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HEALTH INSURANCE “CONNECTORS” SHOULD BE DESIGNED TO SUPPLEMENT PUBLIC COVERAGE, NOT REPLACE IT

By Judith Solomon

In 2006, Massachusetts enacted legislation intended to achieve universal health coverage in the state.¹ The law has attracted a great deal of attention, and a number of states and other organizations are looking at whether the Massachusetts plan can be adapted for use elsewhere to achieve universal coverage or at least reduce the number of uninsured.² One feature of the Massachusetts plan that has received particular attention is the Commonwealth Health Insurance Connector Authority.

The Heritage Foundation, in particular, is promoting connectors or health insurance exchanges as a way to create a single market for health insurance that would offer health insurance to individuals rather than groups. Individuals and families would, under the Heritage proposal, “buy and own” the coverage they want through the connector with few standards governing benefits and out-of-pocket costs. In the Heritage version of a connector — unlike in Massachusetts — all types of policies, including high-deductible health plans and “other new coverage options that might emerge in response to consumer demand” would be offered.³

Heritage and some other organizations also are promoting the use of connectors of this nature as a way to expand coverage to low-income people, who would receive vouchers to purchase individual coverage through the connector.⁴ Heritage suggests that states could offer insurance through a connector to cover individuals and families currently enrolled in Medicaid coverage, with such insurance replacing Medicaid coverage.⁵

¹ Chapter 58 of the Acts of 2006, State of Massachusetts.

² See, for example, “Massachusetts-Style Coverage Expansion: What Would It Cost in California,” California HealthCare Foundation, April 2006.

³ Robert E. Moffit, “The Rationale for a Statewide Health Insurance Exchange, The Heritage Foundation, Web Memo No. 1230, October 5, 2006.

⁴ Martin D. Sellers, “The Impact of Massachusetts Medicaid Reform Throughout the Nation,” BNA Health Care Policy Report, December 11, 2006; Sellers Feinberg, “Washington Blue Ribbon Commission on Health Care Costs and Access, Accessing a High-Quality Affordable Health Care System,” at <http://www.leg.wa.gov/documents/joint/HCCA/Discussion%20Guide%20CoverMoreUninsured.pdf>; Louisiana State Medical Society, Health Access Louisiana, at <http://www.lsms.org/HAL.htm>

⁵ Edmund F. Haislmaier and Nina Owcharenko, “The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs,” *Health Affairs*, November/December 2006.

Other States May Lack Massachusetts' Advantages in Designing Health Care Reform

Massachusetts had a number of strengths to build upon in when it developed its plan for universal coverage: a relatively low rate of uninsurance, substantial federal dollars that could be redirected to financing coverage expansions, a strong base of public coverage, and a highly regulated market for individual health insurance.

- According to Census data, 12 percent of non-elderly Massachusetts residents were uninsured in 2004 to 2005, compared to 18 percent of all non-elderly U.S. residents.ⁱ The state's own surveys show an even lower uninsurance rate: just over 8 percent.ⁱⁱ
- Massachusetts was receiving \$385 million in annual federal payments made through its Section 1115 Medicaid waiver that could be used to help finance its health reform plan. These funds are over and above the federal matching funds that all states receive for their Medicaid and SCHIP expenditures.ⁱⁱⁱ
- Even before enactment of health reform, the Massachusetts Medicaid and SCHIP programs had higher income eligibility levels than most state programs. Massachusetts covered all children and pregnant women in families with income below 200 percent of the poverty line, parents with income up to 133 percent of the poverty line, many people with disabilities with income up to 300 percent of the poverty line, and some unemployed adults with income below the poverty line.^{iv}
- Massachusetts state law requires all health insurers offering individual coverage in Massachusetts to offer insurance to *all individuals who seek it, regardless of their health status*. In addition, the state's "modified community rating" rules make insurance more affordable for individuals with health problems by regulating how much insurers can vary premiums based on characteristics such as age or health status.^v

Other states without these advantages will have a much greater challenge in devising a feasible plan for universal coverage and, generally speaking, will not be able simply to adapt the Massachusetts plan without taking significant additional steps, including increases in financing from other sources and substantially enhanced regulation of the individual health insurance market.

ⁱ Analysis of the Current Population Survey, March 2005 and 2006, by Kaiser Commission for Medicaid and the Uninsured and the Urban Institute; available at www.statehealthfacts.org.

ⁱⁱ John E. McDonough *et al.*, "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs*, web exclusive, September 14, 2006.

ⁱⁱⁱ "Massachusetts Health Care Reform Plan," Kaiser Commission on Medicaid and the Uninsured, April 2006.

^{iv} For 2006, the poverty line was \$9,800 for a single person and \$16,600 for a three-person household.

^v See generally, Mary Beth Senkewicz, "Senate Health Bill Would Preempt States' Small Group Rating Rules," Center on Budget and Policy Priorities, April 26, 2006.

As other states consider the use of connectors or health insurance exchanges as part of their plans to expand coverage, it is important to understand the design of the Massachusetts Connector, how the Connector fits into the Massachusetts plan for universal coverage, and how it differs from what Heritage is advocating.⁶ It also is important to understand certain important ways in which the

⁶ Governor Schwarzenegger has recently offered a proposal for universal coverage for California. While his plan includes many of the elements of the Massachusetts plan, including a requirement that all state residents have health coverage, it does not include a connector. Low-income California residents would be provided with subsidized coverage

Massachusetts health care system differs significantly from the system in other states, such as in the substantial regulation of the individual health insurance market in Massachusetts.

The Role of the Connector in Massachusetts Health Care Reform

The Commonwealth Health Insurance Connector Authority (“the Connector”) is part of a complex plan designed to achieve universal coverage in Massachusetts. Beginning in July 2007, all Massachusetts residents will be required to have health insurance as long as affordable coverage is available to them. (The standard for affordability has not yet been determined.) The plan includes an expansion of Medicaid and SCHIP coverage for children with family incomes up to 300 percent of the poverty line and subsidized coverage for most adults with incomes up to that level.

The Connector — an independent public entity that operates through a board whose members include state officials and appointees of the governor and attorney general — has two main functions. First, it operates a new health plan, the Commonwealth Care Health Insurance Plan. Individuals with income up to 300 percent of the poverty line who are not eligible for Medicaid or Medicare and who do not have access to employer-sponsored insurance can enroll in this new plan.⁷ No premiums are charged to those with income below the poverty line, and premiums are based on a sliding scale for those with income above that level. For the next three years, the only insurers that can offer coverage through the Commonwealth plan are the managed care plans that currently contract with the state’s Medicaid program.

The Connector’s other function is to provide a way for employers with fewer than 50 employees and higher-income individuals without access to employer-sponsored health insurance to purchase coverage in the private market. By July 2007, the Connector plans to offer health insurance products to these firms and individuals. The Connector will provide a “seal of approval” for the plans it approves,⁸ and these plans will have to cover all of the benefits mandated under the state’s insurance laws (though they can have limited provider networks and relatively high cost-sharing).⁹ The Connector is now receiving bids from insurance companies that want to offer their products through the Connector, so the actual design and price of the products that will be offered are not yet known.

through a purchasing pool administered by the state. A summary of the Governor’s plan can be found at http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.

⁷ Individuals with income below the poverty line began enrolling in the Commonwealth plan in October 2006; the plan was opened to those with income up to 300 percent of the poverty line in January 2007.

⁸ Chapter 176Q of Chapter 58 of the Acts of 2006.

⁹ John Holohan and Linda Blumberg, “Massachusetts Health Care Reform: A Look at the Issues,” *Health Affairs*, web exclusive, September 14, 2006. Plans specially designed for young adults (ages 19 to 26) that do not include all of the mandated benefits may be offered through the Connector.

Other Connector Proposals Differ Significantly From the Massachusetts Example

Citing Massachusetts as an example, several organizations are promoting connectors in other states as a way to expand coverage for low-income uninsured people by providing them with private coverage. These expansions would be financed by converting Medicaid payments that now go to hospitals and other health care providers to pay for uncompensated care into subsidies that individuals would use to purchase private coverage through the connector.¹⁰ Federal Medicaid dollars would help finance these expansions, but the coverage provided to individuals and families would not have to meet Medicaid standards for benefits or cost-sharing.¹¹ Going further, some of these proposals would provide some of a state's current Medicaid and SCHIP beneficiaries with subsidies or vouchers to purchase private coverage through the connector in lieu of regular Medicaid and SCHIP coverage.¹²

Louisiana has now incorporated the concept of a connector into its plan for Medicaid reform, and other states are reportedly looking at the concept. Louisiana has submitted a concept paper to the Centers for Medicare and Medicaid Services for a Section 1115 waiver that would include a connector; the connector would offer coverage for both newly eligible and some existing Medicaid and SCHIP beneficiaries.¹³ In addition, Michigan and the state of Washington are reportedly considering the use of a connector in their plans to expand coverage to low-income adults with income below 200 percent of the poverty line.¹⁴

There are critical differences between the Massachusetts Connector and these plans to use the connector to provide private coverage to low-income people, including some people who otherwise would be covered by Medicaid or SCHIP. For example, in Massachusetts, children with family income up to 300 percent of the poverty line and many low-income adults and people with disabilities will continue to receive public coverage through Medicaid and SCHIP.¹⁵ Similarly, the Massachusetts plan contains protections not found in the other plans regarding the standards that the plans offered by the connector to low-income people not enrolled in Medicaid must meet. In Massachusetts for the next three years, these plans will be operated by the companies that already contract with the state's Medicaid program, and premiums will be limited to 1.8 percent of income

¹⁰ Medicaid provides funds, known as disproportionate share funds (DSH), to safety net providers for health care services they deliver to the uninsured. Massachusetts will continue to make payments to safety net providers through 2009. Holahan and Blumberg.

¹¹ The Bush Administration has proposed a new initiative that would allow states to divert payments designed to defray costs that health care providers incur for uncompensated care so these funds are used instead to provide "access to basic, private insurance at an affordable price." More details on this initiative are expected in the President's budget.

¹² Haislmaier and Owcharenko.

¹³ Louisiana's original plan for a waiver would have expanded coverage through Medicaid and SCHIP, but the U.S. Department of Health and Human Services essentially rejected that approach and insisted upon a plan that instead provided individuals with vouchers or other types of subsidies to purchase private health insurance. Jan Moller, "Deal to revamp health care in N.O. stalls," *The Times Picayune*, October 3, 2006.

¹⁴ Sellers, "The Impact of Massachusetts Medicaid Reform Throughout the Nation," Sellers Feinberg, "Washington Blue Ribbon Commission on Health Care Costs and Access, Accessing a High-Quality Affordable Health Care System."

¹⁵ In addition to raising the income eligibility level for children to 300 percent of the poverty line, the Massachusetts plan also raised Medicaid enrollment caps for certain people with disabilities, people with HIV/AIDS and adults without children. These groups are covered under the Massachusetts Medicaid waiver. Holahan and Blumberg.

for those with income at the poverty line and 4.7 percent of income for those at 300 percent of the poverty line.

As explained below, there are three key areas in which the Massachusetts plan is superior to other plans that purport to adopt the Connector: the affordability of insurance for low-income people, the availability of insurance to people regardless of their age or health status, and the extent of coverage provided to children.

Affordability

Health insurance is expensive. A recent analysis found that unsubsidized coverage offered to individuals employed by small businesses with fewer than ten employees would, on average, cost a single person with income at 300 percent of the poverty line 13.8 percent of his or her income, while family coverage would cost an average of 17.2 percent of income for a family at that income status.¹⁶ (The cost of comparable coverage generally would be even higher in the individual market, especially for those with health problems.)

The Massachusetts plan is designed to make comprehensive health insurance affordable for uninsured people with income up to 300 percent of poverty who do not have access to employer-sponsored coverage. Given the high cost of coverage, it is important that the subsidy extend at least up to this income level. By contrast, Louisiana and the other states considering the use of a connector would limit subsidized coverage to people up to 200 percent of the poverty line.

Some Low-Income People in Massachusetts May Still Find Coverage Unaffordable

Even in Massachusetts, some low-income people may have difficulty affording coverage. Workers whose employers provide health insurance and pay at least 20 percent of the cost for family coverage (and 33 percent for individual coverage) are not eligible for subsidized coverage through the Connector. Such workers may find themselves unable to meet the new state requirement that all residents have health coverage if they cannot afford to pay their share of the premium for employer-sponsored coverage. The Massachusetts law allows (but does not require) the Connector to waive this bar to enrollment in the subsidized plan for people in this situation. If a waiver is not provided, the individual would have to seek relief from the new individual mandate on the ground that coverage is not affordable.

Access

In Massachusetts, all individuals who seek to buy insurance through the Connector will be able to purchase comprehensive coverage. (Even prior to the establishment of the Connector, insurers offering individual coverage in Massachusetts were required to offer insurance to all individuals seeking it, regardless of their health status. Insurers were also limited in the degree to which they could vary premiums based on factors such as health status or age.) This is not the case in other states.

¹⁶ Lisa Dubay, John Holahan, and Allison Cook, “The Uninsured and the Affordability of Health Insurance Coverage,” *Health Affairs*, web exclusive, November 30, 2006.

For example, under the Louisiana plan — in which people without access to employer-sponsored insurance would use Medicaid subsidies to purchase individual coverage through the connector — it is not clear what types of plans would be offered through the connector, what benefits the plans would offer, whether plans would have to accept all individuals seeking coverage regardless of their health status, how premium rates would vary depending on health risk and other criteria, and whether the coverage would be affordable.

Most states allow insurers offering individual coverage to turn down people with health problems.¹⁷ People with even minor health conditions often are turned down for coverage or offered coverage that excludes treatment of their existing health conditions, which often are the conditions for which they need coverage. Moreover, policies in the individual market generally provide coverage that is less comprehensive than group coverage, and coverage in the individual market often is either unavailable or unaffordable for older people as well as younger people with significant health problems.¹⁸ If low-income people are provided vouchers to purchase coverage in the individual market, many thus are likely to find that coverage is unavailable or unaffordable. For those who can get coverage, it likely will come with high cost-sharing and limited benefits, putting people with disabilities and chronic health conditions at particular risk.

Coverage

The private health plans available to children through other states' connectors would likely offer benefits that are much more restrictive than children receive through Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Under EPSDT, states must ensure that all children enrolled in Medicaid receive regular check-ups, including vision, dental, and hearing exams, as well as all necessary immunizations and laboratory tests. Children also must receive all necessary follow-up diagnostic and treatment services that can be covered under Medicaid, even if a state has chosen not to provide that service for adults.

In addition, EPSDT requires states to provide children with all health care services necessary "to correct or ameliorate defects and physical and mental health conditions."¹⁹ Under EPSDT, states cannot limit services like speech or physical therapy that a child needs to maintain an optimal level of health. Private insurance plans often cut off such services when an individual's condition is no longer improving, even when the services are necessary simply to maintain progress that has already been made.²⁰

¹⁷ Mila Kofman and Karen Pollitz, "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change," Georgetown University Health Policy Institute, April 2006.

¹⁸ Karen Pollitz and Richard Sorian, "Ensuring Health Security: Is the Individual Market Ready for Prime Time?" *Health Affairs*, web exclusive, October 2002. Lisa Girion, "Healthy? Insurers don't buy it," *Los Angeles Times*, December 31, 2006.

¹⁹ Section 1905(r) of the Social Security Act.

²⁰ Sara Rosenbaum *et al.*, "State Benefit Design Choices under SCHIP — Implications for Pediatric Health Care," Center for Health Services Research and Policy, George Washington University, May 2001.

Conclusion

Massachusetts is not using the Connector to substitute for current public coverage under Medicaid and SCHIP. It has expanded public coverage for children and people with disabilities, and is limiting the use of the Connector to residents who do not receive public coverage. This is important, because public coverage provides more appropriate affordability, access, and coverage for low-income people than is likely to be found in private plans, even in a state like Massachusetts that regulates private plans far more extensively than most other states.

States looking to expand coverage for low-income people should look closely at the Massachusetts plan, which is designed to achieve this goal without simply giving low-income people vouchers that they must use to try to find coverage in the individual market.