy. We have a comprehensive program of payroll audits in our programs so that every year 10% of our groups have somebody knocking on their doors to match the people who are on their health insurance plans against the people who are on their payrolls. Forty percent of the companies that we audit every year have problems in meeting our eligibility rules. In about half the cases, they have people on their health insurance plans that don't belong there. We want them off. In about the other half of the cases, they have people working full-time in their companies based on their definition of full-time employment who are not insured for various reasons. We want those people on. Our job is to help to enforce those rules and we establish penalties for non-compliance including getting kicked out of the group.

Next, you need an information system to keep track of the enrollment, eligibility, to do billing, account reconciliation, reimbursement and reporting back to the customer. It is amazing how inefficient most health insurance plans' administrative and information systems are in the small group marketplace

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because they have no particular incentive to run the program well. It's just a passthrough. Insurance carriers are like the bank in Las Vegas, you know. They're playing with your money and they never lose.

Also, in addition to a management information system, you need to develop some general sense of how you would like your carrier, whoever it is, to track utilization and report it back to you. We used to think that our insurance carrier knew all this stuff and just was keeping it a secret from us. Turns out insurance carriers don't know either. By and large their small group business is done by filing mathematical formulas, rating formulas, with the state insurance commission and their pricing and underwriting is done based on formulas, not based on actual experience. They may have some general idea but if you want to know, of this total small group market, how the COSE membership is doing, they can't tell you because they don't know, because nobody ever asked them to keep track of it before. So, part of an effective system involves an agreement that that type of information system needs to be in place.

Finally, we must go in search of the elusive underwriter. In 1984 when our program was about half the size it is, a mere \$40 million at that time, we thought it would be helpful to test the quality of our product and its price in the marketplace so we sent out a request for a proposal to 65 of the nation's top insurance companies including every name you would recognize. Anybody want to guess how many proposals we received? None, except from our current carrier.

### More On Insurers and Small Employers

Now there are lots of reasons that insurers don't like small employers and don't like associations, and often as I said it's because of bad experiences with poorly run association plans.

Sometimes it's flack from insurance agents. The COSE program has insurance agents in the state of Ohio scared to death because we do not rely on agents to sell and service our programs. It's also tough to make a buck in the small group health insurance business. It's not as profitable as life or long-term disability; it's a low margin business; it's expensive to sell and service; employers turn over quickly. But that employer turnover is generally because small business rating formulas and commissions keep driving people away because prices continue to escalate.

Another reason that carriers don't like small employers and associations is state mandates. It's expensive to fund the provision of state mandated benefits. Plus there is a hidden bonus for insurance carriers in mandated benefits programs. The insurance industry may oppose them publicly and give speeches and pound tables and bitch and moan, but if the state passes a mandated benefits law, insurance carriers will have no choice but to do their patriotic duty and provide high risk coverage, appropriately priced, to people who have got to have it no matter what it costs because the law says they have got to have it.

You can make money on this business. I can prove it to you. Blue Cross/Blue Shield of Ohio says they have lost \$120 million last year in underwriting; not a dime of it was on our program because we help them run it. Last year they probably made about \$3 million on our program, at that time on \$70 million worth of insurance premium and that's not a lot of money by government standards but you know \$3 or \$4 million worth of profit, I mean a 5% profit margin is okay. You can make money. And our experience

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over the last five years proves it.

Now, I personally believe that Blue Cross/Blue Shield plans are the best vehicles to provide this kind of program, for a couple of reasons. First, they are all locally based. They have strong local ties. They are generally the largest single insurer in any community and there's another market related reason. That is that local Blue Cross/Blue Shield plans are just having the tar pounded out of them in their local communities by the increase in competition from commercial carriers and managed care settings. There is something of an incentive for Blue Cross/Blue Shield plans to become involved in this type of a partnership arrangement. But when they are counting underwriting losses, it can be difficult to persuade them to come to the table.

### What Is The Role Of Government?

Now, what can government do? First, government can review insurance regulations. Some states make it real hard for association plans like ours to operate. The only reason that COSE can operate its plan in a state that says associations cannot be formed solely for the purpose of insuring their members is because we are part of a chamber of commerce that provides a very broad range of services to employers in our community. That provision is an artificial provision. I understand where it came from. It came from a desire to keep unscrupulous providers or payers or unscrupulous association plans from operating, closing down and stealing people's money, but I think that it's a little extreme. I think that it would be appropriate for government to review rating formulas and reserve requirements imposed on insurance carriers, particularly in their small group area.

I think it would be real appropriate for government to review industry underwriting practices. It seems that carriers are becoming increasingly tough on small groups. Is that because the state makes them? Or, because the state permits them to? It would be interesting to have an answer to that question. I think that government could look into this issue of the lack of availability of alternative delivery system coverages, HMO's and PPO's. Why don't HMO's and PPO's make their coverages available to companies with fewer than 25 employees? I think that it would be appropriate to review participation minimums, rating formulas, administrative costs. Administrative costs in the small group business run from about 6% to about 40% depending on what carrier you are dealing with and what kind of coverage you are buying. Why the disparity? I think it would be interesting to find that out.

Frankly, if you talk with your insurance carrier and try to get them to separate the risk component of your price of the administrative cost component of your price, you will get some brilliant tap dancing. Once again, we used to think that it was because insurance carriers knew what the difference was and were keeping the information from us. Under most circumstances they don't know what their administrative costs really are. They can tell you what commissions are but that's about all.

How can insurance carriers ignore potential customers? Now this is much the same discussion as took place in the middle part of this decade when liability insurance coverage started to dry up and get real tight. Far be it from me to assume that the insurance industry would actually make use of its federal anti-trust exemption to conspire to fix prices and control markets. But, there is the possibility that something that looks a lot like joint decision making to have an effect on availability of coverage is taking place and I think that at the state level where insurance is regulated, it would be interesting to

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find out what percentage of business XYZ insurance company licensed to do business in the state of Oklahoma does is attributable to their activity in the small group market. I think you will find that everybody has products, everybody has brochures, but very few of them try very hard to get their products to get their products out into the small group marketplace.

Another thing government can do is to find out why the uninsured are uninsured, category by category, because small group pool rating is very imprecise. We have very scarce real information on these phenomena. Nobody has been asking the questions. Why are the uninsured uninsured? Then help us get that information out there. Just help us, just hold some hearings, talk about the issue. See if you can get some answers or at least ask some questions. Help us to figure out how those at the margins, those who work but aren't insurable can be covered either through better coordination between or among private insurance plans or through better coordination between public and private and insurance plans. All this stuff you hear about Medicaid buy-ins is going to require states to figure out how to do that anyway. Why not be proactive about that?

If you are going to establish a state risk pool, why not make it possible for a company with six employees that has five healthy employees and one sick employee to put those five healthy employees in a commercial insurance plan, put that one sick employee in a state risk pool and enable the employer to pay the cost of both. Government can help us get as many people as possible into the private insurance system. That's what I think government can do.

Finally, government can be very careful about mandating benefits. They have a real bad effect on small group plans, a real bad effect; and they don't solve the problem that mandates are intended, I think, to solve. Mostly, they are health insurance plans for the providers of benefits whose services are mandated under state law.

In closing I guess we should all remember four things.

First, no humanly constructed program or system is perfect - not even government. For the first time in ten years, COSE's health insurance plans have reached the front page of our newspapers in a less than favorable light. Why? Because a guy who was involved in our plans and who is diabetic and undergoing laser surgery every month for \$1800 per eye has been classified as a substandard risk in our program and is paying 35% more in premium than he thought he was going to have to pay and he thinks that's not fair so he complained to the newspapers. The "Plain Dealer" (Cleveland newspaper) sent their crack investigative reporting unit out to find out why COSE was doing these terrible things to this poor sick guy who needed health insurance. Whether that kind of a program is fair or not fair depends on whether you are paying more or saving money.

Three hundred groups out of 5,400 in the COSE plan are responsible for 25% of our claims. Three hundred groups are taking out \$15 million in claims from our plan. Is it fair to expect that those 300 groups should pay a little bit more than the remaining 5200 groups which aren't costing us quite so much? Is it fair to the 5200 groups to subsidize that small group of very high utilizers? Once again, fairness I think involves whether you are saving money or whether you are paying the money. But no system is perfect and you can't always treat everybody exactly the same. Our carrier could have cancelled that guy's insurance coverage altogether. We insisted that we try to find a different way to

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make certain that that individual's company could continue to receive coverage albeit at a somewhat higher price.

Second, the private insurance system is far from a failure, as mandate fans charge. I kind of resent that one too. You have got to have mandated benefits because the system is a failure. One hundred eighty million Americans have some form of private insurance and rather than create a new delivery system, it's generally easier and more practical to make the one we have work better.

The third thing we should remember. Let's not try to fool each other or to insult one another about this issue. Opponents of socialized medicine should be reminded that the United States government spends about \$150 billion per year on healthcare now through Medicare and Medicaid matches. That's almost as much as the private sector spends on health insurance every year. For those of us who tout opposition to socialized medicine are talking through our hats. Legislators, no matter what you call them, medical security contributions, insurance premiums, mandated benefits are head taxes on job creation. Those head taxes are imposed mostly on small companies. Those head taxes will cost jobs and they won't solve the problem. I think it is disingenuous in the extreme for any legislator to pretend otherwise. Government ethics is another oxymoronic term but I think particularly this is a place where our elected officials do not do well by our healthcare system.

Fourth, this isn't about whether there is a crisis among the working uninsured among small companies or whether there isn't. Of course, there is a crisis and the crisis is getting worse due to market forces. It's also not about (or shouldn't be about) passing or opposing laws. I think that it's about working together to develop solutions that work and that have a hope in hell of working in the long-term.

I think that there is a role for all of us, government, the business community, big business and small business, the insurance industry, and providers and if we treat it not as a chance to blame and punish one another but as an important creative challenge, it is possible to reach a solution in which we can all be willing and constructive partners.

That's basically the conclusion of my prepared remarks and I would be happy to argue with any of you for awhile if you would like. Questions, comments, cracks? Geez, I've covered it all! Yes, sir.

### **Audience Question**

How does COSE's plans affect the number of working uninsured in Cleveland and/or in Ohio?

### **Answer**

The state of Ohio ranks 41st among the 50 states in the number of the working uninsured. The trend is downward right now but a hiccup in our economy such as occurred in the late 70's and early 80's would send that number way up again. Cleveland was among the first to suffer from the economic contractions of the late 70's and early 80's and one of the last areas to recover from it. One of the questions that I am often asked is how many people who have insurance through our plans would not have insurance if COSE did not exist. Twenty percent of the 5,400 companies that are involved in our programs are one-employee groups and I don't know any place where a company with just one employee can obtain group healthcare coverage in our community except for the COSE. So that's one group that would not have coverage otherwise.

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I suspect that there are some groups of questionable risks who also would not have coverage in our program unless it were available to them through COSE so there is a significant problem of the uninsured. About 40% of the indigent care rendered in the state of Ohio is rendered in Cuyahoga County so the problem is concentrated where we live and we are talking with some large employers in our community about the prospect of joint venturing and the formation of a community-based corporate funded HMO that would provide the indigent and unemployed with access to primary care and some secondary care services. Other questions?

### **Audience Question**

How big are your plans?

### **Answer**

Thirty-eight thousand employees, about 115,000 lives.

### **Audience Question**

How big are you in comparison to the population in your market area?

### **Answer**

One out of every 15 people in Cuyahoga County has a COSE Blue Cross/Blue Shield card. I mean it's a part, it's a small part, but it's 8% of the whole.

An interesting thing is beginning to happen though. We are beginning to have meetings with hospital administrators. We are a very large customer of Blue Cross/Blue Shield in Ohio. Blue Cross/Blue Shield is beginning to contract selectively with hospitals in our area. They have established a fairly aggressive hospital-based PPO program of which we are a founding member and the premiums for which have gone from 0 to 5 million dollars in annual premiums since July so we have begun to have meetings with hospital administrators who, once the guy from Blue Cross leaves the tables, says, "You know, Blue Cross's hospital network is going to contract and we're going to be a part of it.

I mean if we've got to continue to low bid, we're going to be a part of it and we just want COSE to know that we're going to be around for a long time. The concentration of this buying power albeit a relatively small segment of the people in Cuyahoga County has enabled COSE to go from being the last people on earth that anybody wanted to talk to about group healthcare coverage to being among the first meetings that anybody has in town. We have begun to exercise a little bit more economic leverage over hospitals and other providers than we have in the past. So you are right. It is a beginning and five years from now we will probably be twice the size that we are, at least twice the size that we are today. That's just in Cuyahoga County. We are trying to figure out how to take it statewide.

### **Audience Question**

How familiar are you with the Robert Wood Johnson grant programs for the uninsured?

### **Answer**

You know the thing I talked about - about designing a program that would be cheap but that nobody wants to buy? All the Johnson Foundation programs that I have heard, okay, and I'm particularly familiar with one that is in Michigan, I think. The program is being organized so that in order to participate in the program which is like one-third publically sponsored and two-thirds paid by

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employer's premium, companies have to have been in business for five years or less.

They have to be able to prove that they have never had health insurance for their employees. They have got to be able to prove that their employees have never been insured ever before, or at least within the last six months. I mean the restrictions placed on that Johnson Foundation program guarantees that it will never be successful. I think that most of those Johnson Foundation programs if I'm not mistaken have only begun to move now into the implementation stage. They had like a couple of years to study and then a little while to develop a plan and now they're in the process of implementation. I don't know how many of them have actually sold coverage to a significant number of people.

I think that the Johnson Foundation did a wise thing by attempting to provide some seed money to communities that had an interest in dealing with this issue, but I think that by and large the organizations that got the grants were people who read those request for proposal. If I had known that such a program existed four years ago, we probably would have applied for it. But since we do not have anybody whose job it is full-time to figure out how to suck up resources, we didn't have the opportunity.

### Audience Question

Do you have a utilization review and quality control component?

### Answer

We have. One of the things that we try to do as a matter of philosophy is persuade all our providers, including hospitals and insurance carriers, to play in our ballpark. Hospital administrators like to tell you how it's not fair to take a look at prices. It's not fair if you know that Hospital X is charging \$300 for an appendectomy and Hospital Y is charging \$900 for an appendectomy. It's not fair to ask the question of why the difference in price? We like to ask that question a lot. We like to ask things like morbidity and mortality rates. You know, why is it that a hospital on the west side does these weird carotid artery surgeries that Medicare pays for that screws up a lot of old people? And you know, why do 10% of them that check in not check out? They don't like those questions to get asked.

The ones that have begun to answer those questions, who demonstrate that they have some handle on why their costs are what they are, are the ones I think that are preparing to become more like real businesses in the long term. But those are the hospitals that I think have a chance of being viable in the long term. The most expensive hospital in town is making a real mistake, University Hospitals in Cleveland which is often described as a bunch of physicians who share a common heating system. They are the most expensive hospital in town by a factor of at least 25% and they decided they're not going to deal with anybody. They want no PPO arrangements. They want no HMO arrangements. They are not going to be a UCR contractor with any insurance company. They're going to go it alone. They just laid off 250 people. Not because of market pressures but because well, there are other reasons.

Other questions, comments or cracks? I could talk about this for days because it's a lot of fun. Anything, going once? I got 15 more minutes. Anybody want to throw stones? If not, this has been a terrific opportunity. I hope that my discussion has been helpful. You've got some information on our organization in your meeting kits. We have as an organization no higher priority than to try to solve this problem because the working uninsured are our members too. I mean it's not just some group out there; most of the working uninsured work in companies that would like to be members of our

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organization so we have some self-interest at stake in getting the problem solved as well.

This concludes Mr. Polk's remarks.