Strategy	Health Insurance Market Exchange (Connector)
Background:	In theory, the Health Exchange creates a single marketplace through which individuals and businesses can purchase health insurance from competing health plans. It functions like a stock exchange and creates a single market for all types of health insurance plans, health maintenance organizations, health savings accounts, and other coverage options that emerge. The Exchange would enable individuals to purchase insurance with pre-tax dollars. Individuals would then own their insurance; it would no longer be connected to their employer and they could take their insurance with them from job to job. Employers could designate the Exchange as their employer-sponsored plan, which would increase the employers' flexibility in offering different types of health benefits and reduce administrative burdens of selecting and managing health coverage. To take advantage of the current federal tax code, the employer would designate the Health Exchange as their "plan" and then all defined contributions would be tax-free. Employers would then offer employees a Section 125 cafeteria plan so that any premium payments made by employees would be tax-free.
Other States:	Massachusetts has taken the concept of the Health Exchange and adapted it to meet the needs of its reform effort. The Connector, or Massachusetts's exchange strategy, is one of many reforms being implemented in Massachusetts. It will function as an administrative structure that links residents with health insurance and be used by the state as a mechanism through which premium assistance and subsidized health insurance products are provided. This concept is now in the development phase and other states are researching it and exploring its potential for them, including Louisiana, Oregon, Indiana and Minnesota. The Connector has yet to be tested and it is too early to learn any best practices from its implementation. **Health Care Reform in Massachusetts** On April 12, 2006, Massachusetts Governor Mitt Romney signed into law comprehensive health care reform legislation that will provide nearly universal coverage to state residents. Estimates suggest that 95 percent of the population will be covered in three years; approximately, 550,000 people are currently uninsured in Massachusetts.[i] Near universal coverage in Massachusetts will be achieved through a combination of strategies, including insurance market reforms, subsidized insurance availability, Medicaid expansions, employer contributions, and an individual mandate. To implement these reforms, a number of administrative structures have been developed, including a Health Exchange, called the Commonwealth Health Insurance Connector (the Connector). ***Components of the MA health care reform*** <u>The Connector Health Exchange</u> The Connector is a quasi-independent authority within state government that links eligible individuals and small businesses with health insurance plans. The

Strategy	Health Insurance Market Exchange (Connector)
	Connector is governed by an 11-member board of private and public representatives. Individuals and small employer groups (i.e., fewer than 50 employees) are eligible for coverage through the Connector if individuals are a resident of the Commonwealth and have not been offered subsidized health insurance by an employer for the previous six months. The Connector will link residents under 300 percent of the federal poverty level (FPL) to subsidized products, and also offer commercial products to individuals with incomes over 300 percent of the FPL. The Connector is scheduled to begin linking Massachusetts's residents with health plan benefits on April 1, 2007. The Connector is charged with determining which health plans meet the definition of "minimum credible coverage" pursuant to the mandated requirements; certifying whether affordable coverage is available for individuals (the individual mandate is dependent upon coverage being affordable); issuing a seal of approval for health plans, which is the approval given by the board to health plans offered through the Connector to indicate that a health benefit plan meets certain standards regarding quality and high value; and administering the Commonwealth Care Health Insurance Program, which is subsidized health insurance.[ii] To keep insurance costs lower, health plans can use selective contracting and plans available through the Connector will not have to meet certain provider network requirements. Additionally, Massachusetts placed a moratorium on new mandated benefits. <u>Subsidized Health Insurance – Commonwealth Care Health Insurance Program</u> People with incomes less than 100 percent of the FPL will receive insurance without premiums, deductibles, or significant co-payments. Modest co-payments will be required for prescription drugs and emergency department visits; these co-payments will be equal to those required of Medicaid recipients. Individuals with household incomes between 100 and 300 percent of FPL will qualify for insurance premium subsidies based on a sliding scale fee schedule. No deductibles can be imposed on any subsidized plan offered through the Connector. <u>Individual Mandate</u> Beginning July 1, 2007, all Massachusetts residents over the age of 18 are required to have health insurance. Residents will be required to indicate their insurance status on their tax returns. Those who don't will lose their individual personal tax exemption; and beginning in 2008 residents without insurance will be penalized up to 50 percent of the amount of an affordable premium. <u>Employer Responsibility</u> Employers with more than 10 employees will be required to offer a Section 125 cafeteria plan that allows employees to purchase health care with pre-tax dollars. Individual employees not offered insurance through their employer will be able to

Strategy	Health Insurance Market Exchange (Connector)
	use these pre-tax dollars to purchase insurance products through the Connector. Employers who employ more than 10 employees and don't make a "fair and reasonable contribution" to the cost of their employees' coverage will be assessed a "fair share contribution" up to $295 per full-time employee per year.[iii] The contribution will be calculated to represent the cost of free care used by the employees of non-contributing employers. An additional surcharge may also be imposed on employers with 10 or more employees who do not offer to contribute toward or arrange for health insurance and whose employees use free care. The surcharge will be applied when an employee receives free care more than three times, or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10 to 100 percent of the state's costs of services provided to employees, with the first $50,000 per employee exempted. Revenue from the surcharge will be deposited in the Commonwealth Care Trust Fund, which will be used to pay for subsidized health insurance and Medicaid rates.[iv] <u>Medicaid Expansion</u> Medicaid is expanded to include children in families earning up to 300 percent of the FPL; previously children were eligible if living in families earning up to 200 percent of the FPL. Additional Medicaid expansions include increasing the enrollment cap for people with disabilities, the unemployed, and HIV programs. Lastly, benefits such as dental, dentures, and eyeglasses have been restored. The Medicaid expansions will be accomplished through a Section 1115 Waiver. (This Waiver requires Massachusetts to shift funds from the direct subsidies paid to individual safety net hospitals to insurance subsidies for the uninsured.) <u>Insurance Reform</u> The small group and individual health insurance markets have been merged. Policymakers expect that this change will make individual insurance more affordable and available; estimates suggest it will reduce premiums for individuals by 25 percent.[v] The merging of these two groups allows for economies of scale in terms of administration, therefore lowering administrative expenses. It also pools together larger numbers of consumers and allows for their risk to be spread among a greater number of lives. Additionally, two changes have been made to assist young adults in accessing coverage. First, young adults will be able to retain coverage through their parents' plans for two years after their loss of dependent status or up to age 25, whichever comes first. Second, the reform creates specially designed lower cost products that will be available through the Connector to individuals ages 19 to 26. <u>Provider Rate Increases</u> The reform included rate increases for hospitals and physicians, which will be phased in over a three-year period. Beginning in fiscal year 2008, the increases will

Strategy	Health Insurance Market Exchange (Connector)
	be tied to quality standards and performance benchmarks. Health Care Safety Net Trust Fund Part of the Massachusetts reform effort is aimed at converting subsidies now paid to hospitals for treating the uninsured into subsidies for health insurance or premium assistance for low-income uninsured so that they can buy health insurance through the Connector. The legislation enacting the reform gives health systems receiving funding from the state's uncompensated care pool two years to enroll the uninsured patients they serve into their own health insurance plans, with the funding they now receive for uncompensated care being converted into premium subsidies for these patients. As of October 1, 2007, the existing uncompensated care pool will be eliminated and any remaining funds will be transferred to a new fund called the Health Safety Net Trust Fund, which will be administered by Health Safety Net Office within the Office of Medicaid. This new fund will be maintained through the continued payments made by acute hospitals and surcharge payers and federal disproportionate share hospital funds. The money in the trust fund will be used to reimburse hospitals and Community Health Centers for free care. Policymakers anticipate that all of the uncompensated care funds will eventually be transferred to the subsidized health insurance program as the use of free care declines with increased health insurance coverage. Population Covered by the Massachusetts Reform Estimates suggest that up to 215,000 residents will purchase private coverage, and an additional 207,500 residents will receive subsidized coverage through the Connector. The Medicaid expansion is expected to cover 92,500 residents. Approximately 35,000 residents will remain uninsured.[vi]
Application to Texas – Advantages & Disadvantages:	The Massachusetts Exchange, i.e., the Connector, is one strategy to health care reform that Texas might want to use to increase health care coverage for its residents. There are, however, differences in Texas's income and health coverage patterns that will make Texas' experience different. For example, Texas has a larger number of small businesses that don't offer health insurance. Texas also has a larger number of uninsured and a larger proportion of its uninsured have low-incomes. **Advantages:** • Creates a marketplace that facilitates the purchase of health insurance by individuals and small business. • Increases choice. • Enables individuals to use tax-free dollars to pay for health insurance. • Provides ownership and portability of health insurance for consumers; insurance is no longer tied to an employer but an individual.

<table>
<tr><td>Strategy</td><td colspan="8">Health Insurance Market Exchange (Connector)</td></tr>
<tr><td></td><td colspan="8">

Could allow more than one employer to contribute to an employee's health insurance. Consumers with several part-time jobs could access coverage.
Reduces administrative costs and burdens experienced by small employers who have to negotiate, select and manage benefits.
Provides a mechanism through which to offer premium assistance.

<u>Disadvantages</u>:

The insurance take-up rate resulting from an exchange may be low without a mandate.
Requires creation of an administrative entity.

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<tr><td>Meets Medicaid Reform Goal(s):</td><td colspan="8">
<table>
<tr><td>Cost Reduction or Avoidance</td><td></td><td>Maximizes federal funds</td><td>X</td><td>Improves Program Sustainability</td><td>X</td><td>Consumer Choice/ Responsibility</td><td>X</td></tr>
<tr><td>Reduces Number of Uninsured</td><td>X</td><td>Supports Private Market Coverage</td><td>X</td><td>Improves Quality</td><td></td><td>Improves Access</td><td>X</td></tr>
<tr><td>Benefit Options</td><td>X</td><td colspan="6"></td></tr>
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</td></tr>
<tr><td>Populations Affected:</td><td colspan="8">This approach could potentially affect most residents and employers. The total population affected would depend upon how the Exchange was implemented, who was eligible, the cost of coverage, and whether it was part of a larger reform effort. Without subsidies for insurance, the Exchange would most likely assist uninsured, employed Texans with higher incomes as they are more likely to have the disposable income needed to pay for coverage. Providing subsidies would likely expand the number of those who would benefit from an Exchange.

Approximately 4.8 million Texans lack health insurance. Of these individuals, about 2 million are adults (ages 19-64) with incomes below 200 percent of the federal poverty level (FPL).[vii] A Health Exchange would most likely benefit those in the higher income brackets, although an Exchange offering subsidized benefits would likely be more accessible to those with lower incomes.</td></tr>
<tr><td>General Revenue Impact:</td><td colspan="8">The Massachusetts healthcare reform plan is expected to cost $1.2 billion over three years. The reform essentially redistributes existing funds, including federal Medicaid payments previously paid to safety net providers for Medicaid and uncompensated care. Some new funding comes from employers, General Revenue, and new federal matching funds from Medicaid expansions. MA General Revenue funds are estimated to be $308 million over three years.[viii]

The cost of an Exchange would depend upon how it is implemented, its role, and the magnitude of the entire Texas reform effort.</td></tr>
<tr><td>Other</td><td colspan="8">
<table>
<tr><td>Stand Alone Option</td><td></td><td>This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td>X</td></tr>
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<table>
<tr><td>Strategy</td><td colspan="6">Health Insurance Market Exchange (Connector)</td></tr>
<tr><td>Considerations</td><td colspan="6">Massachusetts is using the Connector as a vehicle to implement some of its health care reform efforts. The reform effort is much larger than just the Health Exchange and includes not only the Exchange but also: insurance market reforms, subsidized insurance availability, Medicaid expansions, employer contributions, and an individual mandate, all of which are discussed above in greater detail.

It is important to note that compared to Massachusetts, Texas has a higher proportion of uninsured, low-income residents and a lower percentage of its population covered by employer sponsored insurance.</td></tr>
<tr><td rowspan="3">State and Federal Approval(s) Required:</td><td rowspan="3">Federal</td><td>1115 Waiver</td><td>X</td><td rowspan="3">State</td><td>Rules</td><td>X</td></tr>
<tr><td>Other Waiver(s), [LIST]</td><td>X</td><td>Legislation</td><td>X</td></tr>
<tr><td>State Plan Amendment</td><td>X</td><td></td><td></td></tr>
<tr><td>Implementation Considerations & Timeframes:</td><td colspan="6"><u>Affected Stakeholders</u>
• Individuals who are uninsured and others (small business employees) who would access insurance through an exchange.
• Employers
• Insurance industry
• Healthcare providers
• Health Plans
<u>Systems and Resource Considerations</u>
• Resources for administration would be required and new administrative systems would need to be created.
<u>Implementation Timeframes (in months)</u>
• Massachusetts estimates that it will take approximately one year after the Governor’s approval of the enacting legislation to implement the Health Exchange. It should be noted that the concept and a great deal of the Health Exchange infrastructure was developed over several years.</td></tr>
</table>

Resources:

- Kaiser Commission on Medicaid and the Uninsured, “Massachusetts Health Care Reform Fact Sheet.” April 2006, accessed November 20, 2006.
- Haislmaier, Edmond, “The Significance of Massachusetts Health Reform (WebMemo #1035).” The Heritage Foundation, April 11, 2006; accessed December 1, 2006: http://www.heritage.org/Research/HealthCare/wm1035.cfm
- Moffit, Robert E. The Rationale for a Statewide Health Insurance Exchange (No. 1230), October 5, 2006, The Heritage Foundation; accessed November 20, 2006: www.heritage.org/research/healthcare/wm1230.cfm.

- Haislmaier, Edmund F,"State-Based Health Care Solutions, Issues 2006: The Candidate's Briefing Book. The Heritage Foundation, accessed on December 1, 2006. http://www.heritage.org/Research/features/issues/issuearea/Healthcare.cfm
- General Accounting Office, Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage, October 2001(GAO-02-8).
- Michael Tanner, "No Miracle in Massachusetts: Why Governor Romney's Health Care Reform Won't Work" Cato Institute, June 6, 2006. Accessed on December 9,2006: http://www.cato.org/pubs/bp/bp97.pdf.
- Fitzgerald, Kevin G., Lenz, Ethan D., Rosenfield, Carl B, Waxman, Mark J., "Massachusetts Health Care Reform." Foley & Lardner LLP accessed on November 20, 2006: http://www.foley.com/files/tbl_s31Publications/FileUpload137/3642/Health%20Reform%20Article1.pdf
- California Health Care Foundation Issue Brief: "Massachusetts-Style Coverage Expansion: What Would it Cost in California." April 2006. Available at: http://www.chcf.org/documents/insurance/MAStyleCovExpansionIB.pdf
- Karwaki, Tanya E., "What a Health Insurance Exchange Could Look Like in Washington State." Accessed on November 20, 2006 at: http://www.washingtonpolicy.org/HealthCare/PN2006-14.pdf
- Commonwealth of Massachusetts, "Chapter 58 of the Acts of 2006," April 12, 2006, Accessed November 20, 2006: http://www.mass.gov/legis/laws/seslaw06/sl060058.htm
- Moffit, Robert and Owcharenko, Nina, "Understanding Key Parts of the Massachusetts Health Plan (WebMemo #1045)." The Heritage Foundation, April 20, 2006. Accessed November 20, 2006 at: http://www.heritage.org/Research/HealthCare/wm1045.cfm
- Blue Cross Blue Shield of Massachusetts Foundation. Massachusetts Health Care Reform Bill Summary, Accessed on November 20, 2006 at: http://www.bcbsmafoundation.org/foundationroot/en_US/documents/MassHCReformLawSummary.pdf
- Massachusetts Hospital Association, "Summary of Massachusetts Health Care Reform Legislative Compromise Bill." April 4, 2006. Accessed on: November 20, 2006: http://www.newenglandruralhealth.org/sections/ma/mha_hcrbill.pdf
- Massachusetts Medicaid Policy Institute, "The MassHealth Waiver: An Update." Issue Brief, September 2006. Accessed on December 5, 2006: http://www.massmedicaid.org/pdfs/Waiver_Update_FINALforWeb.pdf

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[i] Health Care Access and Affordability Conference Committee Report, Massachusetts State Legislature. http://www.mass.gov/legis/summary.pdf

[ii] Commonwealth of Massachusetts, "Chapter 58 of the Acts of 2006," April 12, 2006, Accessed November 20, 2006: http://www.mass.gov/legis/laws/seslaw06/sl060058.htm

[iii] Massachusetts Health Care Reform Fact Sheet, Kaiser Commission on Medicaid and the Uninsured, April 2006.

[iv] Health Care Access and Affordability Conference Committee Report, Massachusetts State Legislature. http://www.mass.gov/legis/summary.pdf

[v] Health Care Access and Affordability Conference Committee Report, Massachusetts State Legislature. http://www.mass.gov/legis/summary.pdf

[vi] Massachusetts Health Care Reform Fact Sheet, Kaiser Commission on Medicaid and the Uninsured, April 2006.

[vii] U.S. Census Bureau, March 2005 and March 2006 Current Population Surveys for Texas, Compiled by the HHSC Strategic Decision Support Department, January 2007. The 4.8 million figure is HHSC's estimate of uninsured U.S. citizens and legal permanent residents in Texas out of 5.5 million total uninsured individuals in Texas.

[viii] Massachusetts Health Care Reform Fact Sheet, Kaiser Commission on Medicaid and the Uninsured, April 2006.