



NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

White Paper on Health Insurance Connectors

The National Association of Health Underwriters (NAHU), a professional trade association representing more than 20,000 health insurance agents, brokers and employee benefit specialists nationally, is extremely concerned about how rising health care costs are impacting health insurance coverage in this country. NAHU members help millions of individuals and employers purchase and maintain health insurance coverage, and we are acutely aware of the need for more affordable private health insurance options. As an association, we are committed to reducing the number of uninsured Americans through private-market solutions. NAHU also realizes that there is no one solution to the problem of the uninsured. To make a significant reduction in the number of uninsured Americans, innovative ideas that leverage the resources of the private health insurance market will need to be employed.

With health insurance affordability and accessibility consistently ranking as one of the top domestic-policy concerns, it is not surprising that state and federal lawmakers are considering dramatic proposals intended to make health insurance both less expensive and easier to purchase. In 2006, Massachusetts policymakers enacted a far-reaching health reform plan, creating what is known as the Massachusetts health insurance “Connector,” along with other reforms. Now many policymakers, both in Congress and in other states, are exploring whether the Connector concept is an effective means of reducing the number of uninsured Americans.

NAHU has thoroughly evaluated the policy ideas behind health insurance Connector proposals, and our examination has yielded serious concerns for a number of key reasons. These include: an historical lack of health insurance purchasing pool successes, conflict between federal and state laws, market disruptions leading to increased premiums, functions being fulfilled by the private market being replaced by a public entity, and a Connector’s lack of ability to contain health care costs.

However, we recognize that some states and policymakers believe the Connector concept has promise as a means of enrolling eligible individuals in public health insurance programs, providing a streamlined method of accessing health coverage options and providing income-tax advantages to individual health insurance purchasers. To help states and policymakers interested in pursuing the Connector concept in an affordable and responsible way, NAHU has developed a series of recommendations to assist in the creation of a “Smart Connector.”

What Is a Connector?

A Connector is, in theory, a purchasing pool intended to offer consumers greater access to more tax-advantaged health insurance choices. Sometimes Connectors are referred to as health insurance “Exchanges” or “Partnerships.” In many ways, a Connector operates like the Federal Employees Health Benefit Plan, in which many private insurance plans compete to provide coverage for federal workers. But, unlike the FEHBP, a Connector does not achieve the marketing and other advantages of a homogenous group. All health insurance products sold through a Connector are individual policies, even if they are purchased by an employer in lieu of traditional group insurance coverage. Employers purchasing coverage through a Connector may be required to establish premium-only Section 125 “cafeteria” policies through which the Connector policies would be purchased. In Massachusetts, the Connector **replaces** the individual insurance market and is a means for qualified individuals to enroll in a state-subsidized health insurance option known as Commonwealth Care. Massachusetts’ intention is for the Connector to also become a health insurance purchasing option for small businesses but, as of yet due to legal obstacles, the Connector is only serving individuals.

Since the creation of the Massachusetts Connector, Connector or Exchange bills have been introduced in more than 30 state legislatures and the U.S. Congress. Some proponents of a Connector believe that our nation’s health coverage system should evolve from a primarily employer-based insurance system to an

individually based one. A Connector would partly achieve this goal and could potentially expand employee health insurance options. A Connector also is intended to provide an opportunity for individuals to receive federal tax-favored status. Recently, the IRS clarified existing rules that permit employees to use Section 125 funds to buy individual coverage and receive the group insurance tax exemption. To access the Connector and to facilitate the tax advantage, businesses must establish a Section 125 premium-only plan.

Concerns about Connectors

Proponents say that Connectors are government-managed markets that sell individual private and portable health insurance while preserving market forces and fostering competition. Furthermore, it has been argued that pooling a group of individual policies within the Connector can mitigate some risk and stabilize premiums. NAHU is not convinced these arguments are true. Also, we believe that there will be implementation barriers due to federal laws impacting health insurance coverage, including the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).¹

Financial and Cost-Saving Challenges of Purchasing Cooperatives

Essentially, Connectors, as commonly proposed, are just another variation on a purchasing cooperative. Historically, the creation of health insurance purchasing cooperatives has not resulted in the reduction of costs or improved access to coverage. There are several reasons why past large-scale health insurance purchasing cooperatives have failed, including adverse selection (the “death spiral”) and an inability to reduce administrative costs. Purchasing cooperatives are generally unstable, with groups and individuals transitioning in and out of them at a much faster rate than, for example, a comparably sized large-employer group. Voluntary pools also suffer from adverse selection, because the groups and individuals most likely to seek coverage through these pools are those who could not obtain coverage cheaper or elsewhere. The result is generally higher costs. Individuals and small businesses may have access to some different health insurance options than they would have encountered if buying similar coverage independently, but there is a price consequence to this increased degree of choice. The California Health Insurance Purchasing Cooperative (HIPC), our nation’s largest group health insurance purchasing pool experiment, lasted for more than 10 years before closing its doors in 2006 due to low enrollment. The HIPC offered small-group purchasers a few more coverage choices that were attractive to some employers, but it was never the most cost-effective way to buy health insurance in the state and employers responded to that price disadvantage.

Purchasing cooperatives also have failed to yield significantly lower administrative costs for employers, employees and insurers, and the same will likely hold true for Connectors. It is often argued that many individuals and small businesses purchasing coverage together will be able to translate their bulk purchasing power into discounts normally achieved by large businesses. However, many diverse individuals buying insurance together do not have the same rating and risk profile as one large and generally more homogenous employer group, even if one were to merge individual and small group markets. In addition, the cost savings associated with large-employer coverage primarily comes from the fact that the enrollees work for the same employer and have a standardized point of contact. A Connector would have to individually address the needs of many subscribers and the associated marketing costs to reach them. As a William M. Mercer study on health insurance purchasing cooperatives commissioned by the Commonwealth of Virginia concluded,

“The historical success of HIPCs has been disappointing in general. The enrollments have never reached the expected levels required to enable the HIPCs to be significant negotiators in the market and the hoped-for cost savings have not materialized.”²

Potential Conflicts with ERISA, HIPAA and COBRA

NAHU has serious legal concerns about Connectors, particularly with regard to situations in which employers would be purchasing or sponsoring individual coverage for employees. Depending on a Connector’s structure, we see potential conflicts with a number of federal laws, including ERISA, COBRA

¹ One example of federal preemption challenges is Missouri’s struggle to implement HB 818, passed late in the 2007 legislative session.

² Mercer, William M. *Review of Health Insurance Purchasing Cooperatives (HIPCs)*. Private study Commissioned by the Commonwealth of Virginia. September 15, 1999.

and HIPAA. These laws serve essential functions to protect consumers, and NAHU does not want to see these protections diminished.

Federal ERISA protections apply to all employee benefit plans and supersede any state laws. So while a state may regulate the health insurance carrier or plan that sells coverage to employer-sponsored groups, it may not regulate the employee benefit plan itself. It also cannot impose requirements on self-funded employee benefit plans.³ The only way to avoid this requirement is to seek a federal preemption waiver, such as the one granted to Hawaii in 1975 for that state's employer-mandated coverage legislation (the Hawaii employer mandate legislation predated the enactment of ERISA so the state was granted a waiver almost immediately during the ERISA implementation process). Many Connector proposals would require participating employers to create Section 125 cafeteria plans, as well as mandate coverage of certain benefits and employer contributions. This could trigger potential ERISA challenges. These administrative burdens would add to health insurance administrative costs with little, if any, value to consumers or employers.

Potential conflicts with HIPAA and COBRA are also of great concern to NAHU. In Massachusetts, all policies sold through the Connector are individual policies even if they are offered through an employer. This raises important COBRA and HIPAA questions for employees of companies that previously offered traditional group health insurance coverage but are now offering such coverage through a Connector:

- Do employees forfeit their COBRA rights?
- If not, when is COBRA eligibility triggered? Would it be upon termination of employment or at the time of the employer group enrollment in the Connector individual policy?
- When would group-to-individual portability guaranteed-issue rights under HIPAA be triggered?

These eligibility concerns will likely need to be addressed by federal courts if Connectors become widespread, and the potential for such courts limiting existing rights of group health insurance consumers is significant and worrisome.

HIPAA group health provisions also appear to be problematic for Connector proposals. HIPAA requires that health plans which involve an employer must comply with all of the group health insurance protections the law mandates. Connector plans sold through employer groups would seem to clearly fall under the category of employer involvement, particularly if employer contributions or the creation of a Section 125 plan were involved. Therefore, Connector policies would have to be compliant with all of the HIPAA group health insurance protections, even if they were technically individual policies. These requirements include mandatory guaranteed issue, limitations on preexisting condition look-back and exclusionary periods and non-discrimination rules. The private health insurance market in Massachusetts has always been regulated very heavily and already required individual policies to meet most of these requirements prior to the creation of the Connector. As such, a Connector and associated market reforms have been much less disruptive in Massachusetts than they would be in virtually any other state. And a quick comparison between Massachusetts' premium rates and those available in other less-regulated markets clearly shows that the regulatory requirements increase the cost of coverage.

Potential for Private Health Insurance Market Disruption

The above HIPAA issues are why NAHU believes that the creation of a Connector could cause the complete disruption of the traditional health insurance marketplace without substantive gain in either covered lives or affordability. Guaranteed-issue health insurance is required by federal law for small-employer group coverage, but there is no federal requirement for individual coverage to be issued in this manner. Consequently, only seven states require complete guaranteed issue in their individual markets due to the potential for adverse selection. In the few states where guaranteed-issue individual health insurance is required without an individual mandate to buy coverage, individuals buy insurance when they anticipate they will incur claims that exceed the cost of their premiums. Individual health insurance premiums are extremely high and the covered population is older and less healthy than in other states. The traditional

³ As of January 1, 2009, Massachusetts law mandates all residents to have coverage that satisfies the state's definition of "minimum coverage." All state residents must be sure their coverage meets the state minimum benefit standards. Why didn't the state mandate all employers to offer such coverage? ERISA prohibits it.

exchange programs that have been proposed to date would all, to some degree, require the considering states to offer individual coverage on a guarantee issue basis in order to avoid conflicts with HIPAA.

Along with guaranteed-issue requirements, most Connector proposals would require coverage to be rated not on the basis of insurable risk, but instead on a community or modified community basis. While modified community rating was already law in Massachusetts, only seven states currently employ those rating methodologies in their individual markets and only 12 allow them in their small-group markets. The reason is that market forces clearly show that these “reforms” actually increase costs for the majority of the population.⁴ NAHU is concerned that the guaranteed-issue and limited rating elements of traditional Connector proposals will be very disruptive to the individual markets in most states and significantly raise coverage costs for the vast majority of purchasers, especially in states where these requirements are new. Some might suggest that a compromise solution would be to simply limit the guaranteed-issue and limited rating requirements to the Connector, but that would just create an unlevel playing field in the marketplace that would further exacerbate adverse selection in the Connector’s coverage pool.

Impact on Consumer Protection and Services

Another concern that NAHU has about proposed Connectors is replacing services currently being provided by the private health insurance market with a government entity. Many individual health insurance products are readily available for private sale through licensed professionals and insurance carriers in all 50 states. They are sold through the Internet, over the phone and in person. Licensed agents answer individual questions, provide advice and options, resolve claims issues and help millions of American consumers navigate often confusing health care bureaucracies. NAHU believes a monopolistic government-sponsored health insurance vendor would diminish customer service. Customer support and advocacy functions would likely be diminished. Also, based on existing enrollment challenges in the Medicaid and SCHIP programs, we question whether a new government entity will produce significantly different results.

Connector proposals are often part of a larger attempt at restructuring the health care and insurance market. To that end, we feel that caution is warranted regarding “crowding out” of the traditional private health insurance marketplace, politicizing of health care decisions, and the cost/benefit analysis of making such radical changes to a state’s insurance system. Furthermore, we feel that great emphasis should be placed on the economic impact of a Connector, including the possible unsustainable costs of public program growth and the effect the potential loss of insurance-related jobs in the state could have on the economy.

No Impact on the Cost of Medical Care

Finally, and most important, NAHU feels that Connector proposals would do nothing to address the rapidly rising costs of providing medical care in this country, which is the true source of high health insurance premiums. Health insurance market reform measures, no matter how they are structured, do little to reduce costs. Constraining skyrocketing medical costs is the most critical – and vexing – aspect of health care reform. It is the key driver in rising health insurance premiums and it is what’s putting the cost of health care coverage beyond the reach of many Americans.

The Smart Connector Alternative

Despite all of our concerns about a traditional health insurance exchange, NAHU does recognize the need for greater opportunities to enroll individuals in health insurance coverage. In particular, the issue of individuals who are eligible for public health insurance programs but are not actually enrolling in the coverage needs to be addressed. Of the approximately 47 million uninsured, approximately 14 million people (30 percent of the total uninsured) are actually eligible for a public health insurance program like Medicaid or the State Children’s Health Insurance Program (SCHIP). There is also the perception that uninsured individuals need a centralized place to access coverage option, connect with qualified professionals and make choices based on their individual needs and budgets. Finally, the employer-sponsored health insurance system provides tax advantages but it’s not always an available option for everyone.

⁴ Within a Connector, adverse selection is a big concern, no matter the size of the pool. Community rating will also increase the chance of adverse selection among plans.

Making it easier for individuals to enroll in health insurance programs both public and private is certainly an admirable goal. If a jurisdiction is considering using the Connector model to help address these needs, we hope that they will consider using the components of a “Smart Connector” instead. The components of a Smart Connector are:

- 1. A Smart Connector should focus on individuals who are potentially eligible for publicly subsidized coverage or programs.** A Smart Connector should be a public program enrollment portal. Although it would not make insurance more affordable, it could be considered as a potential additional purchasing option for individual market private health insurance products. However, a connector should not be a purchasing option for employer groups. Involving the group insurance market only creates a host of legal and cost concerns. Furthermore, the parameters of obtaining group coverage are very complicated in most states and do not lend themselves to the Connector concept. The decline in the number of employers offering group coverage has prompted some policymakers to consider making a Connector a group purchasing option. These employer-coverage concerns can be addressed in other simpler and more cost-effective ways described in the points below.
- 2. A Smart Connector should be a public-service gateway that allows people who are eligible for government-assisted plans to verify their eligibility, identify the plan options and determine subsidy levels.** A Smart Connector could be an information portal where all individuals could find information about publicly sponsored programs. It could be source of network provider information, provider outcomes and quality measures and wellness information. Such a portal could also provide information about conventional individual medical plans and the opportunity to request the assistance of licensed insurance producers certified to work with Connector technology and products.
- 3. A Smart Connector should be only one of several delivery channels for individual health insurance products.** A Connector should not replace the current retail distribution system nor should the compensation for producers vary between systems. All Americans should have access to affordable health care coverage. As important as affordability, however, is choice. There needs to be a choice of products, a choice of payers and a choice of benefits, with many price and coverage alternatives.
- 4. To protect health insurance consumers and help people obtain the coverage that best meets their specific needs and budgetary requirements, a Smart Connector should be manned by licensed and specially trained health insurance producers.** Products sold through the Connector should only be sold by licensed producers and, to make sure that there is equity in the offering of Connector and traditionally offered products, compensation for Connector-related sales and enrollment should reflect commissions in the private market.
- 5. The governing authority of a Smart Connector should include licensed health insurance professionals, other insurance industry representation and oversight by the state department of insurance.** Adequate insurance industry participation in a Connector’s governing board is essential to ensure that the goals and activities of the Connector are affordable, realistic and workable within the state’s existing private health insurance market. In addition, oversight by the state department of insurance will provide consumer protection and compliance with existing state and federal statutes relative to health insurance markets.
- 6. To preserve market fairness and choice, any subsidies for coverage made available by the state or federal government as part of the creation of the Smart Connector should not be used exclusively for the Smart Connector.** Allowing people the ability to choose where they buy their subsidized coverage is essential to maintaining a level playing field within the insurance market, preserving consumer choice, and preventing adverse selection within plans inside and outside of the Connector.

7. To address the decline in employer-provided health insurance coverage and extending tax advantages to individual purchasers, a state or the federal government should make small and cost-effective changes to existing law. These steps could be done at the same time as the creation of a Smart Connector, or they could be done independently. The first step would be to clarify that individual health insurance policies purchased by employees with no premium paid by the employer are not the same as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA. The employees own these policies and they stay in force when workers leave their job. In particular, the requirements regarding individual policies sold on a list-bill basis – whereby the employer agrees to payroll-withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premiums – need to be clarified. Furthermore, insurers would have to recognize the individual insurance plan as a valid coverage option for the accounting of the participation guidelines of the insurer.

8. The state or federal government should clarify that employers implementing list-billing arrangements for their employees may also establish Section 125 premium-only plans for their workers. This would enable employees to pay for their individual policies on a tax-favored basis. If an individual participated in a Section 125 plan for a list-billed policy, those premiums should not be eligible for deduction as a medical expense under Schedule A of the federal income tax form.

9. To maintain a level playing field in the insurance markets, ensure consumer protection and prevent fraud, the state should specify that all individual health insurance policies sold under a list-billed arrangement are subject to all state insurance regulations governing the issuance of traditional individual insurance policies. This stipulation would need to extend to rating requirements, issuing requirements and the requirement that such products only be sold by licensed health insurance producers.

Conclusion

NAHU is extremely concerned about the problem of the uninsured and providing easy and affordable access to health insurance coverage. As an association of more than 20,000 committed health insurance professionals, we recognize that there is no one solution to this massive societal problem. The traditional Connector approach, as a means of providing individuals with greater access to affordable coverage, is something that NAHU has studied at length and is an idea we approach with great caution. We believe that there are many significant legal and economic ramifications associated with a Connector. The creation of similar large-scale purchasing pools has done little to increase coverage and control costs. Also, implementing a Connector will not easily mesh with most existing market-friendly state health insurance market regulations as it did with the regulations in its pioneer state of Massachusetts.

We recognize that state and federal policymakers are looking for market-friendly means of streamlining access to coverage. Many also would like to increase the availability of coverage offered through the workplace and extend tax advantages to individual consumers. By offering policymakers the components of a Smart Connector, we hope to provide a positive, affordable and realistic means of meeting those objectives.