A Consumer Guide to Creating a Health Insurance Connector

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INTRODUCTION

The health insurance system is inaccessible to millions of Americans. For people who do not have health insurance through their employer or a public program, barriers such as high costs make obtaining insurance extremely difficult. Similarly, small employers face challenges finding affordable insurance options for employees. Individuals and employees of small businesses often pay more for health plans with fewer benefits.[1]

Recently, the concept of a "Connector," or an organized marketplace of different health plan options, has gained popularity in health policy circles as a way to reduce barriers to acquiring insurance coverage. There are a number of models of health insurance Connectors (or Exchanges), but to date only one state, Massachusetts, has created a Connector.[2] Yet as other states consider Connectors, it is important to note that without certain external health policies and internal elements a Connector will fail to improve a state's insurance system.

A Connector is not a quick fix for the complex, expensive, and inaccessible health care system. In and of itself, a Connector is not likely to reduce the price (or cost) of insurance, make coverage available to all, or reduce the number of uninsured. To achieve these goals, we have identified six policy elements to help a Connector work correctly:

External of the Connector, a state's health policies should:
- ⇒ Provide a strong base of public insurance;
- ⇒ Guarantee access to insurance to all; and
- ⇒ Limit insurers' ability to vary premiums based on health, age or other factors.

Internally, the Connector should:
- ⇒ Offer standardized plans;
- ⇒ Subsidize premiums for lower-income people; and
- ⇒ Provide outreach and enrollment support.

Without these reforms, a Connector is unlikely to improve access to health care.

WHAT IS A "CONNECTOR"?

The Connector is not a new concept; similar entities have existed in state-run purchasing pools since the 1990's. To address problems of high prices and limited access to insurance for small groups, purchasing pools "pooled the risk" of many small employer groups to gain stronger leverage with insurance carriers.[3] Purchasing pools were largely failed experiments, and neither decreased premiums nor increased access to insurance for employees of small businesses. However, we can acknowledge lessons from purchasing pools to create a successful Connector. Generally, purchasing pools have resulted in:

Increased choice of plans. A few purchasing pools successfully enhanced plan choices to employees of small businesses who previously had very limited options.[4]

No reduction in premium costs. If a pool allowed all people to purchase insurance, it could become a place only for the sick, and prohibitively expensive.[5] In

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addition, the administrative costs of working with many small employers and marketing plans are significant.[6] These costs increased premiums for plans.

Limited enrollment. Purchasing pools failed to attract the number of enrollees necessary to gain leverage with insurance carriers. This was due to high premiums, and lack of appealing health plan choices.[7]

A minimalist Connector

In the minimalist version promoted by groups such as the Heritage Foundation, a Connector is a single, private, consumer-driven market that allows individuals and businesses choice of any health plan, without government regulation of policies.[8] This concept of a Connector does not include any standardized benefits or negotiations with insurers on plans. The model presumes premiums will be less costly due to competition between carriers, as well as increased consumer cost sharing in some plans. The Heritage Foundation suggests subsidies in the form of tax credits or vouchers can help low-income families purchase private insurance as a way to replace the Medicaid program.[9]

However, this “weak Connector” model leaves consumers without assistance in sorting through the dizzying array of plan options, and allows insurers to design benefits and pricing to avoid covering sicker, more expensive people. Purchasing pools have shown that competition alone does not reduce the price of plans.[10] This type of Connector would also likely concentrate lower-income people in plans with fewer benefits and higher cost sharing, without improved access to medical care or financial protection against the costs of illness—the very reasons people have insurance.

Envisioning a stronger Connector role

Other recent proposals contemplate a more robust Connector mechanism. In research conducted for the *Roadmap to Coverage* project of the Blue Cross Blue Shield of Massachusetts Foundation, the Urban Institute formulated a reform package to expand access to affordable health care, using Massachusetts as a case study.[11] As one of the “building blocks” of health reform, the Urban Institute proposed a state-administered purchasing pool—a voluntary arrangement to provide individuals and small businesses with one common place to purchase insurance. The pool would certify standardized private insurance plans, provide tax credits to assist lower-income families in purchasing insurance, and negotiate with carriers to keep premiums affordable and benefits adequate.[12] Coupled with reforms such as an individual mandate, Medicaid expansions and subsidized private insurance, this proposal would lead to near-universal coverage.

The Connector in Massachusetts

In Massachusetts, certain protections already existed in the health insurance market. Massachusetts insurance rules do not allow insurers to price plans based on the health status or claims experience of enrollees, and allow all people to enroll in insurance plans.[13] In addition, Massachusetts has a strong safety net of public insurance programs to provide coverage for the poorest and most vulnerable residents.[14] Building upon these reforms, the Massachusetts Connector resembles the Urban Institute’s model.[15] In Massachusetts, the Connector:

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- Designed plans that meet the needs of the low-income population (including a Medicaid “look-alike” plan for all adults under 100% FPL and subsidized plans with no deductibles and limited cost sharing for people up to 300% FPL);

- Set standardized benefits and cost sharing; grouped plans into “actuarially equivalent tiers” so people can compare differences among plans;

- Administers a subsidy program for low-income people that complements, rather than supplants, the Medicaid program;

- Creates greater administrative ease in purchasing insurance through information, outreach, and marketing of plans;

- Permits the portability of insurance across employment for part-time workers or for people who change jobs;

- Allows the purchase of health insurance with pre-tax dollars.[16]

Although Massachusetts’s Connector contains many elements of a “strong Connector,” it could benefit from greater protections. Most notably, the Connector could set minimum loss ratios for insurers, provide greater outreach and enrollment assistance, and ensure robust provider networks for all plans offered through the Connector. In addition, the Connector could have further standardization of benefits and stronger limitations on consumer cost sharing to provide consumers with more meaningful choices.

EXTERNAL HEALTH REFORMS NEEDED FOR A CONNECTOR

Based on the Massachusetts Connector and prior experience with purchasing pools, we can assess what policies a state needs both *inside* and *outside* of the Connector to make insurance more accessible to uninsured individuals and employees of small businesses.

The Connector works within existing state health insurance rules. Strong public insurance programs, and rules that allow access to private insurance and limit the amount that insurers can vary premiums are critical for a Connector. Without these three external health care policies, a Connector will likely fail to increase coverage to the uninsured.

Building on a base of strong public programs

Some states that have proposed a Connector mechanism suggest substituting subsidized private insurance for people previously eligible for Medicaid.[17] To ensure protection of the most vulnerable populations, a Connector should build upon states’ existing Medicaid and SCHIP (State Children’s Health Insurance Program) programs. Public insurance provides comprehensive benefits with minimal premiums and cost sharing to low-income individuals and families. Private insurance plans often do not meet these needs, and may have limited benefits and high cost sharing that leave families financially vulnerable.

Massachusetts, for instance, had a strong foundation of public insurance before creating a Connector. The Connector then built upon this benefit and delivery system by utilizing Medicaid managed care organizations (MCOs) to create a subsidized private insurance program for people not eligible for Medicaid. In addition, Massachusetts created a "Medicaid look-alike" program for adults below 100% FPL, with no premiums or deductibles, and limited cost sharing.[18] The Connector works in concert with public insurance to increase access and affordability to all consumers.

Private insurance market rules

Before creating a Connector, a state should examine its private insurance protections. Insurance rules must be the same inside and outside of the Connector to ensure that the Connector does not become a "dumping ground" for the sick, as occurred with earlier experiences of some purchasing pools. States need to allow all people the right to purchase insurance policies ("guaranteed issue") and to create limitations on charging people more based on health status, age or other factors ("community rating").

Some people will enroll in plans through the Connector as individuals, rather than part of an employer group. Therefore, states must examine their individual (non-group) markets. Most states do not currently have robust consumer protections in the non-group market.[19]

Guaranteed issue

"Guaranteed issue" means that every person can purchase health coverage, regardless of employment, health status, or other criteria.[20] Most states allow insurance carriers to refuse people who apply for insurance without an employer sponsor, usually for existing health conditions.[21] Because many people will enroll in Connector health plans as individuals, a state must decide if it is appropriate for the Connector to be able to refuse people who may have greater health costs. Turning away the sickest individuals, of course, may be contrary to the Connector's goal of increasing access to insurance.

Ideally, people who enroll through the Connector should be no less healthy than those who enroll outside of it. If the state decides to provide guaranteed issue insurance through the Connector, but not in the larger health insurance market, the Connector will likely become a place mainly for the sick.[22] This will greatly increase insurance rates for people in the Connector, limit enrollment, and raise the cost of providing subsidies. With guaranteed issue, a state may need to create rules to prevent people from only buying insurance when they are sick.[23]

Community rating

"Community rating" means that each insurance carrier must charge the same premium for each person covered by the same health plan, regardless of health status, age, or other factors.[24] Without community rating, people who are older or sicker are unlikely to find affordable plans.

If only the Connector, and not the larger insurance market, is community rated, the Connector is likely to become a pool of only sick and older people who find other insurance unaffordable. However, if the market both inside and outside of the Connector

is community rated, premiums are likely to increase for consumers who are younger and healthier. Therefore, to keep premiums affordable in a market with community rating, subsidizing insurance may be important.

Changes in premiums for employees of small business

For small businesses that use the Connector, there will be a change in the way their employees are "rated," or charged insurance premiums. If a state allows plans to vary premiums based on certain "risk" factors, people will *not* be charged a premium based on the combined health risk of their "group," as currently occurs. Instead, insurers charge each person a premium based on her/his *own* "risk."

For instance, employees of small businesses who currently receive insurance in the small group market pay premiums based on the demographics of everyone in their group. In a state that allows variation in premium costs based on age, the "risk" is age, and the ages of older and younger members of a group are pooled together to determine their premium rates in the small group market. However, in a Connector, each individual pays a premium based only on her or his *own age*.

So in a state that allows premiums to differ based on some factors, individuals working for the same employer could have significantly different premiums for the same plan.[25] For this reason, a Connector may not be as attractive to people in the small group as for individuals. The only true fix to this problem of premium variation is community rating.

INTERNAL COMPONENTS OF A STRONG CONNECTOR

Once a state has a robust public insurance program and appropriate private insurance rules, a Connector becomes an option that can increase access to insurance. From earlier experiences with purchasing pools, we examine three policies *inside* of a Connector that are necessary to protect consumers and make insurance more accessible.

➢ ***Standardized benefit package:*** A standard of coverage provides a "floor" of benefits available in any plan in the Connector. This eliminates consumer concern about inadequate benefits in a plan, and creates greater ease in understanding different health benefit options.

Informed choice: With standardized benefits, the Connector can still provide choice—different "tiers" of coverage options beyond the floor of standard benefits. In Massachusetts, the Connector conducted focus group research and found that limited, informed choices are most appealing to consumers: about four to six carrier options, with three to five coverage offerings. The Massachusetts Connector offers three benefit "tiers" through four insurers in each area of the state.[26] Recent polling conducted by the Herndon Alliance also suggests that consumers want quality, but not unlimited, choices.[27]

➢ ***Affordable insurance through subsidies:*** A Connector serves as an effective conduit for subsidized insurance plans. Purchasing pools often failed to lower the cost of insurance to the point of being affordable for people with low and moderate incomes.[28]

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The Massachusetts Connector reduced the cost of unsubsidized plans only through benefit design, increased consumer cost sharing, and limited provider networks; prices for these plans do not vary greatly from those outside of the Connector.[29]

Connectors, if they fail to enroll a sufficient number of people, are likely to have the same problem as purchasing pools that showed premium *increases* in their plans.[30] If a Connector fails to enroll people, premiums are likely to escalate, and the Connector will have reduced power to negotiate with insurers.

With sliding scale premiums, subsidies provided through a Connector make insurance affordable to for low- and moderate-income families and people with significant health expenses. These subsidies will increase enrollment in the Connector, and robust enrollment thus allows greater leverage with insurers. In the Massachusetts Connector, for instance, people with incomes below 300% FPL are eligible for subsidized insurance. Enrollment in the first few months of this program has been strong, but much greater for people with significant insurance subsidies.[31] A variation on subsidies is state-funded reinsurance to reduce premiums of plans offered through the Connector.[32]

Favorable tax treatment: Currently, employers and their employees are able to purchase health insurance using pre-tax dollars as "Section 125 plans." However, people without access to employer-sponsored insurance (ESI) are typically unable use this benefit, and insurance is therefore more costly. A state, however, can require all employers to allow employees to purchase insurance through the Connector with pre-tax dollars, even if a person does not have access to ESI.[33] Tax savings range from 28% to 48%, depending on federal tax bracket.[34]

➢ ***Enrollment support and outreach:*** The Connector can reduce barriers to insurance through outreach, enrollment, and education to individuals and small businesses about insurance products. Such enrollment assistance may be helpful to people without access to ESI.

Transparency of health information: With standardized benefits, consumers have access to greater information about their health coverage. If all Connector plans contain adequate benefits and have clear cost sharing limits, consumers can choose plans based on provider networks, plan type and coverage options.

Administrative ease: The Connector can create tools, such as a website and call center, to enable consumers to easily understand and compare health plan options.

ADDITIONAL IMPORTANT DECISIONS AND CHALLENGES

Many decisions that go into setting up a Connector have significant implications in creating affordable and accessible health care. This section provides a set of questions and potential problems policymakers must consider when creating a Connector.

Does your state need a Connector? If subsidized insurance is only offered through one insurance plan, or as one benefit package, a Connector may not be necessary.[35] Because the Connector encourages competition between insurers and transparency of benefit information, it would not be needed if there were only one carrier or one plan. However, using only one carrier may make it difficult for a state to negotiate prices or benefits.

What sort of entity will the Connector be? The Connector may be a private, public, or quasi-public independent body. To provide accessible health care to all, Connectors should be statewide and have state oversight. If the Connector includes subsidies funded by Medicaid dollars, it is important to retain state oversight over the funds. The Heritage Foundation's model, for instance, advocates a privately operated Connector, but a lack of government oversight will reduce consumer protection.

How will the Connector make decisions? How will the Connector interact with other state agencies? This decision may affect the placement of the Connector. For instance, in Massachusetts the Connector is a quasi-public body with a board comprised of both state commissioners and community appointees.[36] Members of the Administration, including the Commissioner of Insurance and the Secretary of Administration and Finance, are board members along with union leaders and health experts.

Who will be able to use the Connector? The Connector will be a common marketplace for people to compare and purchase insurance plans. Who will be able to purchase insurance through the Connector? Only individuals, or small businesses as well? Insurers are often wary of providing insurance through purchasing pools, as they are not likely to gain an entire employer group; instead, employees may choose plans from other insurers.[37] As a political decision, it may be easier to offer subsidized coverage to only non-group (individual) plans, and wait to expand to the small group market. However, opening the Connector to the small group market may be a good option to aid people in getting health coverage and retaining employer contributions.

Will the subsidized plans only be available to low-income people, or people with significant health costs? What will the sliding premium scale be for subsidized insurance? To enroll enough people in the Connector, plans must be affordable. Limiting premiums and cost sharing levels is critical to the Connector's success.

How will the Connector be funded? Will the Connector be purely state-funded, or rely on an assessment on insurance carriers? While it may be appealing to assess carriers for funding, insurers may pass the expense on to consumers, which will increase premiums. Will employers pay to enroll employees through the Connector? How will the Connector capture employer contributions? A state may decide to require employers to pay a minimum percentage of employee premiums to utilize the Connector.

What insurance plans will the Connector offer? A state must decide which insurers the Connector will allow to provide insurance. Will only non-profit carriers be able to offer insurance products? This may protect consumers from limited benefits with excessive cost sharing. Certain larger insurers? This option may ensure health care access across

the entire state, or target certain underserved communities. Should only certain insurance carriers provide subsidized benefits? This decision depends on those plans that serve low-income populations well. For instance, Massachusetts initially is relying on Medicaid MCOs to provide subsidized benefits, as these carriers have experience providing benefits for low-income populations.

Will the Connector market unsubsidized plans? Will the Connector allow insurance brokers to work within the mechanism? These decisions will affect the number of people enrolled in the Connector, and its role in the larger insurance market.

How will the Connector set standardized benefits for all plans? Many purchasing pools offer a standardized benefit, and then allow individuals to choose among a few plans.[38] In doing so, the Connector can allow informed choice, with less consumer concern over inadequate benefits or considerable cost sharing. Will these plans be offered on the market outside of the Connector? Allowing the market outside of the Connector to offer plans may reduce potential distortion from providing robust plans that appeal to people with greater health needs only through the Connector. However, offering the same plans outside of the Connector may reduce enrollment in Connector plans.[39]

How will the Connector advertise, inform and provide outreach to consumers and small business about insurance plans? There should be a balance between undue administrative costs and providing adequate enrollment assistance to people about the Connector.

CONCLUSION

While Connectors are gaining attention across the country, they are not right for every state. For a state such as Maine that utilizes one insurance carrier and plan for its health reform program, a comparative marketplace of plans does not make sense. Additionally, without a strong public insurance system and private insurance rules allowing all to purchase coverage, a Connector will likely fail to increase access. Therefore, a state may want to consider private insurance reform before creating, or while creating, a Connector.

For policymakers who think a Connector will be a quick, inexpensive fix of the health care system, it should be noted that the Connector cannot significantly reduce the price of insurance on its own, but requires subsidies to make insurance affordable for families. Only working with public programs and private insurance rules, and with standardized benefits that ensure full coverage and limited cost sharing, robust subsidies, and enrollment assistance, can a Connector improve access for the uninsured. A Connector is not a cure for all problems of the health care system, but in the proper climate, it can help expand access to affordable health coverage.

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[1] Rose C. Chu and Gordon R. Trapnell. Study of the Administrative Costs and Actuarial Values of Small Health Plans. Small Business Research Summary. Small Business Administration, January 2003.
[2] See Massachusetts General Law, Chapter 58 of the Acts of 2006. On May 2, 2007, Governor Gregoire in Washington State signed legislation to alter the existing small business purchasing pool and create a pilot Connector mechanism, the Health Insurance Partnership. If the pilot is successful, this Connector will

become larger, and require participation by all small businesses. Accessed at: http://www.leg.wa.gov/pub/billinfo/2007-08/Pdf/Bills/Session%20Law%202007/5930-S2.SL.pdf

[3] Elliot K. Wicks. Health Insurance Purchasing Cooperatives. The Commonwealth Fund, November 2002.

[4] Stephen H. Long and M. Susan Marquis. Have Small-Group Health Insurance Purchasing Alliances Increased Coverage? Health Affairs, February 2001.

[5] Wicks, Health Insurance Purchasing Cooperatives, 2002.

[6] Ibid.

[7] In California, the purchasing pool offered lower premium prices in early years, but now mirrors the health premiums in the larger market. Florida's purchasing pool also had limited success in reducing premiums. See Long and Marquis. Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?.

[8] Nina Owcharenko and Robert E. Moffit. The Massachusetts Health Plan: Lessons for the States. The Heritage Foundation, July 2006.

[9] Ibid.

[10] Wicks, Health Insurance Purchasing Cooperatives, 2002 and Michael Miller. Access to Affordable Insurance for Individuals and Small Businesses: Barriers and Potential Solutions. Community Catalyst, June 2005.

[11] John Holahan et al. Roadmap to Coverage: Synthesis of Findings. Blue Cross Blue Shield of Massachusetts Foundation, October 2005.

[12] Ibid.

[13] Massachusetts has guaranteed issue with modified community rating (allows premium variation based on age, occupation, and geography). As of July 2007, MA also has an individual mandate.

[14] In Massachusetts, Medicaid and SCHIP cover children up to 300% FPL, parents up to 133% FPL, and people with disabilities to any income level. A new Medicaid-look-alike plan covers all adults under 100% FPL in the recent health care reform.

[15] Massachusetts General Law, Chapter 58 of the Acts of 2006; The Commonwealth Health Insurance Connector Authority. www.mass.gov/connector.

[16] The Connector is not yet linking all employees to their employer's Section 125 plan, but there are plans to do so in the summer of 2007.

[17] See Louisiana proposal. Judith Solomon. Health Insurance "Connectors" Should be Designed to Supplement Public Coverage, Not Replace It. Center on Budget and Policy Priorities, January 2007.

[18] As of July 2007, people with incomes below 150% FPL also pay no premiums; however, this group continues to have slightly less robust benefits than in the Medicaid look-alike for people below 100% FPL.

[19] Kaiser Family Foundation. State Health Facts, Managed Care and Health Insurance. statehealthfacts.org.

[20] To date, most states do not have guaranteed issue for non-group plans (only ME, MA, NJ, NY, VT). However, more states provide guaranteed issue in the small group market (only NV does not). Figures as of 2006. State Health Facts.

[21] Solomon. Health Insurance "Connectors," January 2007.

[22] Linda J. Blumberg. Addressing Adverse Selection in Private Health Insurance Markets. The Urban Institute, September 2004.

[23] For instance, a specific open enrollment period or waiting period to enroll can reduce the potential for people to purchase insurance only when it is necessary. A late enrollment surcharge both provides an incentive to maintain coverage and helps offset the cost of people who enroll only when they need services. Alternatively, a state could implement an individual mandate, and require all people to purchase insurance.

[24] Many states utilize "rate bands" rather than community rating. Rate bands limit the amount insurers can vary premiums based on characteristics such as health status or family composition, but in many cases, rate bands significantly increase premiums for people with chronic health conditions. See Families USA. Understanding How Health Insurance Premiums are Regulated, September 2006.

[25] This problem, called "list-billing," emerged in the Massachusetts Connector. Massachusetts allows insurers to vary premiums based on age, occupation, and geography. The Connector is currently attempting to remedy this problem, likely by having the employer choose a certain plan within a "tier" of benefits in the Connector. However, this fix will reduce the consumer's choice of plans and may increase the consumer's contribution. Based on author's conversation with Patricia Bull, Director of Commonwealth Choice, Connector.

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[26] The Commonwealth Connector Authority. Commonwealth Choice Focus Group Highlights. Author's conversation with Kevin Counihan, Commonwealth Connector Chief Marketing Officer, May 24, 2007.
[27] Lake Research Partners and American Environics. Herndon Alliance 2006 Research Summary, January 2007. Poll respondents spoke negatively about the numerous and confusing choices in Medicare Part D.
[28] Miller, Access to Affordable Insurance for Individuals and Small Businesses, June 2005.
[29] See Commonwealth Choice plans, www.mahealthconnector.org. In Massachusetts, the implementation of the individual mandate in 2007 may alter the insurance markets.
[30] Wicks. Health Insurance Purchasing Cooperatives, November 2002.
[31] Commonwealth Connector. Commonwealth Care Board Update, April 3, 2007 mass.gov/connector.
[32] Publicly funded reinsurance means the state takes on the risk for an insurer at a certain price point. For instance, a state may decide to assume the risk of insurers for people with a claim of $100,000 or more at 90%. This reduces the risk borne by insurers, and should reduce consumers' premiums. By only reinsuring policies within the Connector, funds can be targeted to reduce premium costs and increase enrollment in the Connector. See for example Washington State Health Insurance Partnership.
[33] Massachusetts requires employers with 10 or more employees to set up Section 125 plans (cafeteria plans) for employees to purchase insurance through pre-tax dollars, even if the employee does not have access to the employer's health plan. See Massachusetts General Law Chapter 151F.
[34] The Commonwealth Connector Authority. Affordability: Executive Summary Report from Board Meeting April 12, 2007. www.mass.gov/connector.
[35] For instance, Pennsylvania recently decided not to pursue a Connector, as only one plan would offered statewide through health reform proposal. Author's conversation with Michael Campbell, PA Legal Services. See also Dirigo Health Reform in Maine for pros and cons of using one insurer. Jill Rosenthal and Cynthia Pernice. Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine. National Academy for State Health Policy, June 2004. In addition, Vermont's recent health care reform uses multiple insurers, but offers one identical benefit option across all insurers.
[36] Chapter 58 of the Acts of 2006. Commonwealth Connector.
[37] Wicks. Health Insurance Purchasing Cooperatives, November 2002.
[38] The Commonwealth Connector Authority. Commonwealth Choice Focus Group Highlights. Also, Miller, Access to Affordable Insurance for Individuals and Small Businesses.
[39] In Massachusetts, plans certified by the Connector are also offered on the market outside of the Connector. Although there is early data on enrollment in non-subsidized plans through the Connector, no information is yet available on the number of people enrolling in the same plan directly through insurers outside of the Connector. See Commonwealth Connector, Connector Board Meeting June 5.