

## **EMPLOYERS' USE OF HEALTH INSURANCE EXCHANGES: LESSONS FROM MASSACHUSETTS**

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### I. INTRODUCTION

#### A. *Background*

The small-group employer market is a core concern of both federal and Massachusetts' health insurance reforms. Both reform laws require the governmental insurance exchange to include a component specifically for small firms.<sup>1</sup> There are good reasons for this effort to improve the small-group market. Millions of the 40 million Americans who work for small businesses are uninsured.<sup>2</sup> Whereas almost all employers with 200 or more employees offer their employees health insurance, only about half of employers with fewer than ten employees do so.<sup>3</sup> A substantially greater portion of small-group premiums go to cover overhead (profits, administration, sales costs) than for large-group insurance, and small-group insurance tends to have higher cost-sharing obligations for patients.<sup>4</sup> Also, most small firms with insurance select only a single plan, whereas larger firms usually give workers a choice of coverage options.<sup>5</sup>

Small-group insurance exchanges are meant to address these several problems. By standardizing and streamlining benefits, they aim to make it easier for employers or their agents to find affordable insurance. A government clearinghouse for private insurance also seeks to reduce

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1. KAISER FAMILY FOUND., MASSACHUSETTS HEALTH CARE REFORM: SIX YEARS LATER 9 (2012), available at <http://www.kff.org/healthreform/upload/8311.pdf> [hereinafter KAISER FAMILY FOUND.].

2. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey*, ISSUE BRIEF (Emp. Benefit Research Inst.), Sep. 2008, at 3, available at [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_09a-2008.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf).

3. KAISER FAMILY FOUND. & HEALTH RESEARCH & ED. TRUST, EMPLOYER HEALTH BENEFITS ANNUAL SURVEY 36 (2012), available at <http://ehbs.kff.org/pdf/2012/8345.pdf>.

4. *Id.* at 107.

5. *Id.* at 60.

administrative and sales costs, and to focus choice on the insurers that offer the best value. Finally, exchanges are a mechanism by which small employers might feasibly offer health insurance in a fashion that enables workers to choose from a wide array of insurers and plan options.

Despite these promises, most private or government health insurance exchanges so far have failed to gain substantial market share. To date, this track record holds true in Massachusetts. Its exchange, called the Health Connector, has had notable success in expanding coverage for individuals, but so far it has not made major in-roads into the employer-based insurance market.<sup>6</sup> Although Massachusetts employers support reform and have maintained or even increased their willingness to offer insurance, the Connector launched its small group program late in the reform process and few employers have elected to purchase through the Connector.<sup>7</sup> Of 40,000 people who purchase private insurance through the Connector, only about ten percent do so as part of employer coverage, and almost all of these employers are “micro-sized” (five or fewer), with an average of only about 1.5 employees per group policy.<sup>8</sup> This employee enrollment constitutes less than one percent of small-group employee coverage statewide.<sup>9</sup>

Federal insurance reform is modeled substantially on the successful reforms in Massachusetts, including its version of a health insurance exchange.<sup>10</sup> To learn from both the successes and limitations of Massachusetts’ reforms, this study investigates employers’ use of the Connector, in order to inform states and the federal government about best strategies for design and operation of their new small-group health insurance exchanges and market regulations. Prior research on the Connector has focused mainly on its role in enrolling individuals who, with or without subsidies, purchase non-group coverage.<sup>11</sup> Much less attention

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6. KAISER FAMILY FOUND., *supra* note 1, at 4.

7. MASS. HEALTH CONNECTOR, REPORT TO THE MASSACHUSETTS LEGISLATURE: IMPLEMENTATION OF HEALTH CARE REFORM 14-15 (2010).

8. SABRINA CORLETTE ET AL., GEO.UNIV. HEALTH POLICY INST., THE MASSACHUSETTS AND UTAH HEALTH INSURANCE EXCHANGES: LESSONS LEARNED 6, 8 (2012), available at <http://ihcrp.georgetown.edu/pdfs/Mass%20Utah%20Exchanges%20Lessons%20Learned.pdf>.

9. See COMM. OF MASS. DIV. OF INS., 2011 MEMBERSHIP REPORT OF THE MASSACHUSETTS INDIVIDUAL/SMALL EMPLOYER MARKETS FOR HEALTH COVERAGE (2012), available at <http://www.mass.gov/ocabr/docs/doi/companies/fin-reports/memsumrep08.pdf> (reporting that in 2011, about 635,000 people were enrolled in the state’s small group market).

10. SHARON LONG ET AL., STATE HEALTH ACCESS REFORM EVALUATION, NATIONAL REFORM: WHAT CAN WE LEARN FROM EVALUATIONS OF MASSACHUSETTS? (2011), available at <http://www.shadac.org/files/shadac/publications/MassachusettsNationalLessonsBrief.pdf>.

11. See, e.g., AMY LISCHKO, PIONEER INSTITUTE PUBLIC POLICY RESEARCH, FIXING THE MASSACHUSETTS HEALTH EXCHANGE 1 (2011), available at <http://pioneerinstitute.org/download/fixing-the-massachusetts-health-exchange/>.

has been paid to Massachusetts employers' use of the Connector — a gap this study was designed to fill.

The reasons for low employer use of the Massachusetts Connector so far merits close attention. The role of employers is important to the potential success of the new health insurance exchanges. Employer participation will help exchanges achieve economies of scale and market penetration that will allow them to reduce costs and impose competitive discipline on the rest of the market. Also, if employer use of exchanges is not broad-based, then exchanges might become targets for adverse selection.<sup>12</sup> Although each state's market structure is distinct, and some trial-and-error is unavoidable, it can be helpful to know more about what has and has not worked so far in Massachusetts to attract employer participation, and why.

### B. Methodology

This is a qualitative investigation consisting of document review and in-depth interviews. Document review focused on reports, studies, data and other information sources that relate to employers' use of the Massachusetts Connector, such as the Connector's quarterly and annual reports, presentations and minutes from meetings of the Connector's governing board, market reports and surveys from the Massachusetts Divisions of Insurance and of Healthcare Finance and Policy, and analyses of the Connector written by others who have studied it, including some who previously worked with the Connector.

Interviews were conducted by the author, in person or by phone, with 37 key informants identified from public sources and through a "snowball" fashion in which initial sources recommended sources from similar or different perspectives. These interviews included 11 current and former Connector officials, board members, and other government officials; 15 independent insurance brokers (also known as agents) or employee benefits advisors, 4 people with employer industry and trade groups, and 8 people with 4 insurers in the market, including the 3 largest plans in the market. Interviews with insurance brokers included four who have served on the Connector's advisory board, and two who have sold some insurance through the Connector.

These interviews inquired about: the advantages and disadvantages of the Connector for employers, whether insurance should be selected by employers or employees, how billing arrangements work for employee-selected coverage, the role of insurance brokers within the Connector,

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12. TIMOTHY S. JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: EIGHT DIFFICULT ISSUES 8 (2010), available at [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444\\_Jost\\_hlt\\_ins\\_exchanges\\_ACA\\_eight\\_difficult\\_issues\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf).

product design inside and outside the Connector, pricing differences between the Connector and the outside market, any adverse selection issues relating to employers' use of the exchange, and various techniques that have worked and not worked for increasing employer participation. As discussed below, interviews also probed whether these views and experiences are expected to translate to the new Affordable Care Act (ACA) exchange structures in other states, or whether they are unique to the particular features of Massachusetts' reform law or market conditions.

Interviews were semi-structured, following an interview guide developed in consultation with the project's consulting advisors. Detailed interview notes were coded using specialized computer software, and were analyzed, along with documentary materials, using standard qualitative methods,<sup>13</sup> which include triangulation (seeking to confirm or disconfirm points from various perspectives and information sources).

## II. FINDINGS

### A. *Basic Structure and History*

The Massachusetts Connector divides its operations between subsidized insurance for the low-income population, known as Commonwealth Care (or CommCare), and private, unsubsidized insurance, called Commonwealth Choice (or CommChoice).<sup>14</sup> Eight insurers participate in CommChoice, including all of the major companies in the commercial market (Blue Cross, Harvard Pilgrim, Tufts, and Fallon), along with several smaller plans and more recent market entrants (Neighborhood Health Plan, Celticare, Health Net, and Health New England).<sup>15</sup>

Massachusetts has merged its individual and small group markets for most rating and regulatory purposes, but the Connector markets its coverage separately to small groups and individuals.<sup>16</sup> Overall, the Connector's private (unsubsidized) insurance enrollment is dominated by individually-purchased insurance, which accounts for 38,365 people or 89% percent of the 43,119 people in CommChoice, as of December

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13. See Bryan J. Weiner et al., *Use of Qualitative Methods in Published Health Services and Management Research: A 10-Year Review*, 68 MED. CARE RES. & REV. 6 (2011); see also Elizabeth H. Bradley et al., *Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory*, 42 HEALTH SERV. RES. 1758 (2007).

14. CORLETTE ET AL., *supra* note 8, at 4.

15. *Health Reform Facts and Figures*, MASS. HEALTH CONNECTOR (2012), [hereinafter *Facts and Figures*].

16. TERRY GARDINER & ISABEL PERERA, CTR. FOR AM. PROGRESS, SHOPPING AROUND: SETTING UP STATE HEALTH CARE EXCHANGES FOR SMALL BUSINESSES 43 (2011), available at [http://healthreformgps.org/wp-content/uploads/shop\\_exchange.pdf](http://healthreformgps.org/wp-content/uploads/shop_exchange.pdf).

2012.<sup>17</sup> The Connector's employer enrollment accounts for less than 1% of small-firm coverage statewide.<sup>18</sup>

The Connector first made individual (nongroup) CommChoice enrollment available in 2007, but it did not offer small-group employer plans until 2009, and then only on a limited basis.<sup>19</sup> The Connector's small-group program has had two distinct phases. The first, called the "Contributory Plan," was designed to pilot an approach that allowed individual employees to choose their own insurer.<sup>20</sup> Participating employers selected a reference plan that determined their contribution, and employees were then free to select alternative insurers and benefit options within the same tier of benefits the employer selected.<sup>21</sup> After not quite a year, the Connector ended the pilot, having enrolled a maximum of only 77 employers and 207 workers.<sup>22</sup>

The Connector then revamped its small-employer program, which it relaunched in early 2010 under the name Business Express.<sup>23</sup> Mirroring the market's conventional purchasing model, Business Express requires all participating employees to join the single plan that the employer selects.<sup>24</sup> A principal reason for this change, explained in more detail below, was (according to several well-placed sources) the desire to transfer a block of business that was already enrolled with the Connector's third-party administrator (TPA), the Small Business Service Bureau (SBSB).<sup>25</sup> This TPA is also a trade association that, for several decades, has marketed health and other insurance products, and the two parties (SBSB and the Connector) decided that it was mutually advantageous for SBSB to consolidate its small-group health insurance operations through the Connector.<sup>26</sup>

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17. COMMONWEALTH CONNECTOR, MONTHLY HEALTH CONNECTOR SUMMARY REPORT 1 (Dec. 2012).

18. See COMM. OF MASS. DIV. OF INS., *supra* note 9.

19. THE COMMONWEALTH FUND, STATES IN ACTION ARCHIVE MASSACHUSETTS HEALTH CONNECTOR (2011), available at <http://www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Snapshots/Massachusetts.aspx>.

20. GARDINER & PERERA, *supra* note 16, at 42.

21. CORLETTE ET AL., *supra* note 8, at 8.

22. COMMONWEALTH CONNECTOR, CONNECTOR QUARTERLY PROGRAM SUMMARY REPORT 5 (Oct. 2010) [hereinafter CONNECTOR QUARTERLY PROGRAM SUMMARY REPORT 2010].

23. CHERYL IERNA, COMMONWEALTH CONNECTOR, CONTRIBUTORY PLAN UPDATE 4 (2009).

24. GARDINER & PERERA, *supra* note 16, at 42.

25. See *infra* Part II.B.

26. Initially, SBSB and the Connector had agreed to transfer 17,000 subscribers in two stages. The first stage involved moving the 1200-1600 subscribers (exact numbers vary) whose policies already matched what the Connector offered, and the second stage was to have moved the remaining 15,000 or so for whom either new coverage packages would need to be developed, or those who would need to select different coverage. This second, much larger transfer never occurred, however. The exact reasons remain murky. By the time the

As of June 2012, total enrollment in Business Express stood at 1,680 employers, representing 2,489 workers and an additional 1,954 family members, for a total of 4,443 lives.<sup>27</sup> Not all of these enrolled directly with the Connector, however, since many are legacy accounts brought in by SBSB. To date then, the Connector's small-group component clearly has failed to meet its goals. Although the Connector did not begin to actively market its small-group program until the first part of 2012,<sup>28</sup> many observers remain skeptical that it will gain much traction, although some remain hopeful. The competing reasons, broadly considered, can be understood through two sets of factors. The first relates to the Connector's basic value proposition — that is, whether it offers a better, or at least equivalent, value compared to the other products and purchasing mechanisms available in the market. The second set of factors focus on political and institutional factors that might hamper the Connector, apart from whether or not it offers better products at lower prices.

#### B. *The Connector's Basic Value Proposition*

##### 1. Pricing Issues

One long-time market regulator and observer stated a point that was echoed by many others: "it's been really, really hard to figure out what value proposition" the Connector has to offer. The most straightforward reason for this is community rating, which Massachusetts state law requires (as does the new federal law). Community rating requires that insurers offer the same prices inside and outside the Connector for the products with equivalent actuarial value.<sup>29</sup> Therefore, even if the Connector were able to generate economies of scale or bargaining power to reduce costs, those efficiencies would not be uniquely reflected in prices for the Connector's products, compared to the outside market. Instead, by law, insurers must continue to use the same pricing structure for all of their products, regardless of the particular sales vehicles. Even then, a number of brokers thought that some insurers were charging slightly more through the

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second transfer was scheduled to happen, the leading insurers had withdrawn from the Connector's employer program. Some interviewees also thought that insurers objected to the transfer, while others thought that SBSB changed its mind on how advantageous the transfer would be, either for it, or for its customers.

27. COMMONWEALTH CONNECTOR, CONNECTOR QUARTERLY PROGRAM SUMMARY REPORT (June 2012) [hereinafter CONNECTOR QUARTERLY PROGRAM SUMMARY REPORT 2012]; COMMONWEALTH CONNECTOR, MONTHLY HEALTH CONNECTOR SUMMARY REPORT (June 2012).

28. See, e.g., Press Release, Commonwealth Health Ins. Connector Auth., Finding the Right Small Business Health Plan Just Got Easier (Feb. 26, 2012).

29. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1301(a)(l)(c)(iii), 124 Stat. 119, 163 (2010).

Connector than for similar coverage these insurers offer outside the Connector.

a. Administrative Costs

Connector officials noted that one clearly demonstrable cost savings they achieved is eliminating the fee that the smallest employers paid to purchase insurance through intermediary organizations. In Massachusetts, most leading insurers other than Blue Cross do not sell small-group coverage directly to groups smaller than six employees. Instead, such coverage is sold through trade associations, such as SBSB mentioned above or the Massachusetts Business Association (MBA), which work with independent insurance brokers. Prior to the Connector, these intermediaries charged employers a monthly service fee of \$35 per employee for purchasing health insurance. The Connector reduced this fee to \$10 a month and then eliminated the fee altogether,<sup>30</sup> saving employers \$420 a year per worker.

As a result, for a time the Connector's effective prices for groups smaller than six were somewhat lower than the outside market (except for Blue Cross). However, the two leading intermediaries soon eliminated most of this price advantage by reducing their per employee monthly fee to match the Connector's competition.<sup>31</sup> Therefore, although the Connector was able to achieve a moderate, one-time reduction in prices across a portion of the market, it does not maintain a price advantage, in the eyes of most observers.

Several interviewees (including one Connector board member), felt that this apparent cost reduction was not entirely real, however. In their view, the Connector still incurs the administrative and sales costs that the employer fee funded, and so these costs are being shifted to different parts of the market rather than being eliminated. To defray these costs, the Connector charges insurers an administrative fee of 2.5% for groups and 3.5% for individuals.<sup>32</sup> Insurers are able to spread this cost over the premiums they charge outside the Connector via their market-wide community rates.

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30. COMMONWEALTH CONNECTOR, MASSACHUSETTS HEALTH CARE REFORM 2011 PROGRESS REPORT 7 (2011), available at <https://www.mahealthconnector.org/portal/binary/com.epi-centric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/ConnectorProgressReport2011.pdf>.

31. The private intermediaries do still charge an association membership fee of roughly \$125 per company, which the Connector does not charge. This fee also provides access to other association benefits and products.

32. COMMONWEALTH CONNECTOR, MASSACHUSETTS HEALTH CARE REFORM 2011 PROGRESS REPORT, *supra* note 30.

Although the Connector pays brokers' commissions out of this fee, which saves the insurers that expense, insurers see no savings for individual insurance since they pay no commissions for that business. Also, insurers believe that the Connector's administrative services save them little or no money since they have to maintain these same services for their non-Connector clients, and it requires extra effort for insurers to interact with the Connector and its TPA. Therefore, insurers believe that the Connector's fee creates a net added expense, on balance. Whichever side might have the better of this debate, it appears on balance that the Connector at least does not reduce administrative expenses.

b. Rebates and Tax Credits

The Connector believes it offers lower prices in two other ways. First, it is the exclusive source for employers to receive a 15% rebate that the legislature made available, beginning in July 2011, for lower-wage small firms that adopt wellness programs.<sup>33</sup> Eligibility for this subsidy mirrors the eligibility rules for the new federal small-firm tax credit under the ACA.<sup>34</sup> Combined, the state and federal credits could amount to 50% of the employer's contribution to health insurance. Initially, few firms reportedly have taken advantage of the wellness rebate, but it was not actively marketed until early 2012 and so it is too early to judge its impact.

Most insurance brokers and other market participants believe the wellness subsidy will have a negligible impact. They noted, with near unanimity, that the eligibility criteria for this program are too stringent to make it widely available or attractive. Some of these reasons echo those given for the federal tax credit — that the rebate percentage phases down rapidly for firms larger than ten and with average wages more than \$25,000;<sup>35</sup> the rebate reduces employers' existing tax deduction for insurance premiums which further reduces its value; the incentive does not apply to the business owner or family members; and there is no promise that the subsidy will continue beyond its initial few years of funding. Another reason was more specific to Massachusetts: many interviewees noted that wage scales in the Boston area are substantially above national averages,<sup>36</sup>

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33. *Id.* at 13.

34. ACA § 1421 (codified at I.R.C. 45R (2011)).

35. Jon Kingsdale, *How Small-Business Health Exchanges Can Offer Value To Their Future Customers – And Why They Must*, 31 HEALTH AFF. 275, 278 (2012).

36. This is confirmed by an independent analysis estimating that Massachusetts has the lowest percentage of small firms in the country (other than D.C.) whose wages would qualify for the federal tax credit. QUANTRIA STRATEGIES, LLC, SMALL BUS. ADMIN., HEALTH INSURANCE IN THE SMALL BUSINESS MARKET: AVAILABILITY, COVERAGE, AND THE EFFECT OF TAX INCENTIVES 59 (2011), available at <http://www.sba.gov/sites/default/files/386tot.pdf>.



especially for firms with more white collar workers, and so firms that are willing or able to offer insurance are not likely to meet the income limits needed to qualify for the program.

In addition, there was widespread skepticism, and some misunderstanding, about the wellness program's requirements. Some people thought, wrongly, that the incentive accrues only if the wellness features in fact save money, which they doubt would happen. Others thought the wellness program would impose unacceptable demands on employers and workers. To the contrary, the actual requirements appear to be so lenient that knowledgeable sources referred to them as a "laughable" "joke." Initially, all that is explicitly required is that a third of workers fill out a health questionnaire and receive an annual physical, and that employers make efforts to create a healthier work environment, although more requirements might be added.

c. Lower-cost Limited Networks

The second way Connector officials believe they offer lower prices is the fact, confirmed by at least two insurers, that the CommChoice platform has brought new insurers into the commercial market that have substantially lower premiums due to having more limited networks of providers. Some of these insurers mainly use safety net hospitals and community health centers that focus primarily on lower-income patients covered by Medicaid or by the Connector's subsidized CommCare coverage. These plans with more limited networks have prices that are 20-30% below the market leaders. Prior to the Connector, several had not offered private coverage (although some had), and even now, several of them sell mainly through the Connector, by refraining from paying any broker commissions for sales outside the Connector.<sup>37</sup> Most notably, Neighborhood Health Plan, which is based in community health centers, has increased its share of the Connector's private (mostly nongroup) coverage from 18% in 2008 to 43% in 2012, which is twice the share of the next largest insurer participating in CommCare.<sup>38</sup>

Several brokers and employer representatives acknowledged the potential appeal of offering lower-cost networks through the Connector. But despite this potential, most of the insurers with more limited networks have gained only a modest foothold in the Connector. A number of brokers interviewed said they are reluctant to, or refuse to, recommend insurers that

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37. Kingsdale, *supra* note 35, at 279.

38. COMMONWEALTH CONNECTOR, CONNECTOR QUARTERLY PROGRAM SUMMARY REPORT (2008); CONNECTOR QUARTERLY PROGRAM SUMMARY REPORT 2012, *supra* note 27, at 4; JON KINGSDALE, MASS. HEALTH INS. CONNECTOR AUTH., REPORT TO THE MASSACHUSETTS LEGISLATURE: IMPLEMENTATION OF THE HEALTH CARE REFORM LAW, CHAPTER 58 31 (2008).

are less established or recognized, in part because brokers are less familiar with these insurers and do not have established working relationships with their sales and customer relations staff. Some brokers also were concerned about recommending an insurer whose network does not include the major teaching hospitals in Boston affiliated with Harvard and Tufts Medical Schools. They feared that subscribers would complain if they could not access preferred specialists or facilities when they face a serious health problem.

Somewhat paradoxically, other brokers, and sometimes even the same brokers, complained that the Connector currently does not include some of the newly emerging limited network plans now being offered by the top insurers in the market. In response to increasing complaints about high insurance costs for small employers, the Massachusetts legislature, in 2010, required all established HMOs (those with more than 5,000 individual and small group lives) to offer a limited or tiered network option that is priced at least 12% below their standard full-network products.<sup>39</sup> In response, several of the state's leading insurers recently began to market such products very actively, attracting notable interest from brokers and employers. These new products are not initially available through the Connector, however, which led many brokers to complain that the Connector was "stifling innovation."

#### d. Benefits Standardization and Innovation

Some interviewees also felt the Connector did not offer sufficient choice of higher deductible plans designed to fit with health savings accounts (HSA), or other forms of lower benefit options. However, the leading insurers in the Connector opposed the Connector allowing their competitors to offer only limited benefit or limited network options, for fear this would pull in only better risks and leave them exposed to adverse selection. Also, many of these criticisms about excessively rich benefit options appear directed toward the state's "minimum creditable coverage" standards, which apply market-wide and eliminated so-called mini-med plans. These coverage requirements are not unique to the Connector, but interviewees tended to blame the Connector for them since it is the regulatory authority that set the minimum standards.

Within the Connector, the inability to offer innovations in benefit design has been a "sore subject," according to some insurer representatives, since originally innovation was one of the Connector's "mantras." One insurer took advantage of the Connector's invitation to innovate by creating a coverage option that combined a high deductible structure for specialist

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39. MASS. GEN. LAWS ch. 288, § 23 (2010). Tiered networks are those that include a broad array of providers but place them into different tiers, with varying cost-sharing for patients, designed to encourage use of lower-cost providers.

care and hospitalization with first-dollar coverage for primary care. This insurer felt its innovative product was popular, but then the Connector decided, based on focus groups, that its initial range of options was too confusing to individuals, so it required the insurer to eliminate all nonconforming plans.<sup>40</sup> Several brokers also noted that the Connector primarily offers HMO products, which lack the out-of-network feature needed to enroll people who live in bordering states.

Other insurers and observers, however, said that standardization of benefits was not a major problem, despite some "quibbling," "whining and gnashing of teeth." They agreed that simplification of benefit options is necessary in order for the Connector to sell directly to individuals because too much choice "can be numbing," causing people to "freeze like deer in the headlights." The Connector's decision on how to standardize was said (by several sources) to be a "collaborative" process that relied heavily on input from insurers. But, some insurers and brokers sympathetic to the need for standardization for most Connector products still felt insurers should be allowed to offer one or two nonstandard options that are selling well outside that Connector, in order to facilitate innovation. They explained that, although Massachusetts historically has been a rich benefit state, this is changing rapidly with most small groups now "crossing the Rubicon" into high-deductible plans.

Taking note of these criticisms, since 2010 the Connector has offered HSA-qualified high-deductible plans, although deductibles are capped at \$2,000 for individuals and \$4,000 for families, substantially below the federal limits.<sup>41</sup> More recently, the Connector announced that, beginning in 2013, insurers may offer one or more narrow (restricted) network products that cover the standardized benefit plans, and they may propose one or more innovative nonstandard benefit options.<sup>42</sup>

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40. Jenifer E. Urrf, *Determining Health Benefit Designs to be Offered on a State Health Insurance Exchange*, HEALTH REFORM TOOLKIT SERIES: RESOURCES FROM THE MASS. EXPERIENCE 103, 113 (Nov. 2011). Note that standardization of benefits is distinct from offering benefits in tiers, identified by precious metals (or Olympic medals, such as Gold, Silver, Bronze, etc.). The metal tiers are based on a plan's actuarial value determined largely to copayments and deductibles, that is, what percent of covered benefits are paid by the insurer rather than the patient. A given actuarial value can be achieved through a wide variety of benefit structures. Therefore, Connector officials concluded based on market research that additional standardization of copayments and deductibles is needed to simplify choices beyond merely arraying them in actuarial tiers.

41. Commonwealth Health Insurance Connector Authority, 956 MASS. CODE REGS. 5.03(2) (2008).

42. Roni Mansur, Chief Operating Officer, & Sarah Stephany, Program Coordinator, Mass. Health Connector, Presentation at the Mass. Health Connector Board of Directors Meeting: Commonwealth Choice 2013 Seal of Approval (May 10, 2012).

Interestingly, the absence of non-health products in the Connector was not a matter of concern for most brokers. Brokers often arrange “ancillary” products and services for employers, such as optional life, dental, disability and long-term care insurance, and flexible spending accounts, 401(k) plans, and the like. Outside the Connector there are vendors that provide “one-stop shopping” for a suite of employee benefits, which the Connector does not do. However, brokers almost uniformly said that they are well equipped to package health insurance from one source with ancillary benefits from another source — which they often do in any event, even when not using the Connector.<sup>43</sup>

## 2. Enhanced Choice

Aside from price, the other main way the Connector seeks to improve market options for small employers is to offer a superior mechanism to shop for coverage. For all of its programs, the Connector touts the ease of making side-by-side comparisons online of insurers’ prices and benefits — which contrasts with the confusion and complexity of shopping insurer by insurer in the regular market. In addition, the Connector attempted to enhance the degree of choice available to workers in small firms by piloting its Contributory Plan, noted above.

### a. Employee Choice

We begin with a focus on the special features of the Contributory Plan. A variety of explanations were given, repeatedly and by different sources, for why this pilot was not successful. Most basically, there was some skepticism about how much employers actually value letting workers choose their own coverage. In favor of choice, some brokers, employer representatives, and other observers felt that employers would like this option once they experience it, but in Massachusetts employers were not yet used to the idea so they were not drawn strongly to it initially. These sources pointed to the fact that, among employers who did enroll, the reported level of satisfaction was very high,<sup>44</sup> and those who signed up have tended to remain with the product longer than normal. According to one senior employer representative, some employers thought this program “was the greatest thing, they loved it” — a sentiment confirmed by several others.

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43. Moreover, many employers either do not purchase any ancillary services and products, or they purchase them elsewhere. In a recent national survey, only a third of small employers who used an agent to purchase health insurance also used the agent to purchase some other type of business insurance. NFIB RESEARCH FOUND., SMALL BUSINESS AND HEALTH INSURANCE: ONE YEAR AFTER ENACTMENT OF PPACA 7 (2011), available at <http://www.nfib.com/research-foundation/surveys/healthcare-year1>.

44. IERNA, *supra* note 23, at 16.

Other choice proponents felt that there is real potential for a “defined contribution” model in which employers give workers a voucher of a fixed amount to spend on health insurance any way they wish, but they complained that the Connector eschewed a genuine version of this model. Instead, the Connector required (for reasons noted below) that employers select a reference plan and agree to pay at least 50% of its premium, and employees were then allowed to pick alternative insurers or plans only with the same benefit tier.

It was noted in response to these objections that the Connector’s reference plan model was based on the design used by the very successful private exchange in Connecticut (Connecticut Business and Industry Association).<sup>45</sup> Also, it is not immediately obvious why these variations from a pure defined contribution approach would necessarily weaken the Connector’s approach to individual choice. In the pilot, two thirds of workers ended up staying with the reference plan selected by their employer rather than picking a cheaper or more expensive option.<sup>46</sup> Therefore, as one knowledgeable source said, perhaps the employee choice idea was simply “ahead of its time” — something that most employers and workers did not fully appreciate because they were so used to the idea of picking a single broad network for the entire workforce.

Others, however, believed that — while individual choice is a “noble aim” and “interesting concept” that, “at least on paper,” “sounds [like a] fantastic” idea that could “completely revolutionize the market” — in practice employee choice is either inherently too complicated or is not sufficiently meaningful to make a real difference. According to doubters, the employee choice option is, at best, only a “niche product” that will never capture a large segment of the market. One experienced source said that most small employers “just want something credible” and “simple,” and they “don’t want to take the time to figure out” something complicated. Because employee choice is a different way of doing things whose details are not easily understood, employers and brokers tended to “approach [this new idea] with caution,” according to one very experienced market participant.

Inherent complications are noted below. Regarding whether choice matters, these skeptics felt that differences were too minor among covered benefits and networks offered by the leading insurers for choice to be very meaningful. “It’s a facade of choice,” in the view of one broker, because the benefit options and most of the major provider networks are the same. An employer representative objected that employees were allowed only to

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45. ROBERT L. CAREY & JONATHAN M. GRUBER, MARYLAND ASS’N OF HEALTH UNDERWRITERS, A HEALTH INSURANCE EXCHANGE FOR MARYLAND? COMPARING MASSACHUSETTS AND MARYLAND 7 (2010), available at [http://www.marylandahu.com/downloads/mahu\\_exchange\\_study.pdf](http://www.marylandahu.com/downloads/mahu_exchange_study.pdf).

46. Kingsdale, *supra* note 35, at 278.

choose within a tier, but that having “vertical choice” among benefit tiers is more important than “horizontal choice” among insurers with similar benefits. Or, as a broker put it, he would prefer a “Willy Wonka elevator,” one that doesn’t go merely side to side (within a tier) or up and down (across tiers), but that also allows shoppers to “zig and zag” in both dimensions.

b. Complications

A related but counteracting concern, shared by several brokers, is that the employee choice feature required much more effort to explain to employers and workers than selling the employer a single plan. As one broker put it, “how many conversations do you want to have to help everyone figure this out” for just \$10 a month per worker? This thought that employee choice might be a good feature if “there were a way to pay for advising employees” about how to make their selections. Absent that, when employers want to offer employee choice, he prefers to set up a tax-sheltered health reimbursement account (HRA), since that more clearly takes the employer out of the role of choosing or sponsoring a health plan. In contrast, the Connector’s approach conveyed the sense that the employer, and hence the broker, was still responsible for helping employees decide which insurance option they should select.

Another complication of the Connector’s pilot program is that an employer could not know the exact amount of its contribution until workers make their selection, since their precise age-mix determined the base premium, under community rating rules that allow two-fold variation based on age.<sup>47</sup> To make the choice model function properly required “convoluted” pricing calculations, which “you need a Ph.D. to understand.” Age rating creates greater complexity in an individual choice model due to the key difference between “composite rating” and “list billing.” Conventionally, employers in many (but not all) states receive a composite rate that reflects the blend of ages in their covered workforce at the time that workers sign up. The result is that neither the employer’s nor the employee’s contribution varies according to age. Composite rating works when an

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47. Insurers also are allowed, until 2014, to vary rates according to group size to reflect the greater adverse selection that occurs among smaller groups. But, group size rating is difficult to implement in an individual choice model because insurers do not know how many workers will sign up at the point they are asked to quote the rate that employees use to pick a plan. See *generally* INST. FOR HEALTH POLICY SOLUTIONS, STUDY OF SHOP EXCHANGE: ANALYSIS OF KEY MARYLAND SHOP-RELATED POLICY OPTIONS (2011), available at [http://dhmh.maryland.gov/exchange/pdf/FinalSHOPExchangeHPS\\_1.pdf](http://dhmh.maryland.gov/exchange/pdf/FinalSHOPExchangeHPS_1.pdf). Other difficulties and frustrations noted by agents related to the fact that, for various technical reasons, the web interface showed the employer only how much it was contributing, and not what the total premium would be. According to one, “it was just weird – a whole different way of” comparing plans and prices.

insurer enrolls the entire group, but not when workers can select different insurers. Then, each insurer will want to bill separately for each worker, according to the worker's age — which is known as "list billing." Not only does this make the employer more aware of inherent cost differences, but employers then face the dilemma of whether to make different employees contribute different amounts to their insurance premiums.

List-billing is an accepted market practice in a number of other states, but it was not so in Massachusetts. The Connector attempted to mediate this "dicey" issue by using a blended composite rate for all workers who selected the employer's reference plan, but it used list-billing for those who selected alternative plans. This solution created two problems. Employers found the multi-page billing statements "really confusing," and so their brokers had to spend significant time understanding and explaining these complexities, which they found "exasperating," according to a Connector source.

Second, when employees found out (by talking among themselves) that employers were requiring some workers to contribute more than others to health plans that basically were very similar, workers were understandably upset. This disparity arose not only because some employees selected less expensive coverage, but also because those who selected alternative coverage had their premium contribution determined by their actual age rather than by the company's composite rate that applied to the blended ages under the reference plan. According to Connector officials, this differing approach to age rating was done in part to accommodate concerns by some board members that pure list billing would result in age discrimination. However, officials despaired that mixing composite with list billing in this "overly engineered" fashion "really mucks up the works" in ways that "become very difficult to explain to anyone who is not an actuary."<sup>48</sup>

### c. Adverse Selection

Other problems with the Contributory Plan related to the fact that it was a pilot program, which some former Connector officials believe "doomed it

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48. Moreover, this approach creates a third potential problem: Composite rating for one product but list-billed age rating for other products creates an inherent bias towards older workers choosing the reference plan and younger workers opting for alternative coverage. This age sorting did not materialize in the Connector's limited pilot. However, a couple of observers noted that adverse selection might have occurred if this rating structure had remained in place longer such that agents became more aware of this discrepancy and began to advise workers about how to take advantage of it. For thoughtful analysis of other, more complex ways to deal with these difficulties, see RICK CURTIS & ED NEUSCHLER, INST. FOR HEALTH POLICY SOLUTIONS, SMALL-EMPLOYER ("SHOP") EXCHANGE ISSUES 18 (2011), available at [http://www.healthexchange.ca.gov/Documents/Small%20Employer%20\(SHOP\)%20Exchange%20Issues.pdf](http://www.healthexchange.ca.gov/Documents/Small%20Employer%20(SHOP)%20Exchange%20Issues.pdf); INST. FOR HEALTH POLICY SOLUTIONS, *supra* note 47, at 24.

from the start.” It was introduced as a limited test in order to overcome strong objections from some of the major insurers, including Blue Cross, who feared they would experience serious adverse selection if employees were allowed to opt out of the reference plan selected by the employer. Blue Cross based this concern on its experience in the nongroup segment of the market, where it documented receiving enrollment with a worse risk profile than in its small group segment. Blue Cross, along with some of the other leading insurers, reasoned that sicker individuals will tend to choose plans with the broadest networks and healthier patients will opt for cheaper limited networks, leaving them with the “worst of the litter.”

For these reasons, one leading insurer conceded that an employee choice approach “scares the you know what out of us.” Multiple sources explained that, to “assuage” this “paranoia” and “big bugaboo” over adverse selection, the Connector agreed to control the program’s size and profile by conducting it as a limited pilot. Otherwise, some or all of the leading insurers would have refused to participate. This accommodation brought the leading insurers on board “only grudgingly” (according to several sources in so many words), but it meant that the pilot was done “with three hands tied behind our back,” according to one Connector official, or “with one foot in the grave,” according to a benefits consultant.

For instance, the pilot status meant that the new program was not advertised. To limit size and focus its training efforts, the Connector made the pilot available to only about 20 brokers rather than open it to the market as a whole.<sup>49</sup> But, to avoid unfairness to nonparticipating brokers, the participating brokers could enroll only their existing clients rather than using the Contributory Plan to “poach” new business from other brokers.<sup>50</sup> This removed any ability for brokers to promote the new program in order to gain new business. Moreover, they realized from the outset that the pilot might not be continued.

By design, then, the pilot program was never intended to enroll large numbers. The initial hope was to enroll 100 firms with 1000 workers (over no specified time period).<sup>51</sup> But, after almost a year, the pilot ended up enrolling a maximum of only 77 employers and 207 workers.<sup>52</sup>

An additional reason it failed to do better is that adverse selection concerns caused Blue Cross, the market leader, to charge ten percent more through the Connector than in the outside market. It was allowed to do so,

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49. Joshua D. Archambault, *Massachusetts Health Care Reform has Left Small Business Behind: A Warning to the States*, No. 2462 BACKGROUND, Sept. 16, 2010, at 4, 4, available at [http://thf\\_media.s3.amazonaws.com/2010/pdf/bg2462.pdf](http://thf_media.s3.amazonaws.com/2010/pdf/bg2462.pdf).

50. *Id.*

51. *Id.*

52. CONNECTOR QUARTERLY PROGRAM SUMMARY REPORT 2010, *supra* note 22.



despite community rating rules, because the state allows insurers (until 2014) to use a group size factor in their community rates, to capture the element of adverse selection that inherently attaches to choices made by smaller groups.<sup>53</sup> Because the employee choice model slices groups that are already small into even smaller units ("twosies and threesies"), Blue Cross (and other insurers) had regulatory authority to add this ten percent surcharge, which would obviously tend to discourage its customers from switching to the Connector.

Despite these concerns, adverse selection did not materialize in this limited pilot (although it was too short-lived to draw strong conclusions from the experience). An evaluation done after the pilot's first year found that average ages were virtually identical for those who kept the employer's reference plan and those who selected an alternative.<sup>54</sup> Also, of the 35 people who selected an alternative plan, about half selected something more expensive, and they also were not substantially older than those who opted for cheaper coverage. This does not resolve the issue conclusively, however, because risk status was assessed only through crude demographics and not actual costs, disease burden or care utilization. Also, adverse selection patterns may take longer than this pilot period to become pronounced. Nevertheless, the Connector's assessment found that the pilot succeeded in avoiding the problems that were initially feared.

#### d. A Change of Heart

Why did the Connector not promote the pilot into a full scale program, with an ambitious advertising campaign like the one that successfully launched its other, individual-enrollment programs? In the end, no important constituency was enthusiastic about the idea, so it "just wouldn't be worth it" to undergo the "headache of fixing it," according to multiple sources. In addition to tepid response from employers and resistance or opposition by insurers and brokers, several of the people interviewed pointed to the social views of some "pro-consumer" "paternalistic" "lefty" members of the Connector Board, who they felt were philosophically opposed to moving in the direction of defined contribution by employers.

Coupled with this lackluster reception was a different opportunity presented to the Connector in late 2009 to jumpstart a critical mass of enrollment by transferring SBSB's existing block of business to the

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53. DANIEL APICELLA, COMMONWEALTH HEALTH CONNECTOR, PLANNING FOR A RISK ADJUSTMENT PROGRAM IN MASSACHUSETTS 12 (2012), available at <http://www.nescso.org/UserFiles/pdfs/D-Apicella-Massachusetts-Risk-.pdf>. The smaller the group, the more that insurance purchasing decisions are likely to reflect the health conditions of individual employees, including those of the business owner.

54. IERNA, *supra* note 23, at 9.

Connector.<sup>55</sup> As noted above, the Connector contracts with SBSB to administer its unsubsidized private insurance programs. SBSB is one of two large “intermediaries” in the market that enroll the majority of employers with fewer than six workers. To consolidate this dual role, SBSB was willing to transfer its 17,000 subscribers to the Connector, and the Connector was eager to receive this bolus of enrollment — in part because it was under increasing “political pressure” to show the Governor tangible results in “delivering something to employers.”

For SBSB to seamlessly transfer its existing groups to the Connector, however, the Connector had to conform its small group program to the structure that existed in the outside market. This meant abandoning the employee choice features, regardless of how well or poorly the pilot might be seen to have gone. We turn, next, then to learn how choice features functioned under the next iteration, known as Business Express.

e. Employer Shopping

Along with providing employees a choice of plans and making it easier to compare plans, the Connector also seeks to improve the shopping process for employers. Even though it offers the same basic array of insurers and products available in the broader market, the Connector aims to make the key comparisons among these products more transparent, in order to facilitate competition.<sup>56</sup> For the smallest employers, some degree of comparison-shopping was available before the Connector was in place via the trade association intermediaries noted above. However, Blue Cross does not deal with these intermediaries and the product offerings are not standardized. As a result, without a broker it is not feasible outside the Connector to obtain side-by-side comparisons, on an apples-to-apples basis, of plans offered by all of the leading insurers. This point was highlighted in a recent New York Times article, which contrasted one Massachusetts business person who had found it “astoundingly complicated” to shop for coverage outside the Connector and so “ultimately gave up trying” because it “was impossible to compare plans,” with another individual (nongroup) shopper who said the Connector’s website was “super-easy to take a quick look and figure out which price range we wanted . . . and then dive down deep into one or two of them.”<sup>57</sup>

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55. MASS. HEALTH CONNECTOR, REP. TO THE MASS. LEG.: IMPLEMENTATION OF HEALTH CARE REFORM 14 (Nov. 2010).

56. AMY M. LISCHKO, THE COMMONWEALTH FUND, THE MASSACHUSETTS COMMONWEALTH HEALTH INSURANCE CONNECTOR: STRUCTURE AND FUNCTION 11 (2009).

57. Abby Goodnough, *Navigating the Health Care Maze*, N.Y. TIMES, June 13, 2012, at A14.

Insurance brokers and employer representatives did not share this enthusiasm, however. Instead, the following kinds of complaints were heard, repeatedly, mainly from brokers. First, brokers felt that they are well equipped to present informed shopping choices to their employer clients, by using their own tailored spreadsheets based on information they obtain directly from insurers. Because most small employers purchase insurance through brokers, brokers' expertise greatly mitigates the complexity of navigating the market and thus the Connector's comparative information advantage.

Second, brokers noted that they would not be doing their clients justice if they abandoned their spreadsheets and relied only on the Connector. Thus, even if the Connector's portal might be simpler and more complete, from a broker's point of view it presents only an additional layer of work, rather than a means to simplify their search efforts. Even brokers who use the Connector said, repeatedly, that this ends up being "more work for less money," since they continue to also obtain quotes and explore benefits options directly with insurers and the private intermediaries. As one explained who is in favor of the Connector, "my business is finding the smallest of advantages for my customer," and so he compares Connector options with the rest of the market, to see where he might save one or two percent. "That's all more work, but I love" the challenge. Other brokers, however, seemed to resent the "extra work" of shopping the Connector alongside the regular market.

Brokers further noted that there is a greater diversity of plan types and coverage options available outside the Connector, and so providing thorough advice requires continuing to search the outside options. Thus, they saw the Connector's standardization of benefits as a disadvantage, despite its facilitating head-to-head comparisons, since brokers see value in having as many options as possible for them to help employers sort through. Several touted the fact that, outside the Connector, they can search through up to 80 plan options, whereas the Connector presents only about a half dozen.

f. Service and Information Technology Issues

Finally, brokers complained, sometimes bitterly, about "cumbersome," "inept," and "antiquated" features of the Connector's shopping interface (administered by SBSB) that made it more difficult, not less, than dealing with insurers directly or through the existing intermediaries. According to a more charitable view, the Connector's plan comparison systems function well enough, but they're "just not what we're used to," and so takes some time and effort to learn.

One feature that drew complaints is the Connector's "nightmare" requirement that brokers (or employers) enter tax identification numbers and

employee demographics before they can receive a quote, which also then requires that the broker have a unique password for each group. The Connector explained that these are requirements that some insurers insist on, to make sure their quotes are accurate — since rates depend on age, location and industry category. Another explanation given is that Blue Cross in particular insisted on this level of extra detail in order to determine whether its existing clients are considering switching to the Connector, and thus possibly to their competitors.

Regardless of the justification, brokers objected that this kind of information is not required to obtain quotes elsewhere, and that demanding this level and type of information from employers simply to give them quotes is not a good way to solicit business from a new client. Several brokers also criticized the Connector's renewal process for being much more cumbersome than renewals done directly with insurers. The Connector reportedly requires detailed information to be re-entered from scratch each year rather than assuming continuity of the workforce unless changes are noted.<sup>58</sup>

In addition, many brokers complained that the Connector's website at times did not function well, or that they could not receive the assistance they wanted by phone. According to several brokers, after entering lots of information the website would freeze and all the information would need to be entered again, simply to obtain a quote. Also, when brokers needed to speak with someone on the phone, several complained that the Connector's TPA initially was "horrible" because it was much harder to reach than staff with insurers ("awful," 45 minute wait times) or TPA staff did not have answers to basic questions and "were hard to work with," at least at the outset. Some brokers complained that having various functions and responsibilities divided among the Connector, its TPA, and the insurer "can be very confusing, dealing with two or three layers," compared to "dealing with an insurer directly." Also, several brokers said they value the "certain type of access" they have when they are able to "pick up the phone" and reach the right insurer representative who can deal with a client's problem directly, rather than going through an intermediary.

Not all interviewees shared these negative views, however. Some brokers, noted significant improvement over time in service and website

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58. According to two sources, renewals are more troublesome for some insurers than others because some insurers guarantee a composite rate for a year, thus assuming the risk of changes in a group's demographics, and so they need more detailed demographic information at renewal in order to "true up" the group's composite rate (whereas other insurers require the composite rate to be periodically updated throughout the year). Another agent complained that minor discrepancies in the renewal process can result in employers being automatically dropped, leaving them uninsured for a time.

problems. According to one, the TPA and Connector staff are "easy to work with, really smart, on top of things, very responsive and helpful." Another noted that some of the bureaucratic hurdles are imposed by insurers, not the Connector. For instance, selling group coverage to a sole proprietor often requires extremely thorough (or "crazy") documentation that the person has a legitimate business in Massachusetts, but it is wrong to blame the Connector for these demands imposed by insurers. Insurers themselves did not complain about, or were not aware of, any problems with the Connector's online interface and how its TPA is servicing accounts, despite their having a significant stake in these matters.

Some brokers noted that views differ depending on how comfortable brokers and employers are with using a computer online for complex and important matters, in contrast with "older brokers" whose secretaries "do the paperwork." One broker, for instance, said that "trying to make [insurance selection] computer driven just makes you deeply confused," even for "doctors and lawyer clients, . . . forget about plumbers, electricians." And, another broker noted that some clients do not have the ready access to computers needed to take advantage of the Connector's systems, and so they still need live customer service after hours (when they are not at work). In contrast, other brokers said that most of their business and client interactions are done by computer, which they and clients "love." One broker who has placed a fair amount of business with the Connector noted that, although aspects of the experience can be frustrating, once employers are signed up, most of them remain because they have fewer "hassles."

Overall, as one Connector official summed it up, "until you work in the guts of health insurance, you don't realize" that the operational complexity of the group market is "ten times harder" than the nongroup market, and so it's a "stepwise process" in which "you can't achieve perfection on day one." Accordingly, one barely sympathetic broker opined that "we should cut them some slack [since at least] their heart's in the right place." Another broker agreed with colleagues that there had "been some hiccups along the way," but on the whole, the Connector has "actually done a good job" — a view echoed by a well-informed former government official, who thought that "it's a real testament to everyone [involved with the Connector] that they could find middle ground of some kind" between all of the competing considerations entailed in figuring out how to "differentiate itself in the market without being a threat" to insurers and brokers. That is "not an easy dilemma to solve."

### C. *Political, Institutional, and Miscellaneous Factors*

Even if the Connector did everything just right and offered superior choice at a better price, its success might be foiled by opposition from key constituencies based on political, economic, or institutional factors. The

Connector, after all, is a quasi-governmental agency that exercises regulatory authority, and many business people are hostile to government regulation or take a dim view of the competency or propriety of government entering directly into the private market. Many insurers might naturally resist efforts to change the basis on which they compete. Brokers might view the Connector as especially threatening since, if it were to succeed in vastly improving the shopping process, employers might no longer need brokers. On the other hand, some insurers and brokers might welcome the Connector as a vehicle for gaining a better market foothold. Interviews explored whether and to what extent views such as these prevailed.

### 1. Employers' Views

Among employers, there were only moderate signs of "knee jerk" resistance to the Connector based on its governmental auspices. This is confirmed by a statewide survey that found that only one-third of small employers would be "uncomfortable" buying health benefits through the Connector "because it is a quasi-governmental agency."<sup>59</sup> But, several sources noted that Massachusetts generally is more receptive to "big government" than other states, so any signs of resistance based on government "stigma" does not bode well for likely attitudes in other states.

Two business group representatives felt that employers had some reluctance to deal with the Connector as a governmental agency, but another long-time employer representative thought the small business community in Massachusetts realizes they lack the market clout of large business and so they are seeking the government's help to rein in costs. Several other knowledgeable sources said they had not noticed any indications of employer "hostility" to the Connector, and that many employers were at least willing to "take a look at it" to see if it offers better value.

Indeed, several sources said the Connector has a very positive reputation in the general community, based on how effectively it has overseen and implemented Massachusetts' health reform law. According to one benefits advisor, "People are pretty amazed about what they were able to accomplish in a short period of time." Others said the Connector has a lot of "credibility," and so at least some employers respect the "seal of approval" it confers on plans that it offers. One key source thought that employers view the Connector *more favorably* than it deserves, by wrongly

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59. Jon R. Gabel, Heidi Whitmore & Jeremy Pickreign, *Report from Massachusetts: Employers Largely Support Health Care Reform, and Few Signs of Crowd-Out Appear*, 27 HEALTH AFF. w13, w21 (2008). This response was given by a quarter of small employers that offer coverage and half of those that do not. The overall sample size was 629 small employers.

assuming that it provides a subsidized rate for private insurance. According to one broker, when she talks to employers about the Connector, they often think she is suggesting that they join a Medicaid-type program — a false notion that takes extra effort for her to disabuse with clients.

Rather than negative impressions of the Connector, interviewees more often mentioned general lack of awareness by employers. Confirming this, an employer survey conducted by the state each year reported that, in 2010, only 44% of employers offering health insurance were familiar with the Connector (and only 37% of those who do not offer insurance). Several people praised the Connector's "innovative and creative" marketing of its nongroup and subsidized components,<sup>60</sup> but, as Connector officials conceded, marketing for their employer component has been virtually "nonexistent." Initially, this is because it was run as a pilot program. Then, just after the revised employer program was launched, all the leading insurers withdrew for two years, as explained more below, and the Connector did not want to market a program that did not include them. With the major insurers rejoining in 2012, the Connector began to market the small group program very actively, just at the time interviews were being conducted for this study, and many interview subjects had heard or seen them. But, at the same time, there was also active marketing by a new, competing private purchasing cooperative operated by an employer trade group, which tended to steal some of the Connector's thunder.

## 2. Insurers' Views

### a. Generally

As just mentioned, in early 2010 the market's four largest insurers, representing 90% of the small group market, suddenly withdrew or refused to join the second iteration of the Connector's small group program, a month after its launch.<sup>61</sup> This crisis, which many people called a "boycott," occurred at the same time as the Governor's high profile decision in March 2010 to flatly deny any rate increases for most of these insurers' small group products.<sup>62</sup> This decision hit "like a meteor" on the eve of the annual renewal date for many Massachusetts groups (which typically occurs April 1). Blue Cross attributed its nonparticipation in the Connector's new small

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60. For more detail, see JENIFER E. URFF, BLUE CROSS BLUE SHIELD OF MASS., IMPLEMENTING A SUCCESSFUL PUBLIC EDUCATION AND MARKETING CAMPAIGN TO PROMOTE STATE HEALTH INSURANCE EXCHANGES, HEALTH REFORM TOOLKIT SERIES: RESOURCES FROM THE MASS. EXPERIENCE (2011).

61. Archambault, *supra* note 49, at 6.

62. Kevin Sack, *Massachusetts Insurance Regulators Reject Most Requests for Higher Rates*, N.Y. TIMES, Apr. 2, 2010, at A14.

group program to needing more time to work through the necessary systems changes with the Connector, rather than a response to the Governor's rate freeze. Regardless of the reason, when Blue Cross refused to join the revised program, the other three leading insurers, according to multiple sources, also left and would not return until Blue Cross first agreed to do so, two years hence.

It is understandable that major insurers would refuse to play ball with a government that abruptly denied any rate increase for small groups. But, it is less obvious why none of the other insurers would re-enter until Blue Cross was appeased. With Blue Cross having the largest share of a highly competitive market, one might have expected that business rivalry could cause one or more insurers to break rank in order to seize some of Blue Cross' market share.

Several explanations were given. Several people rotely recited the mantra that, as the "800 pound" market leader, when Blue Cross does something, "everyone else takes notice." A couple of people speculated that, under a dynamic where the largest plan tends to experience more adverse selection, it may be that no one else wanted to be at the front of the firing line, especially considering that the Connector generally attracts only the smallest groups, which tend to have higher risks. As a source at one insurer admitted, faced with this risk of adverse selection, "we felt that if Blue Cross isn't going to play nice, we can't be the only ones who play nice."

The most convincing explanation heard was simply that none of the leading insurers is especially eager to participate in the Connector. "They would all just as soon the Connector just go away," according to one Board member — a sentiment echoed in interviews by at least one of the insurers. This insurer explained that, initially they joined to be sure not to miss out on a possible change in the market, but now that they see the market has remained largely the same, they feel "stuck." This and other insurers intimated that they deal with the Connector in large part in order to be a "good corporate citizen" and because it would be "political disaster" if they did not. But, with Blue Cross carrying the most political and institutional weight in the state, other reluctant health plans felt that they were safe to demur until Blue Cross rejoined.

#### b. Blue Cross

For these several reasons, the view, frequently heard, appears well-founded, that Blue Cross's influence "as the big kid on the block" is such that "it can call the tune" and "set the rules." According to observers, this solidarity among leading insurers meant that the Connector had to come to terms with Blue Cross over numerous, sometimes "maddening," operational details since, if Blue Cross "would not play," neither would the others. This created the impression, among many, that leading insurers, including Blue



Cross, "mounted an organized campaign" to resist the Connector's employer program "every step of the way," in ways that "just made [the Connector's] life miserable." Two people said that insurers' objections often were only "smoke and mirrors," since some objections voiced about the employer program were not heard earlier about the nongroup program, and once one issue was resolved "there would be two other" new ones.

Observers speculated that Blue Cross "didn't want to play" because "they were fat and happy the way things were," and so they could only lose from the Connector's new approach. Some informed sources found this position quite reasonable, since in fact Blue Cross has substantially less market share inside the Connector than in the rest of the market, and because people who change insurers are probably better risks, on average, than those who remain (a general phenomenon known as "adverse retention"<sup>63</sup>). These sources felt that this attitude is not peculiar to Blue Cross since it would likely be shared by any dominant insurer. Several others noted that Blue Cross deserves some credit for having helped to bring about the state's health care reform law in the first instance, and that, more recently, Blue Cross has become more cooperative with the Connector, under the leadership of its new CEO and President, who is "true to [the nonprofit] mission" and wants to "do the right thing."

Another explanation for Blue Cross's reluctance is the role of SBSB, the Connector's contracted administrator for private insurance. As noted above, "part of the strange stew" in Massachusetts (in the words of a knowledgeable observer) is that SBSB and Blue Cross are competitors. SBSB sells insurance from Blue Cross' competitors, but not from Blue Cross, because Blue Cross' policy has been to sell its small group coverage directly (and through independent brokers). Because of Blue Cross's larger market share, it could afford to invest in the systems and personnel needed to service very small accounts directly. It prefers to do this rather than turn these key roles over to a third party, whose handling of matters affects customer relations and brand identity. Other leading insurers had decided that it was more economical to outsource service for all of their groups of five or fewer to intermediaries such as SBSB. These insurers sell to these groups only through intermediaries, and never directly.

Despite this competitive alignment, the Connector hired SBSB to administer its private insurance programs because it needed a firm that had the experience and established relationships with most of the market's health plans. Also, the reform law required the Connector to use an administrator domiciled in the state. Blue Cross did not object to SBSB's role in

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63. David Cutler et al., *Selection Stories: Understanding Movement Across Health Plans*, 29 J. HEALTH ECON. 821, 823 (2010).

administering nongroup coverage, but when it came to small group business, Blue Cross was not willing to cede some of its administrative functions to SBSB. Moreover, it felt that it was unfair to have to pay a service fee to the Connector to help support its SBSB contract, for services that duplicated what Blue Cross already provided to small groups and did not want to relinquish.

This uncomfortable alignment spawned a host of technical issues that were difficult to resolve, that delayed Blue Cross' re-joining the small group program, and that still bedevil it to some extent. For instance, one key to giving accurate quotes to insurance shoppers is to have direct access to each insurer's specific rating criteria, which determine how much rates vary by allowable factors such as age, location, business sector, and group size.<sup>64</sup> Other insurers were already used to sharing this competitively sensitive information with SBSB, but Blue Cross was not. Dealing with these "control issues" required "cumbersome" work-arounds behind the scenes to allow Blue Cross' small-group products to be quoted alongside its competitors, according to various sources.

Such complexities are not unique to the Blue Cross and SBSB situation, though. According to Connector officials, employer exchanges have to work through many business rules that might affect profits, costs or perceived fairness, and for each issue different insurers may want to do things in a different way. Examples include: how to validate information in applications, how soon to cancel insurance for nonpayment, and when and how much enrollment can be retroactive. Substantial sums of money are at stake, and each insurer has its own existing systems in place. Therefore, it is a "challenge" to keep them all "at the table" working to find consensus around a common approach.

### 3. Brokers' Views

Next, we come to the critical perspective of independent insurance agents (also known as brokers). It has been widely noted that they are key to the success of group market structures because the great majority of small employers rely on them for advice about purchasing insurance.<sup>65</sup> Small

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64. Terry Gardiner, *Health Insurance Exchanges of Past and Present Offer Examples of Features that Could Attract Small-Business Customers*, 31 HEALTH AFF. 284, 287 (2012); Mark A. Hall, *The Role of Independent Agents in the Success of Health Insurance Market Reforms*, 78 MILBANK Q. 23, 41 (2000). Blue Cross objected that if rating decisions could be made independently by the Connector, then minor differences in how the calculations are made or what information is gathered might result in discrepant quotes to the same group for the same coverage, from two different sources. If so, Blue Cross was concerned that agents would learn to "fool the system" by comparing Blue Cross quotes obtained from different sources.

65. In one recent national survey, 79% of small employers use an agent to purchase their health insurance. NFIB RESEARCH FOUND., *supra* note 43, at 6 n.9.

employers lack expertise or human resources staff to deal with fringe benefits issues, and so brokers often serve this function on an outsourced basis, paid by commissions. An employer representative noted that, even using the Connector's streamlined website presentation, there are still too many choices for employers to feel that the Connector has "taken the guesswork out of the decision." Brokers also emphasize that, in addition to complexity, evaluating health insurance is more than simply a "spreadsheets function;" it also is worrisome because making a wrong decision could jeopardize someone's health or life, including the owner's. "You're not buying a car or furniture. It's called 'your health'," which is why, brokers stressed, that even sophisticated business owners prefer to rely on the expert judgment of a broker they know personally.

The Connector throughout has sought to include brokers, but brokers had reasons to be wary of what they viewed as a "Trojan Horse" or "camel's nose under the tent," trying to "put us out of business." If the Connector were to succeed, they feared the eventual result would be to "disintermediate" brokers — if not by excluding them outright, then by charging employers extra for using them. To compound these fears of being "thrown under the bus," Connector officials initially were not perceived as being "particularly broker friendly." Until this year, the Connector did not have a broker on the governing board,<sup>66</sup> and other board members and key Connector personnel were thought to be dismissive of the role or value of brokers. Even under a more charitable view, the initial leadership had "good people with good intentions, but they just didn't come over that well with the [broker] community."

A second reason for broker resistance is that the Connector initially paid them a significantly lower commission than brokers receive in the regular commercial market. The Connector determined that it could afford only 2.5%, compared with the 3.5% – 4.5% range previously paid in the commercial market.<sup>67</sup> In the past year or so, however, insurers have reduced their prevailing commission rates, to a level similar to the Connector's, in response to pressure on their profit margins from increased governmental scrutiny of their premium rates. And, in one respect the Connector pays more: it pays a commission (\$10 a month) for sole proprietors. Although that isn't much, some brokers view \$10 as "better than nothing," enough to "make a meager living."

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66. See MASS. GEN. LAWS ANN. ch. 288 § 42 (2010) (requiring one member of the Board to be a member of the Massachusetts chapter of the National Association of Health Underwriters).

67. Archambault, *supra* note 49, at 4.

Thus, on balance most brokers interviewed felt that the Connector's commissions are now roughly equivalent to those in the outside market.<sup>68</sup> But, originally this was not the case. Moreover, many brokers felt that, even with similar commissions, there is no especially strong reason for them to use the Connector. With equivalent premiums and fewer options, broker after broker said something to the effect that "the Connector can't give [brokers] a single solid reason to do business with them" rather than dealing with insurers directly. Accordingly, most brokers interviewed have never written a single piece of business with the Connector — including several who are on its board of advisors.

The only possibility for greater broker enthusiasm that was mentioned was that younger and less well-established brokers might embrace the Connector's unique features (including its wellness tax credit) as a good "calling card" to use in soliciting new business. One such broker who had placed business with the Connector thought that it has good ideas about how to structure choices for small employers, ones that only need "a bit of tweaking." But, other observers noted that the health insurance agency business is contracting and so few new people are entering it.

Despite generally dismissive attitudes, brokers claimed that they do not steer clients away from the Connector or avoid it at all costs. Instead, they see their role as offering employers the best value available, regardless of what makes them the most money. It is possible to take self-serving assertions with a certain grain of salt, and some brokers volunteered that not all of their colleagues are as open-minded as they themselves were professing. Nevertheless, most brokers interviewed appeared genuinely open to hearing what the Connector had to offer and seemed sincere in their explanation that they had taken a close look on behalf of clients and would be willing to recommend the Connector if it offered a superior value.<sup>69</sup> Many brokers also praised the Connector's current administration

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68. Some agents insisted this is not the case, but most were agents who have not placed business with the Connector. A few others who have noted that the nominal commission is similar in and out of the Connector, but the Connector does not pay the bonuses that insurers award outside the Connector, for a greater volume of business. Finally, one agent noted that the Connector fails to pay any "override" commission to "general agents," who function as intermediaries or conduits between insurers and rank-and-file agents.

69. For instance, following the interview with one small group agent who seemed to like what the Connector stood for and had previously concluded that it did not offer better value, wrote to say the following: "After our meeting we decided to take a hard look at establishing a stronger relationship with the Connector to see if it brought any value to the small group market and our clients. Unfortunately it does not. Rates are generally higher or the same and plan designs are more limited than what employers can get through the existing small group marketplace. While they will pay more commission to brokers, we believe it would be a disservice to put clients there due to the limitations and some potential service issues."

and leadership for reaching out to their community in constructive ways, and were grateful that the Connector had recently added a broker to its Board of Directors. And one leader in the broker community praised the Connector for its "good job of consumer advocacy, fighting hard for clients."

All that said, "nine out of ten" brokers, by one account, still do not like the Connector, and those interviewed gave a long list of reasons, rehearsed above, why it does not offer better value than the regular market. In addition, brokers resented the feeling that they "got stuck with" a lot of "non-revenue producing activity" required by the reform law in general, which the Connector is charged with enforcing (apart from its role as an insurance exchange).<sup>70</sup>

Some brokers interviewed were openly hostile to the Connector. As justification, they cited a letter that the Connector's original director wrote to all 170,000 small employers in the state, announcing the opening of the revised small-group "Business Express" program, in early 2010. The letter referenced the reduction of fees (described above) for groups of five and under and the availability of lower cost options (described above) that are based on more limited networks not widely available in the regular commercial insurance market. It closed by encouraging employers to "call your broker or go direct to [the Connector's website] and enroll on-line."

According to multiple sources, this letter "hit a raw nerve" that made brokers "furious." The broker community was vehement that it was unfair for "big government" to use its resources to conduct such a large mailing in what they felt was a blatant attempt to "undercut" their existing clients in a manner that "wasn't telling the exact truth." "It became an emotional thing, [the feeling that] you're out there to kill me." Two years later, the letter still "stuck in the craw" of some brokers who "just won't forget," such that, even at the time of these interviews, Connector officials were starting broker training sessions with an apology about past "mistakes."

#### 4. Connector's Mission

Emotions aside, brokers level-headed and hot-headed alike, along with insurers, articulated one overarching theme: that there is no justification for

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70. The reform law requires employers to provide workers a tax-sheltered means to make their premium contributions or individual insurance purchases (known as "section 125 plans") and to file an annual report about meeting their employer responsibility requirements under the law. Small employers often turn to their insurance agents to help with these Connector-enforced requirements, so that agents "felt like [they were] giving the Connector a lot of free service" to help implement the law. *Section 125 Plans – Rules and Regulations*, HEALTH CONNECTOR, <https://www.mahealthconnector.org/portal/site/connector/menuitem.50596a4574af0ace505da95c0ce08041/> (follow "Section 125 Plan" under "Employers with 11 or more full-time equivalent employees") (last visited Feb. 2, 2013).

the government to expend substantial resources on the small group market in a “disruptive” manner that does not significantly lower prices or improve product options. According to various industry sources, the Connector “spent a million dollar marketing budget,” “to compete with brokers,” “for something that’s already in the marketplace,” “just because the Governor said we had to do something.” On balance, its employer programs were “much ado about nothing,” “a lot of smoke and mirrors to duplicate what we already have.” But the “law says we shall, so we shall.”

These sellers acknowledge the need for the Connector to arrange subsidized coverage for the uninsured, and to structure unsubsidized private insurance for individuals.<sup>71</sup> But, with 98% of the state’s residents insured,<sup>72</sup> they feel there is little additional ground to be gained in seeking enrollees from uninsured employers. Therefore, brokers believe that any aggressive attempts to increase small group enrollment necessarily will threaten to take away their existing business but will not significantly advance legitimate health policy objectives. And, insurers wondered “what the point of all of this” time and effort has been, for something that has “turned out to be a nonevent.” Even some Connector officials and Board members (former and current) wonder whether the employer component “was worth all of this attention” and did not “border on being a waste of time.”

The multiple objectives of health reform point to a final institutional factor that explains the Connector’s limited success with small groups. According to many key observers, and some former Connector officials, it properly directed its main attention among its important competing priorities at the outset to launching subsidized coverage and other aspects of the new reform law. Its second priority was then to make individual coverage available in the private unsubsidized market, since that is the market segment that most insurers had neglected under the state’s prior community rating laws. With the small group market functioning comparatively well on its own, the Connector naturally came to it as a third priority. Therefore, the Connector did not implement a small group program until its third year, and even then the program was not marketed since it was still being piloted (for reasons explained above).

Marketing to small groups began in earnest in early 2010, when the small group program was reformed into Business Express, but that marketing included the explosive letter described above. Unluckily still, this letter was soon followed by the precipitous exodus of all the market’s

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71. Because of its prior community rating and guaranteed issue laws, Massachusetts insurers have not paid any commissions for individual (nongroup) coverage, which has made it more difficult for individuals to find insurance. Now, half of this market segment purchases its coverage through the Connector.

72. *Facts and Figures*, *supra* note 15.

leading insurers, sparked by the Governor's rate freeze.<sup>73</sup> Without these "brand name" insurers, the Connector largely suspended its employer marketing efforts until early 2012, when the leading insurers rejoined. Therefore, a full-throated presentation of the Connector's small group program has only recently begun. And even now, the Connector is cautious to avoid direct marketing in a way that might backfire with brokers, as it did before.

On balance, then, it may well be too early to declare the Connector's employer programs a "complete flop" "that went absolutely nowhere" (as two brokers said). Indeed, several informed sources thought that perhaps the Connector's approach to offering individual employee choice that included more limited networks was just "a few years ahead of the market," and Connector officials stressed that its full-scale small-group program had been operating for only a few months at the time of this study.

### III. APPLICABILITY TO OTHER STATES

How relevant are these experiences for other states implementing the ACA's SHOP Exchange? Despite obvious differences, interviewees consistently thought that the experiences in Massachusetts are relevant beyond its particular reform law and market conditions. One way to reflect this generalizeability is to note the various lessons that these informed market participants, observers, and regulators thought could be learned by others from the Massachusetts experience. Each of the following pieces of advice was shared by stakeholders from several different perspectives:

- Focus on the value proposition that an exchange structure has to offer the small group market. Do not simply attempt to replicate the existing market, but consider what its problems and limitations are, and which ones a SHOP exchange realistically can address. And then focus the SHOP exchange on making those improvements rather than attempting to serve multiple purposes and all market components.
- Don't aim for overnight perfection. Building an effective exchange for small employers is complicated and should be done in a step-wise manner that avoids being too complex or overly engineered.
- Use existing expertise in the market and build on technology platforms that insurers and brokers are already comfortable with rather than attempting to build everything from scratch.

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73. Archambault, *supra* note 49, at 6.

- Don't underestimate the influence of brokers and their importance as advisors to employers and their knowledge base in contributing to the successful design and operation of an exchange.
- Don't underestimate the difficulties in reaching consensus with and among competing insurers and in formulating effective operating rules in a way that preserves broad participation and a level playing field.

Although these lessons learned from Massachusetts appear to be broadly applicable to other states under the ACA, there are several factors that might improve or hamper the particular performance of small group exchange structures in other states, compared to the Massachusetts experience. First, other states may have a greater need for an employer-based exchange structure than did Massachusetts, owing to the fact that other states may not have intermediaries already in place that provide some online shopping features for comparing prices and benefits. Also, Massachusetts previously had eliminated medical underwriting, and its employer market was dominated prior to reform by a handful of HMOs with similar networks and benefits. Several people felt that these features gave Massachusetts a fairly standardized set of prices and benefits even before the Connector entered the picture, which might not be the case in states with a broader range of plan types, benefit structures, and underwriting practices. If so, other states might have a greater need to simplify the shopping experience. Two people, however, thought that because of the presence in Massachusetts of some limited network plans, it may have more network diversity, and therefore more to gain from a structured clearinghouse, than other states.

Other important differences were noted between the ACA's provisions and the Massachusetts reform law. Most significant is the ACA's use of a risk adjustment mechanism to address adverse selection problems among competing insurers.<sup>74</sup> Massachusetts lacked this feature, and its small group exchange was hampered by insurers' concerns over adverse selection. However, a number of interviewees commented that risk adjustment would not fully address insurers' selection concerns because risk adjustment is imperfect, and they felt most insurers tend to be "paranoid" that they will be selected against in an exchange setting more than their competitors.

Another important difference in the ACA is its payment of substantial subsidies to individuals purchasing through exchanges, in contrast to Massachusetts where individual private insurance is unsubsidized. The ACA's subsidies are expected to bring many more previously uninsured

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74. See generally MARK A. HALL, *THE COMMONWEALTH FUND, RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT: A GUIDE FOR FEDERAL AND STATE REGULATORS* (2011).



people to the exchanges,<sup>75</sup> which should give them leverage, if they wish to use it, to insist on willing participation in the employer component in order to qualify for participation in the subsidized nongroup component. The Massachusetts Connector also made full participation a formal requirement for insurers selling to individuals, but various sources explained that the Connector never felt it had, and so never attempted to use, enough leverage to force participation in the employer component.<sup>76</sup>

Finally, several people commented that, to some extent, the Connector was “ahead of its time,” and so features that initially failed might well succeed if tried again, or tried elsewhere. In particular, under the ACA the individual choice aspect of the Connector’s initial employer program would not need to be done on a pilot basis, since the ACA mandates offering employers at least the option of providing a worker-choice model. Without the limitations of a pilot program, the employer component would presumably be open to all brokers, and thus could be broadly advertised — overcoming some of the Connector’s initial obstacles. Moreover, the ACA’s provision for funding navigators within exchanges conceivably could help to address some of the concerns brokers expressed about the lack of support for taking on the extra burdens of explaining more complex choice features to employers and workers.

On balance, the Massachusetts Connector’s difficulties in establishing a successful employer exchange amply illustrate the challenges that other states will likely face in establishing SHOP exchanges under the ACA. States need to walk the fine and sometimes faint line between creating a market structure that improves on what already exists in a small-group market segment that typically functions reasonably well already — and to do so in a way that is not unduly threatening to existing market participants. As many informed sources commented, that is a tall order. But, if it is to be filled, the experiences in Massachusetts are a good guide for which strategies have some potential, and which are likely to fail or flounder.

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75. See FAMILIES USA, LOWER TAXES, LOWER PREMIUMS: THE NEW HEALTH INSURANCE TAX CREDIT 1 (2010), available at <http://www.familiesusa.org/assets/pdfs/health-reform/Premium-Tax-Credits.pdf>.

76. The Connector’s subsidized coverage is provided by a different set of Medicaid-based health plans, which do not include the leading private insurers.

