Fixing the Massachusetts Health Exchange

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This paper is a publication of the Health Care Initiatve, which is focused on Medicaid and Health Care budget busters, specifically the cost of Medicaid programs, and long-term care and insurance reforms, cost containment by providing ideas to help businesses, large and small, compete by reducing their health care costs, and tracking the progress of the landmark Massachusetts health care reform.

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Amy Lischko, Ph.D.

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Introduction

The 2011 Massachusetts health care landscape, while significantly altered, is still facing the same core issue as in 2006 of increasing costs. The 2006 law has delivered on many of its promises, but has failed to achieve affordability and choice for health insurance coverage for many residents in Massachusetts.

The Commonwealth Health Insurance Connector Authority (Connector), the exchange entity responsible for implementing the health reform law, was designed to assist both individuals and businesses in acquiring affordable, high-quality health care coverage. The Connector operates both the state-subsidized insurance program called "Commonwealth Care" and the unsubsidized insurance program called "Commonwealth Choice." The Connector was granted and fulfills a comprehensive slate of policy, administrative and educational roles.

Why does the Connector Matter? National & Local Implications

The question of how well the Connector is delivering on the original promises of the health reform is certainly important to Massachusetts residents, especially the indigent and small business employees who previously were uninsured. It is also important to the state's budgetary health and to small business employers, both of which are beset by spiraling health care costs, in turn crowding out core public programs and important private sector investments.

Pioneer Institute has released a series of reports over the past 18 months assessing the success of reform in increasing access, providing equitable and sustainable financing, achieving administrative efficiency, and yielding cost effective quality care.[1] The goal in commissioning these reports and engaging in this debate is to fix what is not working in the Massachusetts reform and to highlight what is.

The importance of this work is especially clear as the Patient Protection and Affordable Care Act of 2010 (ACA) requires a health benefit exchange to be operating in every state by 2014.[2] The question of the Connector's effectiveness is of critical importance to other states as they try to plan and design what an exchange will look like in their own state.[3] For Massachusetts, the ACA provides both opportunities and challenges moving forward.

Has the Massachusetts Connector been Effective?

T he Connector has been successful in providing free or near-free care to 158, 973 of the under 65 population in Massachusetts, which has helped to reduce the uninsured rate to the lowest in the country. The Connector has been less successful at enrolling non-subsidized individuals and businesses. Improving the insurance market by changing how insurance is purchased and putting the consumer in control of insurance decisions does not appear to have been a priority for this administration or the Connector. As a result, officials have not seen dampening of premium costs, and the affordability of insurance is becoming a serious concern for an increasing number of individuals and small businesses. In order to broaden the Connector's success beyond the subsidized population, a comprehensive evaluation and a change of course are needed. The seven ideas offered here are a starting point to move the Connector towards fulfilling reform's original promise of greater value for small businesses along with a more patient-centered health insurance market:

1. **Increase Customer Base: Build Commonwealth Choice**
2. **Fix the Small Business Program: Empower Individuals**
3. **Increase Product Innovation**
4. **Encourage Wellness: Learn from Private Exchanges**
5. **Increase Portability and Continuity of Coverage**
6. **Streamline Operations and Benefits for State Programs**
7. **Reconfigure the Membership of the Connector Board**

Reform Starts with the Connector

On April 12, 2006, Chapter 58, "An Act Providing Access to Affordable, Quality, Accountable Health Care" was passed to reform the Massachusetts health care system. The goals of the legislation were to make health insurance affordable to most every resident and to establish mechanisms to help control health care inflation.[4] The legislation was the product of over two years of work by administration officials, legislators, health care providers, insurers, and consumer groups. The law reformed health care by focusing on the role of the individual within the system. Specifically, the act modernized health insurance laws, eliminated some of the barriers to purchasing health insurance, transitioned existing government assistance from hospitals to the individual in the form of subsidies, encouraged personal responsibility, and attempted to contain health care costs.

[T]he ACA provides an opportunity for Massachusetts policymakers to revisit decisions made during the drafting or implementation of the state-level reform where gaps exist.

A key element of the Massachusetts law was the establishment of the Commonwealth Health Insurance Connector Authority (Connector). The Connector is a health benefit exchange with an independent, quasi-governmental governance structure including an executive director and a 10-member[5] board. The Connector was designed to assist individuals and businesses in acquiring affordable, high-quality, health care coverage through these programs, but it also assumed numerous policy, administrative, and educational roles to facilitate implementation of the overall health reform law.

The Patient Protection and Affordable Care Act of 2010 (ACA) requires states to establish exchanges similar to the Connector for individual and small group purchasers (defined as employers with 100 or fewer employees).[6] For states unwilling or unprepared to manage this responsibility, the federal government will step in to design and operate an exchange for them. The law specifies some parameters for these exchanges but leaves many details to the guidance of the Health and Human Services Secretary (HHS). Because the law provides some flexibility to states, and Section 1321[7] provides some exemption assurance to the Commonwealth from many of the exchange requirements , the scope and design of Massachusetts' exchange – the Connector – may remain largely intact.

For several reasons maintaining the status quo is not advisable for the Commonwealth at this time. First, the ACA provides an opportunity for Massachusetts policymakers to revisit decisions made during the drafting or implementation of the state-level reform where gaps exist. Officials should evaluate how well the Connector is working at meeting all of its original goals and make necessary changes. Second, the federal government will provide funding to states to establish their exchanges, so to the extent that the Commonwealth wants to make significant infrastructure changes, these improvements can be funded by the federal government. Finally, at least one ACA provision – the expansion of Medicaid eligibility to people with incomes up to 133% FPL – will present significant challenges for the revenue structure of Massachusetts' Connector necessitating considerable modifications to the Connector's approach.

As previously documented in Pioneer's report card series,[8] certain aspects of Massachusetts' reform have not been as successful as others. In particular, small employers continue to feel the burden of rising premiums while the Connector has not provided a good alternative for them. This issue brief highlights changes the Commonwealth can make to its reform (while implementing the ACA) that can help address the needs of small employers and create a more sustainable exchange for the Commonwealth moving forward.

1. Increase Customer Base: Build Commonwealth Choice

The Connector was envisioned as a new marketplace for individuals and small businesses to purchase affordable health insurance and was never meant to serve only subsidized individuals. The Connector has had success in enrolling low-income individuals into subsidized plans, particularly individuals in the lowest income category (up to 150% FPL) who are not responsible for any premium cost-sharing. However it has been less successful at providing an alternative distribution channel in both the non-group and small group markets.

86% of Connector's operating revenue is derived from the fee to enroll Commonwealth Care enrollees.

The Connector receives operating revenue for every person it enrolls into insurance coverage. This "administrative fee" is calculated as a percent of the premium and built into the overall premium rate.[9] Thus, in addition to the $25 million received in start-up funds from the legislation, the Connector was immediately able to obtain significant operating revenue based on the Commonwealth Care members it enrolled. As shown in Table 1, about 86% of Connector's operating revenue is derived from the fee to enroll Commonwealth Care enrollees.[10] This fee is paid by both state and federal dollars.

Enrolling subsidized individuals was initially a less daunting task than trying to attract individuals and small employers to a new distribution channel. At the time the reform was passed, the state already had in place a single eligibility portal for Medicaid, SCHIP and the state's safety net program – the Uncompensated Care Pool. Most of the state's safety net program users were in the "system" already and were therefore relatively easy to enroll into the new Commonwealth Care subsidized program upon its initial launch. In fact, tens of thousands of residents who had been receiving medical services through the state's Uncompensated Care Pool prior to reform were transferred to the Commonwealth Care program in late 2006 and early 2007.

Although the Connector has engaged in innovative marketing, outreach and educational strategies to enroll eligible individuals into its programs, these efforts have not attracted large numbers of non-subsidized people and have been very costly – over $5 million in marketing and outreach expenses in the first year alone. Excluding individuals purchasing Young Adult Products (which, in addition to the subsidized population, the Connector has exclusivity to sell), only 19,331 non-group purchasers (about half of individuals newly purchasing in the non-group market) are purchasing through the Connector. As of February 2011, only 164 employees of small employers were enrolled in the Contributory Plan (CP) and 2,275 employees were enrolled in the Business Express Plan (BE) (for more on CP and BE see the Fix the Small Employer Program section).

As implementation of the ACA moves forward, nearly 60% – roughly 95,000 enrollees – currently enrolled in Commonwealth Care will be transferred out of the Connector into Medicaid. The Connector will lose the administrative fee for those members, and as a result almost $11 million dollars.

Federal Law Challenges:

As implementation of the ACA moves forward, nearly 60% – roughly 95,000 enrollees – currently enrolled in Commonwealth Care (people earning <133% FPL) will be transferred out of the Connector into Medicaid. The Connector will lose the administrative fee for those members, and as a result almost $11 million dollars. The revenue projection for the Connector for Commonwealth Care in FY11 was $26,946,851.[11] A reduction

Table 1. Connector Administrative Budget, FY 2010

	FY 2010 YEAR-END ESTIMATE			
	December 2009	May 2010	Variance	
REVENUE				
Commonwealth Care	27,638,906	27,757,843	118,937	0%
Commonwealth Choice	3,789,131	4,490,084	700,953	18%
Bridge	–	–	–	NA
Investment Income	149,558	135,160	(14,398)	-10%
Miscellaneous	10,178	41,718	31,540	310%
TOTAL REVENUE	**31,587,773**	**32,424,805**	**837,032**	**3%**

Bridge is a state-subsidized health insurance program for special status legal immigrants who lost CommCare coverage on August 31, 2009 because of changes in state law. Commonwealth Care Bridge, offers most of the benefits of Commonwealth Care, but does not include dental, vision, hospice, or skilled nursing care.

of 60% would reduce that revenue figure to just over $16 million. The Connector will gain some new members as the ACA increases eligibility for subsidies from 300 to 400% of the FPL. However, it is unlikely that there will be enough new members to balance the loss, since many people at this income level have access to affordable employer-sponsored health insurance.

This loss in revenue will significantly impact the Connector's operating budget. The Connector needs to aggressively focus its efforts on attracting private sector purchasers in order to remain a sustainable model into the future.

2. Fix the Small Employer Program: Empower Individuals

Small employers comprise a limited proportion of the lives insured by the Connector. As shown in Figure 1, as of December 2010 – the latest available data from the Connector's website – employees of small employers make up only 1.2% of the total Connector membership, and .3% of the total health insurance market for small companies in the state.[12] There are several explanations for this situation.

Design and Implementation Issues:
First, the launching of the small business model or the "Contributory Plan" was delayed until early 2009. It ran for a little over a year before closing its doors to new business in February 2010.

The program used an overly complex model with choice only permitted within an actuarial level (i.e., one of the "metallic" tiers – gold, silver or bronze). Participating employers selected a level of plan for their employees, and a base employer contributory amount was set depending on the employer's selection of a plan within that coverage tier. Employees then took the employer contribution and were restricted to selecting any carrier's plan within that tier of coverage. Because employees could not buy a product outside the tier selected by their employer, the employer still controlled the primary health care decision for its employees. In other words, the result was that a single 25-year old was essentially forced to purchase coverage similar to a 55-year old person with four kids, an opposite outcome of the intent of reform.

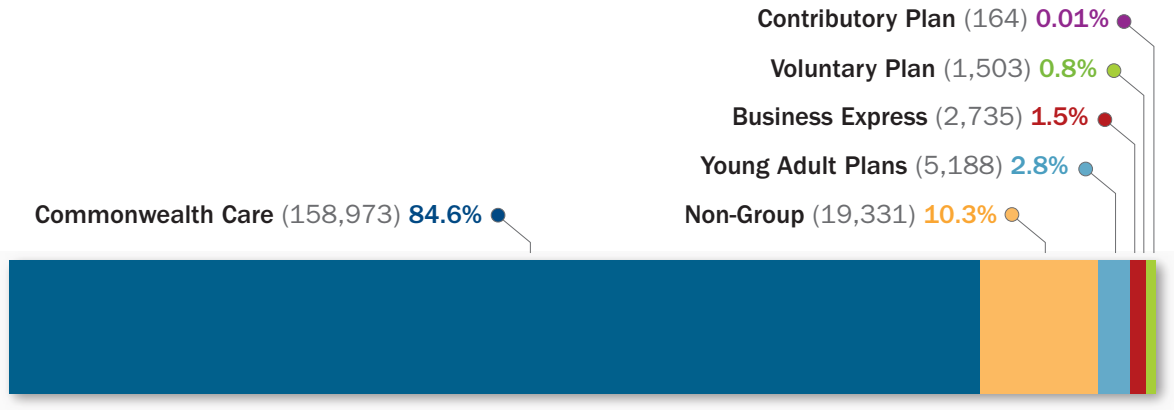
In addition, the Connector required employers to meet the same requirements that were in place in the market outside the Connector, that is, to pay at least 50% towards the premium and meet employer participation rules.[13] This requirement overlooked the fact that these barriers were identified before the reform as reasons some smaller employers couldn't offer health insurance.

Finally, the Connector limited the number of brokers who could sell this product in the state to 20, as well as restricting the client marketing pool. Enrollment take-up during this period was, not surprisingly, extremely low. The program closed its doors to new business only a year after its launch, without much explanation as to why. At the time, the 360 employer members were pleased with the choice model[14] and it posed no problems with respect to adverse selection, something carriers were initially worried about. According to a survey of participants,[15] 81% of employers felt the choice component was important or very important to the small employer offering, and 91% of employees enrolled in the program liked or really liked the ability to choose a product lower than the base product and keep the savings.

The Connector has since focused its small-employer efforts on another program, called "Business Express." The primary focus of Business Express is reduction of membership costs for small businesses that purchase insurance through the Small Business Service Bureau (SBSB), the administrator for the Connector's Choice products. While this program offers employers a small reduction in enrollment fees, it does not allow employees any choice of product. In addition, the option of carriers is extremely limited at this time. Business Express is currently operating without any of the major carriers (i.e., Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan, and even Fallon Community Health Plan) offering a product. Although this was an easy program for the Connector to launch – it simply had to negotiate a reduced fee with its vendor SBSB – it is unclear what long-term value is offered to small employers or their employees. The deal has led to a phased transfer of SBSB clients into the Connector and is the primary reason for a slight increase in the number of small employers purchasing insurance within the exchange.

There is currently a lack of clarity regarding how much flexibility states will have in implementing the Small Business Health Options Program (SHOP) per the ACA; however, it is clear that lawmakers wanted SHOP to facilitate some employee choice. The Connector needs to reinstate its choice model but should consider features such as allowing employers to use a defined contribution,[16] offering employee choice across all products, adding a premium aggregator that can collect premiums dollars from multiple sources (part-time jobs, spouses), eliminating participation and contribution barriers, and opening the program to all brokers and all small employers. Such a model could provide greater choice for employees, valuable predictability for small employers, and possibly help to reduce overall cost trends through greater consumer engagement.

Figure 1. Distribution of Connector subscribers, 2nd Quarter 2011



3. Increase Product Innovation

With the exception of the Young Adult Products, the health insurance products offered through the Connector are the same products that have been and still are offered on the outside market. The Connector initially tried to motivate the carriers to innovate around select and tiered networks. For the most part, carriers did not respond creatively to offer better value and more innovative product choices to individuals and small businesses. One exception was the introduction of a prescription product that incorporated an upfront deductible on branded drugs but excluded generic drugs. However, the Connector limited the number of products that could be sold by each carrier through its venue, and required standardization of products. These actions likely stifled innovation on the part of carriers.

The Connector needs to reinstate its choice model but should consider allowing employers to use a defined contribution, offering employee choice across all products, adding a premium aggregator, eliminating participation and contribution barriers, and opening the program to all brokers and all small employers

The Connector could offer products that employ value-based insurance designs (V-BID). According to the University of Michigan's Center for Value-Based Insurance Design, the goal of V-BID is to structure health plan design elements to optimize patient health through increased utilization of evidence-based health care services. V-BID lowers financial barriers to high-value services and provides disincentives for low-value care.

The Connector briefly explored offering V-BID products[17] and held down lower co-payments for generic drugs for diabetes, high cholesterol and hypertension for Commonwealth Care members as other generic drug co-payments were increased. However, the Connector did not pursue a robust V-BID strategy for either the Commonwealth Care or Commonwealth Choice programs.

The Connector could help to facilitate these designs for small employers and could even manage the program for interested individuals. Enrollee incentives might include rewards, reduced premium share, adjustments to deductible and co-pay levels, and contributions to fund-based plans, such as Health Savings Accounts.

The Connector is a perfect testing ground for these innovative programs to determine whether they can add value for individuals and businesses by improving quality and driving cost savings.

The Connector could also offer additional services to members that would encourage them to use cost-efficient providers and services. They should look to product innovations such as Compass SmartShopper™ that target high-volume elective procedures and diagnostic tests – procedures that are planned well in advance and not considered high-risk such as mammograms and colonoscopies – and direct enrollees to lower cost providers. Shared savings are another feature of this program, with participating employees gaining access to gift cards and cash rewards for choosing cost-effective providers. The Connector could establish a program that allows beneficiaries to participate in shared decision-making programs for care that is costly and where no proven course of action exists. These programs have been shown to both increase patient satisfaction and reduce cost trends, but have been largely untapped in the Massachusetts marketplace. The Connector is a perfect testing ground for these innovative programs to determine whether they can add value for individuals and businesses by improving quality and driving cost savings.

HealthPass, a small exchange in New York City, offers several services to its employer members in this regard. Its Health Advocate program uses registered nurses to help guide members through questions regarding claims, health care bills, authorizations, finding doctors and hospitals, and even scheduling specialists. Another program offered by HealthPass, Medical Cost Advocate, negotiates medical charges directly with health care providers (hospitals, physicians, labs, etc.) to reduce employees' high-deductible health plan medical expenses.

The Connector should assess innovative programs and services that could be of value to price-sensitive small employers and individual consumers, and determine which offer the best opportunities for bending the cost curve in the Massachusetts marketplace.

4. Encourage Wellness: Learn from Private Exchanges

Although some carriers offer modest wellness programs (reduced gym and/or WeightWatchers programs) as part of their general benefit packages, the Connector has not aggressively advocated for the plans in the Commonwealth Care or Commonwealth Choice programs to offer wellness benefits for its members. In fact, Massachusetts has lagged behind other states in encouraging wellness in the health insurance plans it oversees. For example, while many state employee plans adopted wellness programs in the mid 2000s – including health assessments and monitoring, health insurance incentives (ranging from discounts for nonsmokers to financial rewards to workers who reach personal health and fitness goals) and physical fitness programs such as fitness challenges[18] – the Commonwealth's Group Insurance Commission (GIC) still does not provide any of these programs. The National Council of State Legislature's website summarizes legislative action from 2006-2010 regarding wellness initiatives, and 34 states show some activity around this issue, with Massachusetts notably missing.[19]

Although the Connector will be launching a wellness program for small employers with lower income employees beginning this summer, this was not the Connector's initiative; rather it was required by statute, Chapter 288 of the Acts of 2010. This program will apply to only a very narrow segment of the Connector's members. It is available to employees (but not their dependents) of small employers with average wages of less than $50,000. There are currently only 2,439 employees overall enrolled in the small employer program(s). Even if all were income-eligible, it would have a small impact and reach a sliver of the small employer community.

The National Council of State Legislature's website summarizes legislative action from 2006-2010 regarding wellness initiatives, and 34 states show some activity around this issue, with Massachusetts notably missing.

Not all exchanges have taken such a laissez-faire approach to wellness initiatives. The Connecticut Business and Industry Association (CBIA) Health Connections, a private-sector employer exchange which has been in operation for over 15 years, has fully embraced the wellness movement with its new "Healthy Connections" programs. CBIA's website[20] provides a tremendous amount of information for employers including research findings on how employers can realize a return on their investment by implementing employee wellness programs. Health Connections is one of the most successful multi-vendor health insurance purchasing alliances in the country. It offers comprehensive benefits to employers including plan of choice for owner and employees, never needing to switch health plans, consolidated administration, and global budgeting. Most importantly, Health Connections stays abreast of market changes and anticipates the needs of businesses. Similarly, HealthPass in New York City offers every employer member a suite

of discount and wellness programs from all participating carriers.

The Connector should carefully consider its implementation of the wellness legislative mandate and view it as an opportunity to attract small businesses to its distribution channel by adding value to small employers' purchase of health insurance. It can learn from other small business exchanges for ideas about how to best incorporate these wellness features. It should also consider offering certain wellness features in the other plans it oversees.

5. Increase Portability and Continuity of Coverage

At the time the 2006 state law was passed, there was a desire by policymakers to have the Connector subsidize plans to look more like the private market and less like Medicaid. There were a number of decisions made in statute in Massachusetts that led to little to no improvements in portability or continuity of coverage. This is true both for people transitioning from subsidized to nonsubsidized coverage as well as for people transitioning from employer-based coverage to non-group coverage.

First, the statute was far too prescriptive regarding which managed care organizations (MCOs) could offer the subsidized product, precluding any carrier who was not currently offering coverage through the Medicaid program from participating for a period of three years.[21] The statute also required a very generous benefit package for the lowest-income beneficiaries. This meant that anyone transitioning from subsidized to non-subsidized coverage would most likely need to change plans and carriers.

Second, the legislation required the risk pool for the Commonwealth Care population to be separate from the overall non-group market. Rates for Commonwealth Care were actively negotiated by Connector staff, whereas Commonwealth Choice rates were kept at market levels. Similarly, the premiums charged to beneficiaries in Commonwealth Care were not age-adjusted while those in Commonwealth Choice were. The effects of these two rating issues would mean that people transitioning from subsidized to nonsubsidized coverage would face a large price differential even if the benefits were the same.

[A]nyone transitioning from subsidized to non-subsidized coverage will most likely need to change plans and carriers…. [and] would face a large price differential even if the benefits were the same.

Table 2 illustrates this situation for a representative Boston-based Commonwealth Care enrollee. This person is currently subsidized by Commonwealth Care and is in the highest income category, and thus is most likely to transition onto a Choice plan (250.1% to 300% FPL). This person is enrolled in one of the plans offering coverage both in Commonwealth Care and Commonwealth Choice, paying a monthly premium of $151 no matter what their age when subsidized in Commonwealth Care. If this person moves into a slightly higher income category, requiring them to leave Commonwealth Care, this person would be expected to pay between $331 - $404 monthly if they are 35, and between $493 - $602 if they are 50 years of age for a similar benefit. This problem would be further exacerbated for couples or families coming off subsidized coverage.

Should the Commonwealth choose to pursue such changes, this differential can be mitigated by the ACA in two ways. First, subsidies are less generous in the federal law and transition up to 400% FPL, both of which should provide for a smoother transition between subsidized and nonsubsidized insurance. Second, the plans available to subsidized individuals will be fully private plans with merged risk pools using the same carriers for both subsidized and

Table 2. Comparisons of Premiums

	Commonwealth Care		Commonwealth Choice	
Family Size	Income 250.1–300% FPL Age = 35	Income 250.1–300% FPL Age = 50	Income >300% FPL Age = 35 non-group	Income >300% FPL Age = 50 non-group
1	$151	$151	$331 – $404	$493 – $602
2	$302	$302	$953 – $1,164	$1,097 – $1,340
3	$302	$302	$1,374 – $1,678	$1,582 – $1,932

Table Notes: Premiums downloaded from Connector website for coverage date beginning February 1, 2011 for a 35 year old and 50 year old Boston resident in Neighborhood Health Plan. Commonwealth Care Plan is in-between Silver-high and Gold Commonwealth Choice plans. The

unsubsidized coverage and thereby ensuring product and premium consistency.

It is unclear whether the Connector will be required to implement these changes per the ACA or be allowed to maintain its current status. The Connector should carefully weigh the benefits of portability and continuity of coverage with any benefits deemed important to keeping the status quo. Other opportunities exist for improving portability and continuity of coverage, including ensuring that Medicaid plans, both in terms of benefits and cost sharing, are similar to Connector plans, maximizing the number of employers purchasing through the Connector, and to the extent possible, making sure the SHOP and individual exchange are coordinated.

6. Streamline Operations and Benefits for State Programs

The Commonwealth missed several opportunities to coordinate its health insurance programs under one umbrella during its implementation of health reform. In particular, several state subsidized health insurance programs remain outside the Connector including the Medical Security Plan, the Insurance Partnership, and the Children's Medical Security Plan, causing potential confusion and inefficiencies in the marketplace. The Connector did pursue opportunities for collaboration but because these programs are managed by other state agencies, and sometimes within different secretariats, it was not always easy to coordinate. The Connector has begun a procurement process for the Medical Security Plan this year although the programs will remain separate.

The programs noted above serve similar populations as those operated by the Connector but maintain different benefit structures, premiums and cost sharing requirements, and wholly separate operational infrastructures. Appendix 1 provides information on enrollment, and benefits/premiums cost sharing for these programs.

Even within the Connector the operational functions of Commonwealth Care and Commonwealth Choice remain distinct with different systems and vendors responsible for enrollment, customer service, quality assurance, and billing. Economies of scale can likely be achieved by merging at least some of the "back-room" functions across these similar state programs. Alternatively, the Commonwealth should explore whether these legacy programs are even necessary given the recent reforms in Massachusetts and the new provisions in the ACA. The Commonwealth is also investigating, along with other New England states, opportunities to achieve economies of scale in conducting some of these "back office" functional areas that are required per the ACA. Clearly, with the single eligibility system envisioned by the ACA there are opportunities for greater coordination among programs.

7. Reconfigure the Membership of the Connector Board

The Connector is governed by a 10-member Board[22] 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. In light of the recommendations in this paper, it is worth revisiting the make-up of the Connector Board.

The Board consists of four ex-officio members as follows: the Secretary of Administration and Finance (who chairs the board), the Commissioner of Insurance, the Medicaid Director, and the Executive Director of the Group Insurance Commission. There are six appointed board members, serving three year (staggered) terms. Three members are appointed by the Attorney General: an employee health benefits specialist, a representative of a health consumer organization, and a representative of organized labor. Three are also appointed by the Governor, including a health economist, an actuary and a representative of small business.

There are a number of concerns regarding the board composition of the Connector. Ex-officio board members are important for ensuring coordination of policy and operations across state agencies, particularly important in the case of Medicaid and Insurance. In addition, having the Secretary of Administration and Finance on the board makes good sense since Commonwealth Care costs are a significant concern to the state budget. It is less clear, however, whether any coordination of activities has occurred between the Group Insurance Commission and the Exchange, although clearly there are opportunities for such collaboration. Policymakers may want to consider whether this board position is advisable in the future. In addition, policymakers may want to consider whether these ex-officio members should have voting privileges. The Connector Board would be less political if these ex-officio members were non-voting members.

Given the important responsibilities of the Connector Board, Massachusetts policymakers should evaluate whether the current Board appointments, membership, and voting ability is working to meet the interests of its primary target population – individuals, small businesses and their employees – the primary users of the Connector.

The appointed Connector Board positions have also been somewhat problematic. Until January 2011, four of the six appointed members had been with the Connector since the passage of the law in 2006 – all four of them serving beyond their first term. Although re-appointments are permitted under the law, it seems unusual that the Attorney General and Governor have not focused any attention on these appointments. There are several specific concerns to be noted here. First, the current health benefits specialist position is filled by an executive with Taft Hartley plans, arguably a redundant voice with the union representative. This position would be better filled by someone working with non-unionized small employers, a voice that has not been represented on the Board to date. Until this January the small business representative was also a representative of large businesses, and this "conflict" may have affected voting on key policy issues. Finally, the representative from a health consumer organization is currently filled by an academic who is an associate dean at a school of public health and does not interact with potential consumers of the Connector on a regular basis.

Again, this position would be better filled by someone who works with or is a consumer of either Commonwealth Care or Commonwealth Choice products. The Governor and Attorney General should revisit these appointments and make sure that the voices of consumers and small businesses in Massachusetts are being represented on the Board.

Given the important responsibilities of the Connector Board, Massachusetts policymakers should evaluate whether the current Board appointments, membership, and voting ability is working to meet the interests of its primary target population – individuals, small businesses and their employees – the primary users of the Connector.

Conclusion

Although Massachusetts may have been provided a statutory waiver to many of ACA's exchange requirements and can likely continue operating its exchange as currently configured – legislators, Connector board members and staff should take this opportunity to fully evaluate the Connector's strengths and weaknesses and determine where it can make changes to better position itself in the post-ACA environment. Such reforms could include greater consumer control of health dollars and choice, an emphasis on wellness, and greater transparency within the overall health care system. This issue brief provides some recommendations for moving Massachusetts forward.

Some of the ideas discussed here may require additional statutory authority and most will certainly require board member approval. The current make-up of the Connector board may be a barrier to implementing some of these changes. However, working with small businesses and consumers, carriers and brokers, Massachusetts can progressively evolve its exchange and overall reform to better meet the needs of subsidized individuals and all consumers purchasing health insurance in the Commonwealth.

About the Author:

Amy Lischko, a Senior Fellow at Pioneer Institute and Associate Professor at Tufts University School of Medicine, has over fifteen years of experience working for the Commonwealth of Massachusetts, most recently as Director of Health Care Policy and Commissioner of the Division of Health Care Finance and Policy under Governor Romney. Amy holds a doctorate degree in health services research from Boston University and was one of the key authors of the administration's health care reform proposal.

About Pioneer:

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to change the intellectual climate in the Commonwealth by supporting scholarship that challenges the "conventional wisdom" on Massachusetts public policy issues.

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Contracting for Performance: Teacher Union Contract Language in Massachusetts, White Paper, January 2011: http://www.pioneerinstitute.org/pdf/Contracting_01-11-2011.pdf

Agenda for Leadership: Hit the Ground Running, October 2010: http://www.pioneerinstitute.org/pdf/agenda_2010.pdf

Education Tax Credits: A Review of the Rhode Island Program and Assessment of Possibilities in Massachusetts, White Paper, October 2010: http://www.pioneerinstitute.org/pdf/101019_ri_tax_credits.pdf

Endnotes

1. Interim Report Cards on Massachusetts Health Care Reform. Part 1) Increasing Access; Part 2) Equitable and Sustainable Financing; Part 3) Administrative Efficiency; Part 4) Cost-Effective Quality. All located at: http://www.pioneerinstitute.org/pubs_white_papers.php

2. Multi-state and regional exchanges are permitted.

3. Pioneer's prior work on exchanges: Amy Lischko. Drawing Lessons: Different Results from State Health Insurance Exchanges. Pioneer Institute. Policy Brief December 2009.

4. The Health Care Quality and Cost Council, established via Section 16K of the law was tasked with developing health care quality improvement and cost containment goals.

5. The Board of the Connector will be expanded, effective July 2011, from ten tto eleven members. The additional seat will allow for representation on the Connector Board by a member of the Massachusetts chapter of the National Association of Health Underwriters. See sections 42 and 45 of Ch. 288 of the Acts of 2010. http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288

6. The ACA requires states to include employers of up to 100 beginning in 2016 in the Exchange; states may choose to include them beginning in 2014.

7. Section 1321 of the ACA states that "In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section – Standards in this section include: establishment and operation of Exchanges; the offering of qualified health plans through Exchanges; the establishment of the reinsurance and risk adjustment programs under part V; and such other requirements as the Secretary determines appropriate such Exchange meets the standards under this section."

8. Interim Report Cards on Massachusetts Health Care Reform. Part 1) Increasing Access; Part 2)Equitable and Sustainable Financing; Part 3)Administrative Efficiency; Part 4) Cost-Effective Quality. All located at: http://www.pioneerinstitute.org/pubs_white_papers.php

9. The fee started at 4.5% for the Commonwealth Care program but has decreased to 3.2% for the current fiscal year.

10. Connector administrative operating report, MA Health Connector Website, Board Meeting Records, June 10, 2010, Accessed 12/28/2010, www.mahealthconnector.org/portal/site/connector

11. Connector administrative operating report, MA Health Connector Website, Board Meeting Records, June 10, 2010, Accessed on 12/28/2010, www.mahealthconnector.org/portal/site/connector

12. 2,439 employees enrolled in the Contributory Plan and Business Express.199,048 total enrollees in both the CommCare and CommChoice programs. There were 700,000 small group members and their dependents in the market pre-reform.

13. Employer participation rules are: 100% participation for employers with 5 or fewer employees and 75% participation for employers with 6+ employees.

14. Report to the Massachusetts Legislature Implementation of Health Care Reform Fiscal Year 2010, MA Health Connector Website, Accessed 12/28/2010, www.mahealthconnector.org/portal/site/connector

15. Board Meeting presentation November, 2009, Health Connector Website, Accessed 2/15/2011, www.mahealthconnector.org/portal/site/connector

16. A defined contribution is when the amount of the employer's annual contribution is specified upfront.

17. Board meeting presentation, December 11, 2008, MA Health Connector Website, Accessed 2/15/2011, www.mahealthconnector.org/portal/site/connector

18. State Employee Wellness Initiatives, NGA Center for Best Practices, Issue Brief, May 2005.

19. National Conference of State Legislatures, State Wellness Legislation, 2006-2010, Accessed 1/18/2011 http://www.ncsl.org/default.aspx?tabid=13826

20. Connecticut Business and Industry Association, CBIA Health Connections, Accessed 3/8/2011, http://www.cbia.com/ieb/er/healthyconnections

21. The three-year period ended in July 2009 and the Connector procured a fourth MCO to participate in the subsidized coverage.

22. The Board of the Connector will be expanded, effective July 2011, from ten to eleven members.

Appendix 1. Comparison of State Health Programs

	Commonwealth Care	MSP	CMSP	Insurance Partnership
Responsible Agency	**Connector**	Division of Unemployment Assistance	MassHealth	MassHealth
Eligibility	**Income < 300% FPL Legal Resident**	Unemployed receiving unemployment benefits < 400% FPL	Child under 19 years of age, any income	Employers 50 and under and their employees under 300% FPL
Benefits	**Comprehensive benefits offered by 5 insurance carriers**	BCBS or Cobra if available	Limited preventive and primary care	Employer Plans
Premiums	**Sliding scale, 0 for people < 150% FPL**	0 premium for BCBS 20% of Cobra premium	< 200% FPL no premium 200-300% FPL $7.80/child, max of 23.40/family 300-400% FPL $33.14/family > 400% FPL $38.99 per child	
Cost Sharing	**Sliding scale**		$3 generic Rx $4 name brand Rx Small co-payment for dental	Average employer cost-sharing

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