

Employers' Use of Health Insurance Exchanges: Lessons from Massachusetts

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Table of Contents

I. Introduction	3
A. Background	3
B. Methodology	3
II. Findings	4
A. Basic Structure and History	4
B. The Connector's Basic Value Proposition	4
1. Pricing Issues	4
a. Administrative Costs	5
b. Rebates and Tax Credits	5
c. Lower-Cost Limited Networks	5
d. Benefits Standardization and Innovation	6
2. Enhanced Choice	7
a. Employee Choice	7
b. Complications	7
c. Adverse Selection	8
d. A Change of Heart	9
e. Employer Shopping	9
f. Service and Information Technology Issues	10
C. Political, Institutional, and Miscellaneous Factors	11
1. Employers' Views	11
2. Insurers' Views	11
a. In General	11
b. Blue Cross	12
3. Brokers' Views	13
4. Connector's Mission	14
III. Applicability to Other States	14
IV. References	16

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 government insurance exchange to include a component specifically for small firms. 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. Whereas almost all employers with 200 or more employees offer health insurance to their employees, only about half of employers with fewer than 10 employees do so. A substantially greater portion of small-group premiums go to overhead costs (profits, administration, sales costs) than in the large group market, and small-group insurance tends to have higher cost-sharing obligations for patients. In addition, most small firms with insurance select only a single plan, whereas larger firms usually give workers a choice of coverage options.

Small-group insurance exchanges are meant to address these 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 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 the promises of the exchanges, 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 inroads into the employer-based insurance market. 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 insurance through it. Of 40,000 people who purchase private insurance through the Connector, only about 10 percent do so as part of an employer group, and almost all of these employers are “micro-sized” (5 or fewer), with an average of only about 1.5 employees per group policy (Massachusetts Health Connector, 2010). This employee enrollment constitutes less than 1 percent of small-group employee coverage statewide.

Federal insurance reform is modeled substantially on the successful reforms in Massachusetts, including its version of a health insurance exchange (Long et al., 2011). To learn from both the successes and limitations of the 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. Earlier research on the Connector has focused mainly on its role in enrolling individuals who, with or without subsidies, purchase nongroup coverage (Doonan and Tull, 2010; Lischko, 2011). Much less attention 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. Further, if employer use of exchanges is not broad-based, then exchanges might become targets for

adverse selection (Jost, 2010). 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 in attracting employer participation, and why.

B. Methodology

This qualitative investigation consists of document review and in-depth interviews. The 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 performed by others who have studied it.

The author conducted the investigation's interviews, in person or by telephone, with 37 key informants identified from public sources and through a “snowball” approach in which initial sources recommended sources from similar or different perspectives. The interviewees 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; four representatives of employer industry and trade groups; and eight representatives of four insurers in the market, including the market's three largest plans. 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.

The 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, 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 Affordable Care Act's (ACA's) new exchange structures in other states or whether they are unique to the features of the 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 (Bradley et al., 2007; Weiner et al., 2011), including triangulation (seeking to confirm or disconfirm points from various perspectives and information sources).

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, known as Commonwealth Choice (or CommChoice). 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, Health New England).

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. Overall, the Connector's private (unsubsidized) insurance enrollment is dominated by

individual purchasers, who constitute 35,082 or 89 percent of the 39,623 people in CommChoice, as of August 2012. The Connector's employer enrollment accounts for less than 1 percent of small-firm coverage statewide.

The Connector first made individual (non-group) CommChoice enrollment available in 2007 but it did not offer small-group employer plans until 2009, and then only on a limited basis. 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. Participating employers selected a reference plan that determined their contribution; employees were then free to select alternative insurers and benefit options within the same tier of benefits selected by the employer. After not quite a year, the Connector ended the pilot, having enrolled only 77 employers covering 207 workers (or 388 people, including family members).

The Connector then revamped its small-employer program, which it relaunched in early 2010 under the name Business Express. Mirroring the market's conventional purchasing model, Business Express requires all participating employees to join the single plan selected by the employer. 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). 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.¹

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. Not all of these enrolled directly with the Connector, however, as many are legacy accounts brought in by SBSB. To date, the Connector's small-group component clearly has failed to meet its goals. Although the Connector did not begin actively marketing its small-group program until the first part of 2012, many observers remain skeptical that it will gain much traction, although some remain hopeful. The reasons, broadly considered, may be understood through two sets of factors. The first relates to the Connector's basic value proposition—that is, whether it offers better, or at least equivalent, value compared to the other products and purchasing mechanisms available in the market. The second set of factors focuses on political and institutional factors that might hamper the Connector, apart from whether 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 is community rating, which is required by Massachusetts law (and by the ACA). Community rating in Massachusetts and under the ACA requires insurers to offer the same prices inside and outside the Connector for products with equivalent actuarial value. 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 Connectors' products as 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 Connector than for similar coverage they offered outside the Connector.

a. Administrative Costs

Connector officials noted that they achieved one clearly demonstrable cost savings by eliminating the fee paid by the smallest employers 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, they sell such coverage through trade associations such as SBSB 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 the fee to \$10 a month and then eliminated it altogether, saving employers several hundred dollars a year per worker.

As a result, the Connector's effective prices for groups smaller than six were, for a time, somewhat lower than those in 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 competition from the Connector.² Therefore, although the Connector was able to achieve a moderate, one-time reduction in prices across a portion of the market, most observers believe that it has not maintained a price advantage.

Several interviewees (including one Connector board member) felt, however, that this apparent cost reduction was not entirely real. 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 a different part of the market rather than being eliminated. To defray these costs, the Connector charges insurers an administrative fee of 2.5 percent for groups and 3.5 percent for individuals. Insurers spread the fee over the premiums they charge outside the Connector via their market-wide community rates.

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

b. Rebates and Tax Credits

Connector officials believe that it offers lower prices in other ways. The Connector is the exclusive source for a 15 percent rebate to employers instituted by the legislature (as of July 2011) for lower-wage small firms that adopt wellness programs. Eligibility for the subsidy mirrors the eligibility rules for the new federal small-firm tax credit under the ACA. In combination, the state and federal credits could amount to 50 percent of an employer's contribution to health insurance. Initially, few firms reportedly took advantage of the wellness rebate; however, with the rebate not actively marketed until early 2012, it is too early to judge its impact.

Most insurance brokers and other market participants believe that the wellness subsidy will have a negligible impact. They noted, with near unanimity, that the eligibility criteria for the program are too stringent to make it widely available or attractive. Some of the reasons for the wellness subsidy's limited impact echo those given for the federal tax credit (Kingsdale, 2012)—that the rebate percentage phases down rapidly for firms with more than 10 employees and with average wages more than \$25,000; the rebate reduces employers' existing tax deduction for insurance premiums, further reducing its value; the incentive does not apply to the busi-

ness owner or family members; and it is not clear 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,³ especially for firms with mainly 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 doubted would occur. Others thought that the wellness program would impose unacceptable demands on employers and workers. To the contrary, the requirements appear to be so lenient that knowledgeable sources referred to them as a "laughable" "joke." Initially, the program requires only that one-third of workers fills out a health questionnaire and receives an annual physical and that employers make some effort to create a healthier work environment, although more requirements might be added.

c. Lower-Cost Limited Networks

The second way that Connector officials, and at least two insurers, believe the Connector offers lower prices is through its ability to attract to the commercial market new insurers that have more limited networks of providers. Some of these insurers mainly use safety-net hospitals and community health centers that focus primarily on serving lower-income patients covered by Medicaid or by the Connector's subsidized CommCare coverage. Such plans charge prices that are 20 to 30 percent below those of the market leaders. Before the advent of 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 (Kingsdale, 2012). 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 19 percent in 2008 to 43 percent in 2012, which is twice the share of the next-largest insurer participating in CommCare.

Several brokers and employer representatives acknowledged the potential appeal of offering lower-cost networks through the Connector. Nonetheless, most of the insurers with limited networks have gained only a modest foothold in the Connector. A number of brokers said that they are reluctant or refused to recommend insurers that are less established or recognized, in part because brokers are less familiar with these insurers and do not have 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 facing 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 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 priced at least 12 percent below their standard full-network products.⁴ In response, several of the state's leading insurers recently began to actively market such products, attracting notable interest from brokers and employers. These new products, how-

ever, were not initially available through the Connector, leading many brokers to complain that the Connector was "stifling innovation." In response, the Connector invited insurers to include more limited networks in their 2013 plan offerings.

d. Benefits Standardization and Innovation

Some interviewees also felt that the Connector did not offer sufficient choice of higher-deductible plans designed to fit with health savings accounts or of other forms of lower-benefit options. However, the leading insurers in the Connector opposed the Connector's allowing their competitors to offer only limited-benefit or limited-network options for fear that such an offering would pull in only better risks and leave the leading insurers exposed to adverse selection. Moreover, many of the criticisms about excessively rich benefit options appear directed to 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 because it is the regulatory authority that set the minimum standards.

Within the Connector, the inability to offer innovations in benefits design has been a "sore subject," according to some insurer representatives, given that innovation was originally 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 care and hospitalization with first-dollar coverage for primary care. This insurer believed that its innovative product was popular, but, based on focus groups, the Connector determined that offering a lot of options was too confusing to individuals and so it required this insurer and others to eliminate all nonconforming plans.⁵ Several brokers also noted that the Connector primarily offers HMO

products, which lack the out-of-network feature needed to enroll people living in bordering states.

Other insurers and observers, however, said that standardization of benefits was not a major problem despite some "quibbling" and "whining and gnashing of teeth." They agreed that simplification of benefit options is essential if the Connector is to sell directly to individuals; too much choice "can be numbing," causing people to "freeze like deer in the headlights." Several sources said that the Connector's decision on how to standardize benefits grew out of a "collaborative" process that relied heavily on input from insurers. Even so, to encourage innovation some insurers and brokers sympathetic to the need for standardization for most Connector products still felt that insurers should be allowed to offer one or two nonstandard options that sell well outside the Connector. 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 high-deductible plans that qualify for tax-sheltered health savings accounts, although deductibles are capped at \$2,000 for individuals and \$4,000 for families, substantially below federal limits. More recently, the Connector announced that, beginning in 2013, insurers may offer one or more restricted-network products that cover the standardized benefit plans, which one insurer will do in 2013, and may propose one or more innovative nonstandard benefit options, which several insurers have done.

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, vendors provide “one-stop shopping” for a suite of employee benefits, but the Connector does not. However, brokers almost uniformly said that they are well equipped to package health insurance from one source with ancillary benefits from another source and often do so in any event, even when not using the Connector.⁶

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 its programs, the Connector touts the ease of making online, side-by-side comparisons 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, as 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, sources were skeptical about the degree to which employers actually value letting workers choose their own coverage. In favor of choice, some brokers, employer representatives, and other observers felt that employers would prefer employee choice once they experienced it, but Massachusetts employers were not yet used to the idea and therefore were initially not strongly drawn to it. Sources noted that, among employers who did enroll, the reported level of satisfaction was very high (Lerna, 2009) and that employers who signed up have tended to remain with the product longer than normal. According to one senior employer representative, some employers thought that this program “was

the greatest thing, they loved it”—a sentiment confirmed by several others.

Other choice proponents saw potential for a “defined contribution” model in which employers give workers a voucher for a fixed amount to be spent on health insurance any way workers prefer, but these proponents complained that the Connector eschewed a genuine version of this model. Instead, the Connector required (as noted below) that employers select a reference plan and agree to pay at least 50 percent of its premium, with employees then allowed to pick alternative insurers or plans only within the same benefit tier.

It was noted in response to these objections that the Connector's reference plan model was based on Connecticut's highly successful private exchange (Connecticut Business and Industry Association). In addition, it is not immediately obvious why variations from a pure defined-contribution approach would necessarily weaken the appeal of individual employee choice. In the pilot, two-thirds of workers ended up staying with the reference plan selected by their employer rather than selecting a more or less expensive option. 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 accustomed to the idea of employers picking a single broad network for the entire workforce (see also Fronstin, 2012).

Others, however, believed that while individual choice is a “noble aim” and “interesting concept” that “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 employ-

ers “just want something credible” and “simple” and “don't want to take the time to figure out” something complicated. Given that employee choice involves a different way of doing things that is not easily understood, employers and brokers tended to “approach [this new idea] with caution,” according to one highly experienced market participant.

Inherent complications are noted below. As to whether choice matters, skeptics felt that differences were too minor among the 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 to choose only within a tier, even though “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 does not 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 does simply selling a single plan to an employer. 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 broker 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), which takes the employer out of the role of choosing or sponsoring a health plan. Employees can use the HRA to purchase

coverage from whatever insurer they want. In contrast, the Connector's approach conveyed the sense that the employer, and hence the broker, was responsible for helping employees decide which insurance option they should select.

Another complication of the Connector's pilot program is that an employer might not know the exact amount of its contribution until workers make their selection. Employees' precise age-mix determines the group's base premium under community rating rules that allow two-fold variation based on age.⁷ For the choice model to function properly, it requires "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 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 list billing make the employer more aware of inherent cost differences among workers, but employers also face the dilemma of whether to make different employees contribute different amounts to their insurance premiums.

List billing is an established market practice in a number of states, though not 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 using list billing for those who selected alternative plans. This solution created two problems. Employers found the multipage billing statements "really confusing" such that their brokers had to spend sig-

nificant time understanding and explaining these complexities, which they found "exasperating," according to a Connector source.

In addition, 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. The disparity arose not only because some employees selected less expensive coverage, but also because those who selected alternative coverage paid a premium contribution determined by their age rather than by the company's composite rate that applied to the blended ages under the reference plan. According to Connector officials, this bifurcated approach to age rating was partially a response to concerns among 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."⁸

c. Adverse Selection

Other problems with the Contributory Plan related to the fact that it was a pilot program, which, according to some former Connector officials, "doomed it 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. They feared that they would experience serious adverse selection if employees were allowed to opt out of the reference plan selected by the employer. Blue Cross based its concern on its experience in the nongroup segment of the market, where it documented receiving enrollment with a significantly worse risk profile than in its small-group segment. Blue Cross, along with some of the other leading insurers, reasoned that sicker individuals tend to choose plans with the broadest networks and that healthier patients opt for cheaper limited networks, leaving larger insurers with the "worst of the litter."

For these reasons, one leading insurer conceded that employee choice "scares the you know what out of us." Several sources noted 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 operated "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 program's pilot status meant that it was not advertised. Moreover, the Connector made the pilot available to only about 20 brokers instead of opening it to the market as a whole, in order to limit the program's size and focus training efforts. To avoid unfairness to nonparticipating brokers, however, participating brokers could enroll only their existing clients rather than using the Contributory Plan to "poach" new business from other brokers. Such an arrangement kept brokers from promoting the new program 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 1,000 workers (over no specified time period). But, after almost a year, the pilot ended up enrolling only 77 employers with 207 workers (or 388 people, including family members).

An additional reason the pilot failed to do better is that concerns about adverse selection caused Blue Cross, the market leader, to charge 10 percent more through the Connector than in the outside market. Despite community rating rules, it was allowed to do so because the state allows insurers (until 2014) to use a group size factor in their community rates in order

to capture the element of adverse selection that inherently attaches to choices made by smaller groups.⁹ Given that the employee choice model slices already small groups into even smaller units (“twosies and threesies”), Blue Cross (and other insurers) had regulatory authority to add the 10 percent surcharge, which would obviously tend to discourage its customers from switching to the Connector.

Despite these concerns, adverse selection did not materialize in the limited pilot (although it was too short-lived to draw strong conclusions from the experience). An evaluation conducted 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 (Ierna, 2009). In addition, of the 35 people who selected an alternative plan, about half selected something more expensive, and they were not substantially older than those who opted for less costly coverage. The pilot's experience does not conclusively resolve the adverse-selection issue because risk status was assessed only through crude demographics and not through actual costs, disease burden, or care utilization. In addition, adverse-selection patterns may take longer than the pilot period to emerge. Nevertheless, the Connector's assessment found that the pilot succeeded in avoiding the problems initially feared.

d. A Change of Heart

With the only thing to fear being fear itself, why did the Connector not convert 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. It “just wouldn't be worth it” to undergo the “headache of fixing it,” according to several sources. In addition to the tepid response from employers and the resistance or opposition voiced by insurers and brokers, several interviewees 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 jump start a critical mass of enrollment by transferring SBSB's existing block of business to the Connector. As noted, 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 6 workers. To consolidate its 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 transfer its existing groups to the Connector seamlessly, however, the Connector had to conform its small-group program to the existing structure 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.

e. Employer Shopping

Along with providing employees a choice of plans and making it easier to compare plans, the Connector seeks to improve the shopping process for employers. Even though it offers a similar array of insurers and products to those available in the broader market, the Connector aims to make key comparisons among products more transparent in order to facilitate competition. For the smallest employers, some degree of comparison shopping was available before the Connector existed, 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 the leading insurers. A recent *New York Times* article highlighted this issue. It contrasted one Massachusetts business owner who 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 that 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.”¹⁰

Insurance brokers and employer representatives did not share this enthusiasm, however. Instead, brokers in particular repeatedly voiced the following complaints. First, they felt that they are sufficiently equipped to present informed shopping choices to their employer clients by using their own tailored spreadsheets based on information they obtain directly from insurers. Given that 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, it presents—from a broker's perspective—an additional layer of work rather than a means to simplify the broker's search efforts. Even brokers who use the Connector said repeatedly that this ends up being “more work for less money” because they continue to also obtain quotes and explore benefit options directly with insurers and the private intermediaries. As explained by one broker who is in favor of the Connector, “My business is finding the smallest of advantages for my customer” such that he compares Connector options with the rest of the market to see where he might save 1 or 2 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 outside options. Thus, they saw the Connector’s standardization of benefits as a disadvantage. Even though standardization facilitates head-to-head comparisons, 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.

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 their systems are “just not what we’re used to” and take 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 receiving a quote, which also requires the broker to have a unique password for each group. A Connector official explained that these are requirements that some insurers insist on, to make sure that their quotes are accurate, given that rates depend on age, location and industry category. Another explanation is that Blue Cross in particular insisted on this level of extra detail in order to determine whether its existing clients are considering a switch 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 anew each year rather than assuming continuity of the workforce unless changes are noted.¹¹

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 telephone. 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. In addition, when brokers needed to speak with someone on the telephone, 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 that TPA staff could not answer basic questions and “were hard to work with,” at least at the outset. Some brokers complained that the division of various functions and responsibilities among the Connector, its TPA, and the insurer “can be very confusing” as compared to dealing with an insurer directly. Further, several brokers said that they value the “certain type of access” they have when they are able to “pick up the phone” and reach the right insurer representative able to deal directly with a client’s problem 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 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 bureau-

cratic hurdles are imposed by insurers, not by the Connector. For instance, selling group coverage to a sole proprietor often requires extremely thorough (or “crazy”) documentation that the person operates 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 services accounts, despite their 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.” 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 take place via 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 sign 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 “10 times harder” than the nongroup market, and so it’s a “step-wise process” in which “you can’t achieve perfection on day one.” Accordingly, one partially sympathetic broker opined that “we 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 hic-

cup 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’s “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. A statewide survey that found that only a third of small employers would be “uncomfortable” buying health benefits through the Connector “because it is a quasi-governmental agency” (Gabel et al., 2008).¹² Several sources noted, however, that Massachusetts generally is more receptive to “big government” than other states. Therefore, any sign of resistance based on government “stigma” does not

bode well for likely attitudes in other states.

Two business group representatives felt that employers were somewhat reluctant to deal with the Connector as a government agency, but another long-time employer representative thought the small business community realizes that it lacks the market clout of large business and is 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 highly favorable reputation in the general community based on how effectively it has overseen and implemented the 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 at least some employers respect the “seal of approval” it confers on the plans it offers. One key source thought that employers view the Connector *more* favorably than it deserves by wrongly 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 that she is suggesting that they join a Medicaid-type program—a false notion that takes extra effort for her to dispel with clients.

Rather than negative impressions of the Connector, interviewees more often mentioned employers’ general lack of awareness. Confirming this, an employer survey conducted by the state each year reported that, in 2010, only 44 percent of employers offering health insurance were familiar with the Connector (and only 37 percent of those who do not offer insurance). Several people praised the Connector’s “innovative and creative” marketing of its nongroup and subsidized components,¹³

but, as Connector officials conceded, marketing the employer component has been virtually “nonexistent.” The reason is that the employer component initially opened as a pilot program. Then, just after the launch of the revised employer program, all the leading insurers withdrew for two years (as explained 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 active marketing, just at the time interviews were being conducted for this study, and many interview subjects had heard or seen these ads. At the same time, however, 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. In General

As just mentioned, in early 2010 the market’s 4 largest insurers, representing 90 percent 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. This crisis, which many people called a “boycott,” occurred at the same time as the governor’s high-profile decision in March 2010 to deny outright any rate increases for most of these insurers’ small-group products. This decision hit “like a meteor” on the eve of the annual renewal date for many Massachusetts groups (typically April 1). Blue Cross attributed its nonparticipation in the Connector’s new small-group program to needing more time to work through the necessary systems changes with the Connector rather than to 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 agreed to do so, two years later.

It is understandable that major insurers would refuse to play ball with a government that abruptly denied any rate

increase for small groups. It is less obvious why none of the other insurers would re-enter until Blue Cross was appeased. With Blue Cross accounting for the largest share of a highly competitive market, one might have expected that business rivalry would cause one or more insurers to break rank in order to seize some of Blue Cross's market share.

Interviewees provided several explanations. Several people recited by rote 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 be higher risk. As a source at one insurer admitted, faced with the 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 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 with at least one insurer. This insurer explained that it initially joined to be sure not to miss out on a possible change in the market, but now that it sees that the market has remained largely the same, it feels "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, that Blue Cross's influence "as the big kid on the block" is such that "it can call the tune" and "set the

rules" appears to have some foundation. According to observers, solidarity among leading insurers meant that the Connector had to come to terms with Blue Cross over numerous, sometimes "maddening," operational details. 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 interviewees said that insurers' objections often were only "smoke and mirrors" because 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 could only lose from the Connector's new approach. Some informed sources found Blue Cross's position reasonable, noting that Blue Cross has substantially less market share inside the Connector than in the rest of the market and that people who change insurers are probably better risks, on average, than those who remain with a given insurer (a general phenomenon known as adverse retention). The same 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 helping 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, "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's competitors, but not from Blue Cross, because Blue Cross's policy has been to sell its small-group coverage directly (and through independent brokers). Given 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 such 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 with 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 administering nongroup coverage, but it was not willing to cede some of its administrative functions to SBSB for its small-group business. 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 that it did not want to relinquish.

This uncomfortable alignment spawned a host of technical issues that were difficult to resolve, that delayed Blue Cross's re-joining the small-group program, and that still bedevil the program to some extent. For instance, one key to providing accurate quotes to insurance shoppers is direct access to each insurer's rating criteria, which determine how much rates vary by allowable factors such as age, location, business sector, and group size.¹⁴ Other insurers were already used to sharing such 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's 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. According to Connector officials, employer exchanges have to come to grips with many business rules that might affect profits, costs, or perceived fairness, and, for each issue, various insurers may prefer a different rule or practice. Examples include the minimum employee participation and employer contribution rules for various-sized groups, 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 procedures in place. Therefore, it is a "challenge" to keep insurers all "at the table" working to find consensus around a common approach. The Connector's success in doing so appears attributable, in part, to its adopting the approaches that most leading insurers were already using in the outside market.

3. Brokers' Views

Next, we come to the critical perspective of independent insurance brokers (also known as agents). It has been widely noted that brokers are pivotal to the success of group market structures because the great majority of small employers rely on them for advice about purchasing insurance (Gardiner, 2012; Hall, 2000).¹⁵ Small employers lack the 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 is also worrisome because making a wrong decision could jeopardize someone's health or life, including the business 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.

Since its inception, the Connector has sought to include brokers, but brokers had reason 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." First, if the Connector were to succeed, brokers feared the Connector would eventually "disintermediate" them—if not by excluding them outright, then by charging employers extra for relying on them. To compound the fears of being "thrown under the bus," Connector officials initially were not perceived as "particularly broker-friendly." Until this year, the Connector did not have a broker on the governing board, 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 Connector leadership had "good people with good intentions, but they just didn't come over that well with the [broker] community."

Another reason for broker resistance is that the Connector initially paid them a significantly lower commission than brokers received in the regular commercial market. The Connector determined that it could afford only 2.5 percent as compared with the 3.5 to 4.5 percent previously paid in the commercial market. 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 government scrutiny of their premium rates. And, in one respect, the Connector pays more: it pays \$10 a month commission for sole proprietors, whereas insurers pay no commission for this business. Although that amount is low, some brokers view \$10 as "better than nothing," enough to "make a meager living."

Thus, on balance, most brokers felt that the Connector's commissions are now roughly equivalent to those in the outside

market.¹⁶ But, originally this was not the case. Moreover, many brokers reported 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 the Connector's Board of Advisors.

The only possibility for greater broker enthusiasm mentioned by interviewees is that younger and less well-established brokers might view 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 earns them the most money. It is possible to take such self-serving assertions with a certain grain of salt, and some brokers volunteered that not all of their colleagues are as public-spirited as they themselves were professing. Nevertheless, most brokers 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 superior value.¹⁷ Many brokers also praised the Connector's current administration 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 10” brokers, by one account, still do not like the Connector, and those interviewed gave a long list of reasons (already noted) why the Connector does not offer better value than the regular market. In addition, brokers resent 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 (beyond merely its role as an insurance exchange).¹⁸

Some brokers 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) 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, the 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 client relationships 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.” 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: there is no justification for 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 sources acknowledge the need for the Connector to arrange subsidized coverage for the uninsured and to structure unsubsidized private insurance for individuals,¹⁹ but, with 97 percent of the state’s residents insured, they feel that little additional ground is to be gained in seeking enrollees from uninsured employers. Therefore, brokers believe that any aggressive attempts to increase small-group enrollment will necessarily threaten to take away their existing business without significantly advancing 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 non-event.” Even some Connector officials and board members (former and current) wonder whether the employer component “was worth all of this attention” and didn’t “border on being a waste of time.”

The several 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, the Connector properly directed its main focus at the outset to launching subsidized coverage and implementing other aspects of the new reform law. Its second priority was to make individual coverage available in the private unsubsidized market, which is the market segment

that most insurers had neglected under the state’s earlier community rating laws. With the small-group market functioning comparatively well on its own, the Connector naturally saved that market segment for last and therefore did not implement a small-group program until its third year. Even then, the program was not marketed because it was still in its pilot phase (for reasons explained above).

Marketing to small groups began in earnest in early 2010, when the small-group program was restructured into Business Express, but the marketing campaign included the explosive letter described above. Unluckily still, the letter was soon followed by the precipitous exodus of the market’s leading insurers, perhaps sparked by the governor’s rate freeze. 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 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” while Connector officials stressed that the 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 Affordable Care Act’s Small Business Health Options Program (SHOP) exchanges? Despite obvious differences, interviewees consistently thought that the experiences in Massachusetts are relevant beyond the state’s particular reform law and market conditions. One way to reflect this generalizability is to note the various les-

sons that informed market participants, observers, and regulators thought could be learned from the Massachusetts experience. Stakeholders from several perspectives offered the following advice:

- Focus on the value proposition that an exchange structure can offer the small-group market. Do not simply attempt to replicate the existing market, but rather consider which of its problems and limitations a SHOP exchange can realistically address. Focus the SHOP exchange on making those improvements rather than attempting to serve multiple purposes and all market components.
- Do not aim for overnight perfection. Building an effective exchange for small employers is complicated and should be done in a step-wise progression 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 building everything from scratch.
- Do not underestimate the influence of brokers and their importance as advisors to employers, or their store of knowledge in contributing to the successful design and operation of an exchange.
- Do not 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, several factors 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, particularly if other states do not have intermediaries already in place to provide some online shopping features for comparing prices and benefits. In addition, Massachusetts had already eliminated medical underwriting, and a handful of HMOs offering similar networks and benefits dominated its employer market. 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 interviewees, however, thought that the presence in Massachusetts of some limited-network plans may have provided more network diversity such that the state had more to gain than other states from a structured clearinghouse.

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. Massachusetts lacked this feature, and insurers' concerns over adverse selection hampered its small-group exchange. However, a number of interviewees commented that risk adjustment would not fully address insurers' selection concerns because risk adjustment is imperfect, and they felt that most insurers tend to be "paranoid" that they will be selected against in an exchange setting more than their competitors, almost regardless of what rules an exchange adopts.

Another important difference between the ACA's provisions and the Massachusetts reform law is the ACA's payment of substantial subsidies to individuals purchasing through exchanges; in contrast, individual private insurance is unsubsidized in Massachusetts. The ACA's subsidies are expected to bring many more previously uninsured people to the exchanges, likely giving the exchanges more leverage, if they wish to use it, to insist on 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 to sell to individuals, but various sources explained that the Connector never felt it had enough leverage to actually force participation in the employer component.²⁰

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 could conceivably help address some of the concerns brokers expressed about the lack of support for taking on the extra burdens of explaining complex choice and enrollment 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 a fine and sometimes faint line between creating a program that improves existing market structures for small groups without unduly threatening existing market participants or upending features that already work reasonably well. 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 show promise and which are likely to fail or flounder.

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References

- Bradley, E. H., Curry, L. A., & Devers, K. J. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Serv Res* 2007. 42, 1758-1772.
- Curtis, R. & Neuschler, E. "Small-employer ("SHOP") exchange issues." Institute for Health Policy Solutions, 2011. [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).
- Day, R. & Nadash, P. New state insurance exchanges should follow the example of Massachusetts by simplifying choices among health plans. *Health Aff*, 2012. 31, 982-98.
- Doonan, M. T. & Tull, K. R. Health care reform in Massachusetts: implementation of coverage expansions and a health insurance mandate. *Milbank Q*, 2010. 88, 54-80.
- Fronstin P. Private health insurance exchanges and defined contribution health plans: is it déjà vu all over again? Employee Benefit Research Institute, 2010. http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2012_No373_Exchgs2.pdf.
- Gabel, J. R., Whitmore, H., & Pickreign, J. Report from Massachusetts: employers largely support health care reform, and few signs of crowd-out appear. *Health Aff*, 2008. 27, w13-w23.
- Gardiner, T. Health insurance exchanges of past and present offer examples of features that could attract small-business customers. *Health Aff*, 2012. 31, 284-289.
- Hall, M. A.. The role of independent agents in the success of health insurance market reforms. *Milbank Q*, 2000. 78, 23-45.
- Ierna, C. Contributory plan update. Massachusetts Health Connector, 2009. <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2009/2009-11-12/PPT%2520-%2520CI%2520-%2520Small%2520Group%2520Update%2520-%252011%252012%252009.ppt>.
- Institute for Health Policy Solutions. Study of SHOP exchange: analysis of key Maryland SHOP-related policy options, 2011. http://dhmh.maryland.gov/exchange/pdf/FinalSHOPEXchangeIHPS_1.pdf.
- Jost, T. S. Health insurance exchanges and the Affordable Care Act: eight difficult issues. The Commonwealth Fund, 2010. <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx>.
- Kingsdale, J. How small business health exchanges can offer value to their future customers--and why they must. *Health Aff*, 2012. 31, 275-283.
- Lischko, A. Fixing the Massachusetts health exchange. Rep. No. 71). Pioneer Institute, 2011. http://www.pioneerinstitute.org/pdf/110309_Fixing_Connector.
- Long, S. K., Stockley, K., & Dahlen, H. National reform: what can we learn from evaluations of Massachusetts? State Health Access Reform Evaluation, 2011. <http://www.shadac.org/files/shadac/publications/MassachusettsNationalLessonsBrief.pdf>.
- Massachusetts Health Connector. Report to the Massachusetts legislature: implementation of health care reform, 2010. <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%25202010.pdf>.
- NFIB Research Foundation. Small business and health insurance: one year after enactment of PPACA, 2011. <http://www.nfib.com/research-foundation/surveys/healthcare-year1>.
- Quantria Strategies. Health insurance in the small business market: availability, coverage, and the effect of tax incentives, 2011. <http://www.sba.gov/sites/default/files/386tot.pdf>.
- Urff, J. E.. *Health reform toolkit series: resources from the Massachusetts experience: determining health benefit designs to be offered on a state health insurance exchange*. Blue Cross Blue Shield of Massachusetts Foundation, 2011a. <http://www.rwjf.org/files/research/73722.bcbsmass.toolkit3.pdf>.
- Urff, J. E. *Health reform toolkit series: resources from the Massachusetts experience: Implementing a successful public education and marketing campaign to promote state health insurance exchanges*. Blue Cross Blue Shield of Massachusetts Foundation, 2011b. <http://www.rwjf.org/files/research/covmarketingtoolkit2.pdf>.
- Weiner, B. J., Amick, H. R., Lund, J. L., Lee, S. Y., & Hoff, T. J. Use of qualitative methods in published health services and management research: a 10-year review. *Med Care Res Rev*, 2011. 68, 3-33.

Endnotes

- 1 Initially, SBSB and the Connector had agreed to transfer 17,000 subscribers in two stages, starting with the 1,200 to 1,600 (exact numbers vary) whose policies already matched what the Connector offered and then moving the remaining 15,000 or so for whom either new coverage packages would need to be developed or who would need to select different coverage. This second, much larger transfer never occurred, however. The exact reasons remain murky. By the time the second transfer was scheduled to begin, the leading insurers had withdrawn from the Connector's employer program. Some interviewees also thought that insurers objected to the transfer, and others thought that SBSB changed its mind on how advantageous the transfer would be for either it or for its customers.
- 2 The private intermediaries do still charge an association membership fee of roughly \$125 per company, which the Connector does not charge. The fee also provides access to other association benefits and products.
- 3 This is confirmed by an independent analysis estimating that Massachusetts has the lowest percentage of small firms in the country (other than Washington, D.C.) whose wages would qualify for the federal tax credit (Quantria Strategies, 2011, p.60).
- 4 Tiered networks are those that include a broad array of providers but place them in different tiers, with varying cost-sharing for patients, to encourage use of lower-cost providers.
- 5 Note that standardization of benefits entails more than offering benefits in tiers identified by precious metals (Gold, Silver, Bronze, and so forth). The metal tiers are based on a plan's actuarial value determined largely by copayments and deductibles, that is, what percentage of covered benefits are paid by the insurer rather than by the patient. A given actuarial value may be achieved through a wide variety of benefit structures. Therefore, the Connector concluded based on market research that additional standardization of copayments and deductibles is needed to simplify choices beyond merely arraying them in actuarial tiers. Urrf, 2011a; Day and Nadash, 2012.
- 6 Moreover, many employers either do not purchase any ancillary services and products or purchase them elsewhere. In a recent national survey, only a third of small employers who used a broker to purchase health insurance also used the broker to purchase some other type of business insurance (NFIB Research Foundation, 2011).
- 7 Until 2014, insurers also are allowed to vary rates according to group size in order 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 that insurers must quote the rates to be used by employees in selecting a plan (see Institute for Health Policy Solutions, 2011, for more discussion). Other difficulties and frustrations noted by brokers related to the fact that, for various technical reasons, the web interface showed the employer only how much it was contributing, and not the amount of the total premium. According to one broker, "It was just weird—a whole different way of" comparing plans and prices.
- 8 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 toward older workers choosing the reference plan and younger workers opting for alternative coverage. Such 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 brokers became more aware of the discrepancy and began to advise workers about how to take advantage of it. (For thoughtful analyses of other, more complex ways to deal with these difficulties, see Curtis and Neuschler, 2011; Institute for Health Policy Solutions, 2011.)
- 9 The smaller the group, the more likely it is that insurance purchasing decisions will reflect the health conditions of particular employees, including those of the business owner.
- 10 Abby Goodnough, "Navigating the Health Care Maze," *New York Times*, June 12, 2012.
- 11 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 broker complained that minor discrepancies in the renewal process can result in employers being automatically dropped, leaving them uninsured for a time.
- 12 This response was given by a quarter of small employers that offered coverage and half of those that did not. The overall sample size was 629 small employers.
- 13 For more detail, see Urrf, 2011b.
- 14 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 sources. If so, Blue Cross was concerned that brokers would learn to "fool the system" by comparing Blue Cross quotes obtained from different sources.
- 15 In one recent national survey, 79 percent of small employers use a broker to purchase their health insurance (NFIB Research Foundation, 2011).
- 16 Some brokers insisted this is not the case, but most were brokers who have not placed business with the Connector. A few others 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 broker 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 brokers.
- 17 For instance, one small-group broker, who seemed to like what the Connector stood for but had previously concluded that it did not offer better value, wrote the following after the interview: "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."
- 18 The reform law requires employers to provide workers with a tax-sheltered means to make their premium contributions or individual insurance purchases (known as section 125 plans), and employers must file an annual report about meeting their employer responsibility requirements under the law. Small employers often turn to their insurance brokers to help with these Connector-enforced requirements so that brokers "felt like [they were] giving the Connector a lot of free service" to help implement the law.
- 19 Because of community rating and guaranteed issue laws, Massachusetts insurers have not paid any commissions for individual (nongroup) coverage, thus making it more difficult for individuals to find insurance. Now, half of this market segment purchases its coverage through the Connector.
- 20 The Connector's subsidized coverage is provided by a different set of Medicaid-based health plans that do not include the market's leading private insurers.