



# State Coverage Initiatives Health Insurance Connectors & Exchanges: A Primer for State Officials

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## Introduction

The Commonwealth Health Insurance Connector Authority, or “The Connector,” is one of the unique features of the 2006 comprehensive Massachusetts health care reform law that has sparked nationwide attention. The Connector is a structure designed by policymakers in Massachusetts to facilitate the purchase of affordable, high-quality health insurance by small businesses and individuals without access to employer-sponsored health insurance. Although the exact configuration and features of the Commonwealth’s Connector may not work for every state, it may serve as a model or prototype that other states can adapt to meet their policy goals given their specific market conditions.

Policymakers in many states are interested in learning more about the genesis of the Connector, how it differs from the health purchasing cooperatives established in the early 1990s, and whether a Connector will help solve some of the current market and access problems present in states today. AcademyHealth, through the State Coverage Initiatives program funded by the Robert Wood Johnson Foundation, held two small group consultative sessions during the spring/summer of 2007 to bring together several experts in purchasing mechanisms with some 50 state policymakers who are seriously considering advancing a Connector-like structure in their own states. This *Issue Brief* summarizes lessons learned at those meetings and can serve as a primer to others interested in exploring or pursuing similar market reforms at the state level.

## Models

A number of “Connector-like” models have been proposed and/or established over the years, yet none has received the “buzz” that the Massachusetts Connector has received in recent months. There are some important distinctions between the health purchasing cooperatives first established in the early 1990s—such as the Health Insurance Plan of California (HIPC)—and the model envisioned by Massachusetts policymakers. The theory behind the older purchasing cooperative models was that, if a number of small employers were pooled together, efficiencies could be gained and a more competitive premium rate could be obtained from insurers. Health purchasing cooperatives or purchasing pools were created around the country, but most were not deemed successful at constraining health insurance

premiums, achieving adequate market share to maintain efficiencies, or reducing the number of uninsured. Many closed their doors after failing financially, and the model in general did not live up to its promise.

The reasons for failure have been examined in numerous reports and publications (See References 1-6, page 5) and seem quite intuitive in hindsight. They can be summarized as follows: 1) some states required the cooperatives to accept higher-risk groups than what was required outside the pool thereby leading to adverse selection<sup>1</sup>; 2) a number of the cooperatives were unwilling to work with insurers and brokers leading to a limited number of plans selling through the cooperative, and no sales force directing employers to the purchasing pool; 3) the movement toward open-network health plans made it less important for employers to offer employees a choice of plans, which had been one of the more important benefits of a cooperative from a small business owner’s perspective; and 4) carriers did not want to compete against traditional sales (signing up a captive group) and in many places rallied against employee choice pools because they split groups between carriers.

The Massachusetts Connector model, however, differs from these earlier models in several important ways. It is *not* a purchasing pool but rather an “exchange.” While this seems only a difference in terminology it is important to how the Connector is perceived by insurers and the outside world. The Connector does not hold any risk for its commercial products unlike the earlier purchasing pools, some failing because of this risk. In fact, carriers’ Connector plan experience is pooled with all of their other open-market small/non-group plan experience, so risk selection problems are mitigated. It is an important distinction (from earlier pools) that the Connector was not designed to “negotiate better prices for its members” compared to the private market outside the Connector.

The Connector is also being established in a unique environment that is worth highlighting. The Massachusetts insurance market has undergone fairly significant reforms in the past and currently includes modified community rating, and guaranteed-issue. In addition, a significant market reform which merged the non-group and small group markets was also required under the new law. Other features of the new law which interact with the Connector

include a requirement that most employers arrange for the purchase of health insurance by their employees on a pre-tax basis, and a requirement for individuals to maintain health insurance coverage. In this way, the Connector is part of a larger reform plan, whose innovation may lie in its ability to combine insurance market reform with public subsidy reform. This unique combination of reforms has captured the imagination of policymakers and has reinvigorated the discussion around whether this model, alone or in combination with other features, can help solve the problem of the uninsured.

To provide a more comprehensive view regarding the development of a Connector-like structure and some practical guidance regarding implementation issues, three different models were presented to policymakers at the consultative sessions. The first model, the Health Insurance Exchange model, initially developed for the District of Columbia by the Heritage Foundation, is primarily conceptual in that no jurisdiction had fully implemented its design at time of publication. The second model is the Connector, a model based on the Health Insurance Exchange concept, but one that was broadened to include other components of the landmark reform law in Massachusetts. The Connector has been in operation for about a year now and executives from Massachusetts presented on the key elements they considered in designing and implementing the Connector. The third model is often overlooked but has been in operation since 1995 and is arguably the most successful of the health purchasing cooperatives in the country thus far: the Connecticut Business and Industry Association Health Connections. Executives from Health Connections shared more than 10 years of experience running a Connector-like organization. Although the Health Connections model does not include all of the components and functionality being proposed in the Health Insurance Exchange or being implemented in the Connector, the executives have a wealth of on-the-ground experience managing an employee choice pool that provides many of the same administrative functions envisioned in the other two models.

These models share many features and policy goals; however, they also differ in important ways. Each is described briefly below with an emphasis on its commonalities and unique features.

## The Health Insurance Exchange

The Health Insurance Exchange was first detailed in the D.C. Equal Access to Health Insurance Act of 2004 and was designed to make health insurance coverage more readily available to District residents and to promote greater continuity of coverage. It would create a single “clearinghouse,” through which those who live and work in the District could obtain a health insurance plan of their choice. Individuals whose employers elect to make the D.C. Health Benefits Program their “group-health insurance plan” can buy coverage through the program using tax-free contributions made by their employer and themselves.

The benefits of this arrangement are many. First, it ensures portability of coverage because, as individuals change employers, they can keep their insurance. It also provides for administrative simplicity in that all administrative functions can be standardized, such as enrollment, annual open season, and transmittal of premium payments. Small firms can cede these administrative and human resources functions to the exchange. The arrangement also provides a choice of carriers and plans for individuals who work for smaller employers. Finally, it eliminates a lot of cost shifting from one employer to another through premium aggregating mechanisms. Thus, two-earner couples can combine contributions from two employers (or a single person from two different part-time jobs) to purchase health insurance—making the purchase more affordable to both the individual and the employers.

While the D.C. Equal Access bill required that the District government take the lead by providing health insurance to its own employees through the Exchange, a state could choose to include this feature or not. There are several advantages to requiring these employees to join including: 1) beginning with a large number of covered lives in the pool; 2) known medical risk for the initial pool; and 3) carriers that have served those members before are “captive” carriers. Challenges to requiring participation of government employees include the possibility of a poor risk profile initially discouraging others to join, and political resistance. This model was also designed to provide better access to hard-to-reach populations by allowing private social service entities, such as clinics or church groups, to join. The model limits the number of health plans able to participate to between 10-15 plans, with no more than 3-4 of any one type of delivery systems (such as HMO, PPO,

or Indemnity). The reasoning behind limiting plans that can participate is to encourage carriers to compete aggressively for the availability of a spot in the Exchange while providing enough diversity of plans to offer consumers choice without overwhelming them. Whether the Exchange should be an open market (i.e., all plans can participate) or the number of plans should be limited is a decision that must be considered based on the level of competition in a state’s current market and the availability of plans that offer meaningful differences to consumers.

## The Connector

The Commonwealth Health Insurance Connector Authority (the Connector) is part of the system-wide reform in Massachusetts. Through a comprehensive law, Massachusetts: 1) restructured how private insurance is purchased, sold, and administered; and 2) restructured how public subsidies are delivered. By integrating these two major components, Massachusetts hopes to cover most of its uninsured residents within several years.

The Connector is an independent, quasi-governmental entity designed to facilitate the purchase of health care insurance at affordable prices by eligible individuals and small groups. The Connector is a self-governing, separate legal entity from the Commonwealth and is governed by a 10-member board consisting of private and public representatives. After an initial infusion of \$25 million in state appropriations, the future cost of operations will be paid for through retention of a percentage of premiums collected on the subsidized and non-subsidized (private) products sold through the Connector. The Connector began offering subsidized products in October 2006 and private products in April 2007. The board certified seven plans by six carriers signaling to consumers that the approved plans are both comprehensive and affordable.

Employers and employees that purchase health insurance through the Connector enjoy pre-tax premium payments, whether the employees are part-time or full-time. The Connector makes it easier for all businesses to offer insurance to their contractors and part-time workers. In addition, the Connector enables individuals to purchase health insurance which meets their needs and which is portable. Portability is obviously beneficial for consumers, but it is also desirable for the system overall as it provides the incentive to encourage carriers to manage medical risk proactively because members may

stay longer. In addition, carriers need to be responsive to consumers in order to retain their market share.

Employees of employer groups with 50 or fewer employees can be rated individually and have freedom to choose products, or as a group with limited product choice, depending on how their employer wishes to purchase through the Connector. Importantly, rating factors are the same both inside the Connector and outside in the parallel private marketplace, and products sold in the connector can, for the most part, be sold outside.<sup>2</sup> Initially, the law limited purchase of insurance through the Connector to the following:

- Non-working individuals;
- Individuals working for non-offering companies of any size;
- Individuals working for offering companies of any size who are not eligible for benefits (part-timers, contractors, new employees);
- Small businesses with 50 or fewer employees; and
- Sole proprietors.

The Connector will facilitate pro-rata employer contributions for individuals working part-time and/or from more than one employer and also will administer premium assistance for individuals between 150 percent and 300 percent of the federal poverty levels (FPL), and free coverage for those who earn less than 150 percent FPL. The Connector improves portability and ensures choice, two features in little evidence in the current small group market in Massachusetts.

The health care reform act provided for a phasing-out of the non-group market and a merging of people currently purchasing products in the non-group market into the small group market. The non-group market was not functioning as once envisioned as shown by the fact that products sold in that market are 40 percent higher than similar products available in the small group market because of the size and health of the non-group risk pool.

Market changes under the reforms allow insurers to rate individuals and small groups based on smoking status and for participation in wellness programs. The other characteristics of the Massachusetts market remain unchanged, such as guaranteed issue and modified community rating (allowed rating factors are age, employer type, geography, and minimum employee participation rates) within a 2:1 rating

band (i.e., allowing the highest premium for a high cost group to be no more than twice the lowest premium for a low cost group). The health care reform act also imposes a moratorium on any new legislative health insurance mandated benefits through 2008.

### Health Connections

The Connecticut Business and Industry Association Health Connections, a private-sector purchasing mechanism, has been in operation for more than 12 years and is a division of the Connecticut Business & Industry Association (CBIA). Health Connections was one of the first statewide, multi-vendor health insurance purchasing alliances in the country. It serves employers with 3 to 100 employees and provides choice from among any one of four participating health care carriers. It currently operates with more than 6,000 employers with 88,000 members. Health Connections offers many benefits to employers including plan of choice for owner and employees, never needing to switch health plans, consolidated administration, and global budgeting for the employer. In addition, they offer small employers full-service human resources capability. This particularly appeals to smaller firms without in-house human resources departments as indicated by Health Connection's success in the 3-25 employee market.

For the marketplace, as envisioned, this model has stimulated competition in the areas of premium price, network design, and formularies. To address issues of adverse selection, Health Connections uses the same rating rules (age, gender, geographic area, family tiers) as those used in the parallel, modified community-rated small group market and has established a floor of benefits which each of four participating carriers must meet. Each employer group must have at least 75 percent of its eligible full-time employees participating. When offering the program, the employer selects one of two suites of plan design options (one more comprehensive than the other) to make available to their employees. Each employer is required to establish a minimum premium contribution level of at least 50 percent of the premium for the lowest cost plan in the suite offered. Once chosen, the employer would typically pick a "benchmark" plan of benefits within the suite on which to base their premium contribution and establish their monthly premium budget. Employees may then choose to enroll in the "benchmark" plan or opt to "buy up" to a higher level of benefits or "buy down" to a

lower level of benefits within the suite offered. This concept allows employers to establish their premium budget while providing employees the flexibility to choose the plan that best meets their needs.

Health Connection's success is attributed to learning lessons from earlier models, adapting to a changing environment, and focusing on execution of best practices. They have maintained a good relationship with the business, insurance, and broker communities and are small enough to be flexible, nimble, and willing to adapt quickly to changes occurring in the health insurance marketplace. Executives report that developing and maintaining a role for brokers was essential to gain the market share necessary to survive and thrive. In addition, the use of the same underwriting/rating and eligibility rules inside Health Connections as outside in the parallel private market(s) is important in maintaining a good risk-pool and avoiding adverse selection.

### Issues to consider

Policymakers had a number of questions for the experts that ranged from broad design questions to very practical implementation issues. These issues were actively discussed among participants and advice was provided on how to approach thinking about whether a Connector would make sense in each state. First, experts told state policymakers it is important to describe and understand the elements and/or policies contributing to access problems in their state. This includes evaluating, with data and rigorous analysis: 1) the state's insurance markets; 2) the state's employer-based health insurance system; and 3) the characteristics of the uninsured in the state and their current level of access to care.

Second, the problems that are trying to be addressed with the reforms being developed or proposed must be understood and clearly communicated. It is clear that by implementing a connector-like structure alone the entire problem of the uninsured in any state will not be solved. Although the Connector is a large and important part of the Massachusetts health care reform law, it is only part of the plan. Most policymakers believe that a comprehensive approach is necessary to tackle this problem including a restructuring of the safety net. It is important to communicate early on what a Connector can and cannot accomplish; managing expectations is an important task in any policy process.

Finally, consider how this structure fits together with other reforms the state is contemplating, such as changes to public programs, safety-net, or other health insurance market changes.

Some specific technical issues to consider during the design and implementation phase follow:

**Number of Plans:** Each of the three models limits the number of plans and/or carriers that can participate. One reason for limiting plans is to engender competition for the limited number of spots within the Connector and the other is to alleviate confusion in the marketplace. Limiting the plans to those with meaningful differences with respect to cost sharing, network design and/or formularies probably makes sense. Some states may need to require plans to participate to ensure an adequate number of plans so the purchasing mechanism is seen as an attractive option for employers. Exactly how a state limits or requires the number of plans will depend on many factors including the level of competition in their current marketplace and the number of carriers who do business in each state market.

**Coverage Requirements:** The same or similar rules regarding mandated benefits and other coverage requirements should apply inside the purchasing mechanism as in any other market in operation in the state. The experts agreed that as much flexibility as possible is important but that some standardization of plans within the Connector is also warranted to avoid cherry picking and adverse selection via benefit design.

**Underwriting or Rating Rules:** The same rules must be applied inside and outside the structure you create. For a number of reasons, a Connector-like structure works best in a market that is already modified community-rated and one that requires at least some level of guaranteed issue. Understandably, a tension exists with community-rating as you want to encourage good value for younger, healthier people but also want to keep insurance affordable for less healthy, older populations. Exactly where that state lands with respect to rating factors and rating bands will depend on where the state is now, as employers and insurers are unlikely to want to change these factors dramatically. If the desire is to sell to both groups and individuals through this structure, as the Massachusetts Connector is designed to do, it is best if the rating factors are the same for businesses and individuals.

**Risk Management:** There are no clear answers on how to manage risk-selection within the Connector structure. Mandated participation is clearly the most effective way to manage adverse selection. In a voluntary arrangement, some standardization of plans helps to a certain extent. In addition, implementation of a mandatory, self-supporting reinsurance risk pool or risk adjuster could address many of the concerns that insurers will have, but it is important to let insurers contribute to designing the mechanism within certain limits.

**Eligibility:** Questions arise regarding whether any certain type of employer or individual is required to purchase through this structure and/or whether there are restrictions regarding eligibility. Is free competition with the outside market(s) allowed? CBIA allows employers of 3 to 100 employees to purchase through its organization, but its niche market is in employers with 3-25 employees. The Connector allows individuals without access to employer insurance and small businesses with up to 50 employees to join, but no one is required to join except individuals receiving subsidies and those wishing to purchase a Young Adult Plan. The Health Insurance Exchange model allows any employer of any size to join and also allows for groups/social organizations to join. In addition, it would require District of Columbia public employees to purchase through the Exchange. It is evident that to be successful, any entity would need to achieve a certain market share. Issues regarding risk selection and crowd-out need to be considered depending on the specifics of a state's overall reform. Eligibility criteria should respond to the problems a state is trying to solve and the populations it is attempting to reach.

**Functionality:** The exchange or connector structure will need, depending on the breadth of the reforms, the capacity to accomplish the following tasks: application processing; eligibility testing; premium billing; employer contribution monitoring; financial reconciliation; Web site development and maintenance; payment of commission; broker training; ongoing marketing and outreach; electronic interface; and more. The decisions about whether to make or buy these capacities, or whether to partner with state agencies, will depend in large part on the funding available to the entity. The Connector in Massachusetts, for example, was seeded with an initial large appropriation, but tight implementation timeframes may have pushed the staff to make decisions they would not have otherwise made regarding these make-or-buy decisions.

**Other Thorny Issues:** There remain a number of difficult questions that state policymakers posed. The first has to do with the Massachusetts requirement that employers offer Section 125 plans. According to the Department of Labor, carriers may sell individuals policies within a group setting under a "safe harbor" provision of the Employee Retirement, Income and Security Administration (ERISA) regulations. Under this provision, the employer or employee organizations "are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check-offs and to remit them to the insurer." This scenario would not be considered an "employee welfare benefit plan" and "welfare plan" under ERISA (not a group plan), and therefore, would not be subject to Health Insurance Portability and Accountability Act (HIPAA) regulations.<sup>3</sup> This holds true as long as no contributions are made by the employer on behalf of the employee, and participation in the program is voluntary by the employee, and the employer does not receive any consideration (such as cash) in connection with the program. However, if an employer did want to contribute to such a plan it would then become a group health plan and this situation could present challenges for employers regarding HIPAA regulations, especially in states without guaranteed issue.

Another question arose about list billing arrangements and whether a defined contribution would be considered discriminatory if an employer's older employees ended up paying more than their younger colleagues under such an arrangement. The Age Discrimination in Employment Act (ADEA)<sup>4</sup> provides direction on this question for three situations one might encounter in a Connector arrangement: employee-pays-all plans; noncontributory plans; and contributory plans. When the employee is paying the full cost, older employees may be required to contribute up to the full premium cost for their age. In a noncontributory plan (i.e., where the employer pays the full premium) the employer cannot require older employees to pay a portion of the premium if the employer covers younger employees in full. In contributory plans, the required contributions of participants may increase with age so long as the *proportion* of the total premium required to be paid by participants does not increase with age.

Finally, although the experts all agreed a role is needed for brokers in the design and execution of a Connector, exactly what this role should be and how to gain the support of brokers for these changes remains a challenge.

Massachusetts seems to have found a way to navigate these thorny issues thus far, but cautioned states that they still may see a lawsuit some time in the future. This is somewhat uncharted territory with no clear-cut answers. The experts did advise states to secure a good employment benefits attorney familiar with relevant state and federal laws.

## Summary

The Connector in Massachusetts was designed to help small employers and individuals purchase affordable insurance. It achieves this by providing for administrative ease, eliminating paperwork, offering portability and pre-tax treatment of premium, providing choice of plans, and by combining subsidies or defined contributions from one or more sources. Although some of these functions were present in the earlier versions of what were then called purchasing cooperatives or alliances or pools, the Connector diverges from that model by including additional important functionality. Combined with reform of the safety net, this model offers a bipartisan solution to the uninsured problem and the promise of a better functioning marketplace where all individuals have access to affordable, portable insurance, which they choose and own.

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### About the Author

Amy Lischko has more than 15 years of experience working for the Commonwealth of Massachusetts, at both the Department of Public Health and the Division of Health Care Finance and Policy. She has a Master’s degree in Health Policy and Management and extensive

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Lischko is currently pursuing a doctorate degree in health services research with a concentration in outcomes research at Boston University on a part-time basis and began a faculty position at Tufts University in July 2007.

### Endnotes

- 1 Adverse selection is the tendency of persons with higher risk health expectations (and, therefore, higher medical costs) to enroll in plans with more comprehensive coverage or better rates to a greater extent than persons with lower risk health expectations.
- 2 Young Adult Products (those products offered to 19-26 year olds) can only be sold through the Connector.
- 3 [http://mhcc.maryland.gov/health\\_insurance/archive/studysmallgroup03.pdf](http://mhcc.maryland.gov/health_insurance/archive/studysmallgroup03.pdf)
- 4 Section 29 CFR 1625.10(d)(4)(ii)