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Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?

No, but they have produced demonstrable benefits to participating employers and employees.

BY STEPHEN H. LONG AND M. SUSAN MARQUIS

ABSTRACT: We use data from 1993 and 1997 employer surveys to assess whether the three largest statewide small-group health insurance purchasing alliances—in California, Connecticut, and Florida—increased coverage in small business. They did not. Specifically, they did not reduce small-group market health insurance premiums, and they did not raise small-business health insurance offer rates. We explore and discuss some reasons why. Alliances do permit employers to offer much greater choice in the number and types of plans; employees are found to take advantage of this wider choice.

HEALTH INSURANCE purchasing alliances (for brevity, we use the term "alliances") are one component of many state and national health reform plans intended to move us toward the goal of universal coverage.[1] Alliances were intended to expand coverage by making insurance more attractive and affordable to small employer groups. The presence of an alliance also was hoped to stimulate competition in the rest of the small-group market, thereby leading to expanded coverage outside of the alliance as well. Previous work, based on qualitative methods and the perceptions of key informants, suggests that alliances have not generally offered lower prices. However, some observers believe that they have had important spillover benefits to the market as a whole.

The most important feature of alliances that might make insurance more attractive is permitting employers to offer their employees a choice of plans, something that was not practical for small groups otherwise.[2] Some, however, have questioned the importance to employees of expanded choice, especially for those in very small groups. The Florida alliances, for example, planned to eliminate the choice requirement for very small employers (those with four or fewer employees).[3] The choice feature is thought to have helped small employers offer managed care without forcing all of their employees into a single health maintenance organization (HMO).[4] In one state the alliance may have speeded small groups' moving from indemnity to managed care.[5]

Making insurance more affordable is viewed as critical to getting more small groups to offer coverage.[6] Alliances are seen as a means of lowering administrative costs and, in principle, giving small groups collective purchasing power to negotiate lower rates from insurance carriers and health plans. The latest information available from states that have implemented alliances suggests that prices inside and outside the alliances are comparable, however.[7] Hopes of lower admin-

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istrative costs have not been borne out, both because most alliances have not attained substantial scale of operations and because they have duplicated rather than substituted for many of the functions performed both by health plans and by agents and brokers.[8] In California, where the alliance negotiated with health plans on price, it is reported that prices in the first year were 10–15 percent below those in the outside market, while over the next two years price trends inside and outside the alliance were similar. This suggests that alliance prices in California remained below market for the first several years. However, recent reports suggest that pricing in California's alliance now merely accords to that in the outside market. Florida appears to have had a similar experience.[9]

The lack of a price advantage to purchasing within most alliances is cited as a critical factor accounting for their low market penetration. Although some alliances grew very rapidly from their small base levels at first, their ultimate market penetration has fallen far short of initial expectations.[10] Many also point to the initial failure of some alliances to recognize the important role that agents and brokers play in the small-group market (or to reimburse them adequately). Many brokers saw the alliances as a threat to their business and, as a result, refused to promote the alliance products to employers.[11] A final impediment to success for some alliances has been limited marketing.[12]

Nonetheless, many observers have credited alliances with being catalysts for change in the small-group market overall.[13] Pricing parity inside and outside the alliance does not necessarily spell failure in making insurance more affordable. Officials in several states believe that the presence of an alliance promoted price competition, leading to generally lower prices for small groups. This is attributed, in part, to the ease of comparative shopping that the alliance provides, with its standardized benefit packages and published rates.[14] Alliances also have been credited with inducing some insurers to offer multiple benefit designs to their small-group clients, thereby increasing choice outside the alliance.[15] In these ways, the presence of an alliance may indirectly lead to expanded coverage, even if the alliance does not directly enroll a large number of newly insured groups.

The purpose of this study is to explore these issues in the three states with the largest small-group alliances in the nation. We use data from 1997 employer surveys that interviewed both alliance participants and nonparticipants. Our contribution to the literature comes from using quantitative methods to assess the effects of several different alliances in a parallel fashion. Thus, it complements the previous literature reporting results based on qualitative methods.

The Study Alliances

We studied the Health Insurance Plan of California (HIPC), sponsored by the California Managed Risk Medical Insurance Board; Health Connections, sponsored by the Connecticut Business and Industry Association (CBIA); and the Florida Community Health Purchasing Alliances (CHPA).[16] The alliances were similar in several important ways, yet their differences permit us to better generalize about the variety of alliance designs in existence.[17]

All three alliances operated statewide in 1997 and were based on managed competition principles—that is, choice of plans, standardized benefits, and annual open enrollment. California offered complete employee choice of all participating plans operating in the employer's geographic area, which at the time of our study included numerous HMOs and some point-of-service (POS) plans and preferred provider organizations (PPOs). Connecticut offered employer choice from among sixteen options—four insurers times two plan types times two benefit levels—with full employee choice encouraged. Florida offered employer choice among all participating plans in the area but required employers to offer at least some choice. Employee choice was limited to those plans selected by the employer, although in fact most employers offered the full array of options in their area. Each alliance was introduced against a back-

drop of small-group reforms that guaranteed issue of coverage and placed some rating restrictions on the entire small-group market, both inside and outside the alliance.

The alliances differed greatly in their governance. California's was a single, state-sponsored alliance, managed by an independent state agency that had an independent policy-making board. Florida had eleven area CHPAs, each a private, nonprofit organization. The CHPAs were started with seed money from the state government and functioned under state charter and with state agency oversight and management. The CBIA is a private association; Health Connections is open to all small businesses in Connecticut.

In California and Connecticut the alliance was permitted to contract selectively with health plans. In Florida the alliances could not contract with plans and were required to make available all plans that wished to be offered at their market prices. In fact, most insurers in that state were prohibited from offering different premiums based on claims costs for groups in and out of the alliance and could vary only the administrative costs in the premium. Connecticut also prohibited plans from offering different premiums to groups in and out of the alliance. Both Connecticut and Florida required employers to enroll through a broker. In California, employers could enroll through a broker or directly through the alliance. California initially offered a cost advantage to employers in purchasing directly, but this was later eliminated in order to increase brokers' cooperation with the alliance.

Study Data And Methods

We examined employment-based coverage for alliance and nonalliance participants in the three states using data from the 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey. To investigate effects of the alliance on the small-group market as a whole, we measured changes in the market between 1993 and 1997 in the three states and contrasted these with changes occurring in the rest of the nation. Our estimates for 1993 come from the National Employer Health Insurance Survey (NEHIS). The two surveys were comparable in sample and measurement design, administration, and processing. General background on these two surveys has appeared elsewhere.[18] The following details the specific features unique to the present study.

■ **Sample.** The sample frame for both surveys was the Dun's Market Identifiers national census of employment establishments.[19] The RWJF sample was supplemented by a list sample of participants in the three states' alliances. The alliance frame in each state was stratified by geography and establishment size; within each state, the alliance sample was selected in proportion to the nonalliance sample in the same stratum.[20]

The focus of our analysis is small employers: establishments of firms with fifty or fewer employees. The number of small employers interviewed in the RWJF survey was 15,059 and 18,035 in the NEHIS. The 1997 survey included 1,433 small employers in California, 1,253 in Connecticut, and 1,422 in Florida. Among these, 161 were selected from the list of participants in the California HIPC, 87 from the Health Connections list, and 149 from the Florida CHPA's list of participants. The number of small employers interviewed in the NEHIS was 624 in California, 346 in Connecticut, and 473 in Florida.

■ **Measurement.** We measured alliance participation rates and the types of insurance choices offered by alliance and nonalliance participants in the three states in 1997.[21] Details about each insurance plan offered were collected as part of the interview. For establishments that were selected from the alliance lists, however, the plan characteristics were measured from administrative records. Employers were classified as offering a choice of plans if they offered two or more plans, whether of the same or different types and whether through the same or different carriers. We also examined the number of employers offering more than one type of health insurance plan—defined as an HMO, POS, PPO, or indemnity plan.[22] For nonalliance participants, plan types were classified based on the

respondent's self-assessment; for alliance participants, the plan type was defined in the administrative record.

We compared costs facing alliance participants and nonparticipants using the premium for single coverage for each plan offered. The premiums were adjusted for actuarial differences in the benefits of different plans.[23] We computed an average single premium for the establishment as the enrollee-weighted average for all of the separate plans offered.

All small employers in the three states were asked whether they were aware of the alliance operating in their state.[24] They also were asked whether the company consulted an agent or broker to help in evaluating different plans. Alliance participants consulting brokers were asked whether the broker had provided information about plans outside of the alliance; nonparticipants were asked whether their broker informed them about alliance plans.

We estimated the alliances' spillover effect on the small-group market in each of the three states by examining the change between 1993 and 1997 in the share of employers offering insurance, the share offering a choice of plans, and premiums for single coverage. This baseline period was prior to the emergence of the Connecticut and Florida alliances. The California alliance started issuing policies in July of that year, so it was unlikely to have greatly affected the small-group market.

We used multivariate regression methods to control for changes over the period in the composition of small employers (industry, size, and business age composition), in the characteristics of their employees (share of union, part-time, and low-wage workers), and the nature of small-group insurance market reforms in place in the state (guaranteed issue for some or all products, and prohibition against using health differences in pricing plans). To control for unmeasured temporal change that might affect the small-group market, we compared the change in market characteristics over time in each of the three states with that in the small-group market in the rest of the nation.[25] This is usually called a "difference-in-difference estimate." Our difference-in-difference estimate for each state accounted for any difference between each alliance state and the rest of the nation in the changing composition of small employers.

The difference-in-difference estimate accounts for state-invariant temporal factors; however, there may have been state-specific changes over time unrelated to regulations that could bias this comparison. To control for state-specific temporal effects, we assumed that these factors affected medium-size (51–150 employees) as well as small employers in the state. We then compared the change in outcomes over time between small and medium-size employers in each of the three alliance states with the change between small and medium-size employers in the rest of the nation. This is referred to as a "difference-in-difference-in-difference" estimate.[26]

Results

■ **Alliance participation.** Each alliance had a very low share of its state's small-group market (Exhibit 1). Among small employers that offered insurance as a benefit, only 2–6 percent purchased it through the alliance. Employers that had offered insurance for two years or fewer were not significantly more likely to purchase through the alliance than were employers that had offered insurance longer. Therefore, the alliances do not seem to have contributed to attracting new employers to offer insurance. We also did not find differences in the alliance market shares among very small employers (ten or fewer workers) and other small employers (not shown).[27]

Awareness of the alliance varied considerably across the three states (Exhibit 1). Only about 40 percent of small businesses in California that offered insurance reported that they had heard about the California HIPC. In contrast, more than three-quarters of small employers in Connecticut that offered insurance were aware of its alliance.[28] Even among those knowledgeable about the alliance, however, its market share did not exceed 10 percent in any state.

The vast majority of all small businesses

EXHIBIT 1
Small Employers In Three States Participating In And Aware Of Alliance, 1997

	CA	CT	FL
All employers			
Participate in alliance	1%	3%	2%
Employers offering insurance			
Participate in alliance	2	6	5
Participate (have offered insurance 2 years or fewer)	2	5	9
Aware of alliance	40	77	50
Participate, if aware of alliance	5	8	10

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
NOTE: Small employers are establishments of firms with fifty or fewer employees.

offering insurance reported that they used an agent or broker in selecting their employee health benefits, whether or not they participated in the alliance (Exhibit 2).[29] However, a minority of employers that purchased outside of the alliance reported that their agent provided information about the alliance product. One-quarter or fewer of nonalliance participants in California and Florida were provided with information about the alliance by their agent, but the comparable figure in Connecticut was almost half. In contrast, three-quarters or more of alliance participants were presented with information about one or more nonalliance insurance plan options.

Selected characteristics of workers that are related to risk—sex, age, and earnings—did not differ between businesses that did and did not participate in the alliance (Exhibit 2). This suggests that alliances have not attracted groups of greater or less health risk than the broader small-group market.

■ **Choice of plans.** Providing small employers with both the ability and a simple means to offer a choice of plans is widely cited as alliances' strongest selling point. Many employers must offer a choice if they are to participate. Thus, it is not surprising to find that most employers in the alliance offered a choice, whereas few other small employers did so (Exhibit 3). Moreover, employees in a substantial fraction of employer groups in the alliance exercised choice by enrolling in more than one of the offered plans. We observe this exercise of choice in a large number of groups, even though the small size of many of them

EXHIBIT 2
Characteristics Of Small Establishments In Three States Offering Insurance That Do And Do Not Purchase Through An Alliance, 1997

	CA		CT		FL	
Characteristic	Alliance participant	Not participant	Alliance participant	Not participant	Alliance participant	Not participant
Percent of establishments						
Agent helped evaluate options	81%	74%	95%	80%	87%	78%
Informed of nonalliance/alliance option by agent if use agent	84	16	75	49	78	25
Percent of firm employees						
Female	43	44	40	45	40	43
Under age 30	29	30	30	27	30	23
Age 50 and older	13	16	17	19	23	18
Earning less than $14,000 per year	8	16	13	14	23	17

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

EXHIBIT 3
Percentage Of Establishments In Three States Offering And Selecting A Choice Of Health Plans, 1997

	CA		CT		FL	
Type of choice	Alliance participant	Not participant	Alliance participant	Not participant	Alliance participant	Not participant
Multiple plans						
Groups offering	100%	15%	82%	7%	98%	10%
Groups selecting	83	9	59	4	37	7
Multiple plan types						
Groups offering	100	10	59	5	85	8
Groups selecting	32	6	43	3	21	5
Any HMO						
Groups offering	100	57	98	48	91	43
Groups selecting	99	56	88	47	78	42

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
NOTES: "Groups selecting" indicates that individuals within the group enrolled in different plans, different plan types, or a health maintenance organization (HMO). "Multiple plan types" includes more than one of the following: HMO, point-of-service (POS), preferred provider organization (PPO), and indemnity.

would make it not surprising to find all workers in a single plan. This suggests that employees have heterogeneous preferences for insurance that employers cannot fully accommodate by offering a single insurance plan.

The choice offered by the alliance typically provided access to different types of plans (HMO, PPO, and POS) and therefore with access to options about restrictions on choice of providers.[30] In many groups, employees made different enrollment choices between plan-type options, which is further evidence that choice provided value to employees.

Participation in an alliance greatly increased employees' opportunity to enroll in an HMO. Access to HMOs was nearly universal for alliance participants, and a large fraction of these groups had one or more employees who elected the HMO option. In contrast, the number of nonalliance employers offering an HMO ranged between 43 percent and 57 percent in the three states. The alliance may have been a vehicle for small employers to move more rapidly to HMOs while still providing employees who wished a broader choice of providers to pick an alternative type of plan. Enrollment in HMOs among employees in participating businesses was about twenty-five to thirty-three percentage points higher than enrollment among other employees (not shown).

■ **Cost.** Premiums for plans purchased in the California alliance were significantly lower than were premiums for plans offering comparable benefits purchased outside of the alliance, as has been found in other studies addressing this period (Exhibit 4).[31] In contrast, the alliances in the other two states ap-

EXHIBIT 4
Actuarially Adjusted Premiums For Employee-Only Coverage For Alliance Participants And Nonparticipants In Three States, 1997

	CA		CT		FL	
Plan type	Alliance participant	Not participant	Alliance participant	Not participant	Alliance participant	Not participant
HMO	$130	$154	$188	$189	$155	$151
PPO/POS	166	193	217	232	192	186

SOURCE: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
NOTES: HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan.

peared to provide little cost advantage. There was no statistically significant difference in monthly premiums for employee coverage whether purchased in or outside of the alliance in Connecticut or Florida.

■ **Competitive effects on the market.** There is little evidence that any of the three alliances had broader effects on the small-group market in their state. Exhibit 5 shows three key characteristics of that market—employer insurance offer rates, percentage of employers offering a choice of plans, and premiums—in 1993, largely prior to the alliance operations, and in 1997. The 1993 values are adjusted to account for changes that occurred between 1993 and 1997 in the composition of employers in the state and for other market reforms.[32] Changes in offer rates in all three states between 1993 and 1997 were small and not statistically significant; moreover, the direction of the effect was a decline in two states (California and Connecticut). Changes in offer rates in the three states also did not differ significantly from those in the rest of the nation (the "difference-in-difference" measure). Again, even the direction of change in California and Connecticut compared with changes occurring in the nation does not indicate that the alliance increased the availability of insurance to workers in small businesses.

EXHIBIT 5
Change In Characteristics Of The Small-Group Market In Three States, 1993 And 1997, And Contrast With Change In The Rest Of The Nation

Characteristic	CA	CT	FL
Percent offering insurance			
1993 adjusted	37.7%	48.8%	33.2%
1997	34.9	45.7	36.6
Change, 1993–1997	−2.8	−3.1	3.4
Change, 1993–1997, vs. rest of nation (difference-in-difference)	−2.0	−2.3	4.2
Change, 1993–1997, vs. mid-size employers and change for rest of nation (difference-in-difference-in-difference)	−1.8	2.2	1.0
Percent of offerers offering multiple plans			
1993 adjusted	17.3	13.9	8.1
1997	16.2	14.9	14.2
Change, 1993–1997	−1.1	1.0	6.1**
Change, 1993–1997, vs. rest of nation (difference-in-difference)	1.8	2.7	7.8**
Change, 1993–1997, vs. mid-size employers and change for rest of nation (difference-in-difference-in-difference)	−3.8	−6.3	−8.5
Premium for employee-only coverage			
1993 adjusted	$171	$209	$172
1997	163	208	174
Change, 1993–1997	−8	−1	2
Change, 1993–1997, vs. rest of nation (difference-in-difference)	−14	−6	−3
Change, 1993–1997, vs. mid-size employers and change for rest of nation (difference-in-difference-in-difference)	5	−4	−17

SOURCES: National Employer Health Insurance Survey (1993); and 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.
NOTES: Adjusted 1993 value is adjusted to 1997 characteristics of the state's employers, employees, and group insurance reforms. Mid-size employers are those with 51–150 employees.
**$p < .05$

The "difference-in-difference-in-difference" measure compares changes over time in the small-group market in the state with changes in the mid-size market and contrasts these to the national trends. This controls for state-specific changes over time that affect both small and mid-size employers. This change measure is also small in magnitude and suggests that the alliance did not lead to an expansion in coverage.

The results in Exhibit 5 also do not support the hypothesis that alliances led to more choice in the broad market for small employers. The three measures of change are typically small and of inconsistent sign. The only statistically significant change is the increase in choice in Florida, and this change is also significantly greater than the increase in choice offered in the small-group market nationally (the difference-in-difference estimate). However, this appears to be a trend occurring in the state rather than a factor attributable to the alliance, as evidenced by a negative (although insignificant) sign for the difference-in-difference-in-difference measure.

Similarly, alliances do not appear to have led to increased price competition in any of the three states. Changes in premiums for employee-only coverage in the small-group market in these states tended to mirror trends nationally—as seen by the small and insignificant difference-in-difference measures.

Discussion

We hark back to the question posed in our title: "Have alliances increased coverage?" The answer is no—at least, not in the states and time periods we studied, which contain the three largest small-group alliances implemented to date. These alliances encompass a range of models, including public and private sponsorship. Therefore, governance does not appear to be a factor in this conclusion.

What, then, prevented these alliances from contributing to expanded coverage? Except for California, they did not offer insurance at prices lower than those for comparable products in the broader market. The Florida and Connecticut alliances were prohibited by law from doing so. The California alliance aggressively negotiated rates with plans, and plans were not permitted to offer lower prices outside of the alliance. Despite the apparent price advantage in the California alliance, few employers chose to participate. We believe that this reflects the alliances' initial failure to appreciate the way in which most smaller businesses purchase insurance. Many small employers rely heavily on their insurance agents for advice, and the alliance failed to obtain the full cooperation of brokers. Brokers' resistance was also a problem confronting the Florida alliance, as evidenced by the infrequency with which brokers presented the alliance options to customers in these states. Hence, their growth was limited.

In contrast, the Connecticut alliance endeavored to develop good relationships with agents and established an agent advisory board to do so. We see evidence of greater cooperation by agents in presenting the alliance in Connecticut. Nonetheless, with a product that was not less costly, the Connecticut alliance captured only a slightly greater market share than did the others we studied.

Alliances, not having achieved significant market penetration, did not induce enough competitive pressure on the outside market to achieve the hoped-for spillover effects on prices. Moreover, low market penetration makes continued participation in the alliances less attractive to insurers, thereby threatening the alliances' long-term viability. Withdrawal of plans is a problem that has confronted the California and Florida alliances and a factor that has led to the closing of the Florida alliance altogether.

We rephrase our question to ask, "Can alliances increase coverage?" What would constitute a more favorable set of circumstances? The ability to engage in selective contracting is a necessary condition to offering lower prices, but it is unlikely to be sufficient to expand coverage if alliances cannot attract greater market share. Growth might be faster and last longer with full broker cooperation. Elliott Wicks and colleagues suggest a

number of regulatory mechanisms that would encourage the growth of alliances, including requiring that offerers in the small-group market also offer through the alliance, or requiring that small-group coverage only be offered through the alliance.[33] Such options could firm up the alliance's position in the existing market. However, without substantial subsidy support to enhance employees' demand for coverage, major coverage expansion seems unlikely. Most states that introduced alliances did so during debate about national health care reform and expected that subsidies or mandates would be a component of reform. Thus, they did not expect alliances alone to solve the problem of the uninsured.

Although we conclude that voluntary alliances are unlikely to expand coverage in the small-group market, they have produced demonstrable benefits to employers that participate. Their employees have much greater choice in the number and types of plans available to them and take advantage of this choice. Alliance participants also moved to managed care more rapidly than did other small groups. This may have allowed participating employers to reap the cost savings afforded by managed care earlier than their counterparts in the broader market, and without the disadvantage of restricting all of their employees to a single highly managed care option.

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NOTES

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13. Ibid.
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15. Wicks et al., *Barriers.* and Yegian et al., "The Health Insurance Plan of California."
16. The first date coverage became available through them and the size range of employers served, respectively, are July 1993, 2–50; January 1995,

3–50; and June 1994, 1–50. Pacific Health Advantage now operates the California alliance. The CBIA has sponsored pooled purchasing of life and health insurance for a wider range of employer sizes since 1946. The Florida alliance was closed in summer 2000. In an earlier study we examined a much broader set of pooled purchasing arrangements for firms of all sizes, in contrast to the present study, which is limited to small businesses participating in three specific alliances. See S.H. Long and M.S. Marquis, "Pooled Purchasing: Who Are the Players?" *Health Affairs* (July/Aug 1999): 105–111.

17. The descriptive information that follows is based on our own direct contact with the alliances and on several references, including the Institute for Health Policy Solutions Web site, ihps.org/chpglist.html (all); Ross, "Health Insurance Purchasing Cooperatives"(CA, FL); Wicks et al., *Barriers* (CA, FL); and Yegian et al., "The Health Insurance Plan of California."
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19. The sample frame included employers with at least one employee; self-employed individuals with no employees were excluded.
20. The weights for the 1997 survey adjusted for the probability of sampling from multiple frames (the Dun's list and the alliance list) for alliance participants.
21. Participation rates are for groups with 1–50 employees. The Florida alliance was also open to self-employed individuals with no employees, which comprised a substantial share of participants. They are excluded from our measures.
22. The alliances offered indemnity plans to out-of-state employees only; however, many non-alliance participants offered indemnity plans.
23. The actuarial value is the ratio of the expected plan benefit payments to the expenditures for a standardized population.
24. The question was, "Was your company aware that as a small employer it could purchase health insurance coverage for employees through the [relevant alliance]?"
25. This includes medical cost inflation. The premiums for 1993 and 1997 are not adjusted for general increases in price, which therefore would be represented in the simple change for each alliance state but is controlled for in the difference-in-difference estimate. It also includes any changes in the generosity of plans over time. The premiums in our time-series analysis are not adjusted for actuarial differences in plans because we do not have actuarial values for the 1993 plans. Therefore, we assume that changes in actuarial values that occur over time are similar nationwide.
26. For details on the regression model, e-mail the authors: <long@rand.org> and <susanm@rand.org.>
27. Others have reported that the Florida alliance did attract a large number of "microgroups" with one or two persons to the group insurance market that previously would not have been able to participate in the group insurance market. See, for example, M.A. Hall and E. Wicks, "An Evaluation of Florida's Small-Group Health Insurance Reform Laws" (Winston-Salem, N.C.: Wake Forest University School of Medicine, 1999). Our survey did not include the self-employed with no employees, however, which comprise the one-person groups.
28. The CBIA sold health insurance to trade association members for many years prior to establishing the Health Connections alliance for small businesses. It is possible that some small employers in Connecticut were aware of the association plan and so reported awareness of the alliance.
29. In Connecticut and Florida, alliance participants are required to purchase through an agent or broker. Reported use of a broker by alliance participants in these states may be less than 100 percent if the survey responses reflect use of a broker to help evaluate options, rather than simply who sold the product.
30. In the period of our study, the California alliance included HMO, PPO, and POS options. However, subsequently all PPOs and most POS plans withdrew. The Florida alliance included HMO and PPO plans, whereas the Connecticut alliance offered a choice among several HMO and POS plans.
31. Yegian et al., "The Health Insurance Plan of California"; and Buchmueller, "Managed Competition."
32. The adjusted values are predicted values from the multivariate regression for employers with the characteristics of those in the state in 1997 and for market reform characteristics set to the state's 1997 values, as if they were observed in the year in question.
33. Wicks et al., *Barriers.*