

**July 20, 2009**

## **Health Insurance Exchanges: A Typology and Guide to Key Design Issues**

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A common feature of recent proposals for national health reform is the creation by government of one or more health insurance exchanges.<sup>1</sup> The buzz around this concept stems in part from the central role that the Commonwealth Health Insurance Connector Authority played in achieving near-universal coverage in Massachusetts.<sup>2</sup>

While the concept is popular among policy-makers, there is no consensus about what government-chartered exchanges should do or how they should be structured to facilitate shopping. For example, should there be one national exchange, one for each state, multi-state regional exchanges, and/or competing exchanges? Even the Massachusetts Health Connector operates two distinct exchanges: an exclusive distribution channel for its subsidized, low-income beneficiaries (Commonwealth Care), and an alternate buying channel for unsubsidized, non-group and small-group markets (Commonwealth Choice).<sup>3</sup>

We define a health insurance exchange in this context as a government-organized market which numerous purchasers use to choose among competing health plans by comparing price, benefits, provider network and other relevant information. This still leaves great variation in how the exchange facilitates comparison shopping. For example, does the exchange select health plans through negotiations and/or competitive bidding, or does it showcase all licensed carriers? Does it define the benefits to be offered and compared, structure actuarial equivalence among diverse benefit packages, or leave the consumer to try to sort through a multitude of non-comparable benefits? Does it enroll and bill the customer, or refer him/her to the carrier to complete the transaction?

We explore these issues below, beginning with a rough typology of exchanges.

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### ***A Typology of Exchange: Degree of Disruption & Purchasing Power Leverage***

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In an effort to clarify these functions and their policy implications, we categorize exchanges into four types and explore some key design features related to each type. The exchanges in this simplified construct differ along two dimensions: (1) the degree of disruption in current sales practices and premium flows; and (2) the extent to which purchasing power is aggregated for leverage. Variations on these four models are more than possible--they already exist—and elements of more than one type can be combined. But these four illustrate the full range of the policy objectives and political constraints behind different visions of government-sponsored exchanges and correspond to distinct types in existence today. See Exhibit 1.

**A. Information Channel:** At the minimalist end of the functional range, an exchange can simply provide information on the options available in existing markets, help consumers sort these options against their preferences, and link buyers to health plans. As an Information Channel, the exchange showcases available plans--without preference for some carriers or benefit options, without changing the flow of premiums (directly to carriers), and without aggregating buying power. In effect, it organizes information to support decision-making.

The Kelly Blue Book guide to automobiles and FEHBP’s PlanSmartChoice™ exemplify elements of this model. The Blue Book lists virtually every make and model and gives buyers an objective sense of the current value of each one, taking into account original purchase price, years of depreciation and the car’s current condition. An Information Channel could do something similar, but in order to provide any real guidance it would have to offer sophisticated decision-support tools for use in evaluating the coverage and likely out-of-pocket spending associated with various health plans. PlanSmartChoice is a customized comparison tool for evaluating health plans against consumers’ needs, used by employees of the federal government and other large employers to compare premiums, coverage and expected out-of-pocket spending.<sup>4</sup> (However, the employers that use this tool do not fit the Information Exchange model, as they qualify and select the health plans offered to their employees.)

The case for making an Information Channel national in scope and completely automated is strong: the value and functions of an Information Channel are so modest that scale economies are essential to make it worth the effort, and centralization poses no threat to existing players in the distribution chain. In this model, there is little need to coordinate with state insurance regulators, nor to understand local market conditions. Nor is governance really an issue, since the exchange’s impact on the market is so modest.

**Exhibit 1  
Disruption & Leverage Diagram**

	<b>More Leverage →</b>	
   <b>More Disruptive</b>     V	A. Information Channel	C. Purchasing Cooperative
	B. Alternate Distribution Channel	D. Exclusive Distribution Channel

**B. Alternate Distribution Channel:** An exchange can function as one of various sales channels. In this model the exchange specifies plan designs, solicits carriers, markets to target customers, arranges for comparison shopping, and actually sells health insurance. Rather than simply structure information, the exchange tries to manage the sales process and improve the shopping experience for customers. (Offering every licensed insurance product would overwhelm most consumers with too much choice.)

Its public policy rationale is to improve the choice of health plans and “empower” relatively disadvantaged buyers. Small employers and individuals are often cited as such, because they lack information, expertise, product choice, market leverage, and/or effective risk pooling. Typically, exchanges in the United States have been established as Alternate Distribution Channels for small employers. Ten or so have been initiated since the 1990’s, although most of them subsequently went out of business.<sup>5</sup>

The case for establishing Alternate Distribution Channels at the state level is fairly strong. First, this kind of exchange must coordinate with state insurance regulations; otherwise, it is likely to disrupt those regulations in unintended ways and/or suffer adverse risk selection.

Second, local market knowledge is key. By definition, Alternate Distribution Channels compete for customers, so have to understand local tastes and anticipate local market trends in order to win or hold share. Even if uniform, national underwriting rules eventually replace state regulation, local markets vary considerably, reflecting both current regulations and local differences in income, employer offerings, providers and care management.

**C. Purchasing Cooperatives:** This exchange aggregates buying power on behalf of groups of beneficiaries to drive the best deals possible from a select number of qualifying carriers. Its offerings might look something like FEHBP or any other large employer that provides employees with a choice of health plans. The distinction, however, is in aggregating numerous smaller purchasing units into a single risk pool. The challenge is to aggregate risk in such a way as to enroll a cross-sample of the eligible buyers, rather than attract those who are likely to need the most care. Without substantial subsidies, such as employers typically provide their employees, this is a major problem.

A large Purchasing Cooperative need not coordinate with state insurance departments, any more than self-insured employers do. Its rates, like any large employer's rates, reflect its own enrollees' risks, plan design and benefits. They are generally unaffected by underwriting rules in the rest of the market. For example, CalPERS purchases on behalf of state (California) and local governmental entities, which constitute a well-defined set of employers. In theory, health plans bid more competitively, the more "covered lives" are at stake, and the bigger the geographic boundary the more potential lives can be aggregated.

But the leverage from buying for additional lives might be more than offset by the complexity of managing risk across such a broad range of enrollees. For example, opening FEHBP broadly beyond federal workers, as some have proposed, would subject federal employees to adverse selection, unless targeted at a well-delineated set of beneficiaries who are either required to participate or generously subsidized to attract the healthy. Conversely, federal legislation to exempt multi-state "Association Health Plans" from state underwriting rules threaten to pull favorable risks out, leaving states to regulate the residual population of "sicker" small groups. Pooling risk is the biggest challenge to Purchasing Cooperatives.

**D. Exclusive Distribution Channel:** This model monopolizes distribution, which is more feasible, politically and practically, for non-group than for group insurance. For example, a single entity could select and offer health plans for the entire class of non-group buyers, and also administer subsidies for eligible low-income enrollees. An individual mandate would create a compelling public purpose for making non-group insurance as affordable as possible, and for integrating the administration of public subsidies with plan selection and consumer shopping.

This model is similar to that used by the Dutch and the Swiss under their individually mandated, universal insurance systems. One important difference is that, unlike the U.S., health insurance in those countries is all non-group, so to exclude a health plan from the exchange is tantamount to de-licensing it. As a result, they offer all plans. A variant of the Exclusive Distribution Channel described above would be, like the Swiss and Dutch, to offer all licensed health plans that wish to participate in non-group. This version of the model would rely entirely on consumers to select from among the many health plans that meet baseline licensing requirements, using robust decision-support tools to wend their way through the thicket of plans.

By monopolizing sales for one entire segment, this approach largely eliminates the need to integrate the exchange's rules and activities with state insurance regulation. Indeed, both portability and equity concerns suggest that state regulation of non-group be largely pre-empted by national underwriting rules. Therefore, a state-by-state structure would offer relatively little advantage.

Moreover, given the large distribution costs of non-group insurance, the potential savings from consolidating distribution to a central exchange, whether national or regional, are considerable. Under a national individual mandate, these savings could be further enhanced by moving open enrollment and plan design changes to a single anniversary date, as CMS now does with Medicare Advantage plans and some other countries with private insurance do as well.<sup>6</sup>

However, the line between the non-group and small-group markets is not clean. New rules for group insurance, such as a requirement that employers contribute toward group insurance, and/or federal subsidies for small-group coverage, would be needed to minimize unintended subversion of small employer groups, especially the sort of erosion of small-group insurance that systematically biases risk selection. While risk adjustment among carriers within the exchange would focus competition on more socially desirable dynamics and exclusivity would facilitate risk adjustment across the entire non-group market, this cannot address risk selection between the group and non-group markets --unless both markets are subject to a single risk adjustment mechanism.

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### ***Key Design Issues: Organization & Governance, Rules, Underwriting, Risk Adjustment, Benefit Options, Carrier Selection, & Administrative Efficiencies***

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#### **1. How should the exchange be organized and governed?**

Generally speaking, publicly-sponsored exchanges organize markets to help “weak” buyers, enhance individual choice and streamline distribution. One rationale for government sponsorship is to change market dynamics, but political management leads to a worry that the exchange may “tilt” the rules against private insurance or discriminate unfairly among carriers. Presumably, governance should be designed to balance these concerns.

If an exchange is to process commercial transactions, it should be insulated from political influence and able to recruit relevant business expertise. If it is to achieve policy objectives through regulation, tax-financed subsidies, or both, it must be publicly accountable. This combination of requirements suggests the model of a semi-independent, government authority: managed outside the civil service system and governed by a board of directors that has relevant expertise, supports market-based policies, represents a broad political spectrum, serves staggered terms, is appointed by elected officials and is held accountable for stewardship of public funds.

#### **2. What are the “rules of the game” within which insurers must function?**

If similar marketing and rating rules do not apply in and outside of the exchange, insurers, brokers and/or buyers will seek ways to exploit the discrepancies. For example, if the exchange requires guaranteed issue, but alternate channels do not, then it will likely attract higher risks. Similarly, if the range of allowable rate variation in the exchange is more limited than outside, carriers will avoid the exchange in favor of other distribution channels where premiums more closely approximate costs; higher risks will seek the exchange, where their premiums are capped; and lower risks will gravitate to markets where they can realize greater premium reductions. In California, the Health Insurance Plan for California (the “HIPC”) was at a disadvantage in the 1990s, when “outside” insurers could use a +/-10% rate band that HIPC carriers could not.<sup>7</sup>

Especially for an Alternate Distribution Channel, it cannot afford to be more “progressive” than the outside market. Critical questions for leveling the playing field, in and outside the exchange, include: (a) whether/how carriers are required to participate in the exchange? (b) whether brokers’ commissions are made explicit and borne by the purchaser? and (c) how rating rules compare inside and out of the exchange?

#### **3. How may insurers underwrite and rate for risk?**

If an exchange’s role is to facilitate shopping for coverage, it begins with the display and comparison of premiums, benefit levels and networks. For an Information Channel, this may be all it does.

Beyond information, most exchanges also help the customer shop and automate the purchase transaction. Table rating and guaranteed issuance of policies are necessary for instant quoting and completion of the transaction. Otherwise, the consumer must supply additional information and wait for an underwriting process to determine his/her eligibility, coverage exclusions and/or premiums, which means that neither the shopping decision nor the actual transaction can be done online, in real time. For the Alternate Distribution Channel, these rating rules must apply as regulations across the market.

For an Alternate Distribution Channel, are the same benefits available in and out of the exchange? To minimize risk selection among channels, the actuarial value of options within the exchange should mirror the range outside, which implies that some minimum allowable coverage must be set for all channels.

The simplest way to compare premiums would be to use pure community rates—everyone gets the same rate from each carrier. In principle, any adult only need decide on a benefit level and then compare rates. In practice, this also means an implicit subsidy from younger adults to older adults and from healthier to sicker enrollees. While seemingly “fair,” pure community rating provides powerful incentives for carriers to avoid unfavorable risks. To lessen this incentive, some adjustments to pure community rating may be desirable.

How can community rates be adjusted to modulate risk selection? Adjusted community rating (“ACR”) uses age, family size and, frequently, gender, and geography to determine rates. Rate comparisons for any level of benefits are still fairly easy to determine, requiring a person to enter year-of-birth, and zip code. The range of ACR premiums is sometimes constrained, allowing less variation than is actuarially justified, and therefore some implicit cross-subsidies. As an adjunct to ACR, pre-existing conditions can also be excluded from coverage for a defined time period.

#### **4. How can premium revenues be adjusted for risk selection among participating carriers?**

Risk selection is closely linked to premium rating and underwriting rules. The rules for modified community rating aim to mitigate risk selection, but they will not fully account for selection. For example, one insurer with a better brand or fuller network may attract sicker enrollees than another carrier, even within the same age distribution of enrollees.

If comparison shopping through an exchange aims to drive competition on administrative efficiency, service, provider reimbursement rates, care management and networks, then premium differences must reflect these variables, rather than enrollees’ health status. Risk adjustment offers a tool that measures the risk level of an insurer’s enrollment, and then “adjusts” by providing additional payments to insurers with a higher risk burden and offsetting reductions to those with a disproportionately low risk profile.

However, risk adjustment requires several decisions. First, is risk selection among plans significant, beyond what is already accounted for under the allowed rating rules? Second, is the corrective adjustment practical? Third, would it substantially equalize risk? Comparative risk calculation for health plans requires submission and analysis of their claims data. Transfer payments among the plans requires premiums to run through a central source, as in models C and D, or a premium assessment on all competing plans, which is then re-distributed to compensate for risk selection. Risk adjustment must apply across the entire class or segment of insured individuals subject to the applicable rating rules.

The Centers for Medicare and Medicaid Services (CMS) have been managing a comprehensive risk adjustment process for Medicare Advantage since 2004, so many insurers across the country have experience with that and know how to submit data. Beyond Medicare Advantage, there are a variety of well-developed proprietary software applications for adjusting commercial insurance risk.

Another decision is what entity adjusts revenues for risk selection. CMS does this for the Medicare Advantage program--collecting encounter data, calculating risk scores and adjusting payments. Massachusetts’ Health Connector adjusts risk and revenues among its (subsidized) Commonwealth Care plans. A number of for-profit and non-profit organizations (e.g., a university research department) have

the capability to provide risk adjustment services under contract to the exchange. Again, for an Alternate Distribution Channel, risk adjustment must apply equally, in and outside the exchange.

#### **5. How many and what kinds of benefit options should an exchange offer?**

Consumers want an entity they trust to select high-value plans and help them shop. But how much choice and of what kind is a matter of judgment and consumer preference. For example, the CMS website for Medicare Part D drug plans helps seniors make informed choice, by comparing premium, cost-sharing, drugs covered and carrier's reputation across dozens of options. While the authors think it has worked reasonably well, others criticize the program for offering far too much choice.

Organizing choice is one of the primary values of Massachusetts' (unsubsidized) Commonwealth Choice program. Whereas each of some two dozen options available through the Health Connector to all non-group buyers is also available at the same price directly from the six participating carriers, they are organized into three tiers of comparable actuarial value, so that shoppers can compare options and quickly complete the transaction. (Eighty percent of Commonwealth Choice's 22,000 members enroll online.) With experience, the Health Connector has decided that standardizing benefits around the most popular designs will improve consumer choice. So, it is reducing the number of benefit designs available to all non-group buyers from two dozen to seven, and has asked all participating carriers to offer each of the seven designs.<sup>8</sup>

The Connecticut Business and Industry Association, a private exchange, offers employees in the small-group segment over 40 benefit plans from four carriers, and currently serves some 90,000 members. At its peak in 1999, the California HIPC offered small-group employees a choice of 10 HMOs (at two levels of cost-sharing) and served 144,000 members.<sup>9</sup>

Too much choice may confuse consumers and create adverse selection; too little choice may impose one set of preferences on everyone and stifle innovation. These arguments apply at three levels: (i) how many carriers to offer? (ii) how many benefit levels or tiers to offer? and (iii) whether to specify uniform benefits on each tier or actuarial equivalence among different plan designs?

Where public subsidies are involved for lower-income beneficiaries, considerations of equity and progressivity may trump choice. In Massachusetts' subsidized Commonwealth Care program, for example, just one standardized benefit package is offered to each income cohort. Various Congressional proposals for federally subsidized coverage to be offered through exchanges have yet to clarify how prescriptive they would be on benefits and cost-sharing.<sup>10</sup>

#### **6. How should carriers bid and be selected?**

Any market depends upon robust competition among sellers. The exchange cannot achieve its policy objectives if carriers are indifferent to it. The level of carrier participation in the exchange may be influenced by legal compulsion, exclusion of competing channels, the exchange's marketing efforts, use of public subsidies for eligible buyers, and perceptions of fairness, value and efficiency.<sup>11</sup>

Assuming robust interest, an exchange must balance considerations of access to providers, geographic coverage, choice of carriers, and continuity of coverage against the leverage that comes from delivering market share to a limited number of bidders. This is a dynamic equation. For example, in its latest round of contracting (2009), Commonwealth Care used historical claims for a relatively stable population of enrollees to project cost trend and set a maximum premium. The bidders had to decide whether to reject this price (and forego participation), accept it, or bid below the administered price. The incentive to bid lower is that an enrollee earning above 101 percent of FPL pays the entire difference in premium between the plan he/she selects and the lowest priced plan available, and an enrollee earning less than 101 percent of FPL who does not select a plan is auto-assigned to one of the lowest priced plans. Five plans bid, and most bid below the administered price.<sup>12</sup>

This process is fairly "elegant." Commonwealth Care can project trend for all enrollees, calculate acuity differences among the plans and redistribute premiums among the carriers to adjust for

risk. The program reinsures the plans against unpredictable swings and the plans can reliably project “normal” revenue requirements based on history and risk-adjusted capitations. The plans are motivated to negotiate aggressively with providers on reimbursement rates, and members are highly subsidized to buy coverage through the Health Connector.

By contrast, the “bid” process and selection criteria for a market-responsive, Alternate Distribution Channel must incorporate a host of discretionary judgments: Which types of plan designs are demanded by non-group, small group or other target segment(s)? How to select plans on value, when they are free to adjust premiums over time (in and outside the exchange), as enrollment evolves and claim trends develop? How should the exchange adjust benefit designs in response to market evolution without disrupting existing coverage? How can it modulate risk selection without the capacity to adjust premiums for selection? How much risk selection among plans is “tolerable,” without undermining the ability of plans to compete on value?

#### **7. How to create administrative efficiencies?**

The opportunity to reduce administrative costs, especially in the non-group market, is substantial. Medically underwritten, non-group markets offer a bewildering array of benefit choices and hurdles to purchasing coverage. Especially in relatively unregulated markets, individuals often depend on brokers to navigate this complex variability and to find a carrier that will accept them. The brokers are, in turn, paid by the carriers.

The cost of marketing and enrollment for non-group coverage through conventional distribution channels is excessive. The Commonwealth Fund estimates that the percentage of private premium that goes for administrative purposes averages 41 percent for non-group and 29 percent for small-group coverage, a significant portion of which can be streamlined using an exchange.<sup>13</sup>

Many of the functions associated with sales, enrollment, premium billing and collections could be streamlined through a combination of manual rating and electronic processing. If fairly standard levels of benefits are offered, consumers will be able readily to choose the benefit level they prefer and compare premiums. As one example, CMS provides a fairly easy-to-use website enabling seniors to choose among many Part D Prescription Drug Plan options with minimal sales and distribution costs. The Massachusetts Health Connector is self-supporting on an administrative surcharge of about 4%<sup>14</sup>.

A web-based exchange offering a standardized set of options which are not medically underwritten can handle this function at a fraction of conventional costs. For example, individuals can buy from an exchange without using a broker, who in some geographies earn commissions on non-group premiums of 10 percent or more. The cost of processing a paper check may be approximately \$10, while an EFT transaction typically costs \$.25 or so. Similarly, distribution of documents (plan descriptions, policies, etc.) can be provided at low cost through websites. While some carriers are moving in this direction on their own, an exchange can expedite this evolution across the entire industry.

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### ***Conclusion: Value Must Justify Expense***

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At a minimum, exchanges should provide value sufficient to justify their expense. This might be the modest expense and value of providing comparative information on the insurance options available. Collecting plan descriptions, arrayed on a website with a link to the carriers (with or without a benefits calculator) is all that is required to create an Information Channel. Presumably, its value lies in organizing information, much like a telephone directory.

But the Information Channel is deceptively simple. Unless consumers can compare premiums alongside benefits, cost-sharing and network, the information is not very useful. Comparing prices, real-time, would seem to require that carriers guarantee issuance under table-driven pricing, without resorting to medical underwriting. Of course, guaranteed issue and renewal at table-driven prices constitutes a revolution in the “rules of the game.”

The most technically complex and challenging model is an Alternate Distribution Channel, parallel to conventional sales channels for small-group and/or individual coverage. This model requires a viable commercial distribution strategy and entrepreneurial direction, raises fear among commercial interests of unfair competition, and poses regulatory challenges. It may be worthwhile, but the policy objectives should be carefully considered; its structure tailored accordingly; the start-up adequately resourced; and ongoing management in the hands of insurance professionals.

As a Purchasing Cooperative or Exclusive Channel, the exchange can aggregate buying power and achieve considerable efficiencies in distributing insurance to individual households. Both the aggregation of buying power and the pursuit of administrative efficiencies are especially appropriate in the context of an individual mandate, and can readily be combined with the welfare function of subsidizing low-income beneficiaries.

The value of an exchange revolves around the creation of a market and the business of distributing health insurance. If it does not attract and serve customers well, it cannot achieve its mission. If it competes successfully, then it can expect both market and political responses. Non-collusive market responses, such as private-sector imitation, may leverage the value of an exchange for even greater benefit to consumers; but political responses are likely to come from threatened "players" or ideologues who seek to contain or reverse what the exchange has wrought. And whether it attracts customers by competition or by monopolizing discrete segments of the insurance market, of course, its public policy objectives should be clear and realistic.

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<sup>1</sup>At least five recent national reform proposals in the U.S. Senate alone include an exchange or connector: the white paper "Call to Action: Health Reform 2009" released by U.S. Senator Max Baucus November 12, 2008; Senator Wyden "Healthy Americans Act" (S. 334 and H.R. 3163); Senator Enzi's "Ten Steps to Transform Health Care in America" (s. 1783); Senator Richard Burr's "Every American Insured Health Act" (S.1886); and Senator Bingaman's "Health Partnership Act" (S. 325). For a summary, see Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, "An Analysis of Leading Congressional Health Care Bills, 2007-2008: Part 1, Insurance Coverage" (The Commonwealth Fund: January 9, 2009), Figure 2, p. 7.

<sup>2</sup> See, for example references to the "Massachusetts Connector" in the Senate Finance Committee's Description of Policy Options, "Expanding health Care Coverage: Proposals to provide Affordable Coverage to All Americans" (May 14, 2009), pp. 4-7."

<sup>3</sup> The Commonwealth Health Insurance Connector Authority is an independent public authority of the Commonwealth of Massachusetts, established by Chapter 58 of the Massachusetts General Acts of 2006, which explicitly authorizes the creation of these two separate programs. Information throughout this article on the "Commonwealth Connector" have been supplied by its Executive Director, who is a co-author of this paper.

<sup>4</sup> Asparity Decision Solutions, accessed online on 5/29/09: [www.planSmartChoice.com](http://www.planSmartChoice.com)

<sup>5</sup> Elliot K. Wicks, Mark A. Hall, and Jack A. Meyer, Barriers to Small-Group Purchasing Cooperatives (Economic and Social Research Institute: March 2000).

<sup>6</sup> For example, both Switzerland and the Netherlands, which require individual households to purchase coverage and sponsor an exclusive distribution channel, have set annual open enrollment dates. Even some private, employer-sponsored health insurance markets, such as South Africa's, use a single common enrollment date (January 1st).

<sup>7</sup> Information on the California Health Insurance Plan of California ("HIPC") was supplied by the actuarial consultant to the HIPC, who is a co-author of this paper. See also, Elliot K. Wicks, Mark A. Hall, and Jack A. Meyer, Barriers to Small-Group Purchasing Cooperatives (Economic and Social Research Institute: March 2000), pp. 33-45.

<sup>8</sup> "Employer Sponsored Health Insurance - A Comparison of the Availability and Cost of Coverage for Workers in Small Firms and Large Firms," Kaiser Family Foundation, November 2008. Accessed online on 3/9/09: <http://www.kff.org/insurance/snapshot/chcm0111898oth.cfm>.

<sup>9</sup> Ibid. Wicks et al; website of the Connecticut Business and Industry Association (CBIA), [www.cbia.com](http://www.cbia.com); accessed on 3/9/09.

<sup>10</sup> See, for example, Senate Finance Committee's Description of Policy Options, "Expanding health Care Coverage: Proposals to provide Affordable Coverage to All Americans" (May 14, 2009), pp. 9-10 & 11-12. See also US Senate Bill "A Bill to make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce." 111<sup>th</sup> Congress, 1<sup>st</sup> Session, 2009.

<sup>11</sup> For example: carriers with 5,000 or more lives in the small group market are required to "participate" in the Commonwealth Connector's "Choice" program, which the Authority has interpreted to mean that they must submit proposals in response to RFPs; Switzerland and the Netherlands simply exclude use of any other channel than the official government exchange; access to public subsidies for Commonwealth Care effectively excludes the MCOs from using other distribution channels; the rationale for most small-group purchasing coops is to attract employers by pooling volume for negotiating leverage; and both the carriers and consumers will be far more willing to participate if they feel they can trust the connector to be fair and efficient.

<sup>12</sup> Overall, the bids average about 2.5% below the target capitation rate and are projected by the Commonwealth Connector to result in an approximately zero trend from FY 2009 to FY 2010, i.e. no premium increase.

<sup>13</sup> Presentation by Karen Davis, "Driving Competition, Efficiencies and Innovative Practices Throughout the Health Care System: A Public Health Insurance Plan" Briefing Webcast (April 27, 2009), slides 6 and 7.

<sup>14</sup> Presentation by Patrick Holland, Chief Financial Officer, Commonwealth Health Insurance Connector Authority, "Commonwealth Health Insurance Connector Authority: Commonwealth Care Program Budget Update." Connector Board of Directors meeting - June 23, 2009 (Powerpoint file).