



Drawing Lessons: Different Results from State Health Insurance Exchanges

by Amy Lischko

Foreword

In Massachusetts and across the country, the Commonwealth's health care reform has taken on an exaggerated "persona"; for some, it embodies all that is evil about government intrusion into health care markets; for others, it exhibits all the virtues of government action.

The simple fact is that the reform is an experiment. It is likely to succeed on some fronts and fail on others. Given the early stage of our 2006 reform, we are now only starting to gain access to data on outcomes, and the series of years covered is often inadequate to making judgments.

State-level experimentation is needed to test and ultimately to drive the national debate on health care reform. As occurred with welfare reform in the eighties and nineties, robust experimentation allowed federal officials to draw important lessons from the successes and failures of a number of states as they sought a thoughtful national welfare reform bill.

It is undeniably premature to enact a reasoned national-level solution based on Massachusetts' or other state experiments. They have yet to be evaluated. In a field as complicated as health care, where government involvement is already considerable and where states have historically played a defining role, we need a sensible debate based on facts.

That's where *Drawing Lessons* and the upcoming *Interim Report Card* series of reports come in. *Drawing Lessons* compares and contrasts features of the Massachusetts' health insurance "Connector" to Utah's experience with a differently structured exchange. Pioneer's *Interim Report Card* series will be the first comprehensive assessment of the Massachusetts Health Care Reform Act, analyzing its impact on access, financing and affordability, administration, and cost-effective quality of care.

Pioneer has not yet taken a position on the reform act. We seek first to understand and measure its performance empirically. Only after publication of the Report Card series will we begin suggesting fixes and formulating a comprehensive position. The tone and substance of current federal proposals does not remotely resemble the quality of dialogue we need.

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Introduction

Policymakers are considering several options for national health reform, each of which includes some form of “insurance exchange.” These exchanges allow the uninsured, and employees of small to medium-sized businesses, to compare qualified health plans, purchase insurance and, if eligible, receive subsidies toward the cost of their plans. Two states, Massachusetts and Utah, have already established their own, independent insurance exchanges. Their experiences offer many valuable lessons for other states.

Massachusetts’ Commonwealth Health Insurance Connector Authority (Connector) was created by Chapter 58 of the Acts of 2006 as an independent quasi-governmental agency to implement key elements of the Massachusetts health reform law. The Connector serves many integral functions including management of both a state-subsidized insurance program called “Commonwealth Care” and an unsubsidized insurance program called “Commonwealth Choice.” The Connector was designed to assist both individuals and businesses in acquiring health care coverage through these programs, but also assumed numerous policy, administrative, and educational roles to facilitate effective implementation and execution of the overall health reform law.

Massachusetts and Utah have already established their independent insurance exchanges. Their experiences offer many valuable lessons for other states.

The Utah Health Insurance Exchange was established in March 2009 by HB 133 and HB 188. The laws directed the Office of Consumer Health Services to develop an internet-based information portal to connect consumers to information they need to make informed choices about health insurance. The overall goal of Utah’s exchange is “to serve as the technology backbone to enable the implementation of consumer-

based health system reforms.”¹ Small employers may offer “defined contribution” benefit plans through the exchange--reducing their administrative burden and making their annual cost for providing insurance more predictable. On the consumer side, three core functions were identified for the exchange: 1) provide consumers with helpful information about their health care and health care financing; 2) provide a mechanism for consumers to compare and choose a health insurance policy that meets their families’ needs; and 3) provide a standardized electronic application and enrollment system.

The following lessons from these two experiments point to opportunities and challenges that lie ahead regarding future exchanges. They suggest that allowing states flexibility in their execution of this new model will allow best practices to emerge.

Lesson #1: Where the exchange is housed, and under whose direct authority, will play a large role in shaping the culture, practice and effectiveness of the organization.

Utah and Massachusetts offer two distinctly different models for the governance, location of the exchange functions, and primary target populations. The Utah Health Insurance Exchange (UHIE) operates with just two employees within the Governor’s Office of Economic Development. Its location, under gubernatorial control and within an office that has a mission to promote the growth of Utah’s business community, small business in particular, has informed a good deal of the operational choices it has made. The eligibility standards for the Utah exchange initially include the phasing in of small businesses (2-50) and their employees over the first two years, with all businesses eligible to use the exchange by Fall 2011.

The size of the Utah staff dictated that much of the operational work of the exchange be done by private entities. Contracts for the system’s administrative and financial operation were negotiated quickly, with one-year renewal options to allow for flexibility and

modification in vendors and services. Utah's approach in developing its portal is to build on existing technology and work with the existing entities in the health care system to improve the technological interface with consumers.

Utah has developed a cooperative relationship with the business community and relied on significant, unpaid marketing and policy guidance from the private sector. The exchange does not have a board of directors. It does convene business leaders, primarily through the Salt Lake Chamber of Commerce, to solicit input and advice on its operations. In the way of outreach and education, the entire marketing budget for the exchange is \$10,000. The exchange has relied on brokers and business organizations to promote its use. Despite its meager budget and the lack of an individual or employer mandate in the market, demand for participation in the exchange's launch was enough to quickly fill the 100 employer slots allotted for its pilot phase and establish a waiting list of more than 150 for its next round of expansion.

The Massachusetts Health Insurance Connector Authority was established as an independent, quasi-governmental entity that is self-governing and a separate legal entity from state government. The Connector contracts with other state agencies and private businesses in fulfilling its responsibilities. The Connector is governed by a 10-member Board consisting of private and public representatives appointed by the Governor or Attorney General and chaired by the Commonwealth's Secretary for Administration and Finance. The Board approves most policy, regulatory and programmatic decisions at the discretion of the executive director, and generally meets on a monthly basis in a public forum. Massachusetts legislators invested significant decision-making authority in the Connector - which has largely performed both the regulatory and implementation duties for health reform in the Commonwealth.

But creating an entirely new organization to operate an exchange comes at a cost. The Connector's budget for FY09 was \$30 million. It employs about 45 people and pays an average salary of \$100,000.

There has been some criticism over the number of managerial positions created and the salaries paid to top leadership. Overall, the relatively "hands off" approach of the state's legislative and executive branch during the implementation of health care reform has empowered the Connector to act quickly and decisively. Although, it has concentrated major, system-altering decisions in the hands of a few individuals.

One of the fundamental decisions in establishing an exchange is whether it will be under the authority or influence of the state's health care or insurance agency. In Massachusetts, because of the visibility of the Connector as the entity championing health reform, the state's Division of Insurance ceded responsibility for many policy decisions to the new entity. The Connector is led by a former executive at one of the state's largest health insurance plans, but many of its staff are former employees of the state's Executive Office of Health and Human Services. The program is tethered closely to the MassHealth Medicaid program. MassHealth provides eligibility determination services for the Commonwealth Care program, which is similar in design to Medicaid, and until recently relied exclusively on the Medicaid Managed Care Organizations (MMCOs) that served MassHealth to provide benefits for Commonwealth Care enrollees as well (see below for more details).

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This has led to what many perceive as a bias toward the subsidized Commonwealth Care program. Although the Connector serves both individuals and small businesses, the focus has been, by far, on low-income individuals without access to employer-sponsored health insurance who are eligible to enroll in subsidized plans offered through Commonwealth Care. Over 90% of the revenue generated for Connector operations comes from the administrative fee earned by the Connector for administering the

Commonwealth Care population. The Connector board and staff have spent a majority of their time discussing and debating the decisions around affordability and benefit levels for the subsidized population. In comparison, little effort has been spent thinking about how to motivate the carriers to establish Commonwealth Choice plans that add more value for non-subsidized individuals or for small employers.

Lesson #2: The decision to place a subsidized population into a separate market at startup may be more politically acceptable; however, it may also prevent the population from transitioning to the competitive, private insurance market and cause unnecessary risk-segmentation.

Massachusetts offers one model for how to facilitate subsidies and the purchase of insurance for lower-income individuals through an exchange. The primary focus of the Connector has been on the subsidized population, which is its own risk pool and exists entirely within the Connector. When health care reform was passed in Massachusetts, leading policy makers in the Commonwealth and Washington wanted the subsidized plans to look more like the private market and less like Medicaid. Therefore, the role of purchaser and insurance distributor for the subsidized product, Commonwealth Care, was located within the Connector rather than the state's Medicaid program. However, that's where the private market influence ended.

During negotiation of the health reform bill, the safety net hospitals that served a majority of those receiving "free care" in the Commonwealth expressed a strong concern that they would lose the foundation of their revenue stream under a new insurance-based model—particularly since it was proposed that much of the state's Disproportionate Share Hospital (DSH) funding would be redirected to pay for Commonwealth Care subsidies. To address this concern, the final legislation granted the state's existing four Medicaid managed care organizations (MMCO's) (two of which were also safety net providers) the exclusive

right to serve this population for three years. A fifth carrier, Centene Corporation, was approved to offer Commonwealth Care coverage beginning July 2009. Centene was the only new insurer to formally pursue the opportunity when bidding was opened.

The lack of interest by the state's dominant not-for-profit insurers (e.g. Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan) and by national for-profit insurers in serving the subsidized population in Massachusetts is an indication that true competition and market forces have yet to take hold in this segment of the market. Premium increases for Commonwealth Care plans have been kept well below the average increases for private insurance coverage over the last decade. This is primarily a result of the captive nature of the relationship—specifically the dependence of the predominant Commonwealth Care carriers on various forms of state funding. Many believe that significant cost-shifting is still occurring among the various public programs and from public to private plans. Coupled with the strong political pushback on rate increases by the Connector board and the Governor, one can see why most of the state's mainstream insurers and national for-profit insurers have thus far taken a pass.

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This situation could create problems for Commonwealth Care recipients should they transition from subsidized care into private coverage. They will not only face the loss of the subsidy, but many will need to move to another carrier and face the relatively higher cost of the private insurance market, which is pooled separately and is not under the same rate negotiations as the Commonwealth Care program. States considering using exchanges for their subsidized populations will need to carefully

consider whether those receiving subsidies should be part of the larger risk pool and have access to mainstream insurance products.

Lesson #3: System capabilities including IT compatibility and connectivity can limit advances in administrative simplicity and bog down potential innovation.

One of an exchange's primary goals is to transform the purchase of insurance from a confusing web of paperwork to a transaction akin to purchasing an airline ticket online. In order to achieve this, all transactions need to be fully integrated and automated to reduce paperwork, improve system and supply chain efficiency, and increase customer satisfaction. That means that brokers, consumers and employers should be able to compare price and quality information across plans and providers, get quotes, conduct cost-benefit analysis across plan types, combine payments from different payers, pay premium, and enroll in a plan, all via an electronic interface.

In Utah, three of the largest insurers in the state are currently participating in the new defined contribution market through the exchange. Other carriers expressed interest in participating in the launch but were unable to because of internal technology challenges. On the web portal side, the exchange has taken a relatively open approach to the addition of services and functions to its site, which has allowed for an expansion of offerings--even in the short period of time for which the site has been operating.

Massachusetts faced significant technological challenges in both its Commonwealth Care and Commonwealth Choice programs. In fact, the two programs remain operationally separated with distinct vendors responsible for enrollment, customer service, quality assurance, and billing.

In order to get systems up and running quickly, the Connector initially made the decision to purchase services for Commonwealth Care from existing

Medicaid vendors. Immediately there arose a number of billing system challenges, stemming from the fact that Commonwealth Care had a variety of benefit and co-payment structures, which were hard to align with Medicaid's much more standardized billing process. The challenges included the vendor's inability to process accurate monthly premium bills for Commonwealth Care consumers who frequently churn through the system and the renewal process for individuals, which was to many cumbersome and confusing. In addition, the close linkage with the Medicaid program (particularly around eligibility) made it difficult to provide accurate, understandable correspondence to members regarding eligibility and benefits.

Challenges in the Commonwealth Choice program included shortcomings in the initial billing system, which did not allow for e-payment of premiums (an electronic pay system was subsequently set up in Spring 2009). In addition, no technology currently exists for accepting premium payments from multiple sources, such as two spouses or from contributions from multiple employers. The small group employer contributory plan pilot had a very rocky launch due to problems with the program's website and the provision of information to brokers.

Finally, the Connector has thus far failed to provide detailed information relevant to not only health care financing choices, but also quality and transparency of the health care provider system. In Massachusetts, transparency of provider cost and quality information under the state's health reform law was delegated to an organization outside the Connector--the newly established Health Care Quality and Cost Council. As a result, consumers do not have access to fully integrated cost and quality information for insurance plans and providers through the Connector. Information on provider networks and participating primary care providers has just become available on the Connector's website at the end of its third year in operation.

Technology challenges exist for states interested in facilitating a model which transforms the purchase of health insurance from the employer to the individual.

How and with whom the state contracts for these services can make a big difference in the launch and ongoing capabilities of an exchange.

Lesson #4: Small businesses are seeking “added value” through the use of an exchange, including assumption of HR functions, a predictable cost structure (defined-contribution program) and the ability to remove themselves as the middle man in insurance plan selection.

An exchange can operate as a distribution channel for small businesses seeking insurance for their workforce and introduce greater portability, affordability and choice in the small employer insurance marketplace. It can be established as an optional or exclusive distribution channel and Massachusetts and Utah offer two models for discussion.

Technology challenges exist for states interested in facilitating a model which transforms the purchase of health insurance from the employer to the individual.

The need for increased affordability in the small group market in Massachusetts was acknowledged as an important goal for health reform. Choice and portability were also values that the bill’s original architects thought were important. While the Connector began offering a voluntary (non-contributory) insurance program for employees without access to employer sponsored insurance (ESI) in September 2007, its small employer program did not launch until December 2008, and only on a pilot basis.

The Contributory Plan, as it is called, allows small employers with 50 or fewer full-time employees to subsidize their employees’ purchase of health insurance through the Choice program. During the pilot phase, the plan is only available through certain

pilot brokers. An employer selects a level of plan for their employees (Gold, Silver or Bronze), agrees to pay at least 50% towards the employee premium (and meet employer participation rules), and a base employer contributory amount is set based on the employer’s selection of a plan within a coverage tier. Employees can then take that base employer contribution and select any carrier’s plan within the tier of coverage selected by the employer, but they may not buy a product outside the tier selected by their employer.

As of now, the small group contributory plans do not provide for greater predictability for employers as Massachusetts chose not to include a defined contribution method. Moreover, plan offerings are quite limited and similar to those available in the marketplace prior to reform. Because employers must choose a tier of coverage, their employees are not provided with as much choice as they may desire. These factors, plus consistent, double-digit increases in annual premiums, have combined to make this aspect of the Connector’s mission its least successful to date.

An exchange can operate as a distribution channel for small businesses seeking insurance for their workforce and introduce greater portability, affordability and choice in the small employer insurance marketplace.

Although more than 20,000 individuals have signed up for coverage through Commonwealth Choice program, 90 percent of these enrollees have entered the market as individuals. In other words, three years into the state’s reform effort, fewer than 150 employees of small businesses are receiving coverage through the Connector. This can be explained, in part, by the fact that early emphasis was placed on enrolling lower-income individuals. Still, the results are disappointing and reflect an overall inability to attract employers to the Connector’s model.

Meanwhile, rates for businesses under 50 employees have increased by double digits in each of the last two years, enough so that Massachusetts Governor Deval Patrick has announced he will file legislation to expand the state Division of Insurance's authority over health insurance premiums, allowing it to review insurance rates for small businesses before they go into effect and adjusting them if they are deemed "excessive" or "unreasonable." Currently, the Division of Insurance (DOI) does not have the authority to review health insurance rates before they go into effect. The DOI is also evaluating options that could possibly allow small businesses to join together to increase their purchasing power to buy health insurance. It is clear that health care reform and the Connector's model for small employers has not addressed the central issues of affordability and predictability for small employers.

An exchange can be established as an optional or exclusive distribution channel and Massachusetts and Utah offer two models for discussion.

In contrast, the Utah Exchange's biggest drawing card is that it is the only outlet through which employers can establish and fund a defined contribution plan for their employees. Although any individual is able to use the exchange to compare plans, the system was primarily designed for small employers, allowing for comparison, enrollment, premium determination, billing and collection. Employers determine how much they will contribute toward employees' premiums and then establish accounts for them with the exchange. After collecting limited health histories from all employees, the exchange creates a risk premium for the employer and applies it in determining the individual's final premium. Once this is completed, the employee can choose from among the 66 plans offered through the portal. It is too early to tell whether Utah's model will be successful at constraining health care costs for small employers and provide greater choice and portability for employees. However, their decision to extend two

of the most important factors in creating a sustainable exchange - exclusivity and predicability of cost - is promising.

Lesson #5: An exchange with limited product choice for individuals that exists side by side alternative distribution channels should, at a minimum, develop robust consumer information and administrative support in the area of customer service.

An important question for policymakers is how to position an exchange within the existing distribution channels in a state. Will it be an alternative to, work closely with, or subsume the current channels?

The Connector has been most successful in enrolling people in products where the statute deemed it to be the exclusive distributor, that is, in the subsidized Commonwealth Care program and the "young adult marketplace," where carriers may offer plans with more limited benefits to individuals aged 18 to 26. For small employers and non-subsidized adults over 26, it has not made significant progress. Many eligible individuals continue to purchase their insurance outside the Connector.

Since reform began, fewer than half of the 46,000 new enrollees in the un-subsidized, non-group market, have purchased their coverage through the Connector. In some cases this is because they require more assistance in purchasing insurance than the Connector's web-based tool allows. Although the Connector has an established customer service center, they primarily rely on a web-based model for shopping and enrolling in coverage. Consumers who need more guidance for their insurance purchase typically call the carriers directly to obtain individualized support and then enroll from there.

In addition, there is a wider choice of products for individuals outside the Connector. Some carriers offer products that either have not been approved or renewed by the Connector. For example, the authority has developed its own "seal of approval" process through which plans offered through the exchange

must meet higher standards in terms of benefit levels than those already in place for the state's overall insurance market. The Connector conducted focus groups with consumers purchasing in the non-group market and found that consumers generally wanted fewer, more meaningful product choices. That, in combination with the Board members' overall belief that standardization is important, has prompted the Connector to further reduce the number of options available to consumers through the Connector. However, if consumers continue to purchase products offered outside the Connector with greater frequency than inside, the Connector may need to evaluate whether this is a sustainable model.

States considering using an exchange as a distribution channel for individuals can learn from Massachusetts. Experienced staff who have the necessary IT expertise and understand the commercial health insurance market are essential for developing decision tools that present choices to consumers in a way that is easily understood. Licensed health insurance agents are required to provide excellent real-time customer service to individuals requiring additional support for the entire transaction.

Lesson #6: Broker, provider and carrier support for reform is essential to success, both in passing exchange legislation and implementing a functional exchange.

One of the lessons learned from earlier versions of small business purchasing cooperatives was the importance of harnessing broker, provider and carrier support.^{2 3 4} Other states are advised not to underestimate these key stakeholders' influence in maintaining the status quo. Massachusetts and Utah again offer two approaches to consider.

An important barrier to the Connector's success has been resistance from brokers and carriers. An inability to tap the broker and payer networks more effectively in Massachusetts has resulted in continuing difficulties for the Connector, particularly in the small group market. Brokers make more money from a carrier if they bring an employer to a single

carrier versus sharing the administrative fee with the Connector. Brokers also tend to concentrate volume with particular carriers because their commissions go up with volume and there are significant retention incentives.

Although one could argue that it is less work for the broker to bring the employer to the Connector, as the Connector assumes some of the administrative responsibilities, thus far that has not been a persuasive argument. In fact, brokers have remarked that it is more work explaining to employers how this new model operates. Before passage of the reform law, brokers had saturated the Massachusetts small employer market with long standing, trusted relationships. Brokers are often responsible for the multitude of administrative tasks involved with purchasing insurance coverage, including explaining any changes in state or federal law that apply to employers, processing paperwork, and providing human resources support. It seems likely that the Connector needs to offer improvements in broker connectivity and other incentives in order to become a major player in the distribution of insurance to small employers.

Experienced staff with necessary IT expertise and knowledge of the commercial health insurance market are essential to presenting choices in a consumer-friendly way.

Massachusetts carriers also remain skeptical of the Connector and continue to provide and promote direct service to employer groups for administrative and risk selection reasons. The carriers with more market share have the most to lose if the Connector becomes a significant distribution channel for the small employer market. Not only will those dominant carriers give up margin and market share, they will disrupt broker relationships. Moreover, carriers are understandably risk averse and are afraid that if given choices, employer groups will segment themselves in a way that will result in adverse selection. Carriers have not, for the most part, delivered on developing

narrow network plans which would be more affordable and more attractive to small employers in an exchange model. Carriers greatly influenced the Connector to begin with a pilot program for its Contributory Plan for small employers, and to allow employee choice only within a tier of coverage.

Without the individual mandate or subsidies provided for in Massachusetts, policymakers in Utah realized that support for the initiative from the state's insurance brokers was a key element to their future success. Exchange staff developed strong relationships with brokers in designing and implementing their reform plan. Early feedback indicates that consistent, ongoing communication with and guidance from brokers, insurers and the business community has contributed to the enthusiastic reception the Exchange has received.

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The Utah Exchange has addressed the risk concerns of carriers head-on by developing a risk-adjustment methodology and implementing the program in a pilot fashion. This has occurred in what is arguably a more complex environment as Utah allows for rate adjustment for the health of an employer group in Utah while Massachusetts does not. However, only three of the nine carriers operating in the State are offering products in the Exchange during this pilot phase. It will be interesting to watch whether offering a defined contribution model with employee choice will be enough to attract a large number of employers to this new distribution channel.

Many opportunities exist to streamline the way insurance is designed, purchased, and used. An exchange typically touches all of these aspects. Part of what makes an exchange appealing is that it offers hope that the way health care is delivered can be changed. Being mindful of these important lessons

moving forward, states should be allowed flexibility in implementing exchanges so that policymakers can learn what does and doesn't work.

Endnotes

1. From online brochure, accessed 11/09: <http://exchange.utah.gov/brochure.html>
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