



BRIEFLY

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CONNECTING WITH HEALTH CARE

As government officials throughout the country continue (what to date have been relatively futile) attempts at reforming the nation's health care insurance system, one mechanism has risen to the top of nearly everyone's list of possible elements of a solution. Called 'the connector,' it is a state-chartered marketplace for health insurance.

The connector is a prominent element of the health care reforms enacted in Massachusetts last spring. The Massachusetts experiment is being watched by all 50 states. The connector's fans hope it will prove to be the answer to controlling health care costs, broadening access and increasing quality, though even the most optimistic acknowledge that it's a big order to fill. Policy skeptics warn that it is step one of a return to the universal, government-provided, managed health care proposals of the early 1990s.

This policy brief reviews the original intent of the connector, discusses the primary areas of concern, summarizes the proposal currently under review here in Washington, and describes the main problem that should be addressed before committing our state to this kind of sweeping policy change.

BACKGROUND

[The Connector] is an innovative mechanism to promote real consumer choice. . . [It is] a marketplace in which individuals can shop for and buy health care coverage from competing health insurers. Conceptually, the Connector is like a stock exchange, which is just a single market organizing the sale and purchase of equities and securities (Moffit and Owcharenko 2006).

With the ink barely dry on Massachusetts's historic health care reform statute, debate heated up, with critics charging that the state would "become a monopsony purchaser of health insurance similar to the community purchasing pools envisioned under the Clinton health care plan of 1993." (Tanner 2006)

But that is not the intent, says Robert Moffitt, a 25-year policy veteran and director of health policy studies with the conservative Heritage Foundation, who helped shape the idea. The connector should not be a regulatory agency, he says; it shouldn't be negotiating rates and benefits, and it should not be an instrument to establish health care mandates. Simply put, the connector is just a way around the federal tax code and a way to provide subsidies to the low income. "The thing that overwhelmingly drives health care policy is federal tax treatment of health insurance," he says, claiming that individuals pay 40 to 50 percent more for



their health care, if they purchase it with their own after-tax dollars. Federal tax treatment is “the 800 pound gorilla.”

The main groups that are negatively affected by this provision are the unemployed and those who are employed by businesses that don’t offer health benefits. The connector concept offers promise of solving this difficult problem. In a 2003 article, Pamela Short and Deborah Graefe presented convincing evidence that “relatively few people remain uninsured for long periods of time.” Only 12 percent of uninsured individuals are uninsured for a long period, and of the 80 million people (under the age of 65, nationwide) who lost insurance in a four-year period, most were experiencing “gaps” in their coverage—transitioning into and out of coverage or being temporarily employed or unemployed. Short and Graefe suggest that “in designing almost any reform that stops short of universal coverage, policymakers should think of ‘uninsured’ as referring not to people, but to gaps in time” (Short and Graefe 2003).

Moffitt says that a neutral exchange, as the connector is intended to be, provides a solution to this problem. The connector allows individuals to own their own insurance, with contributions from multiple employers—simultaneously or consecutively—or from family or whomever, and to take it with them from job to job and from employment into unemployment into reemployment. The connector would provide an array of affordable, privately offered, health insurance products from which individuals could select the policy most suitable to their personal circumstances, purchase it with pre-tax income (possibly with help from employers or others), and be held responsible in the event they do not insure themselves. The same mechanism would allow the state to operate an assistance program for low-income individuals, as well.

MASSACHUSETTS MIRACLE?

Dr. Jonathan Gruber, a professor of economics at MIT, helped design the Massachusetts plan and is a member of its 10-member connector board. In a recent interview he said that while in theory the plan could work anywhere, in fact Massachusetts is in a relatively unique position as far as the plan’s financing (Klepac and Gutierrez 2007).

Gruber points to the money spent – nearly \$40 billion a year throughout the country, he estimates – on hospital emergency room care to uninsured individuals for which hospitals are not reimbursed. This cost becomes embedded in the higher prices charged to patients with insurance coverage, he says, creating an implicit tax on the insured. Massachusetts, however, has made the tax explicit by taxing businesses and insurers and creating an uncompensated care financial pool from which hospitals are paid for their service to the uninsured. “As you can imagine,” he says, “it’s a lot easier to rededicate an existing tax than to levy a new tax.” While a few states may have the ability to enact a Massachusetts-style plan on their own, “widespread adoption across the states . . . would need serious federal seed money.”

Gruber says that the Massachusetts legislature “punted essentially all the tough decisions to the connector [board], like what should be in the benefits package, how much should people pay for it, and how should it interact with employer provided health insurance.” He believes everyone is “cautiously optimistic . . . employers are pleased that they didn’t get hit



harder in the bill . . . [and] the uninsured are happy about the opportunity but wary that it is going to cost too much.”

OR MASSACHUSETTS MADNESS?

There may have been many details deferred to the connector board, but the Massachusetts legislation retained numerous mandates for its health care service, according to Moffitt. Calling the Massachusetts version of the connector “reality therapy for liberals,” Moffitt says they will learn that mandates equal money (Davis 2007). Early estimates of the minimum monthly premium from Blue Cross/Blue Shield were about \$210 per month per person, he says, but initial bids received by the connector board have placed the monthly premium at \$380 per month per person (Dembner 2007). States can have coverage flexibility, allowing insurance companies to offer ‘no frills’ policies and lower premiums, or they can mandate lots of services that will require higher monthly premiums to pay for the increased risk of expensive payouts. States want to use their size and market purchasing power to force prices down. But it is still true that the more mandated services are required, the more expensive and unaffordable the plan. Most health care economists agree with Moffitt, who says the higher costs associated with mandates are not paid by employers, but instead end up being a tax on labor. And, when the monthly premium is driven so high as to be unaffordable, individual participation cannot be required without government subsidy.

CONNECTOR DETRACTORS

The libertarian CATO Institute is much harsher in its criticism of the Massachusetts connector and of the Massachusetts reforms in general.

The individual mandate is an unprecedented expansion of government power and intrusion into the American health care system. It marks the first time that an individual, simply by virtue of living in a state, has been required to purchase a specific government-defined product...the mandate is likely to prove unenforceable...[and] will almost certainly lead to a cascading series of additional mandates and regulations...resulting...in ever-greater government control of the health care system (Tanner 2006).

The Massachusetts plan “takes us in the wrong direction,” says CATO’s Michael Tanner. Beyond mandating individual behavior, the plan’s subsidies are “both over-generous and poorly targeted,” paying for health coverage for people who already have insurance and encouraging employers to shift costs onto the public by discontinuing their health coverage. Describing connectors as “essentially forms of managed competition,” Tanner says that they “create an artificial marketplace run under strict government control” (Tanner 2006).

WASHINGTON’S PROPOSED CONNECTOR

A connector is the centerpiece to a health care reform bill recently introduced in the Washington State House of Representatives. Substitute House Bill (SHB) 1569 puts the state’s Health Care Authority in charge of administering the connector, guided by a new 12-member connector board to be appointed by the governor.

The issues of greatest concern in designing a connector include:



Participation: Under SHB 1569, participation is mandatory for employers with five or more workers. Beginning January 1, 2009, these businesses are required to have a cafeteria plan that satisfies the connector. As a result, the bill explicitly eliminates association or member-governed group coverage, saying that “a carrier shall not issue or renew” such a plan after January 1, 2009.

Beginning January 1, 2012, the individual health insurance market, the state health insurance pool, the basic health plan, the public employees' benefits board health insurance program, and public school employees would all be integrated into the connector.

As well, by January 1, 2012 all residents over age 18 years will be required to obtain and maintain “creditable coverage” (a term defined in the Federal Health Insurance Portability and Accountability Act of 1996). The only caveat to mandatory individual coverage is whether the insurance is “deemed affordable” by the connector board. The legislation is mostly silent on how these mandates will be enforced.

Mandated services: The connector board is charged in the legislation with developing the set of benefits to be included in various health plans. Private insurance carriers would then sell these plans through the connector. Far from non-prescriptive, the legislation directs the connector to fashion “at least four, but no more than six, benefit packages...[developing for each package] at least three deductible and point-of-service cost-sharing options.” The legislation further requires that the connector “shall make every effort” to maximize health care quality and improved outcomes by incorporating provisions for:

- Preventive care;
- Wellness incentive (including health coaching);
- Limited cost sharing for preventive services, medications for chronic illness and chronic care management visits;
- Payments for chronic care services, including increased reimbursement for primary care visits;
- Coverage for group visits, telephone consultation, and nutrition education to help patients to manage their chronic illness; and
- Provider policies, such as evidence-based protocols.

Rating methods: Premium rates for plans offered through the connector will be community rated with adjustment allowed for geographic area, family size, age, and wellness activities. Rates for any age group can be no more than 375 percent of the lowest rate for all age groups. Experience rating is narrowly allowed for people under 30 years of age, who will not be subject to the 375 percent rule.

Funding: A fiscal note on SHB 1569 has been requested, but is not yet available. The legislation says that 600,000 Washingtonians are uninsured. Even if the proposed program were able to offer coverage as low as \$200 per month per person – an unlikely possibility at best – the annual price tag would be \$1.44 billion. Although funding sources to pay for the substance of the proposal are not specifically identified, the following sources are implied by the legislation:



- Businesses that do not currently offer employee health insurance might be able to pay a portion of such premiums for their employees;
- Individuals could be determined to have the ability to pay for a portion of their own premium;
- Family members could feasibly contribute on behalf of one of their own;
- Premium assistance is envisioned for those who meet certain income requirements;

The connector will apply a surcharge to all of its health benefit plans to pay for its administrative and operational expenses. As part of the premium, the surcharge shall be subject to the premium tax. This surcharge and the tax applied to it, therefore, would be added on to whatever monthly premium amounts are eventually developed.

Separately, legislation introduced at the request of Governor Chris Gregoire also embraces a connector for Washington. The Governor's bill (HB 2098 in the House and SB 5930 in the Senate) generally implements the recommendations of the Blue Ribbon Commission on Health Care Costs and Access. With respect to a connector, the Governor's proposal moves more slowly than HB 1569, calling for the state's Health Care Authority to design a health insurance connector in time for consideration by the legislature in 2008. The House Committee on Health Care and Wellness, however, has amended this provision out of HB 2098. The provision remains in SB 5930, as passed by the Senate Committee on Health and Long-Term Care.

FEDERAL FIX PREFERABLE TO STATE WORK-AROUNDS

Merriam-Webster's Dictionary defines 'work-around' as a "plan or method to circumvent a problem (as in computer software) without eliminating it."

Connectors—even in their most pure, theoretical form—have been conceived mostly as "work-arounds" to the problem with the federal tax code. In his State-of-the-Union address last month, President Bush met that problem head-on, proposing to end the World War II-vintage federal tax provision that favors employer-provided health insurance. The President's proposal would allow a \$15,000 standard deduction for couples (\$7,500 for individuals) to pay for cost of health insurance (Barone 2007a).

The president's speech was followed by a February 13 letter from a bipartisan coalition of ten U.S. Senators that includes Sen. Maria Cantwell. In that letter, the Senators call for the Administration and Congress to "modernize Federal tax rules for health coverage," saying that "Democratic and Republican economists have convinced us that the current rules disproportionately favor the most affluent, while promoting inefficiency" (Barone 2007b).

The Washington Post reports that Senator Max Baucus (D-Montana), who was not one of the authors of the letter, is also receptive to the president's proposal: "Describing the president's tax plan as 'an-outside-the-box proposal' that deserves to be part of the debate, [Baucus] said that, "Whether or not it's enacted into law, he's started a discussion" (Abramowitz 2007).

With any luck federal tax code barriers to health care coverage for individuals and the unemployed can be fixed first, so that states may avoid constructing cumbersome, complicated, and costly 'work-arounds.' Not only are the



long-term consequences of their real-life applications highly questionable, but they have not yet been demonstrated to actually work anywhere.

Governor Gregoire recommends a 'go-slow' approach. We agree. There are still too many questions and not enough answers about connectors. With luck, some of the answers will be supplied by the Massachusetts experiment.

REFERENCES

- Abramowitz, Michael. 2007. "In Tennessee, Bush Talks Up Tax Breaks for the Uninsured, Democratic Response to Health Plan Mixed." *Washington Post*. February 22.
- Barone, Michael. 2007a. "A Fair Health Fix." *U.S. News and World Report*, February 11.
- Barone, Michael. 2007. "Healthcare Legislation in This Congress." *Barone Blog*, February 13.
- Davis, Richard S. 2007. "State health care reform should focus first on choice." *The Everett Herald*. February 14.
- Dembner, Alice. 2007. "Outline for New Insurance Plan Proposed." *Boston Globe*. January 19.
- Klepac, Lauren and Robert Gutierrez. 2006. "Interview with Dr. Jonathan Gruber." *The Heinz School Review*.
- Moffit, Robert E. and Nina Owcharenko. 2006. "Understanding Key Parts of the Massachusetts Health Plan" The Heritage Foundation. WebMemo #1045, April 20.
- Short, Pamela Farley and Deborah R. Graefe. 2003. "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured,." *Health Affairs*, Volume 22, Number 6, November/December.
- Tanner, Michael. 2006. "No Miracle in Massachusetts, Why Governor Romney's Health Care Reform Won't Work." Briefing Paper No. 97, CATO Institute. June 6.
- Washington State House of Representatives. 2007. "SHB 1569: An Act Relating to Reforming the Health Care System in Washington State."