CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

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Contents

Executive Summary

Each year, CHIA reports on the performance of the Massachusetts health care system in order to monitor cost and quality trends over time and to inform policy-making. This report is the third annual look at these trends since the passage of the Commonwealth's 2012 cost containment legislation, Chapter 224.

In 2014, Total Health Care Expenditures (THCE) in Massachusetts grew 4.8% from the prior year to $8,010 per resident ($54 billion statewide). This growth rate exceeded the target benchmark set by the Health Policy Commission (+3.6%), and reflected faster growth than projected national health care expenditures per capita, state inflation, and the Massachusetts economy. These figures reflect CHIA's initial assessment of 2013-2014 growth, and will be finalized next year (see *Final Assessment of THCE* box for updated 2012-2013 statistics).

THCE growth was not distributed evenly across health insurance programs. While spending growth by both commercial health plans and the Medicare program was below the benchmark, spending for MassHealth increased by $2.4 billion (+19%) while Commonwealth Care spending decreased by $561 million (-58%). The striking spending growth for MassHealth reflected a large increase in enrollment (+23%) associated with the state's implementation of the federal Affordable Care Act (ACA). While much of the enrollment increase was due to the ACA's Medicaid eligibility expansion, a portion was also a result of policies designed to protect Commonwealth residents from potential coverage lapses due to the functional limitations of the joint eligibility system used to determine MassHealth and Connector membership (the Commonwealth's Health Insurance Exchange and Integrated Eligibility System). A new MassHealth Transitional coverage category enrolled people who were not able to enroll through MAhealthconnector.org, and the MassHealth program suspended its normal policy of eligibility redeterminations. Some of this enrollment growth was temporary; total Massachusetts public program enrollment dropped by 15% between December 2014 and March 2015.

KEY FINDINGS

4.8%

2014 THCE was $54 billion, or $8,010 per capita, representing a 4.8% increase from 2013 and exceeding the health care cost growth benchmark by 1.2 percentage points.

p.9

$2.4B

Spending for MassHealth increased by $2.4 billion (+19%), while enrollment increased by 23%.

p.9

The quality of Massachusetts providers was generally at or above national benchmarks, but there was performance variation across providers.

p.16

4.9%

Member cost-sharing rose by 4.9% in 2014. Individual purchasers and small group members continued to pay the most out of pocket.

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The proportion of members whose care was paid for using alternative payment methods in the commercial market rose slightly from 34% in 2013 to 38% in 2014.

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2.9%

TME PMPM among commercial payers grew by 2.9% in 2014, compared to a 1.2% increase in 2013.

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Increased enrollment in HDHPs (now 19% of the commercial market) and tiered network plans (now 16%) indicates growing employer interest in containing costs and, in some cases, shifting costs to employees.

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2.6%

In 2014, commercial cost of coverage increased by 2.6% (fully-insured premiums +1.6% and self-insured premium equivalents +3.4%), while benefit levels remained constant.

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Health care spending by commercial payers grew 2.9% in 2014—below the benchmark, but higher than the previous year's trend. Growth was driven by a 13% increase in pharmacy spending, broadly consistent with national trends. The average growth in the cost of commercial health insurance coverage (premiums) increased by 2.6% to $446 per member per month, while member cost-sharing rose by 4.9% and benefit levels remained constant.

For the first time, this report includes data on the cost of commercial health insurance coverage for both the fully-insured and self-insured segments of the market. In 2014, the trend in self-insured premium equivalents, which are based on employers' actual spending, was much higher (+3.4%) than the trend for fully-insured premiums (+1.6%) which are based on projected costs.

Enrollment trends in Massachusetts continued the gradual shifts noted in previous years, toward self-insured coverage and away from HMO membership. Increased enrollment in high deductible health plans (now 19% of the commercial market) and tiered network plans (now 16%) indicate continued interest by employers in alternative plan designs associated with cost containment—and in some cases, cost-shifting to the employee.

Commercial payers continued to expand their use of alternative payment methodology (APM) contracting with providers. The proportion of members who were managed by providers using alternative payment methods in the commercial market rose slightly to 38% in 2014. Commercial APM adoption is almost exclusively concentrated in HMO products, which continue to decline in membership. Nearly all commercial APM contracting reflects a global budget approach, where the member's primary care physician group has incentives (including upside and downside risk) to control the total cost of care by all providers while maintaining or improving quality. Massachusetts uses these kinds of contracts much more regularly than other states and the statewide adoption rate is driven by Massachusetts-based carriers. With one exception, national payers in the state have implemented APMs only to a very limited extent.

Overall APM adoption for MassHealth Managed Care Organizations (MCOs) lags the commercial market at approximately 22% in 2014, which represents a decline from 2013 levels, likely due to enrollment and program changes. Meanwhile, the adoption of APMs for the MassHealth Primary Care Clinician (PCC) Plan increased from 14% in 2013 to 22% in 2014.

The quality of Massachusetts providers tends to be at or above national averages. However, there remain opportunities to improve service quality and patient outcomes, and there is variation in performance across providers, across types of measures, and across patient populations.

Massachusetts hospitals' performance on measures of effective clinical processes and patient experience was similar to national performance and the rate of hospital readmissions has continued to improve slightly. Hospitals statewide performed similar to the national rate on a composite of patient safety indicators, but certain facilities under performed on some measures of health care-associated infections.

Final Assessment of THCE

Each year, CHIA reports an initial assessment of THCE and TME from the previous year, as well as final figures for prior years. The final THCE trend for 2012-2013 was +2.4% (compared to the initial assessment of +2.3% reported last year). The difference between these figures is attributable to updated spending data from public and private payers due to final claims payments and settlements for provider financial and quality performance as well as a slight increase in population estimates for 2012.

Final health-status-adjusted TME figures reflect a number of differences in the performance of individual health plans and providers. Notably, in last year's report CHIA identified a rate of increase by Blue Cross Blue Shield of Massachusetts that was slightly above the benchmark based on preliminary data, while final figures indicate that they were well below the benchmark.

Adult patient ratings of their primary care experiences were generally high, but scores varied by patient's race/ethnicity across all domains of care, especially with regard to access to care.

Conclusion

While 2014 saw a continuation of prior trends in cost and market structure in many respects, statewide trends were driven in large part by Massachusetts's implementation of the ACA. The implementation of significant ACA-required changes to the Massachusetts public and subsidized insurance markets hinged on a new eligibility system and website. These systems were not functioning properly in late 2013 and early 2014, with significant effects in the public and subsidized state-administered programs.

In the commercial market, member cost sharing increases (+4.9%) exceeded overall expenditure trends (+2.9%) and premium increases (+2.6%). To mitigate premium increases, Massachusetts employers and members continue to adopt high deductible health plans, which may leave consumers liable for higher out-of-pocket costs. It will be important to continue to monitor consumer cost trends in future years.

Next Steps

The findings of this report will help inform the Health Policy Commission's (HPC) 2015 Health Care Cost Trends Hearing, scheduled for October 5 and 6.

The annual hearing is a public examination into the drivers of health care costs which engages experts and witnesses to identify particular challenges and opportunities within the Commonwealth's health care system.

Under Chapter 224, CHIA is required to complete and submit its annual report on the Massachusetts health care system 30 days in advance of the HPC's hearing.

Later this fall, CHIA will explore many of these topics in greater depth in the *Performance of the Massachusetts Health Care System Series*. Subjects will include provider quality, changes in enrollment by product type, APMs, and provider price variation.

TOTAL HEALTH CARE EXPENDITURES

BACKGROUND

A key provision of the 2012 Massachusetts health care cost containment law, Chapter 224 of the Acts of 2012, was to establish a benchmark against which the annual change in health care spending growth can be measured. CHIA is charged with calculating Total Health Care Expenditures (THCE) and comparing growth with the health care cost growth benchmark, as set by the Health Policy Commission. For 2013-2014, the Health Policy Commission set this benchmark at +3.6%.[1]

THCE includes health care expenditures for Massachusetts residents from public and private sources, including (i) all categories of medical expenses and all non-claims related payments to providers; (ii) all patient cost-sharing amounts, such as deductibles and co-payments; and (iii) the costs of administering private health insurance (called the Net Cost of Private Health Insurance or NCPHI). It does not include out-of-pocket payments for goods and services not covered by insurance, such as over-the-counter medicines, and also excludes other categories of expenditures such as vision and dental care.

Each year, CHIA publishes an initial assessment of THCE based on data submitted five months after the close of the calendar year, including payers' estimates for claims completion and quality and performance settlements. Final THCE is published the following year, based on final data which is submitted seventeen months after the performance year.[2]

2013-2014 INITIAL ANALYSIS

Based on the initial assessment of THCE in 2014, health care expenditures were $54 billion or $8,010 per capita, representing an increase of 4.8% from 2013. (Figure 1 and Figure 2) This per capita increase was 1.2 percentage points above the state's 2014 benchmark. This is the first time CHIA has identified THCE growth per capita in excess of the benchmark. Per capita THCE in Massachusetts grew slightly faster than projected national per capita growth in health care expenditures (+4.7%), state inflation (+1.6%), and the general Massachusetts economy (+3.6%).[3,4,5]

Both the commercial market and Medicare reported total spending growth of less than 3% in 2014. Accordingly, overall THCE growth was mainly driven by a 19% increase in spending by MassHealth. This growth in total spending was driven by increased enrollment, as total membership across all MassHealth programs increased by almost 23%.[6] While much of the enrollment increase was due to the implementation of the Affordable Care Act's (ACA) Medicaid eligibility expansion, a portion was also a result of policies designed to protect Commonwealth residents from potential coverage lapses due to the functional limitations of the joint eligibility system used to determine MassHealth and Connector membership (the Commonwealth's Health Insurance Exchange and Integrated Eligibility System). A new MassHealth Transitional coverage category enrolled people who were not able to enroll through MAhealthconnector.org (about 300,000 people), and the MassHealth program suspended its normal policy of eligibility redeterminations.[7]

COMPONENTS OF THCE: PUBLIC COVERAGE

MassHealth

MassHealth is the predominant state-run public health insurance program for certain eligible low income residents of Massachusetts, combining Massachusetts's Medicaid program and Children's Health Insurance Program (CHIP). Overall MassHealth expenditures grew considerably by $2.4 billion (+19%) to $15.3 billion between 2013 and 2014.[8] The overall membership also grew 23% by 4.5 million member months (about 379,000 members) between 2013 and 2014. These increases in expenditures and membership were greater than growth in the previous year, and are associated with the implementation of the ACA.[9,10]

KEY FINDINGS

Based on the initial assessment, THCE in Massachusetts in 2014 was $54 billion, or $8,010 per capita, an increase of 4.8% from 2013, exceeding the health care cost benchmark by 1.2 percentage points.

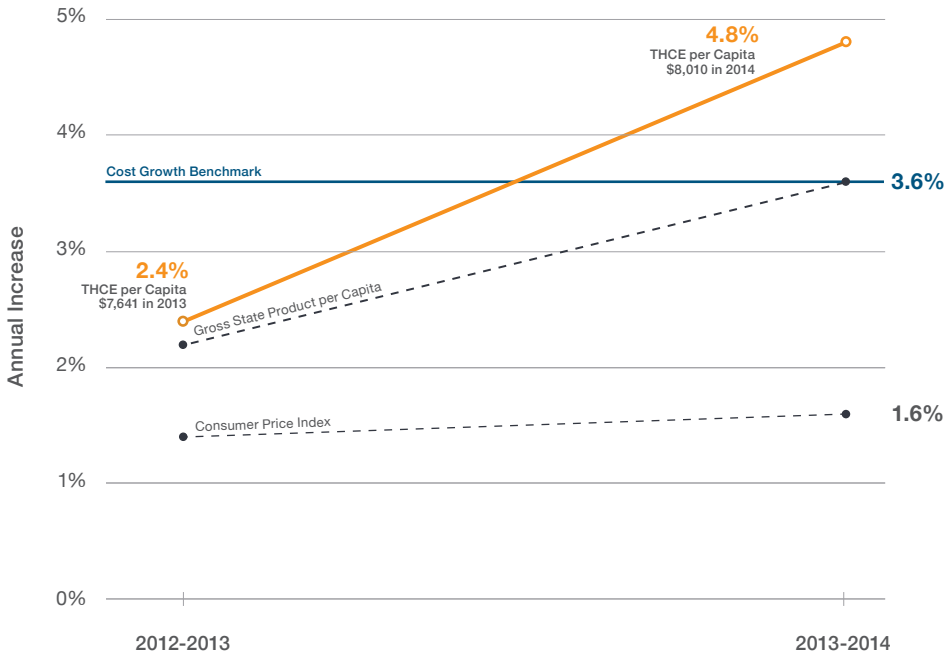
Both the commercial market and Medicare reported total spending growth of less than 3% in 2014.

Spending for the major state health coverage program, MassHealth, increased by $2.4 billion (+19%), which was driven by member enrollment growth.

1 **Total Health Care Expenditure Growth in Context**

Per capita THCE in Massachusetts grew slightly faster than projected national per capita expenditure growth, state inflation, and the general Massachusetts economy.

TOTAL HEALTH CARE EXPENDITURES PER CAPITA GREW BY 4.8%, ABOVE THE HEALTH CARE COST GROWTH BENCHMARK FOR 2014.



Source: CHIA and other public sources. Inflation data from Bureau of Labor Statistics: Consumer Price Index 12-Month Percent Change. Gross State Product data from U.S. Bureau of Economic Analysis: GDP by State in Current Dollars.

Recent data indicates that total MassHealth enrollment in early 2015 was less than peak enrollment at the end of 2014. This is impacted by multiple factors, including successful implementation of the ACA program expansions and improved member eligibility processing.[11]

MassHealth MCOs and PCC Plan

Many MassHealth members receive health coverage through a MassHealth Managed Care Organization (MCO), which is a private health plan that contracts directly with providers and manages the care of its members.[12] Alternatively, members may elect to participate in the MassHealth managed Primary Care Clinician (PCC) Plan.

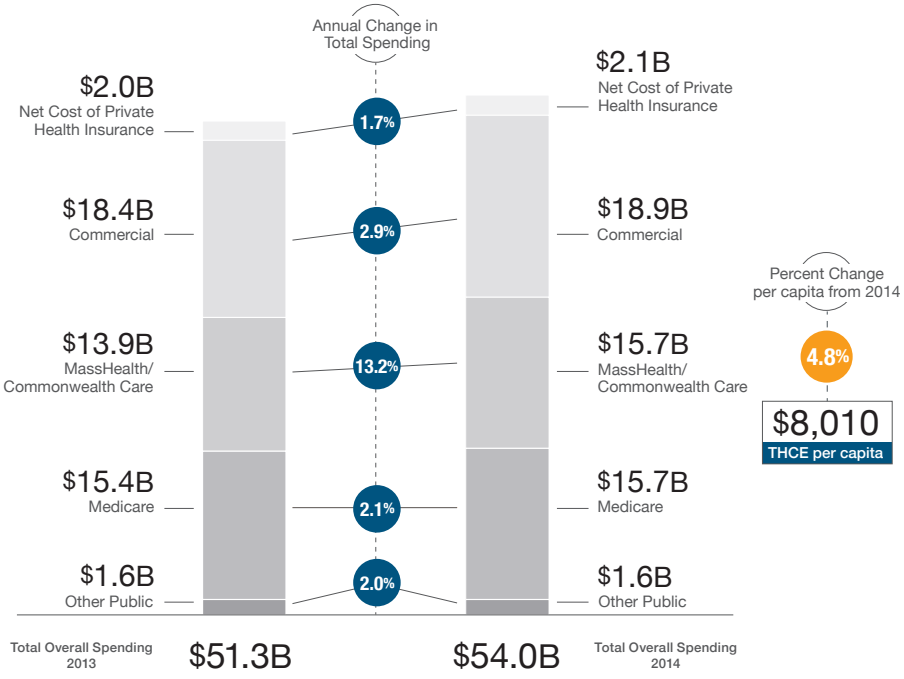
Between 2013 and 2014, overall expenditures for MassHealth MCOs rose by nearly $1.3 billion (+50%) to $4 billion, mainly driven by enrollment growth in the MCOs.[13] Overall membership for these MCOs increased by 2.9 million member months to approximately 9.2 million member months (about 766,000 members) in 2014 (+47%). This enrollment growth was impacted by expanded MassHealth eligibility and the suspension of periodic eligibility redeterminations due to the Commonwealth's Health Insurance Exchange and Integrated Eligibility System limitations. MassHealth MCOs' total medical expenses (TME) on a per member per month (PMPM) basis increased by 2% to $436 in 2014.[14]

Overall expenditures for MassHealth PCC declined by $155 million (-6%) to $2.5 billion in 2014. Overall membership for the PCC Plan also decreased by 631,000 member months (-15%) to 3.7 million member months (about 309,000 members) in 2014. As membership declined at a greater rate than expenditures, the MassHealth PCC Plan's spending PMPM increased to $678 (+10%) for 2014.[15]

MassHealth Fee-For-Service

Some MassHealth members, in specific situations, are exempt from enrollment in managed care and may receive services on a fee-for-service (FFS) basis. Individuals receiving MassHealth FFS are generally individuals with other primary insurance, including Medicare. In 2014, due to the limited functionality of the Commonwealth's Health Insurance Exchange and Integrated Eligibility System, MassHealth also provided temporary FFS coverage for over 300,000 individuals who applied for subsidized coverage and whose eligibility could not be determined, through a Transitional Coverage program that the Commonwealth created in order to ensure that applicants had access to necessary health care services.

Between 2013 and 2014, overall expenditures for MassHealth FFS rose by nearly $773 million to $6.2 billion (+14%). Overall enrollment in MassHealth FFS increased by about 2 million member months to about



2 Components of Total Health Care Expenditures, 2013-2014

THCE represents the total amount paid by or on behalf of Massachusetts residents for insured health care services. It includes the net cost of private health insurance (non-medical spending by commercial health plans), and medical spending for commercially and publicly-insured Massachusetts residents.

HEALTH CARE EXPENDITURES PER MASSACHUSETTS RESIDENT WERE $8,010 IN 2014—AN ANNUAL INCREASE OF 4.8%.

Source: CHIA (payer-reported data) and other public sources. See technical appendix.

Notes: Percent changes are calculated based on full expenditure values. Please see databook for detailed information.

11.2 million member months (about 932,000 members) in 2014, a 22% increase.

Other MassHealth Programs

MassHealth has a number of smaller programs for distinct populations, including the Senior Care Options (SCO) program for certain seniors and the Program of All-inclusive Care for the Elderly (PACE) for persons with disabilities and aged 55 and older. In the fall of 2013, MassHealth launched a managed care program, named One Care, for qualified members aged 21 to 64 who are dually eligible for MassHealth and Medicare. Between 2013 and 2014, overall expenditures for these programs combined, including SCO, PACE, and One Care, rose by nearly $282 million to $1.1 billion (+33%) as enrollment increased by 63% to 619,000 member months (about 52,000 members) in 2014. Since the One Care program is budget neutral by design, spending for One Care members was previously reported in MassHealth FFS prior to the establishment of the program in late 2013.

In addition to program payments for members' health care services, MassHealth also made additional payments to health care providers such as hospitals and nursing facilities. Overall expenditures for MassHealth's non-claim payments to providers increased by $85 million to $1 billion (+9%).

Commonwealth Care

Commonwealth Care was a state insurance program which provided coverage to low- and moderate-income residents with incomes up to 300% of the federal poverty level, who were not eligible for MassHealth coverage. The Commonwealth Care program managed care plans were offered by several private health insurance companies through the Health Connector. Under the ACA, Commonwealth Care enrollment did not enroll new members in 2014 and was ended in January 2015, as eligible members would qualify for other public programs or premium tax credits.[16,17] Accordingly, overall expenditures for Commonwealth Care decreased by 58% to $402 million in 2014, and its total membership also declined by 55% to 1.1 million member months (about 93,000 members).

Medicare

Overall spending for Massachusetts residents in Medicare programs, including Medicare Parts A, B, and D as well as Medicare Advantage, grew by $327 million to $15.7 billion in 2014, an increase of 2%. Total expenditures for Medicare programs accounted for 29% of THCE in 2014, representing nearly half of public program expenditures included in THCE.

Total spending for Parts A and B (inpatient and outpatient medical care) increased by 1.1% to $11.1 billion in 2014, while total spending for standalone Part D (pharmacy) increased by 12% to $1.9 billion. During this period, the number of Massachusetts beneficiaries covered by Parts A and/or B decreased by 0.5% to 942,000 in 2014, and the number of standalone Part D beneficiaries increased by 0.6% to 540,000. On a per beneficiary per year basis, Parts A and B spending increased by 2% to $11,734 in 2014, while Part D spending increased by 11% to $3,442.

The Medicare Advantage plan (Part C) is a type of Medicare managed care plan offered by commercial payers under contracts with Medicare to provide beneficiaries with all Part A and Part B benefits, sometimes accompanied by prescription drug benefits. Overall expenditures for Massachusetts residents covered by Medicare Advantage plans grew by 0.3% to $2.8 billion in 2014. Overall membership in Medicare Advantage plans increased by 3.2% to 2.3 million member months in 2014. As a result, per member spending by Medicare Advantage plans decreased by 2.8% to $1,201 PMPM in 2014.

Other Public Programs

Total expenditures for other public health care programs that serve Massachusetts residents accounted for just 3% of THCE in 2014. These programs include the federal Veterans Affairs program, and the state administered Health Safety Net (HSN) and Medical Security Program (MSP). Aggregate spending for these programs increased by 2.0% to $1.6 billion in 2014.

Veterans Affairs

Veterans Affairs (VA) provides coverage for veterans living within Massachusetts. VA spending grew by 4.3% to $1.1 billion in 2014. On a per beneficiary per year basis, VA spending increased from $2,931 in 2013 to $3,018, a 3% increase, which was below than the national VA per-beneficiary medical spending growth nationally of 6.1%.

Health Safety Net

HSN pays acute care hospitals and community health centers for medically necessary health care services provided to eligible low-income uninsured and underinsured Massachusetts residents. HSN payments to providers increased slightly by 2.4% to $420 million[18] in 2014.

Medical Security Program

In 2014 MSP was available to Massachusetts residents who were receiving unemployment insurance benefits. MSP spending decreased by 49% from $49.6 million in 2013 to $22.8 million in 2014. This substantial decline was due to the elimination of this program in 2014 in preparation for the ACA implementation, as members were transitioned to other coverage options, resulting in a 33% decrease in the membership of MSP direct coverage.[19]

COMPONENTS OF THCE: COMMERCIALLY INSURED

Between 2013 and 2014, overall expenditures for the commercially insured rose by nearly $540 million to $18.9 billion in 2014, an increase of 2.9%. These expenditures consist of claims and non-claims payments (such as quality or financial performance payments to health care providers), as well as member cost-sharing which may include deductibles, co-payments, and co-insurance.[20]

Between 2013 and 2014, total expenditures increased by 2% for those members covered by a comprehensive set of benefits by a single payer ("full-claim" members). For "partial-claim" members (for whom the payers are unable to collect and report spending information for carved out services such as behavioral health and prescription drugs), total expenditures increased by an estimated 5%.[21] PMPM commercial full-claim spending increased by 2.9% to $439 in 2014.[22]

NET COST OF PRIVATE HEALTH INSURANCE

NCPHI captures the costs of administering private health insurance. The total amount of NCPHI increased by $35 million to $2.1 billion in 2014 (+1.7%).[23]

2012-2013 Final Analysis

The final assessment of 2013 THCE indicates that health care spending was $51.3 billion, or $7,641 per capita, an increase of 2.4% from 2012. The initial assessment of this period was a per capita increase of 2.3%. The difference between these figures is attributable to updated spending data from public and private payers due to final claims payments and settlements for provider financial and quality performance as well as a slight increase in population estimates for 2012.

SUMMARY

The initial assessment of 2014 THCE was $8,010 per capita, representing an increase of 4.8% from 2013, exceeding the health care cost growth benchmark. One of the contributing factors for this growth was the substantial increase in MassHealth spending, which was driven by significant enrollment growth as a result of ACA implementation and the Commonwealth's Health Insurance Exchange and Integrated Eligibility System limitations. CHIA will continue to monitor and report enrollment in the commercial market and in public programs in our *Enrollment Trends* series.

Endnotes

1 Pursuant to M.G.L. c.6D, §9, the benchmark is tied to the annual rate of growth in Potential Gross State Product (PGSP). Detailed information available at http://www.mass.gov/anf/docs/hpc/pgsp-presentation-anf.pdf (Last accessed: August 20, 2015).

2 Detailed methodology and data sources for THCE are available at: http://www.chiamass.gov/assets/docs/r/pubs/15/THCE-Methodology-Paper.pdf (Last accessed: August 20, 2015).

3 Centers for Medicare and Medicaid Services. National Health Expenditure Data: Projected. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (Last accessed: August 20, 2015). Note that National Health Expenditures is more comprehensive and contains certain spending categories that are not included in the THCE model such as dental care, government public health activities, and research.

4 Inflation data source: Bureau of Labor Statistics: Consumer Price Index 12-Month Percent Change. Available at: http://data.bls.gov/timeseries/CUURA103SA0?data_tool=XGtable (Last accessed: August 20, 2015).

5 The number presented here is GSP Per Capita growth. Gross State Product (GSP) data source: U.S. Bureau of Economic Analysis. GDP by State in current dollars Available at: http://bea.gov/regional/index.htm (Last accessed: August 20, 2015). Population data source: U.S. Census Bureau. http://quickfacts.census.gov/qfd/states/25000.html (Last accessed: August 20, 2015). The Massachusetts population had a 0.54% increase from 6,708,874 in 2013 to 6,745,408 in 2014.

6 Membership is measured by member months.

7 For information on enrollment trends from 2011 to first quarter of 2015, please visit http://www.chiamass.gov/enrollment-in-health-insurance/ (Last accessed: August 20, 2015). See also CHIA's Massachusetts Health Insurance Survey, showing that uninsurance remained low at 3.7% in 2014. Detailed information available at http://www.chiamass.gov/assets/docs/r/pubs/15/MHIS-Report.pdf (Last accessed: August 20, 2015).

8 MassHealth total expenditures include payments made by other state agencies (e.g., Department of Public Health and Department of Mental Health) for MassHealth members.

9 Because the Health Connector and MassHealth were experiencing delays in processing applications through MAhealthconnector.org, the Commonwealth provided temporary coverage to applicants who applied for subsidized health insurance coverage in 2014. Applicants who were enrolled in Commonwealth Care, the Medical Security Program or MassHealth could retain their current coverage status. Other applicants who did not have other coverage and were waiting to receive an eligibility determination were able to receive temporary MassHealth coverage. Details can be found at http://www.masshealthmtf.org/sites/masshealthmtf.org/files/FAQs%20Temporary%20Coverage%20Updated%2002-14-2014.pdf (Last accessed: August 20, 2015).

10 See CHIA *Enrollment Trends* for latest Massachusetts health insurance enrollment information at www.chiamass.gov/enrollment-in-health-insurance (Last accessed: August 20, 2015).

11 MassHealth resumed eligibility redeterminations in 2015. It is anticipated that enrollment declines as a result of this process will be seen more prominently beginning in the second quarter of 2015.

12 These MassHealth MCOs include traditional MCOs and CarePlus MCOs, excluding Senior Care Options and One Care plans.

13 MassHealth MCO data used here was filed with CHIA directly by the following MCOs: BMC HealthNet Plan, Neighborhood Health Plan, Network Health, Celticare, Fallon Health, Health New England. The reported data by these MCOs includes those under the traditional MCO plan and the new CarePlus plan from the ACA expansion.

14 The TME PMPM presented here represents actual expenses without adjusting for member health status.

15 MassHealth attributes the higher rate of expenditures primarily to the remaining PCC plan members having more complex medical needs, on average, than the members who shifted into MCOs.

16 For more information see http://www.mass.gov/eohhs/docs/masshealth/aca/provider-update-on-aca-coverage-changes.pdf (Last accessed: August 20, 2015).

17 Commonwealth Care was ended in January 2015. Commonwealth Care participants who were not eligible for expanded MassHealth coverage (either MassHealth Standard or CarePlus) could enroll in a new subsidized "state wrap" program known as ConnectorCare, administered by the Health Connector, which provides benefits and cost-sharing subsidies similar to those provided under Commonwealth Care. Details can be found at http://www.massbudget.org/reports/pdf/FY-2015_H2_Budget-Brief_FINAL.pdf (Last accessed: August 20, 2015).

18 HSN spending in a given year is capped by appropriation from the state legislature.

19 See CHIA *Enrollment Trends* for latest Massachusetts health insurance enrollment information. See www.chiamass.gov/enrollment-in-health-insurance (Last accessed: August 20, 2015).

20 Please see technical appendix for detail on the data sources.

21 The estimates for the partial claims spending were developed for each applicable payer's partial-claim population based upon its full-claim population. Please see technical appendix and THCE methods for details.

22 For individual commercial payers' and physician groups' health status adjusted TME growth between 2013 and 2014, please see chartpack and databook for detailed information.

23 Please see technical appendix for detailed information on NCPHI by market segment and by payer.

QUALITY OF CARE IN THE COMMONWEALTH

KEY FINDINGS

Massachusetts hospitals' performance on measures of effective clinical processes and patient experience was similar to national performance in 2013.

Statewide, hospitals performed similar to the nation on a composite of patient safety indicators, but certain hospitals under performed on some measures of Healthcare-Associated Infections. Overall, performance on measures of patient safety varied across hospitals.

Hospital readmissions improved slightly from 15.9% in 2011 to 15.0% in 2013.

Adult patients' ratings of their experience with primary care were high in 2014, but scores varied by patient's race/ethnicity across all domains of care, especially with regard to access to care.

BACKGROUND

CHIA monitors and reports on the quality of care provided in the Massachusetts health care system using a standardized set of metrics, the Commonwealth's Standard Quality Measure Set (SQMS).[1]

This chapter summarizes performance of Massachusetts acute hospitals and primary care providers on selected measures of patient experience, patient safety, and potentially unnecessary care. These measures were selected because they summarize performance of the health system on high impact and high priority areas of care.

PATIENT EXPERIENCE

In Hospitals

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey captures patient experience during a recent acute hospital admission on 11 dimensions of care, such as communication with providers, pain control, and receiving help when needed. Massachusetts hospitals' performance was close to national averages on all dimensions except noise levels. Sixty-one percent of patients nationwide reported that their room was "always" quiet at night, compared to only 52% of patients in Massachusetts.

After being discharged from the hospital, a patient's care can extend into new settings. Measures of patient-provider communication at discharge show a gap between patients being informed about their care and understanding their care instructions. Although 87% of patients reported they received care instructions at discharge, only 52% of patients surveyed "strongly agreed" that they understood their care instructions at discharge. (Figure 1) This gap in understanding is not unique to Massachusetts, which scores at the national average, but it suggests a need for more effective provider-patient communications about post-acute care plans.

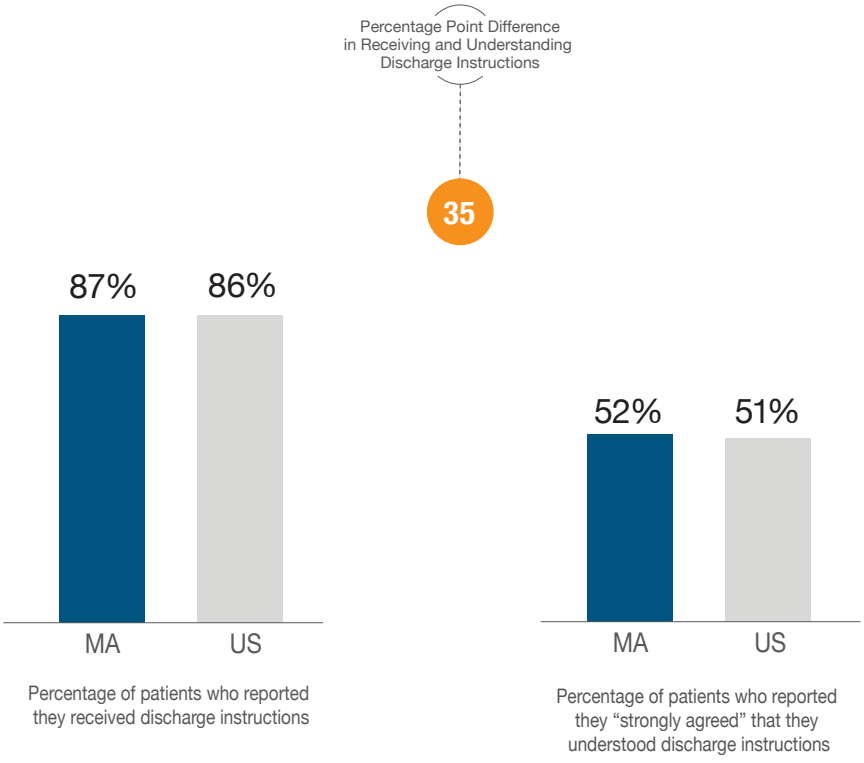
In Primary Care Offices

Consistent with 2013 results, adult patient experience ratings of Massachusetts primary care medical groups in 2014 were high overall, especially on communication. There were, however, differences in how patients experienced primary care services; Asian and Hispanic or Latino adults reported the lowest patient experience scores in each survey domain. This disparity was greatest in the organizational access domain, which captures patients' ability to schedule an appointment when one is wanted, the promptness of provider responses to medical questions, and the length of wait times in a provider's office.[2] (Figure 2)

PATIENT SAFETY

The SQMS contains two types of patient safety measures: six measures of Healthcare-Associated Infections (HAI) and a composite of procedure-based patient safety indicators. Across the HAIs in 2013, the majority of Massachusetts acute care hospitals performed the same as expected based on their hospital-specific case mix. There were some Massachusetts hospitals, however, that performed worse than expected on several measures, especially on the catheter-associated urinary tract infection and hospital-onset *C.difficile* measures.

Hospitals' performance on the Serious Complications composite was similar to the nation in 2014.[3] Furthermore, Massachusetts's statewide Serious Complications score improved from 2013 to 2014. Although measures of patient safety and health care associated infections provide a way to compare Massachusetts results with the nation overall, they do not reflect all safety considerations for hospitalized patients.



1 Patient-Reported Experiences with Receiving and Understanding Care Instructions at Discharge, 2013

The Consumer Assessment of Healthcare Providers and Systems hospital survey is a standardized tool used to assess patients' experiences during their hospital admission. Higher scores on these measures signify better patient-reported experiences.

ALTHOUGH 87% OF MASSACHUSETTS PATIENTS REPORTED THAT THEY RECEIVED INSTRUCTIONS AT DISCHARGE, ONLY 52% OF PATIENTS "STRONGLY AGREED" THAT THEY UNDERSTOOD THEIR CARE INSTRUCTIONS.

Source: CMS Hospital Compare.
Notes: All payers, ages 18+.

POTENTIALLY UNNECESSARY CARE

Patients should receive the right care in the most suitable setting and at the most appropriate time. Much of quality measurement aims to distinguish appropriate care from potentially unnecessary—and potentially harmful—care.

Potentially Avoidable Admissions

Prevention Quality Indicators are used to measure inpatient admissions that might have been avoided if individuals with chronic conditions were able to perform preventive self-care and use primary care services to help manage their diseases. The SQMS contains these measures of potentially avoidable admissions for four clinical conditions: short-term diabetes complications, asthma in younger adults, chronic pulmonary obstructive disease (COPD) or asthma in older adults, and heart failure. Compared to the nation, Commonwealth residents with diabetes were less likely to be admitted for short-term diabetes complications. Admissions for asthma in older adults or COPD improved substantially in 2014 and also fell below national rates. However, the Massachusetts rates of potentially avoidable admissions for asthma in younger adults and heart failure were higher than national rates. (Figure 3)

Maternity Care

Although most women are able to deliver vaginally, one-third of babies born in Massachusetts hospitals were delivered by cesarean section in 2012. Although this rate is in line with the cesarean section rate nationally,[4] evidence suggests that cesarean deliveries are at times performed unnecessarily, posing greater risks to the mother and infant and incurring additional costs.[5] Further, in 2012 there was a range of 29 percentage points between the Massachusetts hospitals with the highest and lowest rates, indicating great variation in the care provided to mothers and infants in the Commonwealth. Early elective deliveries—scheduled deliveries for non-medical reasons between 37 and 39 weeks gestation—have been the subject of targeted quality improvement efforts in Massachusetts hospitals. In January 2015, CHIA reported a marked decline in early elective deliveries, as the range of rates between the highest and lowest performing hospitals dropped from 38 to 5 percentage points between 2012 and 2013. In 2014, however, some hospital rates began to shift upward again, indicating a need for continued focus and monitoring.

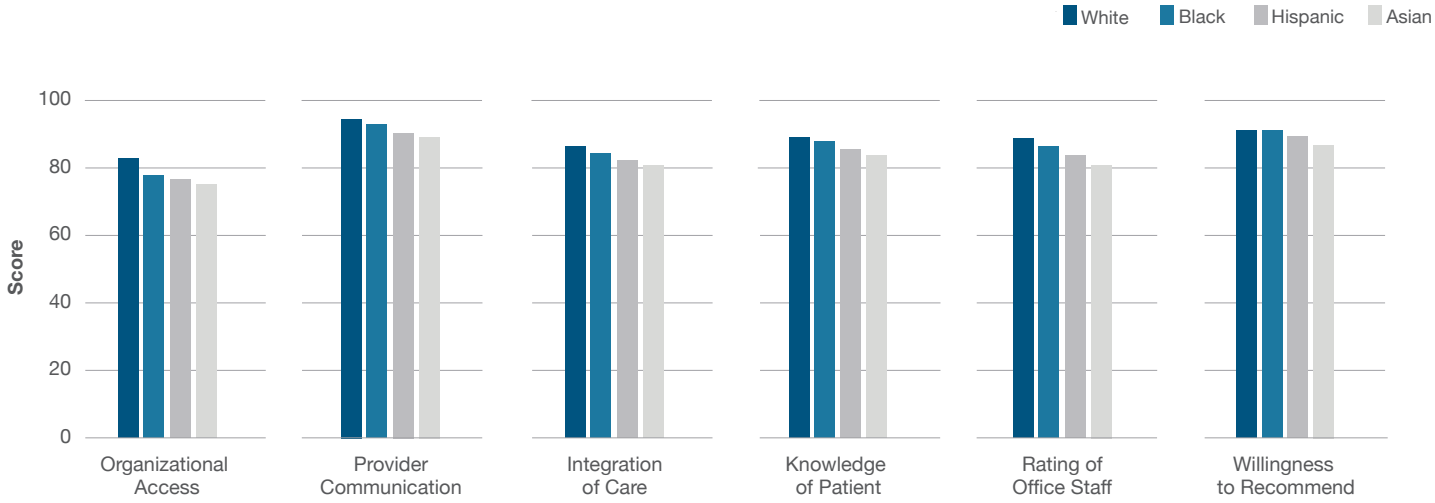
2 **Adult Patient Experience by Race, 2014**

The Consumer Assessment of Healthcare Providers and Systems survey is a standardized tool used to assess patients' experiences accessing and receiving primary care services. Higher scores on these measures signify better patient-reported experiences.

Source: Massachusetts Health Quality Partners.

Notes: Commercial HMO/PPO members, ages 18+.

ADULT PATIENTS IN MASSACHUSETTS RATED THEIR EXPERIENCE WITH PRIMARY CARE HIGHLY IN 2014, BUT SCORES VARIED BY PATIENT'S RACE/ETHNICITY ACROSS ALL PATIENT EXPERIENCE DOMAINS, ESPECIALLY ON ACCESS TO CARE.



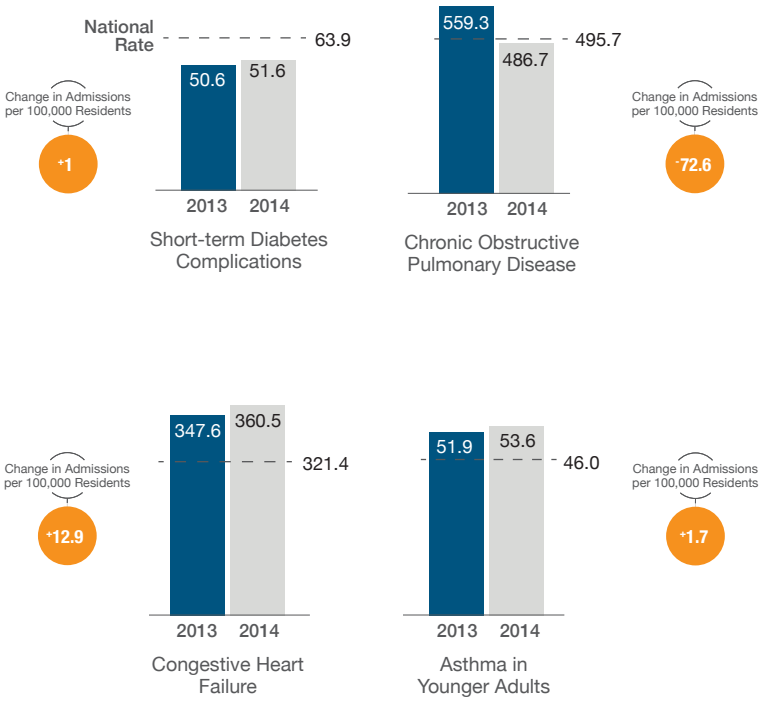
Hospital Readmissions

Hospital readmissions have been the subject of increased focus because they may signal inadequate care coordination and increase cost. Fifteen percent of hospitalizations in the Commonwealth resulted in a readmission within 30 days of discharge in 2013.[6] While most of these readmissions can be attributed to a small proportion of patients, this rate suggests there may be areas of inadequate care transition planning, suboptimal care in post-acute facilities, or insufficient social supports in the Massachusetts health care system.

Summary

Massachusetts acute hospital performance is similar to the nation in both effective care delivery and patient experience.[7] Primary care patients continue to report relatively high satisfaction with their care and providers have generally high performance on measures of clinical care. Within the system, there are opportunities to improve care planning and transitions, reduce health care associated infections, address differential patient experiences with accessing primary care, and examine the use of potentially unnecessary interventions in maternity care.

In October, CHIA will provide further details on these findings in the second edition of *A Focus on Provider Quality*. The report will include hospital mortality rates, hospital-based inpatient psychiatric care, and post-acute care in skilled nursing facilities and by home health agencies.



Lower Scores Are Better

3 Potentially Avoidable Hospitalizations per 100,000 Residents, by Condition, 2013 and 2014

Prevention Quality Indicators calculate the rate of potentially avoidable hospitalizations in the population that are related to certain conditions. These measures assess the effectiveness of primary and outpatient care in reducing or preventing hospitalizations. High-quality primary care, appropriate self-care, and early interventions can prevent complications and hospital admissions for these conditions.

COMPARED TO THE NATION, MASSACHUSETTS AVERAGED MORE POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR CONGESTIVE HEART FAILURE AND ASTHMA IN YOUNGER ADULTS.

Source: CHIA Hospital Discharge Database.

Notes: All payers, age ranges vary by measure. Denominator is all Massachusetts residents for each measure.

Endnotes

1 See technical appendix for further details on the SQMS.

2 The Agency for Healthcare Research and Quality has found racial disparities nationally on a wide range of measures of access to and experience with health care. All groups analyzed (Black, Hispanic, Asian, American Indian and Alaskan Native) had worse care than Whites on a substantial percentage of these measures. In 2013, Massachusetts was among the states in the lowest performing quartile on the average difference in overall quality between Blacks, Hispanics and Asians compared to Whites. 2014 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; May 2015. AHRQ Pub. No 15-0007.

3 Performance on the Serious Complications composite measure is an average of performance on 11 risk-adjusted safety indicators developed by the Agency for Healthcare Research and Quality. National performance is based on data publicly available on CMS Hospital Compare. For both HAIs and Serious Complications, hospitals with more advanced data reporting capabilities may capture more infections and adverse events and appear to have higher rates.

4 The cesarean delivery rate nationally is 32.8%. Centers for Disease Control and Prevention. Births: Preliminary Data for 2010. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf (Last accessed: August 20, 2015).

5 Kozhimannil, Law, Virnig. (2013). Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality and Cost Issues. Health Affairs, vol. 32(3), 527-535.

6 In June 2015, CHIA published Hospital-Wide Adult All-Payer Readmissions in Massachusetts: 2011-2013. Available at: http://www.chiamass.gov/assets/docs/r/pubs/15/CHIA-Readmissions-Report-June-2015.pdf.

7 Based on CMS-reported measures of care processes and the HCAHPS survey.

TOTAL MEDICAL EXPENSES & PAYMENT METHODOLOGIES

KEY FINDINGS

TME growth among commercial payers was 2.9% in 2014, an increase over the 2013 growth rate of 1.2%.

TME growth in the Mass-Health MCO program was 2.4% in 2014, representing a slower rate of growth than in 2013 (+3.9%).

The proportion of members whose care was paid using APMs in the Massachusetts commercial insurance market rose from 34% in 2013 to 38% in 2014.

Although the proportion of APM adoption among MassHealth MCOs fell from 32% in 2013 to 22% in 2014, MassHealth MCO membership whose care was paid using APMs increased by 14,027 member months (+0.7%). Meanwhile, the adoption of APMs for the MassHealth PCC Plan increased from 14% in 2013 to 22% in 2014.

BACKGROUND

CHIA monitors health care spending by public and private payers using a metric called Total Medical Expenses (TME). TME represents the full amount paid to providers for health care services delivered to a payer's member population, expressed on a PMPM basis. TME includes the amounts paid by the payer and patient cost sharing, and covers all categories of medical expenses and all non-claims related payments to providers, including provider performance payments.

In addition to spending levels and trends (as represented by TME), CHIA collects information on how those payments are made. Historically, the majority of health care services were paid for using a FFS method. However, as payers increasingly look to promote coordinated, higher value care, they are shifting toward alternative payment methods (APMs), using non-FFS models. Broadly speaking, APMs are intended to give providers new incentives to control overall costs (e.g., reduce unnecessary care and provide care in the most appropriate setting) while maintaining or improving quality.

This section focuses on 2013 final and 2014 preliminary TME data,[1,2] and APM data submitted by payers for 2013 and 2014.

STATEWIDE TRENDS IN TOTAL MEDICAL EXPENSES

From 2013 to 2014, commercial full-claim TME PMPM rose by 2.9% to $439 PMPM, higher than the rate of growth between 2012 and 2013 of 1.2%.[3]

As noted in the THCE section, MassHealth enrollment grew substantially in 2014. However, MassHealth MCOs reported low TME PMPM growth of 2.4% to $436 in 2014.

Service Categories

While most medical spending is for hospital and physician services, pharmacy spending—which comprises 17-18% of commercial and MassHealth MCO spending—grew the fastest among these service categories from 2013 to 2014. (Figure 1) Pharmacy spending for commercial full-claim and MassHealth MCOs increased by 13-14%, which was broadly consistent with national trends.[4,5]

1 Pharmacy Spending Growth by Insurance Category, 2012-2014

	Rx Share of TME PMPM	% Change PMPM	
Insurance Category	2014	2012–2013	2013-2014
Commercial Full-Claim	16.7%	-0.3%	12.5%
MassHealth MCO	18.2%	5.0%	14.4%

Source: Payer-reported TME data to CHIA, 2012-2014.

PAYER TRENDS IN TOTAL MEDICAL EXPENSES

TME also can be examined on a health-status-adjusted (HSA) basis for each payer's member population using payer-reported risk scores to adjust for the illness burden of the covered population between years.[6]

2013-2014 PRELIMINARY TME

Despite relatively low growth in unadjusted statewide TME in 2014, six commercial payers and two MassHealth MCOs reported increases in preliminary HSA TME that exceeded the benchmark for this period. (Figures 2 and 3) Notably, the two largest commercial payers, Blue Cross Shield of Massachusetts (BCBSMA) and Harvard Pilgrim Health Care (HPHC), reported HSA TME growth below the benchmark. These initial measurements will be refined by the payers next year.

2 Preliminary Health Status Adjusted TME Growth in the Commercial Full-Claim Population by Payer, 2013-2014

		Preliminary Unadjusted TME, 2014	Preliminary Growth of HSA TME, 2013-2014
MA-based Payers	BCBSMA	$467	3.0%
	HPHC	$464	0.5%
	Tufts	$468	4.3%
	Fallon	$435	-1.6%
	HNE	$350	4.6%
	NHP	$383	6.8%
	Network Health	$184	-8.5%
	BMC HealthNet	$120	-8.2%
	Minuteman Health	$130	n/a
National Payers	CIGNA - EAST	$322	3.2%
	Aetna	$359	4.2%
	United	$460	45.2%
	CIGNA - WEST	$416	21.7%
	CeltiCare	$93	-26.5%

Source: Payer-reported TME data to CHIA, 2012-2014.

3 Preliminary Health Status Adjusted TME Growth in the MassHealth MCO Population by Payer, 2013-2014

		Preliminary Unadjusted TME, 2014	Preliminary Growth of HSA TME, 2013-2014
MA-based Payers	BMC HealthNet	$433	-5.1%
	NHP	$511	4.3%
	Network Health	$407	-2.4%
	Fallon	$377	-9.2%
	HNE	$334	26.9%

Source: Payer-reported TME data to CHIA, 2012-2014.

CHIA will report the final assessment of these payers' HSA TME growth between 2013 and 2014 in September 2016. The preliminary TME assessment includes payer estimates for claims completion and performance incentive payments. Final TME may be different from the preliminary figures as payers will have more complete actual payment data available.[7]

2012-2013 FINAL TME

In examining 2013 final HSA TME for the full-claims population, CHIA identified some significant differences from the preliminary amounts reported last year. One payer, BCBSMA, was reported to have a growth rate of 3.65% based on the preliminary 2013 data, slightly exceeding the benchmark. Based on final TME data, BCBSMA's actual rate of growth for 2013 was 0.7%, well below the health care cost growth benchmark. Other payers, who were not identified as exceeding the benchmark for 2013 based on the preliminary data, had final HSA TME growth rates between 2012 and 2013 in excess of the benchmark, including CeltiCare (+23%), Fallon (+11%), and Health New England (+10%). These three payers collectively accounted for 7% of the commercial market in 2013. The differences in the number of payers whose 2012-2013 HSA TME growth exceeded the benchmark between the initial and final assessment may be due to a combination of multiple factors: change in risk adjustment tools resulting in updates in health status scores, projected claims completion used in the initial assessment versus the actual, final claims payments, and finalization of provider performance payments.[8]

STATEWIDE TRENDS IN ALTERNATIVE PAYMENT METHODS

The proportion of members whose care was paid using APMs in the Massachusetts commercial insurance market rose from 34% in 2013 to 38% in 2014. [9] (Figure 4) In contrast, membership under APMs fell 10 percentage points among MassHealth MCOs over the same time period, from 32% to 22%. The MassHealth PCC Plan reported an increase in the use of APMs from 14% in 2013 (through the Patient-Centered Medical Home Initiative) to 22% in 2014 (through the new Primary Care Payment Reform Initiative).

Although commercial APM adoption increased by less than four percentage points, this represented more than 1.4 million additional member months, or roughly 10% growth in APM membership from 2013 to 2014. Conversely, while the APM adoption rate for MassHealth MCOs fell substantially, due to overall MCO enrollment growth MCO membership under APMs actually increased slightly by approximately 14,000 member months, a 0.7% gain.

As part of the data quality assurance process, CHIA discussed with MassHealth MCOs possible explanations for these trends. As MassHealth MCOs expanded into new geographic areas, enrolled more members under the ACA's Medicaid expansion provisions, and as members transitioned into MCOs from discontinued forms of coverage, implementation of APMs for these members' care may have slowed. In addition, one payer noted that as they expanded into new geographic areas, the vast majority of new contracts involved FFS payment arrangements.[10]

PAYER TRENDS IN APMs

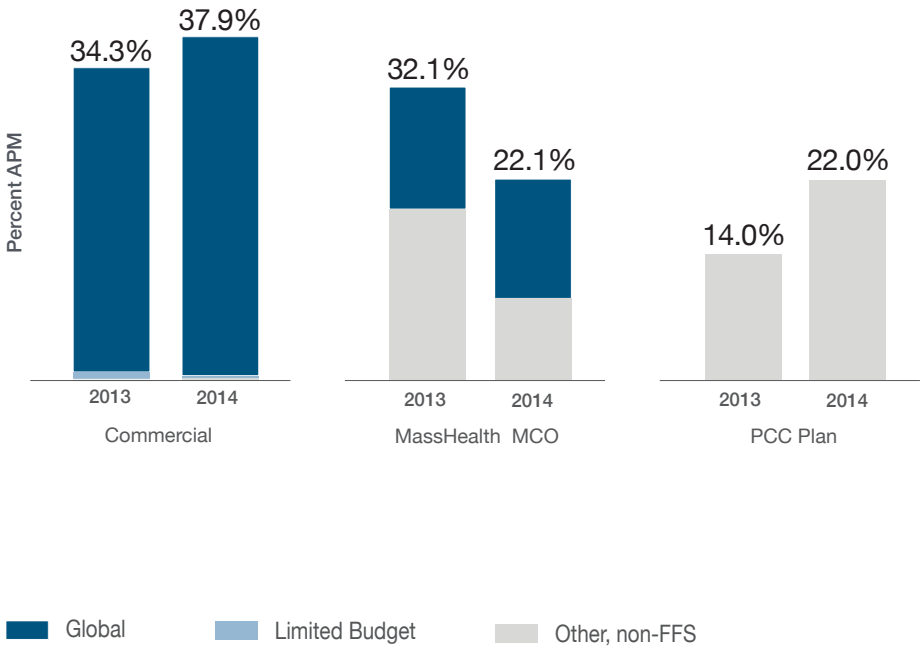
Commercial

Seven of 14 commercial payers reported zero or negative growth in APM adoption between 2013 and 2014. (Figure 5) APM adoption remained much more common among Massachusetts-based payers than national payers. Notably, the top three payers, BCBSMA, HPHC, and Tufts—which accounted for 73% of commercial membership in 2014—all had APM adoption rates above 40% in 2014. Health New England (HNE) continues to have the highest APM adoption rate, exceeding 70% in all three years of APM data collection.[11]

In contrast, national payers have implemented APMs only to a very small extent in Massachusetts, if at all, and reported little to no changes between 2013 and 2014. The exception was Aetna, which more than doubled its membership covered under APMs between 2013 and 2014 to reach 5% of membership.

MassHealth MCOs

APM adoption also varied substantially across MassHealth MCOs, ranging from a low of 4% (CeltiCare) to a high of 74% (HNE). Between 2013 and 2014, four of six MassHealth MCOs reported declines in APM adoption. (Figure 6)



4 Adoption of Alternative Payment Methods by Insurance Category, 2013-2014

The proportion of membership under APMs decreased by 10 percentage points among MassHealth MCOs. This trend likely was driven by the fact that MCO membership grew substantially, and the majority of new contracts involved FFS payments.

BETWEEN 2013 AND 2014, THE APM ADOPTION RATE INCREASED SLIGHTLY AMONG COMMERCIAL PAYERS AND THE MASSHEALTH PCC PLAN, AND DECREASED AMONG MASSHEALTH MCOS.

Source: Payer-reported APM data to CHIA, 2013 and 2014.

Note: Percentages illustrate the share of members covered by APMs in a given year.

TRENDS IN GLOBAL PAYMENT ARRANGEMENTS

As in previous years, global payment arrangements remained the most common form of APM in 2014. In the commercial market, where 38% of members' care was covered by APMs, global payments were used almost exclusively (98%). For MassHealth MCOs, where 22% of members' care was covered by APMs, global payments were used less often (59%) but remained the predominant APM. For the first time, in 2015 CHIA collected information from payers reporting global payment methods about the nature of their risk arrangements; specifically, whether providers assume upside risk only (i.e., shared savings agreements), or both upside and downside risk. Under commercial payer global payment arrangements, providers commonly assumed both upside and downside risk (88%). Providers in MassHealth MCO networks were much less likely to engage in two-sided risk contracts. Slightly more than half (54%) of the global budget membership fell under this type of risk contract. It is important to note that this data does not capture information about actual risk levels (i.e., percent of payments at risk).[12]

5 APM Adoption by Commercial Payers, 2013-2014

	Payer	APM Adoption Rate 2013	APM Adoption Rate 2014	Change (pps) in APM Adoption Rate, 2013-2014	Change (%) in APM Member Months, 2013-2014
MA-based Payers	BCBSMA	49%	48%	-1.4	-2.6%
	HPHC	26%	46%	19.6	65.9%
	Tufts HP	41%	44%	2.2	1.6%
	Fallon	21%	26%	4.9	22.5%
	HNE	72%	71%	-0.7	-1.5%
	NHP	13%	13%	-0.7	18.3%
	Network Health	0%	0%	0.0	0.0%
	BMC HealthNet	0%	3%	3.1	n/a
	Minuteman Health	n/a	0%	n/a	n/a
National Payers	Cigna	0%	0%	0.0	0.0%
	Aetna	2%	5%	3.4	203.4%
	United	0%	0%	0.0	0.0%
	UniCare	2%	1%	-0.7	-37.6%
	CeltiCare	0%	2%	1.6	n/a

Source: Payer-reported APM data to CHIA, 2013 and 2014.

Note: Within each geographic category, payers are listed by descending share of total commercial member months in 2014.

6 APM Adoption by MassHealth MCOs, 2013-2014

	Payer	APM Adoption Rate 2013	APM Adoption Rate 2014	Change (pps) in APM Adoption Rate, 2013-2014	Change (%) in APM Member Months, 2013-2014
MassHealth MCOs	BMC HealthNet	45%	31%	-14.2	-8.4%
	NHP	13%	10%	-2.5	12.4%
	Network Health	28%	17%	-10.6	-13.3%
	CeltiCare	n/a	4%	n/a	n/a
	Fallon	81%	54%	-26.9	29.3%
	HNE	72%	74%	1.6	68.5%

Source: Payer-reported APM data to CHIA, 2013 and 2014.

Note: MassHealth MCOs are listed by descending share of total MassHealth managed care member months in 2014.

Endnotes

1 Final TME has at least 14 months of claims run out and finalized performance payment settlements. Preliminary TME data represents, at minimum, three months of claims run-out. In order to report preliminary TME that is comparable to the previous year's TME data, payers apply completion factors, which include payer estimates for the expenses for services that have been incurred but not reported (IBNR) by service category. See technical appendix for more information.

2 TME data presented here is for the commercial full-claim population and MassHealth MCOs. TME data is annually submitted by commercial payers.

3 The commercial full-claims population accounts for about 70% of the commercial market, while commercial partial-claims accounts for the other 30%. Because commercial partial-claims do not account for all of a member population's medical spending, this chapter will focus on the commercial full-claims population.

4 IMS Health Institute for Health Informatics (2014). Health Care Costs and Spending on Medicines. Available at: http://www.imshealth.com/portal/site/imshealth/menuitem.762a961826aad98f53c753c71ad8c22a/?vgnextoid=3f14a4331e 8c410VgnVCM1000000e2e2ca2RCRD (Last accessed: August 20, 2015).

5 Centers for Medicare and Medicaid Services. National Health Expenditure Data: Projected. Per capita spending growth for prescription drugs is projected to be at 6.8% nationally in 2014, while the Rx spending growth for private insurance and Medicaid is projected to be at 6.3% and 24.0%, respectively. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (Last accessed: August 20, 2015).

6 The tools used for adjusting TME for health status of a payer's covered members vary among payers so that adjustments are not uniform or directly comparable across payers. Please note that TME data is not adjusted for differences in covered benefits within payers and between payers. Health status adjusted TME for the commercial partial-claim populations are not comparable between payers due to wide variation in covered services, and the lack of uniformity in health status risk adjustments.

7 Please see this report's accompanying chartpack and databook for the HSA TME of managing physician groups.

8 Please see technical appendix for detailed information.

9 Membership under APMs is measured by the share of member months associated with a primary care provider engaged in an alternative payment contract with the reporting payer.

10 For an examination of potential barriers to implementing APMs for Medicaid populations, see Blue Cross Blue Shield of Massachusetts Foundation's March 2015 publication, *Alternative Payment Models and the Case of Safety-Net Providers in Massachusetts*. Available at: http://bluecrossfoundation.org/publication/alternative-payment-models-and-case-safety-net-providers-massachusetts (Last accessed: August 20, 2015).

11 Health New England shares a parent company, Baystate Health, with the Baystate Health System and Baycare Health Partners physician organization and has been focusing their business on specific geographic areas. Due to these features, Health New England has been more able to have their members' care managed by physician groups that are under global payment contracts.

12 This information is collected by the Massachusetts Division of Insurance, under "Risk Bearing Provider Organizations" registration requirements. For more information, see: http://www.mass.gov/ocabr/government/oca-agencies/doi-lp/risk-certificate-application-information.html (Last accessed: August 20, 2015).

ENROLLMENT IN THE INSURANCE MARKET

KEY FINDINGS

Commercial enrollment increased slightly (+1.5%) from 2012 to 2014.

Massachusetts public program enrollment increased sharply between 2013 and 2014 (+35%), before declining during the first quarter of 2015 (-15%) as several public programs ended.

From 2012 to 2014, commercial enrollment in the self-insured market segment grew (60%, up three percentage points) and became less concentrated in HMO products (43%, down three percentage points).

One in five (19%) commercial members were enrolled in a HDHP in 2014, up five percentage points since 2012.

16% of commercial members were in a tiered network plan in 2014, up two percentage points from 2012. Nearly all tiered network enrollment remained within BCBSMA and payers offering GIC plans.

BACKGROUND

CHIA collects and analyzes Massachusetts commercial enrollment health insurance data to monitor the evolving health care landscape, including changes across payers, market sectors (employer size), and product types (HMO/PPO). Additional enrollment data are available in the databook.

Commercial health insurance is administered on a contract-basis. When a payer sells an insurance contract to a Massachusetts employer, premiums are set for all employees and dependents under that contract, regardless of state residency. Unless otherwise noted, the remaining sections highlight contract membership.[1]

MASSACHUSETTS HEALTH INSURANCE ENROLLMENT

In 2014, two-thirds (67%) of Massachusetts residents had private health insurance administered by a commercial payer.[2] Most had employer-sponsored insurance (59%), though 8% purchased individual, "non-group" coverage directly from a payer or through the Massachusetts Health Connector. This combined population is referenced as "commercial" throughout this section.

Commercial enrollment increased slightly (+1.5%) from 2012 through 2014,[3] as market shares of the Commonwealth's largest commercial payers remained constant. BCBSMA remained Massachusetts's largest commercial payer (46%), with membership exceeding that of the next three payers combined.

FUNDING TYPE TRENDS

Massachusetts membership in self-insured plans, those in which an employer rather than an insurer assumes the risk for members' covered medical expenses, continued to increase. By 2014, 60% of commercial membership was self-insured, up three percentage points from 2012.[4] Self-insurance was particularly prevalent among employers with over 500 employees: 83% of their membership was self-insured. There continued to be little self-insured enrollment by employers with fewer than 100 employees. (Figure 1)

PRODUCT TYPE TRENDS

The shift towards self-insurance, especially by larger employers, was associated with the steady membership move from Health Maintenance Organization (HMO) to Preferred Provider Organization (PPO) products. PPO products allow members to receive care from providers outside the plan's preferred network in exchange for higher levels of cost-sharing.

Massachusetts HMO membership declined by three percentage points since 2012 to 43%, as PPO and other product membership increased to 57%. HMO membership declined in both the fully- and self-insured segments of the market, though it remained highly concentrated within the fully-insured: 70% of fully-insured members were in an HMO product compared to only 24% of self-insured members. (Figure 2)

HIGH DEDUCTIBLE HEALTH PLAN ADOPTION

High Deductible Health Plan (HDHP) membership continued to rise in 2014.[5] HDHPs offer members lower premiums in exchange for potentially higher cost-sharing.[6] One in five (19%) commercial market members were enrolled in an HDHP, up five percentage points since 2012. By 2014, more than half of members in individual plans were in an HDHP, as were more than

1 Commercial Contract Membership by Fully-/Self-Insured and Market Sector

Self-insured employers assume the risk for members' covered medical expenses instead of an insurer. Employers are classified into categories, or market sectors, based on their number of employees. In 2014, 83% of membership within the jumbo sector (500 or more employees) was self-insured.

BY 2014, 60% OF COMMERCIAL MEMBERSHIP WAS SELF-INSURED, UP THREE PERCENTAGE POINTS FROM 2012.

Source: CHIA payer-reported data.

Notes: Based on MA contract-membership, which may include non-MA residents. See technical appendix.

43% of members of small employers (fewer than 50 employees). (Figure 3)

HDHP membership growth was driven by increased adoption within jumbo employers, which were responsible for 63% of commercial market membership. Jumbo-member HDHP adoption rates increased by four percentage points to 11% in 2014, adding 100,000 net new Massachusetts HDHP enrollees.

The *CHIA 2014 Massachusetts Employer Survey* also found that 45% of Massachusetts employers reported offering HDHP options to their employees, up 12 percentage points from 2011. Massachusetts payers have noted "significant" employer interest in offering HDHP plans as a method for "controlling costs."[7]

Public Program Coverage

Total enrollment in Massachusetts public programs—MassHealth, Commonwealth Care, and MSP—increased sharply between December 2013 and December 2014 (+35%)*, as the ACA expanded Medicaid eligibility (see CHIA's *Enrollment Trends*).

MassHealth also suspended eligibility redeterminations and created a temporary, transitional program during the 2014 ACA Open Enrollment period to maintain coverage for people awaiting eligibility determination. Commonwealth Care and MSP continued to provide subsidized coverage for existing, qualified Massachusetts residents.

Enrollment totals declined during the first quarter of 2015 (-15%)* as MassHealth Transitional, Commonwealth Care, and MSP closed.

Massachusetts Health Insurance Survey (MHIS)

In mid-2014, 16% of Massachusetts insured residents responding to the MHIS reported receiving their primary medical coverage through one of the state public programs.** An additional 16% identified Medicare as their primary medical coverage. The reported uninsurance rate for Massachusetts's residents was 3.7%.

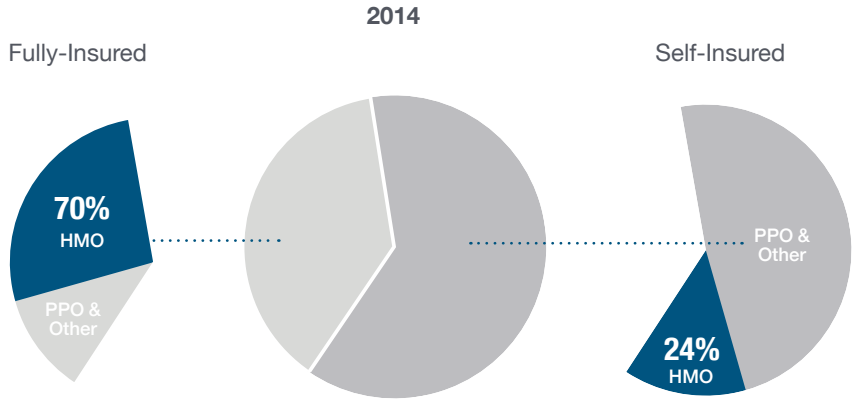
* Based on program-reported monthly enrollment.

** Survey responses may vary from program-reported enrollment. MassHealth estimates that its primary, medical programs covered 19-20% of the Massachusetts population in 2014.

2 Commercial Contract Membership by Product Type and Fully- and Self-Insured

HMO plans have a closed network of providers while PPO products allow members to receive care from providers outside the plan's preferred network in exchange for higher levels of cost-sharing. HMO membership declined in both the fully- and self-insured segments of the market, though 70% of fully-insured members belonged to one in 2014.

BY 2014, 43% OF COMMERCIAL MEMBERSHIP WAS COVERED BY AN HMO.



HMO Membership

	2012	2013	2014
Fully-Insured	73%	72%	70%
Self-Insured	26%	25%	24%
Total	**46%**	**44%**	**43%**

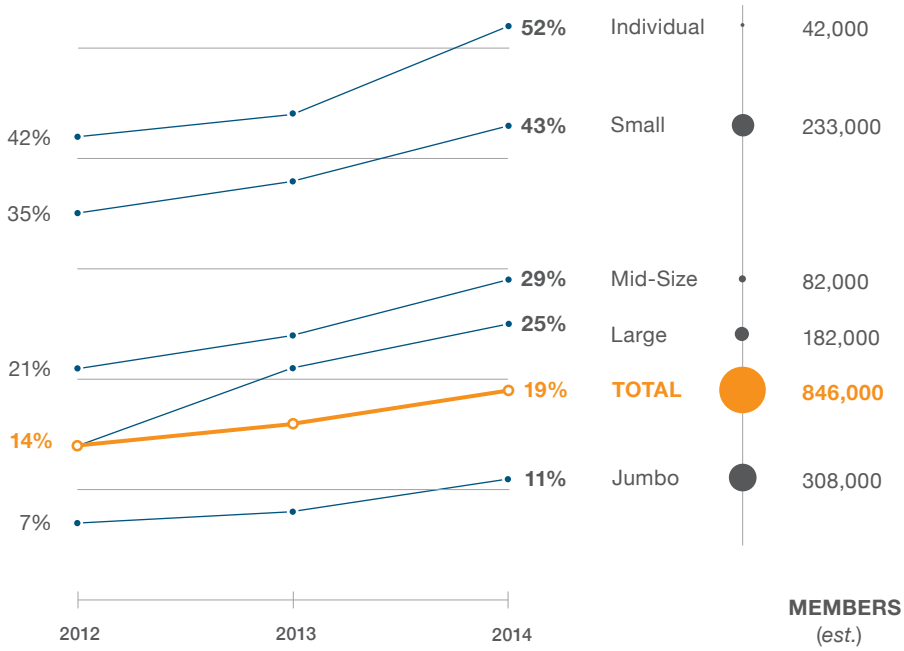
Source: CHIA payer-reported data.

Notes: Based on MA contract-membership, which may include non-MA residents. See technical appendix.

3 Commercial High Deductible Health Plan Membership by Market Sector

HDHPs offer members lower premiums in exchange for potentially higher cost-sharing. Membership in HDHPs grew across all market sectors, or employer sizes, but were especially common in smaller sectors. By 2014, more than half of members in Individual plans were in a HDHP, as were more than 43% of members of employers with fewer than 50 employees.

ONE IN FIVE (19%) COMMERCIAL MARKET MEMBERS WERE ENROLLED IN A HIGH DEDUCTIBLE HEALTH PLAN, UP FIVE PERCENTAGE POINTS SINCE 2012.



Source: CHIA payer-reported data.

Notes: Based on MA contract-membership, which may include non-MA residents. HDHPs defined by IRS Individual plan standards. See technical appendix.

Tiered Network Adoption

Tiered network health insurance plans—plans that segment provider networks by quality and/or cost measures, with varying levels of member cost-sharing—continued to report membership growth. In 2014, 16% of commercial market members were in a tiered network plan, up two percentage points from 2012.

BCBSMA and payers that offered GIC plans, including Tufts, Anthem (UniCare), and HPHC, covered nearly all of Massachusetts's tiered network membership.

CHIA will publish a brief with more analysis of tiered network adoption later this year.

Endnotes

1 Chapter results based on contract-member data provided by Aetna, Anthem (UniCare), Blue Cross Blue Shield of Massachusetts, CIGNA, Fallon Health, Health New England, Harvard Pilgrim Health Care (incl. Health Plans Inc.), Neighborhood Health Plan, Tufts Health Plan (incl. Network Health), and United Healthcare.

2 "Findings from the 2014 Massachusetts Health Insurance Survey," May 2015. Data collection ran from May 14 – June 30, 2014. http://www.chiamass.gov/assets/docs/r/pubs/15/MHIS-Report.pdf (Last accessed: August 20, 2015).

3 Results for Massachusetts's 4.4 million "contract-members," individuals who received coverage through an employer purchasing insurance in Massachusetts. Premiums are set based upon these contract-populations, though not all members under these contracts may reside in Massachusetts. Trends for Massachusetts resident-members (see *Enrollment Trends*) are consistent with those shown for contract-members.

4 Note: several payers were added with the 2014 data collection; data points may differ from previous reports.

5 IRS definition, as applied to Individual plan deductibles: $1,200 in 2012; $1,250 for 2013 and 2014. HDHPs are typically paired with Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), or Health Savings Accounts (HSAs) as part of Consumer Directed Health Plans (CDHPs) to offset member cost-sharing. These employer-based reimbursement arrangements are not accounted for in payer data provided to CHIA and are not reflected in this report's results.

6 In 2014, the average MA HDHP premium was 13% less than the average non-HDHP premium; HDHP cost-sharing was 84% greater than non-HDHP cost-sharing. (Fully-insured comparison only, including all payers.)

7 CHIA offered payers the opportunity to provide input and context around market trends as part of the 2015 Annual Premiums Data Request July Addendum.

COMMERCIAL PREMIUMS & MEMBER COST-SHARING

KEY FINDINGS

The average cost of coverage in Massachusetts increased by 2.6% to $446 PMPM between 2013 and 2014, slightly ahead of inflation (+1.6%), as benefit levels remained steady.

For fully-insured employers, the average premium increased 1.6% to $435 PMPM from 2013 to 2014. Benefit levels remained constant.

For self-insured employers, the average premium-equivalent increased by 3.4% to $456 PMPM from 2013 to 2014. Benefit levels held constant.

From 2013 to 2014, average member cost-sharing across both the fully- and self-insured segments of the market increased by 4.9% to $45 PMPM.

BACKGROUND

CHIA collects annual commercial health insurance premiums and premium-equivalent data from payers, allowing for insights into the costs borne by Massachusetts employers and employees. CHIA monitors membership concentrations, premium values scaled by full benefits, and consumer cost-sharing over time.[1] Additional premiums, premium-equivalent, and member cost-sharing data are available by payer, market sector (employer size), and product type (HMO/PPO) in the databook. This section includes data for commercial payers only.[2]

THE COST OF COVERAGE: PREMIUMS & PREMIUM-EQUIVALENTS

The average cost of coverage in Massachusetts increased by 2.6% to $446 PMPM between 2013 and 2014, higher than the rate of inflation (+1.6%),[3] as benefit levels held constant.[4]

The cost of fully-insured coverage is measured by the annual premium an employer pays to a commercial payer to assume the risk of eligible employees and employee-dependents' medical expenses.[5] Fully-insured membership, including individual purchasers of health insurance, accounted for 40% of the commercial market in 2014.

The cost of self-insured coverage is measured by the annual premium-equivalent, the sum of two components: the amount an employer pays providers annually for the medical costs of its employees and employee-dependents;[6] and the amount an employer agrees to pay a payer or third party administrator to design its plans, administer its claims, and/or utilize its network of negotiated provider rates.[7] Self-insured membership accounted for 60% of the commercial market in 2014.

While both premiums and premium-equivalents represent the total annual cost to employers of providing health care coverage to their employees, they are not directly comparable. Premiums are set prospectively by payers, based on expected health care claims; this includes the cost to the insurer ("risk premium") of carrying the medical expense liability associated with a given population. Premium equivalents, by contrast, are based on actual claims paid directly by employers. For example, if market claims and/or utilization are higher than expected for a given year, premium-equivalents would immediately reflect these costs, while premiums would not.

Each year, both fully- and self-insured employers assign employees a total "premium" rate that reflects the assessed value of the health coverage benefits received. Typically, the employer pays a portion directly, and deducts the remainder from employee wages. In Massachusetts, on average, employees directly contribute one quarter of the premium cost.[8]

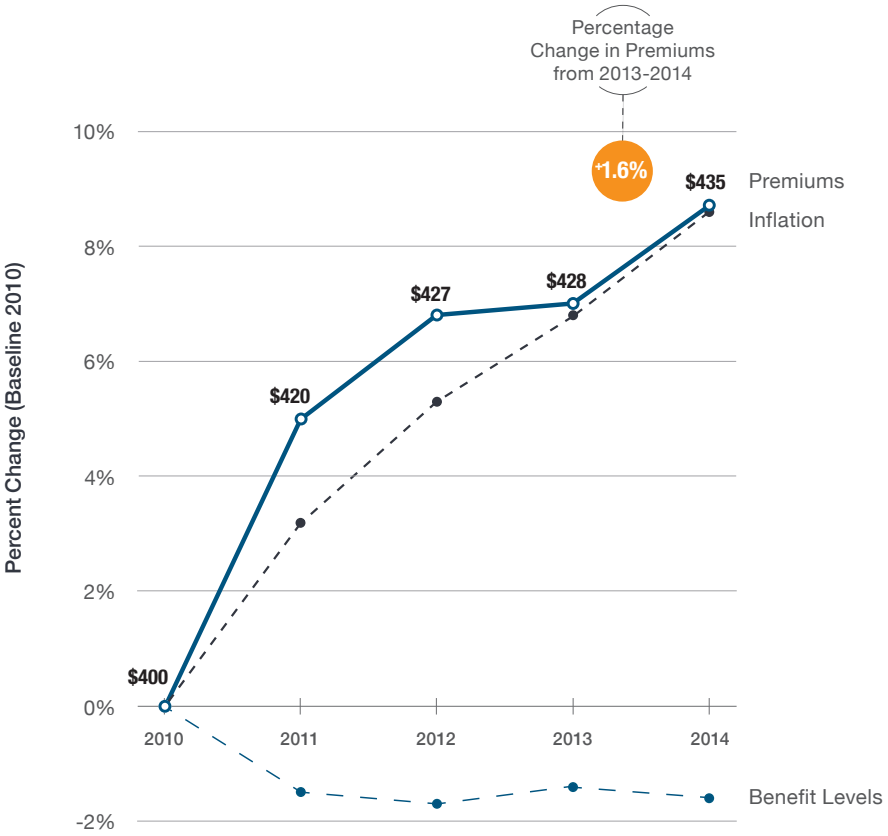
FULLY-INSURED PREMIUM TRENDS & BENEFIT LEVELS

For fully-insured employers,[9] average premiums increased 1.6% to $435 PMPM from 2013 to 2014, while benefit levels remained constant.

Premiums increased across all employer sizes, except for individual purchasers within the merged market, where premiums decreased to $450 PMPM (-2.4%). Payers noted that muted premium growth may be attributable to the rapidly increasing penetration of HDHPs (see Enrollment in the Insurance Market section), as members "seek out [and] choose lower priced [HDHPs] with higher member cost sharing."[10,11] Merged market premiums may have been also impacted by new premium rating factor limits established with the implementation of the ACA.[12]

1 Fully-Insured Premiums and Benefit Levels 2010-2014

A fully-insured employer pays an annual premium to a commercial payer to assume the risk of eligible employees' and employee-dependents' medical expenses. After holding steady from 2012 to 2013, premiums again increased from 2013 to 2014. This rate of growth (+1.6%), however, was similar to the rate of inflation (+1.6%).



Fully-Insured Payers	Members (Est.) 2014	Premiums PMPM 2014	Change 2013-2014
BCBSMA	885,198	$436	0.8%
Fallon	115,775	$447	5.7%
HNE	86,712	$379	-1.6%
HPHC	315,002	$458	4.5%
NHP	80,346	$383	-0.9%
Tufts	242,501	$464	2.0%
United	16,205	$404	-4.9%
Total*	**1,788,126**	**$435**	**1.6%**

*Full market membership totals

AVERAGE PREMIUMS INCREASED 1.6% TO $435 PMPM FROM 2013 TO 2014, WHILE BENEFIT LEVELS REMAINED CONSTANT.

Sources: CHIA payer-reported data; US Bureau of Labor Statistics Consumer Price Index.

Notes: Based on MA contract-membership, which may include non-MA residents. Premiums net of MLR rebates and scaled by the "Percent of Benefits Not Carved Out." See technical appendix.

In 2014, Anthem (UniCare), Tufts, and HPHC members had the highest average premiums (PMPM), while HNE and NHP members had the lowest.[13] Fallon reported the greatest average premium growth PMPM between 2013 and 2014. (Figure 1) Higher premiums are often the result of higher benefit levels. (Figure 4)

SELF-INSURED PREMIUM-EQUIVALENT TRENDS & BENEFIT LEVELS

For self-insured employers, average premium-equivalents increased by 3.4% to $456 PMPM[14] from 2013 to 2014. Benefit levels held constant.

Premium-equivalents are almost exclusively driven by medical claims[15] and by the experiences of employers with greater than 500 employees, which accounted for 88% of self-insured membership and 93% of self-insured claims in 2014. BCBSMA, United, and HPHC were Massachusetts's largest self-insured administrators.

Anthem's self-insured population had the highest premium-equivalents in 2014. HNE and Fallon self-insured populations, which are more highly concentrated in Western Massachusetts, had the lowest premium-equivalents. Members of plans administered by Tufts, HPHC, and BCBSMA reported the greatest increases in their premium-equivalents from 2013 to 2014. (Figure 2)

Commercial payers charged self-insured employers, on average, $22 PMPM to provide administrative services including plan design and network access, claims adjudication, and/or medical and disease management services.[16] Average administrative service fees were unchanged from 2012 to 2014. Payers cited "competitive

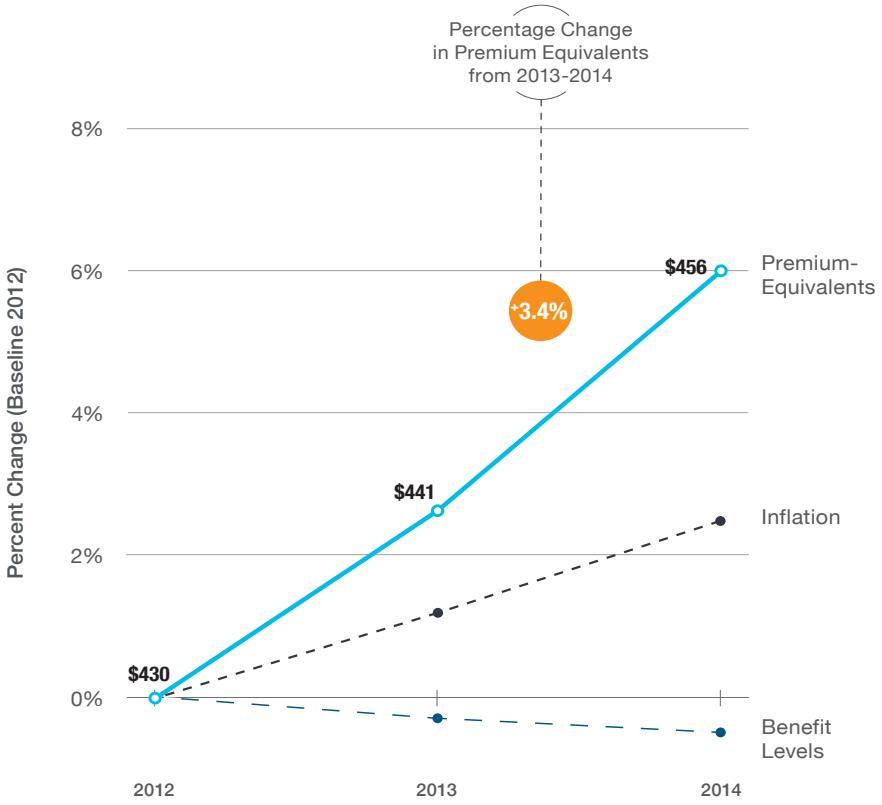
2 Self-Insured Premium-Equivalents and Benefit Levels, 2012-2014

The cost of self-insured coverage is measured by a premium-equivalent, the sum of two components: the medical claims of employees and employee-dependents; and the amount an employer agrees to pay a third party administrator to design its plans, administer its claims, and/or utilize its network of negotiated provider rates. Medical claims comprised 95% of premium-equivalents in 2014.

Self-Insured Admins	Members *(Est.)* 2014	Premium-Equivalents PMPM 2014	Change 2013-2014
Aetna	45,605	$424	2.5%
Anthem	90,502	$523	0.4%
BCBSMA	1,179,973	$440	2.9%
Fallon	21,603	$422	1.4%
HNE	27,698	$413	-3.6%
HPHC	383,023	$500	4.8%
Tufts	235,746	$451	6.0%
Total*	**2,660,588**	**$456**	**3.4%**

*Full market membership totals

AVERAGE PREMIUM-EQUIVALENTS FOR SELF-INSURED EMPLOYERS INCREASED BY 3.4% TO $456 PMPM FROM 2013 TO 2014. BENEFIT LEVELS HELD CONSTANT.



Sources: CHIA payer-reported data (Cigna and United excluded); US Bureau of Labor Statistics Consumer Price Index.

Notes: Based on MA contract-membership, which may include non-MA residents. Premium-equivalent components scaled by the "Percent of Benefits Not Carved Out." See technical appendix.

pressures" and "improvements in efficiency with claim payments" as reasons for the low fee cost growth.

From 2012-2014, Massachusetts's largest self-insured employers increasingly "carved-out" benefits for specialized administration (e.g., pharmacy benefit organizations, managed behavorial health organizations, etc.), the local presence of multi-state third-party administrators grew, and more stop-loss products designed for smaller employers entered the market.[17,18,19] CHIA will continue to monitor these trends.

MEMBER COST-SHARING

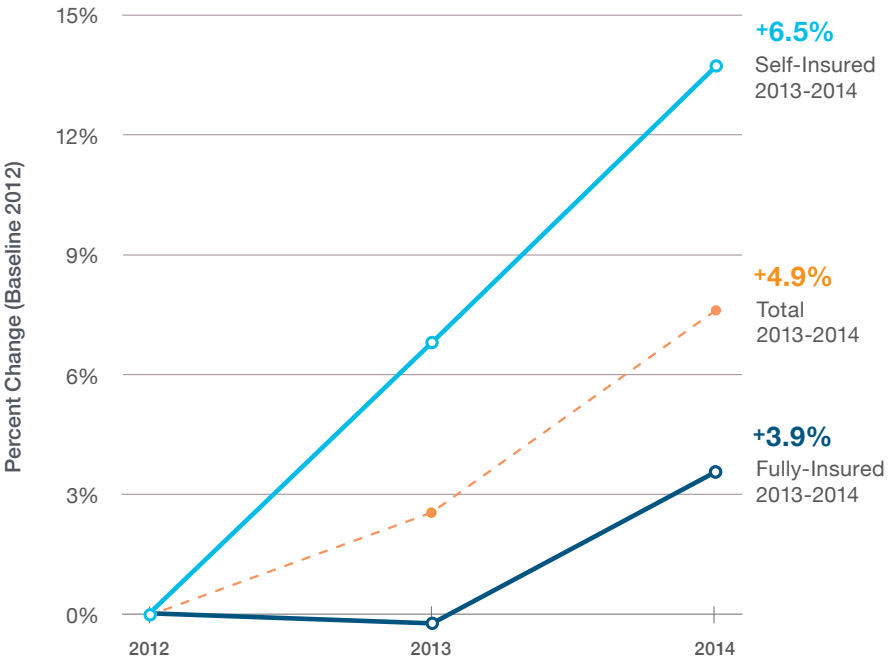
From 2013 to 2014, average commercial medical cost-sharing across both the fully- and self-insured segments of the market increased by 4.9% to $45 PMPM. Member cost-sharing includes all medical care expenses covered by a member's plan, but not paid for by the member's payer or administrator (e.g., deductibles, co-payments, and co-insurance); it is an average of all members' incurred medical cost-sharing each year.[20] This average includes members who had little to no cost-sharing in a given year, as well as members who may have experienced significant medical costs.[21]

Since 2013, member cost-sharing grew faster for members of self-insured plans (+6.5%) than members of fully-insured plans (+3.9%).[22] (Figure 3)

Smaller employer groups continued to face the highest levels of member cost-sharing in 2014: while individual purchasers paid $73 PMPM in average cost-sharing, members of employers with over 500 employees paid only $41 PMPM. Medical cost-sharing levels may be related, in part, to HDHP penetration, as well as the leverage of larger employers to negotiate more generous plans for their members. (Figure 4)

3 Average Cost-Sharing PMPM by Fully- and Self-Insured, 2012-2014

Member cost-sharing includes all medical care expenses covered by a member's plan but not paid for by the member's payer or administrator (e.g., deductibles, co-payments, and co-insurance). As an average of all members' medical incurred cost-sharing each year, it includes members who had very little cost-sharing as well those who paid large amounts in cost-sharing.



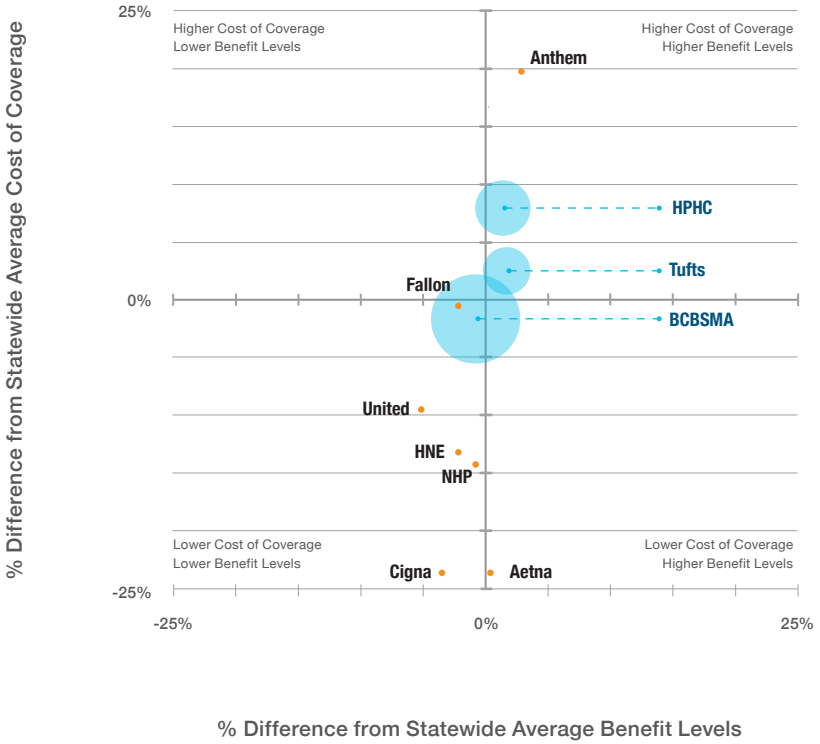
Market Sector	Members *(Est.)* 2014	Cost-Sharing PMPM 2014	Change 2013-2014
Individual	80,158	$73	5.0%
Small Group (1-50)	538,899	$57	4.0%
Mid-Size Group (51-100)	278,122	$51	5.9%
Large Group (101-499)	738,137	$44	3.6%
Jumbo Group (500+)	2,813,399	$41	5.9%
Total*	**4,448,714**	**$45**	**4.9%**

*Full market membership totals

FROM 2013 TO 2014, AVERAGE MEMBER MEDICAL COST-SHARING INCREASED BY 4.9% TO $45 PMPM.

Source: CHIA payer-reported data (Cigna and United self-insured data excluded); US Bureau of Labor Statistics Consumer Price Index.

Notes: Based on MA contract-membership, which may include non-MA residents. Claims scaled by the "Percent of Benefits Not Carved Out." See technical appendix.



4 Payer Cost of Coverage and Benefit Levels vs. Statewide Average, 2014

Some commercial members may prefer the higher up-front costs in exchange for higher benefit levels, while others may prefer lower premiums in exchange for lower benefit levels.

PAYER PREMIUM AND COST-SHARING VARIATION MAY REPRESENT DISTINCT CONSUMER CHOICES IN THE COMMERCIAL HEALTH INSURANCE MARKET.

Source: CHIA payer-reported data (Cigna and United self-insured data excluded).

Notes: Based on MA contract-membership, which may include non-MA residents. Premiums and premium-equivalent components scaled by the "Percent of Benefits Not Carved Out." Premiums net of MLR rebates. See technical appendix.

Endnotes

1 Results shown in this section are scaled to full benefits, unless otherwise noted.

2 Chapter results based on contract-member data provided by Aetna, Anthem (UniCare), BCBSMA, Cigna (FI only), Fallon Health, Health New England, Harvard Pilgrim Health Care (incl. Health Plans Inc.), Neighborhood Health Plan, Tufts Health Plan (incl. Network Health), and United Healthcare (FI only).

3 Measured by the Consumer Price Index (CPI) for the Boston Metro area. Available at: http://www.bls.gov/regions/new-england/home.htm (Last accessed: August 20, 2015).

4 Benefit levels are measured by the ratio of paid-to-allowed claims. Use of actuarial value produces similar results. See technical appendix.

5 Payers set premiums prospectively based on factors that may include the expected medical costs for an employer's membership; allowable rating factors (plan tier, geography, age, and tobacco use); the expected need for reserves to cover potential financial risk; the expected cost to administer the plan(s); the taxes the payer expects to incur; the enrollment distribution between available plans; and the size and negotiating leverage of the employer group. Premiums may also vary by product type, network, and/or generosity of benefits.

6 Most self-insured employers have stop-loss insurance, for which they pay a premium in exchange for coverage against unexpected aggregate and/or specific catastrophic claims.

7 Larger employers may contract with multiple payers for a combination of medical, behavioral health, pharmacy, dental, and/or stop-loss coverage.

8 MEPS-IC 2014 employee contribution rates: single plan, 25.0%; employee plus one plan, 26.2%; family plan, 27.3%. Available at: http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2 (Last accessed: August 20, 2015).

9 Includes individual purchases.

10 A recent RAND study found that HDHPs reduced health care spending, but also reduced member use of covered preventive health care services. Available at: http://www.rand.org/pubs/research_briefs/RB9588.html (Last accessed: August 20, 2015).

11 CHIA offered payers the opportunity to provide input and context around market trends as part of the 2015 Annual Premiums Data Request July Addendum.

12 The ACA disallowed Massachusetts insurers from using "group size" as a merged market rating factor. Through its phasing in, the gap between Massachusetts's individual and small group premiums narrowed from $47 PMPM in 2013 to $29 PMPM in 2014. See additional CMS (https://www.cms.gov/CCIIO/Resources/Files/Downloads/market-rules-technical-summary-2-27-2013.pdf; last accessed: August 20, 2015) and BCBS Foundation (http://bluecrossfoundation.org/tag/chapter-58/merged-individual-and-small-group-market; last accessed: August 20, 2015) guidance for more detail.

13 Market and payer results consistent after adjusting for benefit levels and other employer/member factors (geography, sex, gender).

14 Where employer benefits were "carved-out," payers provided CHIA with the estimated the percentage of missing claim-dollars, which was used to scale reported claims and administrative service fees.

15 Medical claims comprised 95% of premium-equivalents in 2014.

16 ASO fees may also be determined on a per employer per month or per subscriber per month basis; shown scaled.

17 From 2012 to 2014, carve outs, as a percent of claims, increased by one percentage point to 6% of all claim dollars.

18 MA DOI Third Party Administrator Year End Summaries. Available at: http://www.mass.gov/ocabr/insurance/providers-and-producers/third-party-administrators/ (Last accessed: August 20, 2015).

19 See Robert Wood Johnson Foundation Brief (http://www.rwjf.org/en/library/research/2012/07/small-employers-and-self-insured-health-benefits.html; Last accessed: August 20, 2015) and WSJ article (http://www.wsj.com/articles/SB10001424127887323336104578503130037072460; Last accessed: August 20, 2015).

20 This does not include other out-of-pocket expenses not included in health plan coverage, such as most over-the-counter drugs and other non-covered services; nor does this include potential cost savings, as experienced from flexible savings accounts (FSAs), health reimbursement arrangements (HRAs), or health savings accounts (HSAs).

21 According to the *2014 Massachusetts Health Insurance Survey*, in 2014, "one in five [respondents reported] difficulty paying medical bills and more than one in four report[ed] an unmet need for health care due to costs over the past 12 months." Nearly 16% of respondents with a family income at or above 400% of the Federal Poverty Level also reported an unmet need for health care because of costs over the past 12 months in Massachusetts. Available at http://www.chiamass.gov/assets/docs/r/pubs/15/MHIS-Report.pdf (Last accessed: August 20, 2015).

22 Member cost-sharing PMPM for fully-insured members in 2014 was $50; for self-insured members it was $40.

COMMERCIAL PAYER USE OF FUNDS

BACKGROUND

CHIA monitors payer premium retention—the premium dollars used for non-medical, operational spending—to better frame payer expenses related to providing commercial health insurance. The following section summarizes trends in payer retention by expense category. Additional retention and retention decomposition data are available by payer in the databook. This section includes data for commercial payers only.[1]

FULLY-INSURED PREMIUM RETENTION

The vast majority of premium dollars (89%) were used to pay for member medical care in 2014. The "retained" remainder (11%) was used by payers to pay for plan administration, broker fees, and premium taxes, among other expenses, with residual funds representing surplus or deficit (profit or loss).[2] During both 2013 and 2014, payers retained approximately $47 PMPM, on average, from their fully-insured plans, as increasing medical claim expenses (+2.2%) were offset by increasing member cost-sharing (+3.9%). Payers retained the least from their merged market membership, particularly from individual purchasers, who cost payers more in medical claims than they generated in premiums (-$28 PMPM).[3]

In 2014, Massachusetts's largest commercial payers were expected to maintain a Medical Loss Ratio (MLR) of 0.89, unchanged from 2013. This indicates approximately nine out of every ten premium dollars collected were used to directly pay for member medical claims or other qualifying expenses.[4]

FULLY-INSURED RETENTION DECOMPOSITION

In 2014, general administrative expenses, including cost of plan design, claims administration, and customer service, comprised nearly three-fifths of all large group non-medical claims spending; broker commissions comprised one-fifth.[5,6] Payer contribution to surplus (profit), declined from 13% of payers' average non-medical claims spending in 2013 to only 0.2% in 2014, as taxes and fees increased by 13 percentage points to 20% of non-medical claims spending.[7] (Figure 1)

PAYER ADMINISTRATION COSTS: FULLY-INSURED VS. SELF-INSURED

While payers use a portion of premium revenues from fully-insured plans to cover plan administration expenses and profit, for self-insured plans, payers charge an explicit fee for administrative services.

Payers retained $51 PMPM from their largest fully-insured employers on average, in 2014; $30 PMPM of which was used by payers for general administration and profit. Self-insured administrators collected $20 PMPM in administrative service fees from similarly sized employer groups.[8] Self-insured administrators, however, do not bear the risk for members' medical claims, nor do they incur many of the taxes and fees that apply to fully-insured plans.

KEY FINDINGS

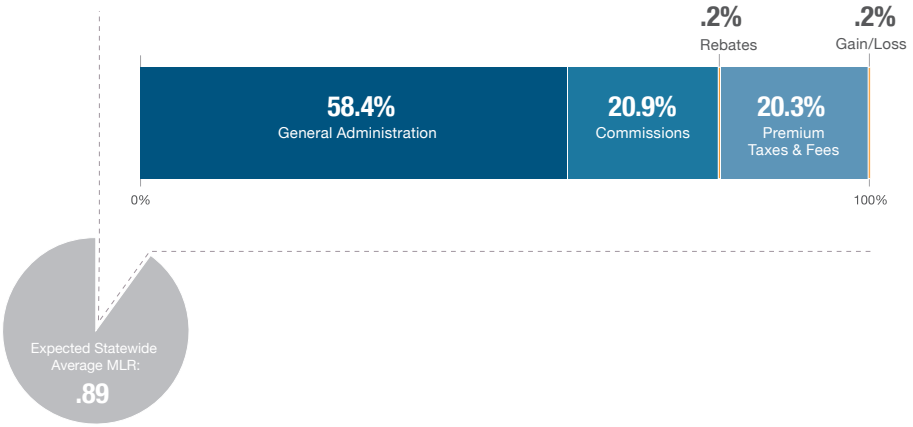
In 2014, payers retained an average of $47 PMPM, approximately 11% of premiums. This amount was largely unchanged from 2013, as increasing medical claim expenses were offset by increasing member cost-sharing.

In the individual segment of the merged market, payers spent $28 PMPM more, on average, on medical claims than they collected in premiums.[9]

On average, in 2014, payers administering large employer groups retained ten cents of every premium dollar to cover costs. Of those ten cents, six cents were used to cover general administrative expenses, two cents were spent on commissions, two cents were spent on taxes, and only two hundredths-of-a-cent were kept as surplus (non-merged market membership).

1 Retention Decomposition, 2014

The vast majority of large group premiums are used to pay for member medical care: on average, in 2014, ten cents of every premium dollar were retained by payers to cover costs. Of those ten cents, six cents were used to covered general administrative expenses, two cents were spent on commissions, two cents were spent on taxes, and only two hundredths-of-a-penny were kept as surplus (non-merged market membership only).



ON AVERAGE, IN 2014, TEN CENTS OF EVERY PREMIUM DOLLAR WERE RETAINED BY PAYERS TO COVER COSTS, WITH SIX CENTS USED TO COVER GENERAL ADMINISTRATIVE EXPENSES.

Source: Payer-submitted federal Supplemental Health Care Exhibit reports, as analyzed by Oliver Wyman.
Note: All payers.

3R Amounts

The ACA includes three programs—Risk Adjustment, Reinsurance (temporary program), and Risk Corridors (temporary program)—that are intended to protect consumers by stabilizing premiums and protecting against adverse selection during the initial years of the law's implementation.

Massachusetts Risk Adjustment results were released in June 2015 for payers insuring enrollees in the Massachusetts merged market. Transfers of $61 million were assigned to balance out the risk and cost. (For more information, visit the Massachusetts Health Connector at www.MAhealthconnector.org).

CHIA collected data from payers on the financial amounts associated with the "3Rs," which can be found in the databook. (For more information on how these programs work, see this Kaiser Family Foundation issue brief at http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/).

Endnotes

1 Chapter results based on contract-member data provided by: Aetna, Anthem (UniCare), Blue Cross Blue Shield of Massachusetts, CIGNA (FI only), Fallon Health, Health New England, Harvard Pilgrim Health Care (incl. Health Plans Inc.), Neighborhood Health Plan, Tufts Health Plan (incl. Network Health), and United Healthcare (FI only).

2 While retention is similar to the Net Cost of Private Health Insurance (NCPHI) and the inverse of MLR, as discussed within the Annual Report, these values differ based upon what they include and exclude in their calculations. See technical appendix for more information.

3 The 2013 to 2014 premium retention drop for individual purchasers was particularly notable. Retention fell from -$8 PMPM to -$28 PMPM. The continued transition of likely higher-cost Commonwealth Care, and/or Medical Security Program members, through individual Health Connector purchases, may have impacted payer retention levels with large QHP presences. The phase out of group size as a rating factor may also have contributed to higher individual losses, as such plans may be increasingly subsidized by small group plans.

4 MLR in Massachusetts is defined as the sum of a payer's incurred medical expenses, their expenses for improving health care quality, and their expenses for deductible fraud, abuse detection, and recovery services, all divided by the difference of premiums minus taxes and assessments. Massachusetts 2012 and 2013 small group MLRs were higher than the 0.80 federal standard at 0.90, while its large group MLR was consistent with the federal standard at 0.85. Massachusetts's required MLR for small group was 0.89 for 2014. Other adjustments may also be made.

5 Non-merged market only, as 3R costs are still being reported. Full payer retention decomposition not available, as revised financial submissions contained estimates of 3R amounts; actual amounts for the merged market were expected to vary, sometimes substantially, from initial assessments.

6 Retention decomposition data is from payer-submitted federal Supplemental Health Care Exhibit (SHCE) reports, as analyzed by Oliver Wyman. Analysis is restricted to non-merged market business as final risk adjustment and MLR rebate amounts were not available when payers filed their SHCE reports. MLR data is from payer-submitted Massachusetts Division of Insurance reporting for rebate purposes. MLRs may not fully reconcile to federal CCIIO figures. Total is the weighted average of the ten payers shown.

7 Reported paid claims increased by 2.5% to $396 PMPM and taxes and fees increased by 173% to $10.41 PMPM. Massachusetts payers reported a profit of $1,519,436 in 2014, down from $95,205,314 in 2013.

8 Fully-insured retention decomposition data from the Supplemental Health Care Exhibit. Self-insured administrative service fee data from CHIA's annual premiums data request; shown unscaled.

8 Excludes 3R amounts.

Glossary of Terms

Actuarial Value (AV): A measure of a plan's generosity. The estimated percentage of the total allowed costs paid by the plan, as opposed to the percentage paid by the participant. Actuarial values may be estimated by several different methods.

Alternative Payment Methods (APMs): Payment methods used by a payer to reimburse heath care providers that are not solely based on the fee-for-service basis.

Administrative Service Fees: The fees earned by payers or third party administrators for the full administration of a self-insured health plan excluding any premiums collected for stop-loss coverage.

Administrative Service Only (ASO): Commercial payers that perform only administrative services for self-insured employers. These services can include plan design and network access, claims adjudication and administration, and/or population health management.

Claims, Allowed: The total cost of medical claims after the provider or network discount.

Claims, Incurred: The total cost of medical claims after the provider or network discount and after member cost sharing.

Cost of Coverage: The annual cost of providing primary medical coverage, borne in part by the employer and in part by the employee, expressed on a per member per month basis. For fully-insured coverage, the annual premium an employer pays to a commercial payer to cover the medical expenses of eligible employees and employee-dependents. For self-insured coverage, the annual premium equivalent.

Cost-Sharing: The amount of an allowed claim for which the member is responsible; includes copayments, deductibles, and coinsurance payments.

Fully-Insured: A fully-insured employer contracts with a payer to cover a portion of pre-specified medical costs for its employees and dependents.

Funding Type: The segmentation of health plans into two types—fully-insured and self-insured—based on how they are funded.

Health Care Cost Growth Benchmark (Benchmark): The projected annual percentage change in THCE in the Commonwealth, as established by the Health Policy Commission (HPC). The benchmark is tied to growth in the potential gross state product (PGSP). Chapter 224 has set the PGSP for 2014 at 3.6 percent. Subsequently, HPC established the health care cost growth benchmark for 2014 at 3.6 percent.

Health Maintenance Organizations (HMOs): Plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. These plans generally require members to coordinate care through a primary care physician, but may also provide open access to in-network providers.

High-Deductible Health Plans (HDHPs): Health plans with an individual deductible exceeding $1,200 for 2012 and $1,250 for 2013 and 2014.

Managing Physician Group Total Medical Expenses: Measure of the total health care spending of members whose plans require the selection of a primary care physician associated with a physician group, adjusted for health status.

Market Sector: Average employer size segregated into the following categories: individual products (post-merger), small group (1-50 enrollees), mid-size group (51-100 employees), large group (101-499 employees), and jumbo group (500+ employees). In the small group market segment, only those small employers that met the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04 were included.

Medical Loss Ratio (MLR): As established by the Division of Insurance: the sum of a payer's incurred medical expenses, their expenses for improving health care quality, and their expenses for deductible fraud, abuse detection, and recovery services, all divided by the difference of premiums minus taxes and assessments.

Merged Market: The combined health insurance market through which both individual (or non-group) and small group plans are purchased.

Payer Retention: The difference between the total premiums collected by payers and the total spent by payers on incurred medical claims.

Percent Benefits Not Carved Out: The estimated percentage of a comprehensive package of benefits (similar to Essential Health Benefits) that will be covered under a payer's allowed claims. This value is less than 100% when certain benefits, such as prescription drugs or behavioral health services, are not paid for by the plan.

Preferred Provider Organizations (PPOs): Plans that identify a network of "preferred providers" while allowing members to obtain coverage outside of the network, though to typically higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician.

Premiums, Adjusted: Premium rates adjusted for membership differences in age, gender, area, group size, and benefits across payers.

Premiums, Earned: The total gross premiums earned prior to any medical loss ratio rebate payments, including any portion of the premium that is paid to a third party (e.g., Connector fees, reinsurance).

Premiums, Earned, Net of Rebates: The total gross premiums earned after removing medical loss ratio rebates incurred during the year (though not necessarily paid during the year), including any portion of the premium that is paid to a third party (e.g., Connector fees, reinsurance).

Premium Equivalents: For self-insured plans, the sum of incurred claims and the administrative service fees that payers receive to process claims for their self-insured clients, excluding any premiums collected for stop-loss coverage.

Product Type: The segmentation of health plans along the lines of provider networks. Plans are classified into one of three mutually exclusive categories: Health Maintenance Organizations, Preferred Provider Organizations, and Other.

Qualified Health Plans (QHPs): A health plan certified by the Massachusetts Health Connector to meet benefit and cost-sharing standards.

Risk Adjustment: The Patient Protection and Affordable Care Act program that transfers funds from Merged Market plans with lower-risk enrollees to those with higher-risk enrollees.

Self-Insured: A self-insured employer takes on the financial responsibility and risk for its employees and employee-dependents' medical claims, paying claims administration fees to payers or third party administrators.

Third Party Administrators (TPAs): Companies that contract with self-insured employers to administer their claims or to grant them access to their networks and negotiated provider fees.

Tiered Network Health Plans: Plans that segment provider networks by quality and/or cost measures, with varying levels of member cost-sharing.

Total Health Care Expenditures (THCE): A measure of total spending for health care in the Commonwealth. Chapter 224 of the Acts of 2012 defines THCE as the annual per capita sum of all health care expenditures in the Commonwealth from public and private sources, including (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by CHIA; (ii) all patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of private health insurance, or as otherwise defined in regulations promulgated by CHIA.

Total Medical Expenses (TME): The total medical spending for a member population based on allowed claims for all categories of medical expenses and all non-claims related payments to providers. TME is expressed on a per member per month basis.

For more information, please contact:

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