Massachusetts Insurance Market Reform, Affordability and MassHealth Sustainability

Executive Office of Health & Human Services

January 26, 2017
Massachusetts Insurance Market Reform and Affordability

**Overview**

- The Baker-Polito Administration has made it a priority to control spending growth at MassHealth, which covers 1.9 million (over 1 in 4) residents of the Commonwealth and ~40% of the state budget.
- Since taking office, we have reduced spending growth from historical double-digits (15% in FY15) to single digits (3.8% in FY17).
- However, MassHealth growth continues to outpace state revenue growth. 85% of growth has been driven by enrollment, which will account for $600M of growth in FY18.
  - MassHealth enrollment continues to grow despite our near universal health care coverage, steady population numbers and low unemployment. If we don’t address this growth, MassHealth will generate a $1.1b net funding gap by 2020.
- MassHealth was projected to grow by $1.228 billion gross, $581 million net, in FY18. With the reforms filed in the Governor’s FY18 budget, spending growth is instead $997 million gross (6.6%), $140 million net (2.3%).

**Why is MassHealth enrollment growing?**

- Massachusetts had to make changes in our insurance market to conform to the ACA. Those changes created unintended consequences impacting employer-sponsored insurance (ESI). Since 2011:
  - Almost half a million lives have shifted from commercial ESI into public coverage.
  - The percentage of residents on commercial insurance has decreased by 7 percentage points while MassHealth enrollment increased by 7 percentage points over the same period.
- These policy changes have been compounded by increasing costs of health care.

**Four Massachusetts Insurance Market Reforms**

- To protect taxpayers and ensure the sustainability of the MassHealth program, we propose a multi-faceted approach to manage spending growth at MassHealth and in the commercial health insurance market.

1. **Affordability:**
   - Establish a cap on growth rates for certain health care providers; eliminate certain facility fees that insurers and consumers pay to hospital systems; institute a five-year moratorium on new insurance mandates; implement additional transparency and offer new employer options through the Connector.

2. **Flexibility:** Submit a federal waiver for relief from ACA employer mandate to simplify health care administration burden for employers.

3. **Reinstate Ch. 58 principle of employer contribution to universal coverage** for employers with 11 or more FTEs.

4. **Continue controls for MassHealth sustainability and program integrity,** such as:
   - Strengthen controls for program integrity, including implementing a Third Party Administrator to manage long term services and supports, and other cost avoidance and recovery measures to control fraud, waste, and abuse.
   - Restructure MassHealth into integrated, accountable care models through the 1115 waiver.
   - Align certain CarePlus benefits with commercial plans.
Why is MassHealth enrollment growing?

Enrollment drives 85% of MassHealth growth in FY17

MassHealth Program Spending Breakdown
Percent change since 2007

- MassHealth spending has doubled since 2007
- MassHealth enrollment has increased 70% since 2007

Total spending
Enrollment
Cost per member

• 270,000 members determined ineligible in FY15 due to:
  - Redeterminations
  - Temporary Coverage expiration

• Remaining members had higher acuity, resulting in higher average per-member cost in FY16

Projected

Projected
Why is MassHealth enrollment growing?

MassHealth enrollment growth has been driven by a shift of MA residents from commercial coverage to public coverage

MA population by primary health coverage type*
Million residents

<table>
<thead>
<tr>
<th></th>
<th>Sep-11</th>
<th>Sep-13</th>
<th>Sep-15</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>6.7</td>
<td>6.7</td>
<td>6.8</td>
<td>6.8</td>
</tr>
<tr>
<td>MassHealth</td>
<td>14%</td>
<td>15%</td>
<td>21%</td>
<td>21%</td>
</tr>
<tr>
<td>Medicare</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>Commercial</td>
<td>65%</td>
<td>63%</td>
<td>59%</td>
<td>58%</td>
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Change 2011-2015

- MassHealth enrollment growth has been driven by a shift of MA residents from commercial coverage to public coverage.
- MassHealth enrollment has increased by 523k, while commercial coverage has decreased by 454k.

* MassHealth enrollment including members with primary Medicare or commercial coverage represents 28% of population in 2016.

Source: CHIA
Why is MassHealth enrollment growing?

Shift away from commercial coverage has been driven by 1) fewer employees enrolling when offered and 2) fewer employees offered coverage by their employers.

<table>
<thead>
<tr>
<th>Full-time employees not on ESI</th>
<th>Change 2011-2015</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>2015</td>
</tr>
<tr>
<td>Not offered insurance</td>
<td></td>
</tr>
<tr>
<td>740</td>
<td>859</td>
</tr>
<tr>
<td>109</td>
<td>147</td>
</tr>
<tr>
<td>Offered insurance, not enrolled</td>
<td></td>
</tr>
<tr>
<td>632</td>
<td>712</td>
</tr>
</tbody>
</table>

- **+15%** in # of full-time employees not on ESI
- **+118k** full-time employees not on ESI (est. **+300k lives** including dependents)
- ~50/50 between small group and large group employers

<table>
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<th>Offered insurance, not enrolled</th>
<th>Change 2011-2015</th>
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<td>2011</td>
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Source: Medical Expenditure Panel Survey / Insurance Component
Why is MassHealth enrollment growing?

MassHealth spend on employed individuals has increased more than 2.5x since 2011

MassHealth employed members annual spend and count ($M)*

NOTE: Employed MassHealth members only. Does not include ConnectorCare/CommCare members prior or post ACA. Prior to ACA estimated additional ~40k employed individuals were enrolled in CommCare plans 1 and 2A.

* Only employees, dependents not included
** Includes 81k temporary MH members / $179M spend
*** Includes 15k temporary MH members / $11M spend (no temp members after Q1 2015)

Source: MA Department of Revenue; MassHealth
Why is MassHealth enrollment growing?

Insurance market trends driven by multiple factors since 2013

Rising healthcare costs
- Small group premiums increased 15%+ from 2013-17
- Out-of-pocket (OOP) costs grew from 16% to 25%
- Cost sharing among private commercial members continued to increase faster than inflation and wage growth, members continue to bear a greater share of healthcare costs*

Increased access to subsidized public coverage
- Employees with available ESI** gained access to subsidies
  - Under Ch. 58, access to ESI disqualified from CommCare
  - Under ACA, Connector coverage available if out-of-pocket costs for ESI >9.5% of income
- Population <138% FPL gained access to MassHealth as of 1/1/14

Changes in regulatory landscape
- Ch. 58 Fair Share Contribution repealed July 2013
- ACA employer mandate for employers >50 FTEs has not been implemented

Demographic trends
- Despite healthy economic growth in MA, number of people with low income has increased

* CHIA
** ESI = Employer Sponsored Insurance
# Four insurance market reforms

<table>
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<th>Description</th>
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<tr>
<td><strong>Health care affordability</strong></td>
</tr>
<tr>
<td>▪ Establish cap on growth rates for certain health care providers</td>
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<td>▪ Eliminate certain facility fees that insurers and consumers pay to hospital systems</td>
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<td>▪ Institute a five-year moratorium on new insurance mandates</td>
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<td>▪ Implement additional cost transparency reporting by CHIA</td>
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<td>▪ Create new options for small group employers through the Connector</td>
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<td><strong>Federal flexibility</strong></td>
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<tr>
<td>▪ Submit federal waivers for flexibility, including for relief from ACA employer mandate to simplify health care administration burden for employers</td>
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<td><strong>Reinstate Ch. 58 principle of employer contribution</strong></td>
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<td>▪ Reinstate Ch. 58 commitment to universal coverage by reinstituting employer contribution requirement for employers with 11 or more FTEs</td>
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<tr>
<td>▪ Administrative Bulletin: companies doing business with the Commonwealth must offer health insurance</td>
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<tr>
<td><strong>Continued controls for MassHealth sustainability and program integrity</strong></td>
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<td>▪ Continue to strengthen controls for program integrity, including implementing a Third Party Administrator to manage long term services and supports, and other cost avoidance and recovery measures to control fraud, waste, and abuse</td>
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<td>▪ Implement the five-year federal 1115 waiver that will restructure MassHealth toward Accountable Models of Care</td>
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1. Capping rate growth for certain health care providers

- The Commonwealth will establish a cap on certain health care provider rate increases on a graduated scale
- Effective date: all rates in effect on or after July 1, 2018
- Providers will be split into 3 tiers, from lowest to highest, based on their Commercial rates (weighted avg. for hospital, professional)
- Commercial health plans will only be allowed to increase rates to providers in each tier within specific limits:
  - Tier 1: no cap
  - Tier 2: <1%
  - Tier 3: 0%
- The thresholds for each tier will be specified in DOI regulation in consultation with EOHHS and CHIA
- Health plans must demonstrate compliance in their rate filings to DOI, through a file and approve process (with presumptive disapproval so that rates could not go into effect without DOI’s express approval)
- Certain exceptions to these rules encourage investment in more sustainable models of care and to address access:
  - Excludes primary care and behavioral health providers
  - Providers with value-based contracts (e.g., ACO contract) can receive a rate increase 1% higher than caps above
- DOI to review growth caps and tiers in 3 years
2. Rebalancing away from facility-based care

- Hospitals charge a “facility fee” for services, intended to cover the overhead costs of operating a 24-hour hospital, in addition to charges for physician/professional services.
- Today, these facility fees are also sometimes charged for services provided in an office/clinic, such as a hospital’s on-site primary care clinic or a satellite clinic operating under the hospital’s license.
- The reform will eliminate or reduce the facility fee for clinics so that insurance payments more appropriately reflect the actual costs of operating such facilities.
- Effective date: all rates in effect on or after July 1, 2018.
- Insurers would be required to pass on savings through lower premiums and/or by reinvesting in raising rates for providers (e.g., for primary care).
- DOI, in consultation with EOHHS and CHIA, will specify the circumstances in which the facility fee may be paid, provide for exceptions and set minimum standards for reinvestment of savings.
- Health plans must demonstrate compliance in their rate filings with DOI through a file-and-approve process (with presumptive disapproval so that rates could not go into effect without DOI’s express approval).

3. Moratorium on new coverage mandates

- 5-year moratorium on new health insurance coverage mandates.
Health care affordability: 5 components (cont.)

4. Transparency

- CHIA will provide consumer friendly cost information on the weighted average reimbursements for common procedures and services by individual provider (across Commercial health plans)
- CHIA will collect data from the health plans to develop a market-level report
- This enables employers and consumers to make informed choices

5. New employer options through the Connector

- New options through the Connector starting in CY2018 to reduce administrative burden for small employers
- For the first time, small employers will be able to offer employees a choice among a range of insurance through a new Connector small business platform
  - Employers make a contribution for employees
  - Employees then shop on the Connector and choose from a range of plans
  - Employees may choose to select lower cost plans, with a potential to save up to 30% off the average small group plan
  - Consumers and employers will have transparent, plan comparison features
- Employers will have two options for implementing this approach:
  - Option 1 (defined contribution model): the employer offers Employer Sponsored Insurance (ESI) and selects which plans their employees can access through the Connector Small Business Platform
  - Option 2 (HRA*): employers can make a contribution to an employee’s HRA; the employee can then shop for coverage as an individual on the Connector. There may be opportunities to access federal subsidies.
- The options significantly simplify the administration of health insurance for small employers and can reduce costs

* Health Reimbursement Account
Federal flexibility

- The Commonwealth will seek greater flexibility from the federal government to achieve goals inherent in the ACA and Medicaid programs while meeting the needs of our state.

- We will seek a waiver of the Employer Mandate under the ACA, including the penalty for not offering insurance (not yet implemented), and burdensome paperwork requirements associated with the mandate.

- We will also seek additional waivers for flexibility in areas such as:
  - State-specific approaches to actuarial value calculators, rating factors for small group premium development, and open enrollment rules.
  - Benefit rules beyond what is permitted under the Essential Health Benefits rules.
  - A more flexible risk adjustment system or not to apply risk adjustments.
  - Insurance products offered through group purchasing cooperatives or professional employer organizations.
  - Administrative rules and regulations, simplification regarding compliance and other reporting requirements.
  - Greater flexibility and authority to ensure compliance with mental health parity rules.
  - Waiving conflicting eligibility rules between Medicaid and the Exchange.
  - Use of defined contribution plans and HRAs.
Reinstate Ch. 58 principle of employer contribution

▪ Reinstate Ch. 58 principle of employer contribution to universal coverage for employers with 11 or more FTEs

▪ Updated parameters:
  – Employer Contribution is $2,000 per FTE*, if owed (excludes temporary employees such as seasonal workers and interns)
  – Adequate coverage from an employer is defined as $4,950 for full time employees (>35 hours/ week) for employer-sponsored insurance, or a contribution to a defined benefit plan such as an HRA ($4,950 or another amount as determined by DOR). No additional requirement for spouses/ dependents
  – Employee uptake threshold is 80% of FTEs

▪ If an employer offers adequate coverage and at least 80% of FTEs take coverage, no Employer Contribution is required

▪ If an employer offers adequate coverage but less than 80% of FTEs take coverage, the Employer Contribution is only applied to the difference between the # of FTEs on coverage and 80%
  – Example: if 65% of FTEs uptake, the Employer Contribution only applies to 15% of FTEs (80% - 65%)

▪ DOR will issue regulations, in consultation with EOHHS

▪ If the ACA employer mandate is implemented, employers will be credited for any federal penalties before being assessed for their Employer Contribution.

▪ Effective date: Plan renewal dates after January 2018

*FTEs calculated as the total number of employee hours per quarter / 500, for employers with at least 1 month tenure, with a maximum of 500 hours counted per employee. This formula avoids incenting employers to shift more full-time to part-time employees
Updated Chapter 58

Threshold for adequate coverage from an employer

Employer provides at least $4,950 for coverage for full-time employees (>35 hrs/week)

Uptake threshold:

>80% of FTEs uptake → No Employer Contribution

<80% of FTEs uptake

Employer Contribution applied to difference between # of FTEs on coverage and 80% threshold
- Ex: if 65% of FTEs uptake, employer pays Employer Contribution on 15% of FTEs

Employer does not offer coverage or provides <$4,950 for coverage

Employer Contribution applies to 100% of FTEs

Uptake rate = \[
\frac{\text{# of employees on coverage}}{\text{Total # of FTEs}}
\]

Total # of FTEs (FTEs defined as total number of employee hours per quarter / 500, for employers with at least 1 month tenure, with a maximum of 500 hours counted per employee)
### Reinstate Ch. 58 principle of employer contribution: example

<table>
<thead>
<tr>
<th>Employer</th>
<th>Employer offer of coverage</th>
<th>Employees enrolled</th>
<th>Uptake rate</th>
<th>Current cost</th>
<th>Applicable FTEs*</th>
<th>Employer Cont. (EC) ($2,000 x applicable FTEs)</th>
<th>Total cost incl. EC</th>
<th>Total cost per FTE (total divided by 20 FTEs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer 1</td>
<td>$6,000 (85% of premium) for full-time employees</td>
<td>16 full-time</td>
<td>80% (16 / 20 FTEs)</td>
<td>$96,000</td>
<td>0 FTEs</td>
<td>$0</td>
<td>$96,000</td>
<td>$4,800</td>
</tr>
<tr>
<td>Employer 2</td>
<td>$5,000 (70% of premium) for full-time employees</td>
<td>14 full-time</td>
<td>70% (14 / 20 FTEs)</td>
<td>$70,000</td>
<td>2 FTEs (10% of 20)</td>
<td>$4,000</td>
<td>$74,000</td>
<td>$3,700</td>
</tr>
<tr>
<td>Employer 3</td>
<td>Does not offer coverage</td>
<td>--</td>
<td>0%</td>
<td>--</td>
<td>20 FTEs</td>
<td>$40,000</td>
<td>$40,000</td>
<td>$2,000</td>
</tr>
</tbody>
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Each employer has 20 FTEs (Full Time Equivalents):
- 18 full-time employees (18 FTEs)
- 4 part-time employees (2 FTEs)

* FTEs required to meet 80% uptake threshold
MassHealth sustainability and program integrity: overview

- We are committed to a sustainable, robust MassHealth program that meets the needs of the 1.9 million (or 1 in 4) residents of the Commonwealth on MassHealth

- 85% of MassHealth growth has been driven by enrollment growth ($600M in FY18)

- The administration has reduced spending from historical double-digit growth to single digit annual growth;
  - 15% Gross Program spend in FY15
  - 8.5% Gross Program spend in FY16; 3.8% Gross Program spend in FY17

- This slowing of trend is the result of strengthened management of the program:
  - Fixing eligibility systems and completing redeterminations
  - Curtailing unrestrained growth in long-term services and supports
  - Instituting new audits, authorizations, and controls to limit inappropriate spending
  - Securing a five-year federal 1115 waiver that will restructure MassHealth toward Accountable Models of Care

- MassHealth will also better align its CarePlus benefits with commercial insurance coverage by eliminating non-emergency transportation (except for SUD) and glasses/contacts
MassHealth sustainability and program integrity: we have reduced spending from historical double-digit growth to single-digit annual growth

MassHealth Program Spending

$ billions

- Gross Program Spend
- Net State Cost

<table>
<thead>
<tr>
<th>Year</th>
<th>FY10-13</th>
<th>FY13-15</th>
<th>FY16</th>
<th>FY17 Est.</th>
<th>FY18 Est.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>5.1%</td>
<td>12.5%</td>
<td>8.5%</td>
<td>3.8%</td>
<td>6.6%</td>
</tr>
<tr>
<td></td>
<td>(7.3%)**</td>
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Note: Actuals through FY16. Excludes ELD Choices spending. Net numbers include NF assessment revenue.

* Commonwealth lost >$1B in federal revenue with sunset of American Recovery and Reinvestment Act (ARRA)

** Excluding Insurance market reforms