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Issue Brief

The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions

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ABSTRACT: The Commonwealth Health Insurance Connector Authority is the centerpiece of Massachusetts' ambitious health care reforms, which were implemented beginning in 2006. The Connector is an independent quasi-governmental agency created by the Massachusetts legislature to facilitate the purchase of affordable, high-quality health insurance by small businesses and individuals without access to employer-sponsored coverage. This issue brief describes the structure and functions of the Connector, providing a primer to policymakers interested in exploring similar reforms at the state and national level. The authors describe how the Connector works to promote administrative ease, eliminate paperwork, offer portability of coverage, and provide some standardization and choice of plans. National policymakers looking to achieve similar policy goals may find some of the structural components and functions of the Connector to be transferable to a national health reform model, say the authors.

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BACKGROUND

President Obama and members of Congress are poised to reform the U.S. health care system to ensure affordable access to health insurance for all Americans. As policymakers consider options for reaching this goal, they may wish to take a close look at the model chosen by the Massachusetts legislature to implement much of the state's comprehensive health reform law: the Commonwealth Health Insurance Connector Authority (Connector). The Connector, an independent quasi-governmental agency, was designed to facilitate the purchase of affordable, high-quality health insurance by small businesses and individuals without access to employer-sponsored coverage. This issue brief describes the structure and functions of the Connector, providing a primer to policymakers interested in exploring similar reforms at the state and national level.[1]

Under Chapter 58 of the Acts of 2006, Massachusetts restructured how private insurance is purchased, sold, and administered, and how public subsidies

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are delivered. The Connector serves many integral functions, including the management of both Commonwealth Care and Commonwealth Choice, the two insurance programs developed to increase statewide coverage. In this intermediary role, the Connector assists individuals and businesses in acquiring health coverage. The Connector also serves numerous policy, administrative, and outreach functions to facilitate effective implementation and execution of the health reform law.

Other features of the new law which interact with the Connector include a requirement that most employers arrange for the purchase of health insurance by their employees on a pretax basis and an individual requirement to maintain health insurance coverage. Therefore, the Connector is part of a larger reform plan, whose innovation may lie in its ability to bring various components of the reform together.

Although the exact configuration and features of the Commonwealth's Connector may not be applicable nationwide, it can serve as a model which can be adapted to meet the nation's policy goals. The success of the Connector has reinvigorated discussion around whether this model, alone or in combination with other features, can help solve the nation's uninsured problem.

CONNECTOR STRUCTURE AND FINANCING

The Connector is a self-governing, separate legal entity from the Commonwealth of Massachusetts and includes features typical of both public agencies and private organizations. It also contracts with other state agencies and private businesses in implementing the Commonwealth Care and Commonwealth Choice insurance programs.

The revenue sources for the Connector include a mixture of state funding and revenue from operations. After an initial infusion of $25 million in state appropriations, ongoing operations are funded by revenues obtained through retention of a percentage of premiums collected on both the subsidized and nonsubsidized insurance products administered by the Connector.

The Connector is governed by a 10-member board consisting of private and public representatives appointed by the governor or attorney general and chaired by the Commonwealth's secretary for administration and finance. The Board approves all major policy, regulatory, and programmatic decisions, and generally meets on a monthly basis. Meetings are held in a public forum, with meeting minutes made available to the public through the Connector's Web site. According to its report to the legislature, the Board met 25 times during its first year to determine a number of important decisions.

The Connector's leadership team comprises 10 senior staff members, and the agency employs approximately 50 individuals overall. Some employees work exclusively on Commonwealth Care and some on Commonwealth Choice, while others have responsibilities that include both programs as well as regulatory and policy development. In addition to staff hired by the Connector, the Connector contracts with other organizations to complete various functions. For example, it has a contract with a vendor, a "subconnector," for handling administrative functions associated with the Choice program, such as eligibility and enrollment assistance, customer support services, and premium billing, collection, and remittance services.

FUNCTIONS OF THE CONNECTOR

The Connector has been charged with creating an exchange whereby affordable health insurance options are made available to previously uninsured or underinsured residents. It now manages two new health insurance programs: Commonwealth Care (Care) and Commonwealth Choice (Choice). Care is a subsidized insurance program available to adults earning up to 300 percent of the federal poverty level (FPL) who do not have access to employer-sponsored insurance (ESI) or other subsidized insurance and who meet additional eligibility guidelines. Choice is a commercial insurance program available to individuals not eligible for subsidized coverage and to small employers. The Connector began offering Care products in October 2006 and Choice products began enrolling

individuals in May 2007. Choice group products also became available to small employers in December 2008. The Connector facilitates enrollment of individuals into both subsidized and unsubsidized insurance plans. Administrative tasks required for the implementation and management of these programs are described below. Because Care was implemented first, more information is available about the experiences of this program.

Commonwealth Care

Benefit Packages and Premium Contribution Schedule

The Connector is responsible for establishing the benefit package and premium contribution schedule for those with incomes between 150 percent and 300 percent of FPL (details for those under 100% FPL were outlined in statute). This set of decisions is particularly challenging for the Connector's staff and board, as they need to consider a number of issues, such as minimizing incentives for crowd-out, costs to government and individuals, and equity among state programs. In September 2006, the Board approved the initial benefit package and enrollee contribution schedule for Care, and enrollment began on October 1, 2006.

For individuals earning 150 percent of FPL or less, coverage is similar to the Medicaid program, with identical cost-sharing features and no monthly premiums. For individuals earning between 150 percent and 300 percent of FPL, monthly premiums begin at a low level and increase with income, approximating a gradual move to private insurance. Premiums, copayment schedules, and benefits approximate typical employer-sponsored health insurance for people above 200 percent FPL, although no deductibles are allowed in the Care plans. All plans must cover preventive care services, inpatient services, outpatient services, inpatient and outpatient mental health services, substance abuse services, and prescription drugs.

The initial Care program was composed of four different plan types, each with a corresponding cost-sharing arrangement. Income levels solely determined assignment to Plan Type 1 (less than 100% of FPL) and to Plan Type 2 (100.1% to 200% of FPL). Members earning between 200.1 percent and 300 percent FPL could choose between Plan Types 3 or 4. Plan Type 3 offered lower premium contributions with higher copayments, while Plan Type 4 required higher premium contributions with lower copayments (Table 1).[2]

Plan Selection and Procurement

Pursuant to the health reform law, from July 1, 2006, through June 30, 2009, the Connector is allowed to contract only with Medicaid managed care organizations (MMCOs) under contract with MassHealth

Table 1. Commonwealth Care Plan Types by Copayments and Premium Contributions

Plan Type	Household Income (as % of FPL)	Enrollee Cost-Sharing	Lowest Premium Available (7/1/08)
1	0%–100%	Copays only for Rx* ($3 copayment for *nonemergency* visits to emergency room)	$0
2A	100.1%–150%	Copays for Rx and all medical services	$0
2B	150.1%–200%	Copays for Rx and all medical services	$39
3	200.1%–300%	Copays for Rx and all medical services (lower premium, higher copays compared with Plan 4)	200.1%–250% FPL: $77 250.1%–300% FPL: $116
4	200.1%–300%	Copays for Rx and all medical services (higher premium, lower copays compared with Plan 3)	(eliminated in July 2008)

Source: Report to the Massachusetts Legislature, 2008.

(Massachusetts' Medicaid program) to provide managed care services for individuals enrolled in the Care program. Thus, in the summer of 2006, the Connector issued a request for responses (RFR) to the four MMCOs to solicit bids. These MMCOs were: Boston Medical Center Health Net, Cambridge Health Alliance's Network Health, Fallon Community Health Plan, and Neighborhood Health Plan. All four MMCOs responded to the RFR and all four were selected to participate in the program. Contracts with these MMCOs were effective from October 1, 2006, through June 30, 2008.

In early 2008, the Connector undertook a contract renewal process with the four MMCOs (completed in the spring of 2008 for fiscal year 2009). This procurement included extended negotiations with the four MMCOs, resulting in contracts with increased copayments and member contributions that were designed to lower the aggregate increase in MMCO capitation rates from 15.4 percent to 9.4 percent. When this contract concludes in June 2009, the Connector will not be statutorily limited to these four MMCOs and is authorized to open up bidding to other health insurers.[3]

In October 2006, the Connector began enrollment in the Care program for eligible adults earning 100 percent of FPL or less. Eligible individuals in this income bracket who had enrolled in the Uncompensated Care Pool in the current fiscal year were automatically enrolled in the Care program. In January 2007, enrollment was opened to eligible individuals earning 300 percent of FPL or less. Enrollees are required to stay in their MMCO for one year or until they have an open-enrollment period to switch plans. Open-enrollment periods occur annually. In addition, the Connector may also conduct additional open enrollments if or when significant changes to plans are made.

Eligibility

Commonwealth Care provides health insurance coverage to adults who are uninsured and meet specific eligibility requirements as defined by statute.[4] These requirements include:

- must be a U.S. citizen/national, qualified alien, or alien with special status;
- must be a resident of Massachusetts for the previous six months;
- must not be eligible for any MassHealth program or for Medicare;
- must be age 19 or older;
- must not have been offered health insurance coverage through an employer in the last six months for which he/she is eligible and for which the employer covers 20 percent of the annual premium cost for a family insurance plan or at least 33 percent of the cost for an individual insurance plan;
- must not have accepted a financial incentive from his/her employer to decline ESI; and
- must have family income at or below 300 percent of FPL.

Additional eligibility guidelines were passed by the board specifying that individuals eligible for TriCare (federal health insurance program for active military members), the Massachusetts Fishermen's Partnership (state health insurance program for low-income fishermen), Qualifying Student Health Insurance Programs (for college students in Massachusetts), or the Massachusetts Division of Unemployment Assistance's Medical Security Program (subsidized health coverage for people collecting unemployment benefits) are not eligible for Commonwealth Care.

The Connector works in conjunction with MassHealth in the operations of Commonwealth Care. MassHealth played a central role in the initial eligibility and enrollment process. In order to facilitate implementation of Commonwealth Care in a short timeframe, the Connector amended MassHealth's existing contract with a vendor to assist them with a variety of administrative functions, such as enrollment, premium

billing, and customer service support. The Connector has since employed a formal bidding process for these services and contracts with a different vendor than MassHealth.

Program Integrity

The Connector is responsible for ensuring program integrity for the Care program. This includes monitoring and reporting on customer service needs of enrollees, as well as ensuring that public dollars are being appropriately spent.

Beginning in late 2007, the Connector initiated annual eligibility redeterminations, which update all of the information that affects a member's eligibility—income, household size, and availability of other health insurance. In addition to annual redeterminations, change in member circumstances at any time during the year prompt eligibility checks. This process ensures that the program is meeting state and federal requirements and helps guarantee that individuals are enrolled in the most appropriate health insurance program.

As another part of the eligibility monitoring process, the Department of Revenue (DOR) provides information to MassHealth throughout the year on changes in the reported income of Massachusetts residents compared with membership in MassHealth and the Care program. When differences exist between information contained in the DOR file and the Care membership file, the Connector contacts the member with the discrepancy to determine whether income changes have occurred. This process both redetermines eligibility and ensures that individuals are enrolled in the most appropriate program or plan type if still eligible for Commonwealth Care or MassHealth.

In order to minimize "crowd-out" of existing health insurance, the eligibility process for Care requires individuals to indicate if they currently have ESI or had access to ESI in the last six months. The Connector monitors this process; if an individual responds positively to the question or provides information that suggests this possibility, the Connector follows up directly with the applicant to confirm if ESI is obtainable.

The Connector additionally contracted with an outside vendor for further assistance with eligibility determinations. The vendor conducts data-matching to determine if an individual enrolled in the Care program is currently enrolled in alternative commercial insurance or has access to ESI. The vendor then verifies the policy information—premium levels, effective dates, and coverage types—to determine whether the applicant/member is still eligible for Commonwealth Care. Based on this review, the Connector then makes a determination as to the applicant/member's continued eligibility for Commonwealth Care.

Lastly, during the summer of 2008, the Connector began an operational audit of the MMCOs. The Connector contracted with a vendor to conduct this audit. Its activities included: an audit of claims adjudication, payment accuracy and reporting, an assessment of the adequacy and competitiveness of the provider networks, and an evaluation of the effectiveness of care management programs and other operational and administrative activities.

Waivers and Appeals

The Connector has developed a waivers-and-appeals process for the Care program. An enrollee may make any one of the following three requests or appeals: 1) request a waiver or reduction of premiums or a waiver of copayments due to extreme financial hardship; 2) request a change of health plans during the plan year (i.e., at a time other than open enrollment); or 3) file an appeal to challenge decisions related to Commonwealth Care. The Connector adopted a review process, subsequently reviewing and tracking requests and appeals.[5]

Risk-Sharing

The Connector included several provisions in its contracts with the MMCOs in order to address risk with the Care population. All plan types included an aggregate risk-sharing program. Under these initial contracts negotiated with the MMCOs, the Connector will share half of an MMCO's costs if actual medical expenditures are more than 5 percent above total capitation payments to the MMCO.[6] On the other hand, if actual

medical expenditures are between 50 percent and 95 percent of an MMCO's total capitation, the MMCO must share the savings with the Commonwealth. These provisions are intended to enable the Connector to control program costs while decreasing financial risk for the state and the participating MMCOs. In addition to the aggregate risk-sharing provision, the Connector includes an arrangement in which each MMCO pays 1.25 percent of the monthly capitation payment to the Connector for a stop-loss pool. If the costs for a specific enrollee exceed $150,000, the stop-loss pool covers the rest of the cost.[7]

Budget

A number of variables have a direct impact on the cost of the Care program, the most significant being the total number of enrollees and the demographic/health mix of enrollees. Health care utilization levels and appropriate capitation rates were initially difficult to establish for Care enrollees. The actual capitation rate paid to each MMCO per enrollee varies based on the age, gender, and residence of the member, as well as the plan type. As described previously, to account for this uncertainty, the Connector used provisions intended to provide both the Commonwealth and the MMCOs with some financial protection.

As illustrated in Table 2, spending on the Care program exceeded early budget projections for FY 2008 by more than $150 million because of higher-than-anticipated enrollment. The monthly cost per member for Care enrollees has remained close to budget for the past two years. No results have been reported to date with respect to biased selection among plans.

Commonwealth Choice

Plan Selection

The Connector solicits bids from insurers and selects the health insurance plans for the commercial health insurance Choice program. In January 2007, Connector staff received and reviewed the submissions from 10 insurance carriers and recommended that the Board approve contracts with six. These selected carriers were: Blue Cross Blue Shield of Massachusetts (BCBS-MA), Fallon Community Health Plan (FCHP), Harvard Pilgrim Health Care (HPHC), Health New England (HNE), Neighborhood Health Plan (NHP), and Tufts Health Plan (Tufts). The board gave the Connector Seal of Approval (SOA) to all seven plans offered by each of these carriers. The SOA confirms that these health benefit plans offer consumers good quality and value, according to standards set by the Connector.

The plans are designated as Gold, Silver, or Bronze based on their actuarial value, which is the amount of an average person's health care costs they are deemed to cover. A fourth level, Young Adult Plans (YAPs), was created exclusively for young adults ages 19 to 26 and offers a somewhat narrower benefit package (Table 3).

Implementation

Implementation of Choice occurred in phases. In May 2007, health insurance products were available for individual (nongroup) purchase from the Connector. Consumers were able to learn about the various health insurance plans and purchase insurance online at the Connector Web site (www.MAhealthconnector.org) or by contacting the enrollment call center at

Table 2. Commonwealth Care Expenditures for FY2008

FY 2008 Budgeted and Actual	FY08 (Budget)	FY08 (Actual)	FY08 (Variance)
Year-End Membership	147,774	175,617	27,843
Average Capitation Rate per Member per Month	$358.64	$351.76	($6.88)
Total Spending Including Risk-Sharing	$471,937,546	$627,658,743	$155,721,197

Table 3. Commonwealth Choice Monthly Premium Ranges by Plan Level

Plan Type	Monthly Premium Range (August 2008)
Gold	$337–$551
Silver	$269–$415
Bronze	$193–$287
Young Adult Plan (with Rx)	$158–$196
Young Adult Plan (without Rx)	$133–$176

* These premium ranges represent the range in monthly premium costs among those plans available to a single 35-year-old living in the Boston area. For Young Adult Plans, the premium range represents those plans available to a single 25-year-old living in the Boston area.

1.877.MA.ENROLL. Coverage was effective beginning on July 1, 2007.

In September 2007, the Connector began offering a voluntary (noncontributory) insurance program for employees without access to ESI. The employer creates a "Section 125 plan" for part-time, contract, or other employees not eligible for ESI, while not contributing to the actual purchase of health insurance. A Section 125 plan allows employees to purchase health insurance with pretax dollars. Using a Section 125 plan, eligible employees can then purchase a health plan through the Commonwealth Choice program.

In December 2008, the Connector launched the Contributory Plan, which allows small employers with 50 or fewer full-time employees to subsidize their employees' purchase of health insurance through the Choice program. During the current pilot phase, the plan is only available through certain pilot brokers. An employer selects a level of plan for their employees (Gold, Silver, or Bronze), agrees to pay 50 percent toward employee premiums, and a base employer contributory amount is determined.[8] Employees can then take that base employer contribution and buy up or buy down within the tier of coverage selected by the employer. Employees may not buy a product outside the tier selected by their employer.

Cost Containment

The Connector has implemented several cost-containment strategies within its Choice program. During the Connector's renewal procedures for Choice plans, the specifications addressed the importance of cost control to the success of health reform and promoted strategies to control costs—instead of simply shifting costs from the member's monthly premiums to greater point-of-service cost-sharing. One idea was to introduce limited or tiered networks, which can reduce monthly premiums without increasing cost-sharing or restricting access. Four carriers offer limited network plans through the Connector. The Connector also encourages carriers to submit plans that do not exceed a 5 percent annual increase in the base premium rate.

CONNECTOR POLICY FUNCTIONS

In addition to managing the Care and Choice programs, the Connector has responsibility for developing several policy and regulatory components of the reform. These include: defining "Minimum Creditable Coverage" for the individual mandate, establishing an affordability schedule for the individual mandate, developing regulations to implement Section 125 plans for employers, outreach and marketing, customer service, and overall financial management of the Connector model.

Minimum Creditable Coverage

Most Massachusetts adults must be covered by an insurance policy that meets Minimum Creditable Coverage (MCC). MCC identifies the set of benefits that serves as the benefit "floor." The state statute directs the Connector Board to define what constitutes MCC on an annual basis for those covered by commercial insurance, while also designating certain health coverage types as meeting creditable coverage, such as MassHealth, or Medicare Parts A or B. The

definition of MCC establishes the coverage level that individuals must have to satisfy the individual mandate.

In the development of a definition of MCC, the Connector considered affordability and comprehensiveness of benefits. The Connector held hearings on draft regulations throughout Massachusetts to ensure adequate community input into the creation of these definitions.

The current regulations require individuals to have a health insurance plan that provides a "broad range of medical services," including:

- inpatient acute care, physician services, diagnostic tests and procedures, outpatient care, and prescription drugs;
- deductibles that are capped at $2,000 for an individual or $4,000 for a family each year;
- visits to the doctor for preventive care covered prior to a deductible;
- an annual cap on out-of-pocket spending of $5,000 for an individual or $10,000 for a family (for plans with upfront deductibles or coinsurance on core services);
- no cap on total benefits for a particular sickness or for a single year.[9]

The Connector Board developed a transition to the MCC requirements in order to minimize disruption of employer-sponsored insurance and allow sufficient transition time for plans to meet the new benefit requirements. Prior to January 1, 2009, individuals enrolled in a plan that meets state licensure requirements or a self-insured plan offered by an employer that meets federal ERISA requirements were considered to be in compliance with the individual mandate. Beginning January 1, 2009, an individual must be enrolled in a plan that meets the standards described above for MCC compliance or be covered by one of the statutorily-defined "creditable coverage" plans.

Affordability Schedule and Individual Mandate

The Connector is responsible for developing an annual affordability schedule that specifies maximum monthly premiums for an MCC-compliant plan for individuals, couples, and families based on a progressive, sliding-income scale. The affordability schedule is used to determine which health insurance options are considered affordable and, thus, appropriate for an individual to be compliant with the individual mandate. If the monthly contribution to ESI or the monthly premium for the lowest-cost insurance plan available through the Connector does not exceed the corresponding maximum monthly premium for the individual's income bracket, the adult will be deemed able to purchase affordable health insurance. Individuals who are determined to be able to afford coverage but do not acquire it must pay a tax penalty.

The Connector staff drafts the affordability schedule and holds statewide hearings to obtain feedback. Next, the Board must approve the final affordability schedule. The Connector Web site also provides an interactive "affordability tool" to help individuals determine if they have the option of an affordable health insurance plan.

The Connector and DOR jointly developed a system to handle appeals and waiver requests filed by individuals regarding the individual mandate and the tax penalty. The Connector also developed a process that allows individuals to obtain a certificate of exemption (COE) or waiver prior to filing their taxes. For instance, when the affordability tool reveals that an individual may not be able to access an "affordable" plan, the individual may apply to the Connector for a COE before filing taxes. Individuals may also apply for a COE if they have suffered a hardship that prevents them from being able to afford the lowest-cost plan available. If granted a COE, the individual receives a letter with a certificate number to provide to DOR to indicate exemption from the mandate when filing her or his Massachusetts income tax.

Section 125 Plan

The Connector develops regulations to implement the Section 125 plan requirement for all employers with 11 or more full-time employees. A Section 125 plan allows employees, both part-time or full-time, to purchase insurance with pretax dollars, making the net cost of health insurance more affordable by using pretax payment of premiums. The Connector provides Section 125 plan communications materials for both employers and employees; employees without access to subsidized coverage can enroll in the non-contributory plans through the Connector as mentioned earlier.

Outreach and Marketing Functions

The health reform law required extensive marketing, public education, and outreach around the various components of the law. For consumers, the focus was on the insurance mandate while the business community needed to be educated about the MCC, the requirement for a Section 125 plan, and other issues.

The Connector established its own Public Information Unit (PIU) to respond to inquiries regarding health reform from the public and employers. In addition, the Connector launched numerous public education and outreach campaigns, collaborating with state agencies, community organizations, and corporate and civic organizations. The Connector's many outreach and marketing activities were supported by advertising campaigns of the insurance carriers (MMCOs and commercial insurers). The activities included:

- A series of statewide forums called Connect-to-Health events. In collaboration with state legislators, municipal officials, local hospitals, community health centers, and community groups, the Connector sponsored 30 events in 20 communities across the state;
- A postcard mailing to nearly 3 million Massachusetts taxpayers. The card provided information on the requirements of the new law and the opportunities for purchasing insurance through the Connector;
- Outreach activities in collaboration with the Massachusetts Bay Transportation Authority (MBTA). Public education included display posters addressing the law in MBTA cars and tear-away note cards for contacting the Connector in order get additional information on health insurance programs;
- Partnerships with several corporate and civic organizations in order to disseminate information on health reform to the public, including CVS stores and the Boston Red Sox baseball team.

The PIU responds to public inquiries regarding the health reform law via e-mails, letters, and direct calls. The issues the PIU addresses pertain to the individual mandate, employer requirements under health reform, and MCC.

Customer Service

The Connector has established a call center system for responding efficiently to the customer service needs of individuals interested or enrolled in either the Commonwealth Care or Commonwealth Choice programs.

The Connector also developed and manages a Web site (www.MAhealthconnector.org) that serves as a gateway to assist individuals and other parties in acquiring information on the new requirements and options associated with health reform. The Web site provides consumers with information about the both the Commonwealth Care and Commonwealth Choice programs. In addition, the site allows individuals and members of small groups to browse and compare the different health insurance plans available to them. Individuals can purchase and enroll in Commonwealth Choice plans through the site. It also provides tools and information to assist individuals in determining eligibility for Commonwealth Care as well as instructions for completing the application process. However, individuals cannot enroll directly in Commonwealth Care online, since eligibility screening must be conducted by MassHealth.

Table 4. Administrative Fees for Commonwealth Care and Commonwealth Choice

	FY07 administrative fee	FY08 administrative fee	FY09 administrative fee
Commonwealth Care	5%	4.5%	4%
Commonwealth Choice	(revenue generated began in FY08)	4.5%	4.5%

Overall Financial Management

The Connector received an initial appropriation of $25 million to fund its start-up costs and operating expenses. Following this infusion, the Connector is expected to generate its own revenue to sustain operations. The Connector is statutorily authorized to attach an administrative fee on all health benefit plans, based on a percentage of the capitation payments for Commonwealth Care and monthly premiums for Commonwealth Choice.

As illustrated in Table 4, in fiscal year 2007 a 5 percent administrative fee applied to Commonwealth Care. In FY08, the administrative fee for both programs was 4.5 percent. For FY09, the administrative fee applied to Commonwealth Care has been further reduced to 4 percent, and remains at 4.5 percent for Commonwealth Choice. The Connector had a significant operating loss in its first full fiscal year. This was because of the need to hire staff, procure outside assistance, and launch programs, all while building initial enrollment.[10]

MASSACHUSETTS CONNECTOR IS NOT LIKE EARLIER MODELS

Although there have been previous attempts to create a central market for health insurance coverage, there are some important distinctions between the health purchasing cooperatives first established in the early 1990's, such as the Health Insurance Plan of California (HIPC), and the model envisioned and implemented in Massachusetts. The theory behind the older purchasing cooperative models was that if a number of small employers were pooled together, efficiencies could be gained and a more competitive premium rate could be obtained from insurers. Most of the purchasing cooperatives or purchasing pools that were created around the country were not deemed successful at constraining health insurance premiums, achieving adequate market share to maintain efficiencies, or reducing the number of uninsured. Many closed their doors after failing financially, and the model generally did not live up to its promise.

The reasons for failure have been examined in numerous reports and publications and seem quite intuitive in hindsight. They can be summarized as follows: 1) some states required the cooperatives to accept higher-risk groups than what was required outside the pool, thereby leading to adverse selection; 2) a number of the cooperatives were unwilling to work with insurers and brokers, leading to a limited number of plans selling through the cooperative, and no sales force leading employers to the purchasing pool; 3) the movement toward open-network health plans made it less important for employers to offer employees a choice of plans, one of the more important benefits of a cooperative from a small business owner's perspective; and 4) carriers did not want to compete against traditional sales (signing up a captive group) and in many places rallied against employee choice pools because they split groups among carriers.[11,12,13,14,15,16]

The Massachusetts Connector model, however, differs from these earlier models in several important ways. It is not a purchasing pool. The Connector does not hold any risk for its commercial products unlike the earlier purchasing pools, some of which failed because of this risk. In fact, carriers' Connector plan experience is pooled with all of their other small/non-

group plan experience, so risk selection problems are mitigated.

Another important distinction from earlier pools is that the Connector was not designed to "negotiate better prices for its members" compared with the private market outside the Connector. Because of the innovative reform strategy and the resulting visibility of the Connector, it has, however, been able to put some pressure on carriers to keep rate increases low overall.

Finally, the Connector was established in a unique environment that is worth highlighting. The Massachusetts insurance market had undergone fairly significant reforms in the past and currently includes elements not found in all locations, such as modified community rating and guaranteed-issue. In addition, a significant market reform which merged the nongroup and small-group markets was also required under the new law. These insurance reforms, in combination with an individual mandate, allow for a broader pool in which to spread risk.

CONCLUSION

The Connector was designed to help individuals and small employers purchase affordable insurance in Massachusetts. The Connector is intended to promote administrative ease, eliminate paperwork, offer portability and pretax treatment of premium, and provide some standardization and choice of plans. There are many functions that the Connector performs for the various programs it manages; some of these functions are administrative while others are more policy-oriented. In order for the Massachusetts health reform model to be successful, it needs to continue to promote affordability, sustainability, and administrative efficiency, not only for the viability of the Connector but for other key players in the market as well.

National policymakers looking to achieve similar policy goals may find some of the structural components and functions of the Connector to be transferable to a national health reform model. However, several important questions remain regarding implications of the Massachusetts Connector for national reform:

- How does the Connector model promote a better functioning marketplace and more value for the purchase of health care insurance by individuals and small employers?
- How does the Connector model improve upon the flaws of earlier health insurance purchasing cooperatives?
- What challenges has the Connector faced operating side-by-side with other distribution channels in the state?
- Which features of the Connector model are transferable to a national model of health reform?
- Is a national version of the Connector feasible or would regional organizations be more feasible?
- Would a national Connector focus on individuals or small employers, or both markets?

SOURCES

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Commonwealth Health Insurance Connector Authority. *Massachusetts Health Care Reform 2007/2008 Progress Report.*

Commonwealth Health Insurance Connector Authority Web site (www.mahealthconnector.org).

NOTES

1 The information presented in this issue brief derives from the authors' experience with the Connector, a Report to the Legislature from the Connector Authority, applicable statutes, and relevant literature, as cited.

2 The Connector subsequently made amendments to the cost-sharing structures associated with Plan Types 2, 3, and 4. In July 2007, premium contributions were eliminated for members earning 100.1 to 150 percent of FPL. By July 2008, Plan Types 2 and 3 required higher premium contributions and increases in some copayments, while Plan Type 4 was removed.

3 A fifth carrier (Caritas Christi Health Care and Centene Corporation) was approved to begin offering Commonwealth Care coverage beginning July 2009.

4 M.G.L. c. 118H § 3(a).

5 Ibid.; 956 CMR 3.11(5)(a).

6 Report to the Massachusetts Legislature, *Implementation of the Health Care Reform Law, Chapter 58, 2006–2008.* The Massachusetts Health Insurance Connector Authority. Oct. 2, 2008.

7 Ibid.

8 Employers must also agree to contribute 25 percent towards family members' coverage and meet minimum participations standards.

9 Ibid.

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