

The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned

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Executive Summary

One of the most significant reforms contained within the Patient Protection and Affordable Care Act (ACA) is the requirement that states create—or have the federal government create—health insurance exchanges. Designed to help individuals and small businesses shop for and purchase health insurance, access pre-mium and cost-sharing subsidies, and facilitate health plan competition based on price and quality, these exchanges are projected to be the gateway for approximately 29 million people to access coverage.

Exchanges are not new, and two states in particular have garnered national attention for illustrating the diverse approaches states may take to establishing and maintaining an exchange. To many, the Massachusetts and Utah exchanges represent opposite points on a continuum of what exchanges can provide for consumers and small businesses. Yet the stereotype of Massachusetts' exchange as an "active purchaser" and the Utah Exchange as the open market model is, in the words of one observer, "a false stereotype...perpetuated by... a media that likes simple contrasts."

In our research we found a much more complicated picture of each exchange. We examine three primary dimensions of each exchange: the quality and choice of plans, the affordability of coverage, and ease of enrollment. Selected "lessons learned" from both states include the following:

- **It's not an "either-or" choice.** States seeking to establish their own exchanges do not need to choose either the Massachusetts or the Utah model. While the ACA sets some minimum standards, states have discretion to develop an approach that will best serve the residents of their state, including elements from both the Massachusetts and Utah models. The experience of both states underscores that ongoing refinement will be necessary.
- **Policymakers must consider exchanges' interactions with broader insurance market rules.** Massachusetts' Connector grew from market reforms previously in place, while Utah moved to reform its statewide small group rating rules to improve exchange outcomes. Further, the ACA's market reforms and standards for exchanges may address some of the challenges both states are facing. For example, the ACA's prohibition on health status underwriting

in 2014 will allow Utah to simplify what is currently a complicated rating and enrollment process.

- **Exchanges can be effective market innovators.**

For both exchanges, perhaps the most innovative contribution to the landscape is the web-based mechanism through which consumers and small business owners can make informed comparisons among health plans. Massachusetts' Connector in particular has used decision-support tools and a streamlined set of benefit packages to help make consumers' purchasing decisions simpler and easier. And giving consumers confidence that they are choosing among quality products, i.e., through certification or a "Seal of Approval," can promote the selection of lower cost plans.

- **Exchanges require the participation of both consumers and health plans.** A successful exchange must strike a balance between effective consumer protections and being attractive to the insurance carriers from whom enrollees wish to purchase. The stereotype of Massachusetts as an "active purchaser" is belied by the fact that the Connector has never turned away a carrier that expressed a wish to participate, while on the other hand, Utah's open market has not attracted all of that state's carriers. Both states have made efforts to encourage insurers to participate.

- **Effective "active purchasing" requires market knowledge and nimbleness in the face of consumer demands.** Even without the leverage of premium subsidies, the Massachusetts Connector has effectively streamlined the insurance products on its shelves in part through market research that provided clear data that consumers were demanding greater standardization of products. However, being an active purchaser requires staff expertise and resources. As one observer put it, "If you want to take 'any willing plan,' it's a lot easier. But then you don't add much value, either."

- **You get what you pay for.** While the Connector's \$30 million budget is dramatically more than what the

Utah Exchange spends for administration, it reflects both substantially higher enrollment (approximately 220,000 vs. 2,200) as well as a much broader scope of responsibilities. In addition, the lack of budget and staff has made it difficult for the Utah Exchange to respond and adjust to problems as they arise.

- **Exchanges without associated subsidies can do little to make insurance more affordable.** Premium and cost-sharing subsidies will be critical for most individuals and will help exchanges attract and sustain their enrollment. But for those who are unsubsidized, such as small business purchasers, exchanges will likely struggle to provide a product that is more affordable than what is available in the outside market. The ACA's small business tax credit will help small group exchanges with enrollment, but it is narrowly targeted and limited to three years.

- **A "defined contribution" model for employer-sponsored coverage will not necessarily attract small employers to exchanges.** Utah's creation of a "defined contribution" market inside its Exchange for small employers was designed with the twin goals of helping employers limit their financial exposure to rising health costs and encouraging employees to select lower-cost plans. In practice, however, implementation of a defined contribution model for small businesses in both states does not appear to have enticed more small employers to enter the market. And in Utah, it appears that many participating employees have simply stayed with the plan they were in before, rather than exercising their new ability to "shop" for new policies.

- **Public outreach and simple enrollment are keys to success.** Exchanges must attract a critical mass of enrollees early on to be sustainable. Extensive public education about consumers' new rights and responsibilities will be necessary, as well as one-on-one assistance to help those who are new to the process. And if the eligibility and enrollment process is burdensome and time consuming, it will discourage many from participating, particularly those not eligible for subsidies (including small businesses).

Introduction

One of the most significant reforms contained within the Patient Protection and Affordable Care Act (ACA) is the requirement that states create—or have the federal government create—health insurance exchanges. Designed to help individuals and small businesses shop for and purchase health insurance, access premium and cost-sharing subsidies, and facilitate health plan competition based on price and quality, these exchanges are projected to be the gateway for approximately 29 million people to access coverage.¹

States have flexibility in the design and implementation of exchanges under the ACA. For example, they can open their exchange to all qualified plans within the state, or they can limit participation to certain plans. They can provide an almost unlimited number of product choices for consumers, or they can establish a standardized set of benefits and limit the number of products. They can offer separate small business and individual market exchanges, or merge the two. They can run a solely state-based exchange, operate multiple exchanges in the state, or partner with other states to run a regional exchange.

Exchanges are not new, and two states in particular have garnered national attention for illustrating the diverse approaches states may take to establishing and maintaining an exchange. Massachusetts established its exchange (the “Connector”) as part of a comprehensive health reform effort in 2006, and Utah first piloted its exchange in 2009. To many, the Massachusetts and Utah

exchanges represent opposite points on a continuum of what exchanges can and should provide for consumers and small businesses. As one Utah official put it, “Utah and Massachusetts may well serve as bookends for other states.”² In this framework, Utah’s exchange represents a pure “free market” approach to the regulation and oversight of an insurance market, while the Massachusetts Connector represents a proactive, hands-on approach. Utah officials stress that until January 2011, Utah’s Exchange had only experienced a “Limited Launch” and much more will be learned in the year ahead.

This paper provides a closer look at these two exchanges and reveals a much more complex and nuanced picture of each exchange in their design, execution, and impact on consumers and small business owners. We examine three primary dimensions: the quality and choice of plans, the affordability of coverage, and ease of enrollment.

To prepare this report, we conducted stakeholder interviews with key constituencies in both Massachusetts and Utah in person and by telephone between December 2010 and February 2011. We analyzed various program materials, secondary source materials and other data during this period as well. To preserve the confidentiality of those interviewed, in most cases we have identified them only by occupation or affiliation. The findings in the paper are the authors’ alone and should not be attributed to any individual or group with whom we spoke.

Background on Massachusetts’ and Utah’s Exchanges

Insurance Markets

The Utah Health Exchange and Massachusetts Connector both operate within their states’ existing insurance markets. Each state has laws and regulations that set the rules for insurance sold to its citizens, and the way in which the broader health insurance market works has informed the creation of the exchanges and their ongoing development. Massachusetts established its exchange in 2006 when its percentage of uninsured was 10.6%; the rate declined to 4.4% in 2009.³ Health

insurance premiums in Massachusetts are among the highest in the nation.⁴ In addition, Massachusetts has long had a market dominated by local, non-profit health plans that have historically been rated highly on quality and customer service. And while one large carrier has significant market share, the insurance market is less concentrated than in many other states.⁵ In Utah, the health system reforms that led to its exchange began in 2008, when the state’s uninsurance rate was 13.2%; the rate rose to 14.8% in 2009.⁶ The cost of coverage in Utah ranks in the bottom tier of states—44th in 2009.⁷

Since the mid-90s, Massachusetts has required guaranteed issue of insurance to individuals and groups, and prohibited health plans from charging higher premiums to individuals or groups based on their health status, although they can vary based on age or geographic location (called “modified community rating”). Utah, on the other hand, previously allowed considerable variation in premiums in the small group market based on health status, gender, industry, group size, and other factors—the highest rates could vary up to 25 times the lowest.⁸ Both states, though, made changes to their insurance market rules as they developed their exchanges.

In establishing its exchange, Massachusetts enacted insurance reforms to merge the individual and small group markets, so they now form one risk pool, subject to the same rules. While the merger had a small impact on premiums, it was moderated by the Commonwealth’s prior insurance reforms aligning the rating and guaranteed issue rules between the two markets. In addition, to address concerns about adverse selection against its exchange, insurance products must be priced the same whether they are marketed inside or outside the Connector. These reforms have helped Massachusetts launch and sustain its exchange with minimal disruption to its insurance markets.

In Utah, policymakers responded to concerns about price, low enrollment and the number of available plans in the Exchange with further regulation of Utah’s small group market. They required small group rating practices to be the same inside and outside of the Exchange and limited rating criteria to age, family composition, and geographic area. They required more plan options to be offered in the Exchange and moved to penalize insurers who do not participate in the Exchange market by disallowing them from joining later. The application timeframe was changed from an annual open enrollment period to a rolling process that allows for effective dates throughout the year.⁹

Vision and Goals

Just as the establishment of American Health Benefit Exchanges has been viewed as integral to national health insurance reform, the establishment of the Massachusetts Connector in 2006 was seen as critical to achieving the Commonwealth’s vision of universal or near-universal coverage through the combination of insurance reforms,

premium subsidies and “shared responsibility” to obtain or offer coverage.¹⁰

The enabling statute identifies the “purpose” of the Connector as facilitating the “availability, choice and adoption of private health insurance plans to eligible individuals and groups....”¹¹ And the statute charges the Connector’s Board with facilitating the “purchase of health care insurance products...at an affordable price.”¹²

As established, the Massachusetts Connector manages two exchanges: Commonwealth Care (“CommCare”) for individuals below 300% of the Federal Poverty Level (FPL)¹³ and eligible for premium subsidies, and Commonwealth Choice (“CommChoice”) for individuals not eligible for premium help. CommChoice also includes “Business Express,” a program for businesses with up to 50 employees.

Similarly, Utah’s health insurance exchange is a major piece of the health system reform efforts that have been underway in that state since 2008. Legislation passed in 2008 created the Health System Reform Task Force, made up of state legislators, to develop and implement a strategic plan for health reform in Utah.¹⁴ The Task Force, in turn, spearheaded the passage of legislation in 2009 to create the Utah Health Exchange. The Exchange is intended to facilitate the state’s transition to a health care system that enhances the collection and sharing of information required by consumers, employers, insurers, and agents/brokers. The Utah Exchange is envisioned to become a clearinghouse for all of the state’s health insurance markets and aims to:

- Provide consumers with helpful information about their health care and health care financing
- Provide a mechanism for consumers to compare and choose a health insurance policy that meets their families’ needs
- Provide a standardized electronic application and enrollment system¹⁵

The core missions of the Utah Health Exchange are to facilitate communication between parties and to create a defined contribution option for employers. It does not provide premium subsidies and has thus far focused only on the small group market. Further, it acts as a market organizer rather than an active purchaser—that is, it does not “negotiate” on prices, set minimum quality standards, or attempt to limit variation among plan offerings.

Governance and Financing

Massachusetts established the Connector as a “quasi-public agency, outside the supervision or control of the Executive branch.”¹⁶ However, as a practical matter the Connector works very closely with the Executive branch to meet the goals established under the 2006 reform law. The authorizing statute created a Board of Directors to govern the Connector, composed of 11 members. To promote cross-agency coordination, the Board includes the Secretary for Administration and Finance (who serves as Chair), the Director of Medicaid, Commissioner of Insurance, and the Executive Director of the health benefits agency for state employees, who serve as ex-officio members. The balance of the Board is comprised of a mix of stakeholders and experts, including representatives of small businesses, consumers, and organized labor. In addition, the law requires the appointment of an actuary, a health benefits plan specialist, and a health economist. The law prohibits any representative of a health insurance company from serving on the Board, but in 2010 the legislature enacted a new requirement that one Board seat be held by an insurance broker.¹⁷

The Connector was financed through an initial \$25 million appropriation, but now is self-sustaining through surcharges on health plan premiums. Its current operating budget is approximately \$30 million, with a staff of 46 full-time employees. This level of funding allows the Connector to meet its broad obligations under the 2006 reform law, such as outreach, public education and marketing, eligibility and enrollment services, and market surveys and focus groups to assess consumer and employer needs.

The Utah Health Exchange is administered by the Office of Consumer Health Services within the Governor’s Office of Economic Development (GOED). It operates on a relatively small budget—a \$600,000 initial appropriation and ongoing support from GOED for the Exchange’s two staff members. The vendors that operate the Exchange also charge \$6 per employee per month to support system operations and employees are charged \$37 per month as a fee for the brokers who support enrollment. Utah’s governor appoints members to a Risk Adjuster Board, which manages the risk sharing mechanisms for the Exchange’s defined contribution market.¹⁸ Utah law further provides for an Exchange advisory board that consists of representatives of state agencies, insurers, producers, and consumers.¹⁹

Activities

Massachusetts’ health reform law established the Connector not just to help organize the insurance marketplace and improve consumers’ ability to make informed health insurance purchasing decisions, but empowered it also to make fundamental policy decisions relating to the Commonwealth’s reform efforts. For example, the Connector was charged with defining “minimum creditable coverage”—the minimum level of coverage all state residents must have to satisfy the requirement to maintain insurance coverage. In addition, the Connector is responsible for setting and updating an affordability schedule, which establishes the maximum amount, based on a percentage of income, an individual or family must pay for insurance. These early foundational decisions were the focus of extensive debate and some controversy.²⁰ Because the ACA sets standards for the essential benefits package and affordability of premiums, most state exchanges will not be required to wrestle with these difficult policy choices unless their state chooses to go beyond the minimum federal requirements.

However, just as exchanges will be required to do under the ACA, the Connector determines eligibility for individuals and groups to purchase through the Connector and receive subsidies. It also determines whether an individual may receive a waiver from the requirement to maintain insurance, enrolls individuals and small employer groups into coverage, and collects and distributes premium payments.²¹

Many observers consider the Connector’s most innovative contribution to the reform landscape to be the web-based mechanism through which consumers and small business owners can make informed, “apples-to-apples” comparisons among health plans and quickly and simply purchase the policy of their choice.

The Connector currently enrolls approximately 220,000 individuals in coverage, through both the subsidized and unsubsidized products. Of this figure, 4,500 are enrolled through small business employers.²² Commonwealth Care, for subsidized individuals, accounts for 38% of the state’s coverage expansion. However, for those who don’t receive subsidies, a large portion of the newly insured continue to access coverage outside of the Connector—as of March 31, 2010, about 72,000 of the newly insured purchased coverage through their employer or on their own from private insurance carriers.²³

While it aims to transform all of Utah's health insurance markets, to date the Utah Health Exchange has focused almost entirely on developing a defined contribution market for the state's employers. This market does not provide state subsidies to enrollees²⁴ and is open only to small businesses. While the state planned a pilot for large group employers in early 2011, as of February it is on hold.

Typically in the small group market, employers choose a plan and contribute toward employees' premiums, while employees have limited plan options. Insurance carriers in Utah's small group market require employers to contribute at least 50% of the premium. The defined contribution market inside Utah's Exchange, by contrast, prohibits insurers from requiring that employers contribute at least 50% of the premium, allowing employers to choose what percentage of the premium they wish to cover or to pay a fixed dollar amount. This set or "defined" contribution option can give employers more predictability in health insurance costs from year to year, but as health costs rise, a set dollar amount may cover less of the total premium that employees face. Unless employers choose to vary contributions based on age, a set dollar amount is also likely to result in older employees paying significantly more in premiums than younger ones.

The greater range of plans available on the Exchange may give families with higher health needs access to plan options with more robust benefits than they would otherwise have, but the defined employer contribution may not be sufficient to make the plan affordable for such employees. Conversely, the greater number of plan options could give an individual or family with low health needs access to a more bare-bones insurance policy at a lower premium. The Exchange's design also allows it to serve as a "premium aggregator," that is, it can allow employees to apply premiums from different sources to the purchase of a product of their choice. Thus, an employee with contributions from multiple employers or a couple with contributions from each spouses' employers can use funds from all available sources to cover a portion of their plan's premium.²⁵

The Utah Exchange's defined contribution market opened in a limited launch in August 2009 to small employers with 2–50 employees. By January 2010, thirteen businesses with 161 employees participated.²⁶ By February 2011, the Exchange reported that 811 employees of small businesses and 1,370 dependents participated, for a total enrollment of 2,181. Relatively low participation has been attributed to higher premium rates inside the Exchange than were available outside, as well as to an onerous application, rating, and plan selection process, which is described below.²⁷

Quality and Choice of Plans for Consumers and Small Businesses

While the roughly 40,000 members of the Connector's CommChoice* program are not currently eligible for premium or cost-sharing subsidies, a key goal of the Massachusetts reform effort is to give these individuals and families confidence that any health insurance product they purchase would provide high quality, cost-efficient, and comprehensive coverage.²⁸ The law thus requires health insurance carriers to receive the Connector's "Seal of Approval," be state licensed, and meet enhanced transparency requirements.²⁹ In determining whether a carrier merits the Seal of Approval, the most recent requirements listed by the Connector include:

- Participate in all CommChoice offerings (i.e., individual, small group, and young adult plans);
- Offer all standardized benefit packages for all plan benefit levels (Gold, Silver, Bronze);
- Offer all products with the broadest possible provider network available to the carrier; and
- Offer products that offer "good value" with comprehensive benefits.³⁰

Currently, seven insurance carriers have received the Seal of Approval and offer products through CommChoice.³¹

*As noted above, the Massachusetts Connector operates two exchanges: CommCare as the marketplace for individuals eligible for subsidies and CommChoice as the entry point for unsubsidized individuals and small businesses. Because CommCare was for several years statutorily circumscribed in the type of plan it could accept, this section focuses primarily on CommChoice as the locus of comparison.

The law requires all carriers with more than 5000 enrollees in the nongroup market to submit a bid to the Connector, but a few carriers have structured their bids in such a way as to make it clear they do not wish to participate.^{32,33} While the Connector has a national reputation as an “active purchaser,” in fact it has never turned away a carrier that expressed a wish to participate, and it offers all of the large and mid-sized HMOs in Massachusetts. As the Connector’s former Executive Director, Jon Kingsdale, observed to us: “The ‘active purchaser’ vs. ‘Travelocity’ dichotomy is a false stereotype of the Massachusetts Connector and the Utah Exchange, perpetuated by...a media that likes simple contrasts.”³⁴

With CommChoice, the Connector engages in an ongoing balancing act. On the one hand, it promises consumers that it will screen carriers based on a high standard of quality.³⁵ And it delivers: of the six participating carriers with sufficient experience to be rated, all receive four stars or an “Excellent” accreditation status according to the health plan report card published by the National Committee for Quality Assurance (NCQA).³⁶ This helps give consumers confidence that they can choose a lower-priced or less well-known plan without sacrificing on quality.

On the other hand, if the Connector sets the bar too high, or imposes requirements that carriers find too burdensome, it will be unable to attract a sufficient mix of the plans that consumers want. Kingsdale uses this analogy: CommChoice is an insurance store, it sells health plans. Without premium subsidies as bait, the store has to offer better value to attract customers, and it cannot do so without a broad choice of plans.³⁷ Recently, the Connector has tried to add more value to CommChoice by streamlining the shopping experience, so that consumers can make easier comparisons among insurance products. The Connector’s interactive website allows consumers to compare products based on benefit tier, monthly cost, annual deductible and insurance carrier.³⁸ And the Connector is planning to launch soon a provider search tool that will allow consumers to determine whether their chosen physicians or hospitals are within a plan’s network.³⁹

In the early years of the Connector, plans were allowed to vary cost-sharing considerably within each benefit level. However, in consumer focus groups, respondents indicated that the degree of choice originally offered

through the Connector was overwhelming.⁴⁰ As a result, the Connector now requires participating carriers to offer a standardized set of benefit packages. Currently, carriers can offer only one Gold product, three Silver products, and three Bronze products. The Connector provides cost-sharing specifications for each product based on their surveys of the market that indicate what products consumers are choosing. As a result of this market research and feedback from participating carriers, the Connector is further streamlining its shelves by limiting the Silver level to just two product designs.⁴¹

The Connector’s limits on plans’ flexibility serve two purposes. First, as indicated above, standardizing the products on the Connector’s shelves makes it easier and faster for consumers to compare like products and make better-informed purchasing decisions. Second, and less obvious, is that standardization limits insurers’ ability to use benefit design to attract healthy individuals and discourage high-risk individuals from purchasing their products. According to Kingsdale: “One objective of reform is to narrow the opportunity for insurers to compete mainly on risk selection. If you can narrow that opportunity, you can focus insurers on value as a business strategy.”⁴²

The Connector’s push for greater benefit standardization has not come without dissent. Health plan representatives in the Commonwealth express concerns that the standardized products limit their efforts to implement value-based benefit design and provider tiering strategies to contain costs.⁴³ Health plans in Massachusetts are, however, only constrained in what they must offer inside the Connector. They can sell innovative new benefit designs outside the Connector, as long as they are compliant with the state’s private insurance rules. However, in its most recent RFP, the Connector is accommodating plans’ concerns by loosening some of the prescriptiveness on cost-sharing.⁴⁴

The Massachusetts Connector’s experience stands in contrast to the approach taken by Utah’s Health Exchange. According to its proponents, one of its key assets is the significant expansion of consumer choice. In 2010, there were 146 plan options for 436 enrollees, although not all of these options are available to everyone.^{45,46} For employees of small businesses who would typically have very limited choice of insurance products, access to the Exchange is likely to result in more

options with respect to plan networks, benefits, cost-sharing arrangements, premiums and insurance carriers.⁴⁷ And proponents believe that enhancing consumer choice will result in consumers choosing products that are more cost effective, which in turn will lead to reductions in the rate of health care cost growth.

Utah's Exchange does have mechanisms to simplify the shopping experience for consumers through software programs that help narrow the options based on family structure, health history, income, and other factors. In practice, however, the large number of choices appears to be overwhelming and confusing to potential enrollees. According to a Utah agent who has worked with many small businesses exploring the Exchange, many employees enroll in the "default" product because they prefer to have their product chosen for them and the default option was most similar to what they had purchased previously outside the Exchange. The Exchange has begun to track data on employees' plan choices and expects to have more accurate information later this year. Most enrollees appear to choose a few plan options. In a survey conducted by the Exchange of employers who registered but did not ultimately enroll, 55% stated that "Choosing a health plan was not an easy process."⁴⁸ One small group purchaser interviewed for this report that tried unsuccessfully to buy coverage through the Exchange in both 2009 and 2010 found the process very confusing and said employees have "too much choice."⁴⁹ In the state's survey following the first launch, 74% of employers said that a broker or agent had helped them through the process.⁵⁰

Massachusetts' Business Express product has also struggled in its early phases, but with somewhat different issues relating to plan choice. The Connector has faced challenges providing an attractive mix of plan choices for employers and their employees. Large carriers attempted to withdraw in 2010 but the Connector leadership, recognizing the importance of having "brand name" products on its shelves, pushed hard to keep those carriers in and most have decided to stay in the program. As the Connector's current Executive Director, Glen Shor, noted to us, for Business Express to be successful, "[w]e need to have some of the most popular plans in the Commonwealth; we need a good selection for people."⁵¹

In its early days, the Connector piloted a small business product similar to Utah's model, the "Contributory

Plan," in which small employers picked a benefit level and employees chose a product within that level. The Connector found through focus groups that small business employees liked the idea of being able to choose their own health plan, as opposed to the traditional approach of having the employer choose it for them.⁵² However, enrollment did not meet expectations. A subsequent evaluation found that administrative complexities and a limited choice of plans (e.g., it included HMOs only) discouraged employers from enrolling.⁵³ The pilot also engendered immediate opposition from carriers, particularly larger ones that perceived a threat to their market share.⁵⁴

As a result, the Connector's leadership decided to create Business Express as a small business exchange that offered traditional small group products, but with lower administrative fees than competing intermediaries. In April 2010, the Connector purchased a book of business from an insurance intermediary that served "micro-groups," businesses of 1–5 employees. Acquiring these small group purchasers from the Small Business Service Bureau (SBSB) accomplished two main goals: Business Express gained an initial 1,641 subscribers and was able to reduce administrative fees from 4.5% to 3.5%, a reduction that was matched by the competing intermediary, saving small employers market-wide roughly \$300 per subscriber per year.⁵⁵ Today, Business Express has roughly 4500 paid members (about 1500 employer groups).⁵⁶

Except for the new business from SBSB, Business Express has been slow to expand its share of the small group market. Many small employers are loyal to their insurance brokers who help them understand their options and access coverage.⁵⁷ And the brokers, in turn, view the Connector as a competitor that has aggressively encroached on their business and reduced their commissions. As one broker representative noted, the legislature's intent in creating the Connector was to connect the uninsured with insurance, not to solicit employers already offering coverage. But the Connector has worked hard to do just that, earning the ire of the broker community. Noting that the Connector had accessed Department of Revenue information to send mailings to all small businesses in the state and tapped state funds to contract with SBSB for their enrolled groups, the broker we spoke to commented on an "insatiable appetite for the Connector to create legislated competitive advantages for itself."⁵⁸

Utah has also found insurance brokers to be critical to the participation of small employers. Without an insurance broker to assist in navigating the choices, it appears to be very difficult for small employers and employees to navigate and understand the wide variety of plan options in Utah's Health Exchange.

Changes required by the ACA in 2014 will require some standardization of plans as an essential benefits package and benefit tiers (Bronze, Silver, Gold, and Platinum) are established. This may address some of the difficulties that consumers and employers currently face in choosing a plan.

Affordability for Consumers and Small Businesses

Perhaps the most important issue with respect to the success of any exchange is the affordability of the coverage. The premiums that employees pay in Utah's Exchange market are complicated by the Exchange's goal of providing for employee choice of plans while still offering group coverage. Essentially the Exchange must first establish a group rate based on the overall risk of the small group and then determine the premium to be paid by individual employees and their dependents. To do so, once an employer expresses interest in participating, the Exchange requires each employee to complete a lengthy health history questionnaire and provide underwriting information to the insurance carriers, who use the information to rate the group. The group's rating and the employer's contribution, combined with the employee's age and family composition, determine the prices that the employee sees when he or she accesses the Exchange website to choose a plan. To mitigate adverse selection among participating carriers, the insurers have a complex system of risk adjustments developed by the Risk Adjuster Board.⁵⁹ As mentioned above, the state does not provide additional subsidies to help employees afford coverage.

Early reaction to the Utah Exchange highlighted *that costs were actually higher inside Utah's exchange*. In response, the state enacted reforms in 2010 to ensure that "comparable coverage" would be priced at the same level in and out of the Exchange. Data are lacking to determine with precision if these reforms have succeeded in ensuring comparable pricing in and out of the Exchange. While Exchange enrollment has grown somewhat, there are reasons to be concerned that prices continue to differ. For the small group purchaser we interviewed, who tried to purchase coverage through the Exchange again in 2010 hoping prices had come down, premiums were \$60–150 a month higher than for a comparable product outside of the Exchange. According to state officials, these pricing

discrepancies may reflect the "non scientific" nature of the underwriting process in which a group rate is assigned based on the health status of each employee. Under the ACA, rating based on health status will be prohibited in 2014, so employees enrolling through the Exchange will no longer have to submit to underwriting.

Another possible reason for the higher rates in Utah's Exchange is that carriers are building in extra risk since they don't know which employees will pick their plans through the Exchange—under its employee choice model, employees of a given business are no longer guaranteed to enroll in the same plan. If this is the case, it suggests that the current system of risk adjustment developed in conjunction with the Risk Adjuster Board is not sufficient to allay the fears of some health plans that they will be the victims of adverse selection when employees are given a choice among multiple plans.

Another issue raised about the effectiveness of the reforms is that pricing need only be comparable for the same carrier and if the group renews on its anniversary date of its current coverage. A number of stakeholders mentioned that because of the difficulties in completing the enrollment process (which includes submitting health questionnaires, group and individual underwriting, and employees choosing their health plan options) by the anniversary date deadline, a group may lose the comparable pricing protection if the timeline is not met.

For Massachusetts, the success and sustainability of its health reform effort hinges on making coverage affordable for consumers and small business owners. At the same time it imposes a requirement that all residents purchase insurance, the Commonwealth confronts some of the highest health care costs in the country, with average family premiums at \$14,723 and projected annual increases in premiums of 6%.⁶⁰

Thus, the Connector not only provides premium subsidies for families up to 300% of the federal poverty level, it also uses its leverage as a “large purchaser” of coverage through CommCare to lower costs for enrollees and taxpayers. As noted above, CommCare is the access point for subsidized health insurance for approximately 158,000 Massachusetts residents. As such it is essentially a separate risk pool, with no “outside” market to compete with. If a resident is eligible for premium subsidies (and not eligible for other coverage), CommCare is the only place to access them.

For CommCare’s first three years, the only plans eligible to participate were four managed care plans under contract with MassHealth, the state Medicaid program.⁶¹ However, the Connector was under no obligation to accept their bids, and has administered the exchange in a manner designed to encourage plans to submit the lowest possible bids. For example, the Connector automatically enrolls participants who fail to choose a plan into the lowest cost plan. The Connector also administers risk sharing to protect plans against enrolling disproportionately costly individuals. And the requirement that enrollees pay the difference if they choose a plan that is more costly drives enrollment to the lower cost plans.⁶²

In addition, in 2009, the statutory limitation on health plans’ eligibility for CommCare ended, and in 2010 the Connector added a new health plan to CommCare: Celticare, sponsored by Centene, a national for-profit Medicaid carrier. According to some observers, the Connector worked hard to ensure Celticare’s participation, with an aim to expand members’ plan choices and leverage lower prices from the original four plans.⁶³ This effort was successful, resulting in the first new plan in Massachusetts in almost two decades, and successfully garnering lower bids from the other participating plans.^{64,65}

The Connector’s efforts to aggressively manage cost growth in CommCare have produced savings for the state. Since the inception of CommCare in 2006 through fiscal year 2010, the average annual rate of increase in CommCare premiums per covered person has been held under 5%—about half the rate of growth in commercial health insurance. The resulting savings for the state are estimated to be \$16–\$20 million in FY 2010, and roughly \$21 million in savings expected in FY 2011.⁶⁶

The Connector has far less ability to constrain cost growth or provide cheaper products inside CommChoice. As noted above, state law requires that prices for health insurance products be the same inside and outside the Connector.⁶⁷ As a result, if plans were to offer discounts to the Connector, they would have to commensurately lower their prices for plans outside the Connector. As one Board member told us, CommChoice is a small book of business for the plans, meaning the Connector doesn’t have sufficient market power to demand big discounts.⁶⁸

However, the Connector leadership points to empowered consumer decision-making as one mechanism for helping connect people with lower prices for coverage. Within CommChoice, plans with a lower cost structure have a greater market share inside than they do in the outside market. Conversely, one of the Commonwealth’s higher-cost plans with a gold-plated network has a smaller market share inside the Connector than it does outside. Kingsdale and others attribute this to consumers’ ability to shop with confidence among plans that have received the Connector’s Seal of Approval, and use web-based tools to compare benefits.⁶⁹

Providing affordable insurance options has been a challenge in Business Express, the Connector’s small business exchange. Almost everyone we interviewed agrees: this is one area in which the Connector has fallen short of its goals. The reasons cited are numerous: the urgency to launch the individual market exchange led to a lack of early focus on the small group market, opposition from brokers and health plans, and the inability of the Connector to differentiate itself from existing purchasing pools (called intermediaries) that currently serve most small businesses.⁷⁰

As yet, the Connector has been unable to meet small employers’ most pressing need: lower insurance prices. The Connector’s proponents hope that it can soon gain a modest price advantage with employers through further cuts in administrative charges and a new state initiative to offer subsidies and technical assistance to small businesses that establish wellness programs. This assistance is available only to eligible businesses that enroll through the Connector.⁷¹ In addition, beginning in 2014, the ACA will provide health insurance tax credits to eligible small businesses in both Utah and Massachusetts, if they enroll through the state insurance exchanges.⁷²

Outreach and Access

By any measure, Massachusetts has done extensive work to educate residents and businesses about the 2006 reforms. Observers have summed it up as a “top down, bottom up” approach.⁷³ Outreach included mailings to new residents with the help of the state realtors’ association, mailings to all taxpayers and small businesses through the Department of Revenue, informational posters and brochures at the Registry of Motor Vehicles and paid advertising—television, radio and print.⁷⁴

In addition, the Connector staff sponsored 30 events in 20 communities designed to educate and, where possible, enroll individuals. The Connector’s partnership with the Boston Red Sox was also particularly helpful in reaching younger uninsured residents, particularly young men, with information about the new requirement to obtain health insurance.⁷⁵

The Connector relies on the Medicaid program to perform CommCare eligibility and enrollment functions, which has been helpful in simplifying enrollment in subsidized insurance.⁷⁶ In addition, the Connector uses one application for all public programs, so that individuals don’t have to apply to multiple agencies to find out for which programs they are eligible. And the Connector has staff devoted to troubleshooting consumers’ enrollment issues.⁷⁷

Moreover, the state spends \$3.5 million annually in grants to 51 community based organizations to provide application and renewal assistance. A recent evaluation has concluded the grant program has played a “significant role in achieving the health care reform goal.”⁷⁸ One observer noted that many community groups are “deputized” to work directly with state Medicaid and CommCare enrollment staff to resolve consumers’ problems and help them enroll in the right program.⁷⁹ Many of these groups have found that consumer outreach needs to be continuous. Because many individuals first enroll through a hospital or clinic when they have an immediate health care need, it can be more difficult to get them to renew their coverage a year later when they are healthy and don’t place as high a priority on health insurance.⁸⁰

A number of features make enrollment relatively simple. As mentioned above, the Connector website facilitates a

simple, streamlined shopping experience for individuals signing up through CommChoice. And as one former Board member told us, both the process and prohibition on medical underwriting make the shopping experience “respectful” by removing the requirement that a potential enrollee report any pre-existing conditions.⁸¹ In fact, 70% of those who complete an application for CommChoice enroll in coverage.⁸²

However, other features are unnecessarily complicated and present barriers for consumers. For example, coordinating coverage between public programs and private plans has not been seamless. In particular, the dates for enrollment and disenrollment between public and private coverage are not aligned, so that individuals losing Medicaid eligibility early in a month must wait until the first of the following month to enroll in CommCare.⁸³

The legislature also recently enacted open enrollment periods in response to concerns about individuals “jumping” from self-insured employer-sponsored plans to individual market coverage in order to access state-mandated benefits such as bariatric surgery and IVF.⁸⁴ The state also changed the definition of “eligible individual” to exclude those with access to employer-sponsored coverage.⁸⁵ These changes have resulted in a small decline in CommChoice enrollment.⁸⁶

Given the relatively low enrollment in Utah’s Exchange, the question arises as to how many of the barriers to participation are related to cost, difficulties inherent in any change, and/or enrollment barriers and complexity in the system. According to the state’s survey of employers, high cost was the primary reason for nonparticipation. However, 21 of 66 surveyed groups didn’t participate because of the complexity of the health questionnaire (necessitated by the underwriting process), the application process, the timeline and other factors. The top specific reason given (55%) was that the “Universal Health application was very difficult and hard to complete.”⁸⁷

While the health questionnaire has been improved, it still appears to be a barrier to participation (in concert with the short timelines employers and employees have to participate in the process). When reapplying in 2010, employees of a small group purchaser that had applied the

previous year found the form a little more user-friendly but employees still had to provide a great deal of medical history and had to start from scratch even though they had filled out the questionnaire in the previous year.⁸⁸ Employees often expressed concerns about the intrusion into their privacy inherent in the process.⁸⁹ As noted above, once the ACA's rating reforms are implemented in 2014, employees should no longer be required to complete a health underwriting questionnaire.

The Utah Exchange has also struggled with its technology, currently being provided by private vendors. Numerous problems were identified, from login passwords not working to employees being charged premiums for someone who isn't enrolled.⁹⁰ Because Utah's Exchange is run with such a limited staff and investment from state government, it is hard to resolve glitches as they arise. Funding provided through the ACA may help the state address some of these issues.

Lessons Learned

States seeking to establish their own exchanges do not need to choose either the Massachusetts or the Utah model. While the ACA sets some minimum standards (i.e., eliminating health status rating, limiting consumers' out-of-pocket costs, and requiring coverage of a comprehensive set of benefits), states have considerable discretion to pick and choose elements from Massachusetts and Utah that will best serve the residents of their state.

Choice and Quality

Because choice and quality of coverage are so critical to consumers and small business owners, many states will want to pay critical attention to the role of their exchange in providing consumers with a reasonable number of attractive plan choices. Reaching a reasonable number requires striking a balance between establishing consumer protections and making the exchange attractive for plans. Many experts have observed a dichotomy between exchanges that act as an active purchaser and those that serve as a market organizer. The Massachusetts' and Utah's experiences demonstrate that whatever the strategy, exchanges must be attentive to the needs of both consumers and insurance carriers.

In Massachusetts' case, rather than "active purchaser," a more apt description of the Connector's market role when it comes to CommChoice would perhaps be "active market organizer."⁹¹ While it has little leverage to negotiate on price with insurance carriers, it can and does effectively use its management of the store shelves to provide consumers with high-value products.

For exchanges that pursue a strategy geared toward active purchasing, it requires sensitivity to the markets in which

the exchange operates, nimbleness in adjusting standards in response to data on consumers' preferences, and working in partnership with plans to provide products that meet consumers' needs. As noted by one Connector board member, being an aggressive purchaser requires a lot of work, staff time and market expertise. She went on to say: "If you want to take 'any willing plan,' it's a lot easier. But then you don't add much value, either."⁹²

Utah's Exchange is open to any willing carrier that meets certain minimal requirements and features a large number of individual products offered by four carriers. The four carriers participating in the Exchange represent a combined 62% of market share in Utah's group market. Of the top five carriers, three are participating.⁹³ A market organizer strategy, therefore, does not guarantee participation of carriers—exchanges must work to attract and keep carriers that offer good value. This job will be made easier in 2014, when plans will need to participate in exchanges in order to access premium subsidies.

In addition, the significant number of employees in Utah's Exchange who simply remain in the product they were in before suggests that, at least initially, employees need substantial help in choosing among insurance options. Both Utah and Massachusetts' experiences indicate that too many product choices can be overwhelming for consumers.⁹⁴

Affordability

It appears that for exchanges to be successful, they must address the critical issue of affordability of coverage. Premiums for family coverage in an employer-sponsored plan average \$13,770 nationally, making comparable coverage in an exchange unaffordable without substantial subsidies.⁹⁵ This fact, coupled with the ACA's requirement

that individuals purchase insurance, make premium and cost-sharing subsidies essential to helping people obtain adequate and affordable coverage. Recognizing this, Massachusetts made their first priority the operation of their subsidized program, CommCare. As a result, they have had substantial coverage gains for families under 300% FPL, from 77% in June 2006 to 91% in the Fall of 2009.⁹⁶ Conversely, where coverage is unsubsidized, i.e., in the Massachusetts CommChoice program and Utah's Health Exchange, cost remains an enormous challenge for individuals and small business owners, and enrollment has been far less robust. In 2014, the ACA will provide subsidies for families up to 400% FPL that enroll through exchanges, substantially expanding access to more affordable coverage. But for unsubsidized individuals and small business owners, an insurance exchange by itself will not make coverage more affordable.

Utah has worked to address the affordability of coverage for small business owners by allowing them to make a defined contribution to their employees' premium. While there may be significant benefits to a defined contribution/employee choice model, there are drawbacks as well. Employees tend to like the idea of greater choice, but fixing employer contributions to a set dollar amount, especially in the absence of any subsidies, is likely to raise the proportion paid by employees as health costs increase over time.

One effect of the model is to minimize the employer's role in health insurance decisions—they provide only a fixed contribution while the exchange organizes plan options and employees choose among them. But employers contribute to premiums because they see providing coverage as a means to attract workers in competitive labor markets. These employers compete based on their ability to provide affordable and high quality coverage to their employees, and this often requires significant levels of employer contributions and involvement in choosing a plan. Moreover, the owners of small businesses often use their companies' group policies to purchase coverage for themselves and their families. As one insurance industry representative told us, employers continue to look at the purchasing decision as one that turns on the overall value to the group, rather than a matter for individuals to weigh and decide for themselves.⁹⁷

Over the longer term, as federal and state policymakers work to implement payment and delivery system reforms that, over time, could moderate the growth in health care spending, they should not neglect the potential of

exchanges to “bend the cost curve.” For example, states could build on the work in Utah and Massachusetts to implement web-based decision-tools to guide consumers towards more value-oriented plan choices.⁹⁸ Because the ACA requires minimum quality standards for all participating plans, consumers signing up through exchanges will be able to shop for less expensive plans with more confidence that they are getting a quality product.

Outreach and Access

An early and important job for all state exchanges will be public education, outreach and enrollment. Exchanges don't just need health plans to participate. They will need to attract a critical mass of enrollees and/or small businesses to be sustainable.⁹⁹

One critical lesson from Massachusetts is that a big early investment in education and outreach is essential. Studies have demonstrated that the Commonwealth's “top down, bottom up” approach, including \$3.5 million annually in grants to local community groups to knock on doors and public service announcements from the Red Sox were key to reform's success in that state.¹⁰⁰ The Massachusetts experience also illustrates the importance of sustaining those efforts after the initial launch to ensure consumers are aware of their options when it comes time to renew their coverage.

Once consumers are motivated to shop for insurance through the exchange, states must also make the eligibility and enrollment process as simple and easy as possible in order to ensure that enrollment is robust. As discussed, Utah's complicated health questionnaire was the top specific reason given by employers who chose not to enroll through the Exchange.¹⁰¹ The extremely small budget and staff of Utah's exchange appear to have limited the state's ability to address problems that have arisen in the enrollment process—problems which have clearly contributed to low enrollment in the Exchange.

In conclusion, the experience of both Massachusetts and Utah underscores the importance of ongoing refinement as feedback is obtained from both consumers and small employers who interact with the exchange. Exchanges will need some degree of authority and flexibility to identify and respond to consumers' needs as they are identified. Involvement of consumers in the exchange governance structure, as well as focus groups and other efforts to solicit feedback from “end users” of the exchange will prove critical to ensure that exchanges function effectively.

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