Creating an Exchange: Lessons from Massachusetts

Massachusetts' experience with health reform offers useful lessons as Congress considers creating a national health insurance Exchange. Massachusetts' success in near-universal coverage was due not only to the work of the Massachusetts Health Connector, as Massachusetts calls its insurance Exchange, but also other important policy decisions.

Massachusetts teaches us that:

- The Exchange is just one piece of reform, and must be built on a strong foundation of insurance market improvements;
- Maximizing enrollment enhances the value of an Exchange; and
- Setting benefit standards is important to providing consumers with adequate coverage and informed choices; an actuarial value standard alone is insufficient.

A Strong Foundation of Insurance Market Reform

Prior to creating the Connector, Massachusetts implemented strong private insurance reforms to promote affordable coverage through fair insurance rules. The Connector would not have functioned successfully without existing guaranteed issue and renewal protections in the small group and individual health insurance markets. In addition, Massachusetts required modified community rating in the individual market, allowing rating only by age and geography, and enabled self-employed individuals to purchase as a "group of one" in the small group market. As part of its 2006 health reforms, Massachusetts made additional changes by merging the small group and individual markets, which greatly reduced premiums for individuals without significantly increasing costs for small groups. Because of these reforms, insurance is available to everyone, regardless of health status or pre-existing health conditions. In addition, modified community rating makes premiums more affordable for older and sicker patients.[1]

Based on these experiences, a national health care reform plan should include private insurance standards such as guaranteed issue and renewal, modified community rating, and prohibition of pre-existing condition exclusions to maximize effectiveness of the Exchange. Without these reforms, many people may not be able to access affordable coverage. States should be allowed to set stronger rating standards than the national baseline. To avoid adverse selection, it is critical that standards for rating and underwriting be the same both inside and outside of the Exchange. While combining the individual and small group markets may be more difficult nationally than by each state, both markets should operate under the same insurance rules.

Given the wide variation in current market practices across the country, a phased-in approach to private insurance reforms will be necessary. The federal government could set a path for private insurance reforms, identify steps in this process, and require states to meet certain milestones.

Maximizing Enrollment Enhances the Value of an Exchange

One goal of Massachusetts' reform was to enable the Connector to act as a purchaser and organizer of health plan options, and in doing so, foster innovation and make insurance more

affordable. To achieve this, it was important to maximize the number of people who purchase insurance through the Connector. Subsidies for people under 300 percent of the federal poverty level who are not eligible for Medicaid are only available through the Connector.[2] People with subsidized coverage comprise 90 percent of those insured through the Connector. Subsidized plans are highly standardized, with robust benefits and very limited cost-sharing (no deductibles or coinsurance, and minimal copayments).

Enrollment in the Connector has been much lower among individuals without subsidies than those eligible for them, in large part because people can purchase the same health plans elsewhere.[3] In addition, private insurance carriers are able to offer other plans outside of the Connector, which raises the potential for insurers to try to attract only healthy people. Private insurers' ability to offer plans outside the Connector has limited its ability to promote innovation and value in the private insurance market.

To maximize participation on the national level, an Exchange should provide incentives for people and for health plans to join. A national reform plan could offer subsidies for people with low and moderate incomes only through the Exchange. Plans should be comprehensive and standardized, with limited cost sharing and sliding scale premiums. Additionally, an Exchange could be the exclusive venue to buy coverage for the entire individual market and either the micro group (between 2-10 employees), or the entire small group (up to 50 employees) market.

Setting Benefit Standards

The Massachusetts Connector sets standards for unsubsidized plans. The Connector defines the most comprehensive plan (Gold) based on benefits and cost-sharing, and then identifies two additional tiers (Silver and Bronze) based on a percentage of actuarial equivalence of the Gold plan. Using actuarial value as a standard allows for major differences in benefit limits and cost-sharing among plans in the same tier, and makes comparisons difficult for consumers.

A national Exchange should offer plans that have similar benefits and cost-sharing to allow for meaningful comparisons. Polling conducted by the Herndon Alliance suggests that consumers want quality, but not unlimited, choices.[4] Based on Massachusetts' experience, relying on actuarial value creates wide variation between plans. Therefore, an Exchange should consider designing tiers with similar benefits and out-of-pocket costs to enable easier comparisons.

Excessive variation between plans could also encourage insurers to design benefits in a way that reduces their risk. To prevent this at a national level, insurers should be required to offer plans in each benefit tier and to pool the risk of everyone they insure.

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[1] Massachusetts set maximum rate bands at 2:1 for age and 1.5:1 for geography.
[2] Medicaid enrollees do not go through the Connector.
[3] As of April 2009, only 21,863 people were enrolled in unsubsidized plans in the Connector, while 169,000 were enrolled in subsidized plans. Commonwealth Connector meeting materials April 9, 2009. Commonwealth Care Quarterly Update and Commonwealth Choice Enrollment Update.
[4] Lake Research Partners and American Environics. Herndon Alliance 2006 Research Summary, January 2007. Poll respondents criticized the numerous and confusing choices in Medicare Part D.