ISSUE BRIEF

STATEWIDE HEALTH INSURANCE EXCHANGE: THE RATIONAL AND THE REALITY

Health insurance is a family matter, especially for the self-sufficiency of families. The family perspective on health insurance attaches importance to affordability, choice of plan or provider, ownership, portability, transparency, and increased flexibility to exercise conscience in risk pool participation. In short, family control over health insurance is an important step toward *ownership* of health decisions that in turn promotes the family interest in self-sufficiency.

The Rationale

Most insured families are covered through the employer of a parent or spouse using pre-tax dollars. Alternatively, government insurance programs are another source of health insurance for low-income or elderly families. Disruptions in employment, as well as the complex of federal and state laws governing private insurance, make it difficult for working parents to purchase insurance and stay insured. One approach to rectify an imperfect and highly regulated—if not overregulated—insurance market is to develop a statewide health insurance exchange (the Exchange) equipped with non-policy-making pooling and purchasing mechanisms.

The Exchange is a single organizational entity of a state authorized to act as a clearinghouse to "connect" individual and small businesses with health insurance products. It performs the necessary business and administrative functions to organize and to enlarge the health care market by consolidating a larger number of consumers. Small employers can relieve themselves of administrative costs associated with offering health insurance by voluntarily participating in the Exchange. Leveraging a larger volume of individuals and collecting employer contributions and government subsidies could permit state governments to increase the availability of affordable insurance using pre-tax dollars. In addition, consolidation creates a market to provide private health

insurance to individuals and families who lack insurance or who struggle to maintain coverage continuously during the year. Consequently, the Exchange is one promising and innovative avenue—though not a utopian one—to promote the family interests in insurance.

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Health experts at the Heritage Foundation champion an Exchange with restricted powers and functions:

"The specific functions of an exchange would be mechanical, not regulatory. An exchange should not license or standardize health plans or impose underwriting rules or benefit mandates. The focus should be on processing paperwork—mostly processing employer and employee contributions or independent premium payments—and administrating enrollment and coverage selections through an annual open season. It should function just like the human resources department of a very large employer. An exchange could also be a mechanism for the administration of government subsidies for low-income persons . . . . An exchange should be administered by a non-governmental entity operating under a special state government charter. Irrespective of the organizational structure, the functions of an exchange could be contracted out to private entities or private third-party administrators."[1]

The Exchange, when set up and functioning in accord with restricted powers, appears to address most of the flaws of the health care market at the state level. It provides a place where individuals can purchase group-rate insurance with pre-tax dollars—hopefully at an "affordable" cost for the family budget. Families having multiple employment sources can pro-rate the contributions from each source to cover the full cost of insurance. Because the Exchange is a locus of insurance separate from the place of employment, one's policy will likely remain available while shifting between jobs. The volume of purchasers makes the Exchange financially attractive to carriers; hence, there is expanded choice of products as well. The Exchange can make price and benefit comparisons between health plans available to families by requiring carriers to make such financial information available to it for analysis as a condition of selling at the Exchange. These advantages should not be underappreciated; however, as significant as they are, the proof is in the details of real Exchanges in their political environments.

The Reality

Sometimes even the best-laid plans can go awry when implementing reforms amid political realities. Massachusetts is a case in point. In April 2006, Massachusetts enacted a landmark health care reform law, creating the *Commonwealth Health Insurance Connector* (Connector), a quasi-public statewide health insurance exchange. The Connector's statutory purpose is to "facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups."[2] To increase the purchasing volume, the Connector will be available to non-group and small businesses groups with 10 to 50 employees. One analysis based on data from the Massachusetts Senate projects that about 422,000 of the total 550,000 uninsured citizens of the state will have the

opportunity to purchase private, affordable health insurance through the Connector either with state aid (estimated at 207,000 newly insured) or without it (estimated at 215,000 newly insured).[3] Although having insurance appropriate to a family's need is fundamentally important, there are other considerations regarding the nature of the insurance that are equally important for giving control to families.

Massachusetts' version of the Exchange has its proponents,[4] but if the early policy decisions are any indication of where the state policy makers are taking the Exchange, its design may well fall short of several key family interests (i.e., portability, choice, transparency, and affordability). Portability, unfortunately, remains an advantage only for job transitions within the state. Portability across state lines would probably require action from the U.S. Congress. Choice for low-income families (e.g., 200-300 percent of federal poverty levels—or FPL) is limited to only four carriers permitted to offer subsidized plans through the Exchange during the first three years. Moreover, at this time it appears that there will be only one plan offered to families for each designated increment of income above FPL. Another way that choice is constrained for low-income working families is by denying them the opportunity to participate in a Health Savings Account (HSA)—an option that could give families the greatest control over their health care decisions (Subsidized plans cannot have deductibles).

The new law does *not* provide subscribers any right to express their conscience through risk pool participation. Health benefits reflect the social trend to cover controversial elective procedures that may offend the moral and religious conscience of subscribers, such as abortion and in vitro fertilization, as well as treatment for the consequences of poor behavioral choices, such as alcohol abuse.[5] Short of genetic traits, strong families typically contribute to good health and well-being. The time and dedication families invest in caring for one another and their young should be sufficient grounds to hold families harmless from paying excessively priced insurance premiums.

Massachusetts health providers have a right of conscience to refuse the delivery of abortion, sterilization, and contraceptive services without discrimination.[6] A subscriber's right to his or her conscience also needs also to be honored. As it stands, the plans in the Connector cover abortion as an outpatient service.[7] Although the Massachusetts Supreme Court has ruled that taxpayers must pay for abortion if the state subsidizes other health services to low-income families, the state chose to cost-share this controversial service by commingling state funds with private premiums and co-pays through the Connector, rather than opting to instruct the state Medicaid agency to pay for abortion services directly outside the Connector and thereby avoid an unprecedented expansion of abortion financing policy.

At a minimum, the Connector should not disrupt informal networks of families that band together to assist one another with the medical costs of health care through direct payment (rather than insurance). Such a network is a financial sharing cooperative and not an insurance entity because it helps its members pay their medical bills directly. For instance, the Connector undermines—if not discriminates against—non-risk-bearing, faith-based health support networks, such as Samaritan Ministries International (SMI) and other similar health ministries whose members are devoted to the longstanding biblical instruction "to bear one another's burdens." Massachusetts health law is rife with mandated insurance benefits (such as alcoholism rehabilitation, in vitro fertilization, contraceptives, drug abuse treatment, and hair prostheses). The state considers the inclusion of government's comprehensive list of mandated health benefits necessary for sufficient coverage, but the so-called "comprehensive" benefit packages include coverage for services that some families would not use. The Connector, furthermore, should not judge SMI's generous list of approved medical services to be inferior just because—from the perspective of the state—the network's list does not constitute "creditable coverage."

The Connector is authorized to define and determine affordable health plans. Affordability is a concept that remains controversial in practice. Judgments could be compromised by the fact that the cost of family insurance is already high in the state. According to the Council for Affordable Health Insurance, family coverage in the Boston area is already among the least affordable in the U.S.[8] Obviously, comprehensive benefit packages will influence the affordability and adequacy of the policies. Comprehensive packages bump up the cost of premiums and tie up funds in the family budget that might be used for other pressing needs, such as education, transportation, or housing. Uninsured families under 300 percent FPL were provided free or subsidized insurance starting in the fall of 2006. The average managed care premium for a family of four ($50,000 to $60,000) is $268 per month (about 5.8 percent of the family budget).

The Connector is now in the process of developing affordable plans for families with incomes greater than 300% FPL. The state plans to offer three types of plans with the lowest being 60% of the actuarial level of the highest premium. Families in non-group plans may benefit from participating in the group purchasing of the Connector, seeing their premiums lowered by as much as 24 percent. At the same time, it is difficult to avoid thinking that the Connector is granted a very significant influence over family budgets.

The ability of the Connector to deliver all the advantages it promises to families may well depend upon how policy makers respond to fiscal and political temptations of the future. Given that the Connector lacks internal structures to promote choice and competition among plans, it may harm the interests of

families over time. Even now, notwithstanding the improvement it offers to a complex health care market, the Connector falls short of giving families the *ownership* of health insurance.

Notes

[1] Robert E Moffit, "The Rationale for a Statewide Health Insurance Exchange," Web Memo no. 1230 Heritage Foundation (October 5, 2006).

[2] Commonwealth of Massachusetts, "Chapter 58 of the Acts of 2006." (April 12, 2006). Available at: http://www.mass.gov/legis/laws/seslaw06/sl060058.htm (accessed January 10, 2007).

[3] Kaiser Commission on Medicaid and the Uninsured. "Massachusetts Health Care Reform Plan," (April 2006). Available at http://www.kff.org/uninsured/upload/7494.pdf

[4]John McDonough, et al., "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* 25 (September 14, 2006): w420-w431. Available at http://content.healthaffairs.org/cgi/content/abstract/25/6/w420

Robert E. Moffit, "Health Insurance for the Masses," WashingtonPost.com (May 31, 2006). Available at: http://www.washingtonpost.com/wp-dyn/content/article/2006/05/30/AR2006053000926.html

[5] A state-by-state comparative listing of mandated services for The Council for Affordable Health Insurance is available at: http://www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf ; Commonwealth of Massachusetts; Office of Consumer Affairs and Business Regulation, Division of Insurance. Massachusetts General Laws Mandating that Certain Health Benefits Be Provided by Commercial Insurers, Blue Cross & Blue Shield and Health Maintenance Organizations. Available at: http://www.mass.gov/Eoca/docs/doi/Consumer/HealthLists/mndatben.pdf (accessed January 17, 2007).

[6] General Laws of Massachusetts, Chapter 112: Section 12I & Chapter 272: Section 21B

[7] See the memo from Jon M. Kingsdale to Insurance Connector's Board of Directors dated August 30, 2006, Appendix II. Available at: http://www.mass.gov/Qhic/docs/memo_enrollee_contribution.doc (accessed March 2, 2007); The estimated premiums structure for the Commonwealth Care program are available at: http://www.hcfama.org/act/Documents/Comm%20Care%20Premium%20Chart.pdf (accessed March 2, 2007).

[8] "Massachusetts' Health Care Reform Plan: Too Many Sticks; Not Enough Carrots." Available at: http://www.cahi.org/cahi_contents/resources/pdf/massachusetts.pdf (accessed January 17, 2006).