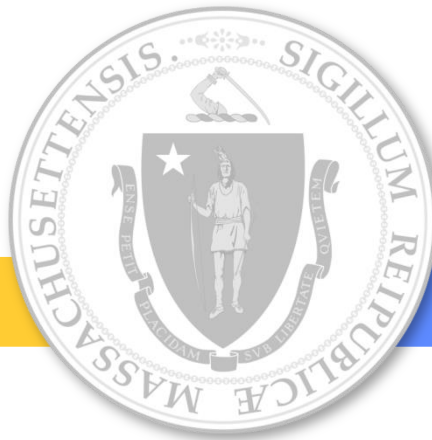


Massachusetts Insurance Market Reform, Affordability and MassHealth Sustainability

Executive Office of Health & Human Services

January 26, 2017

Massachusetts Insurance Market Reform and Affordability

Overview

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

Why is MassHealth enrollment growing?

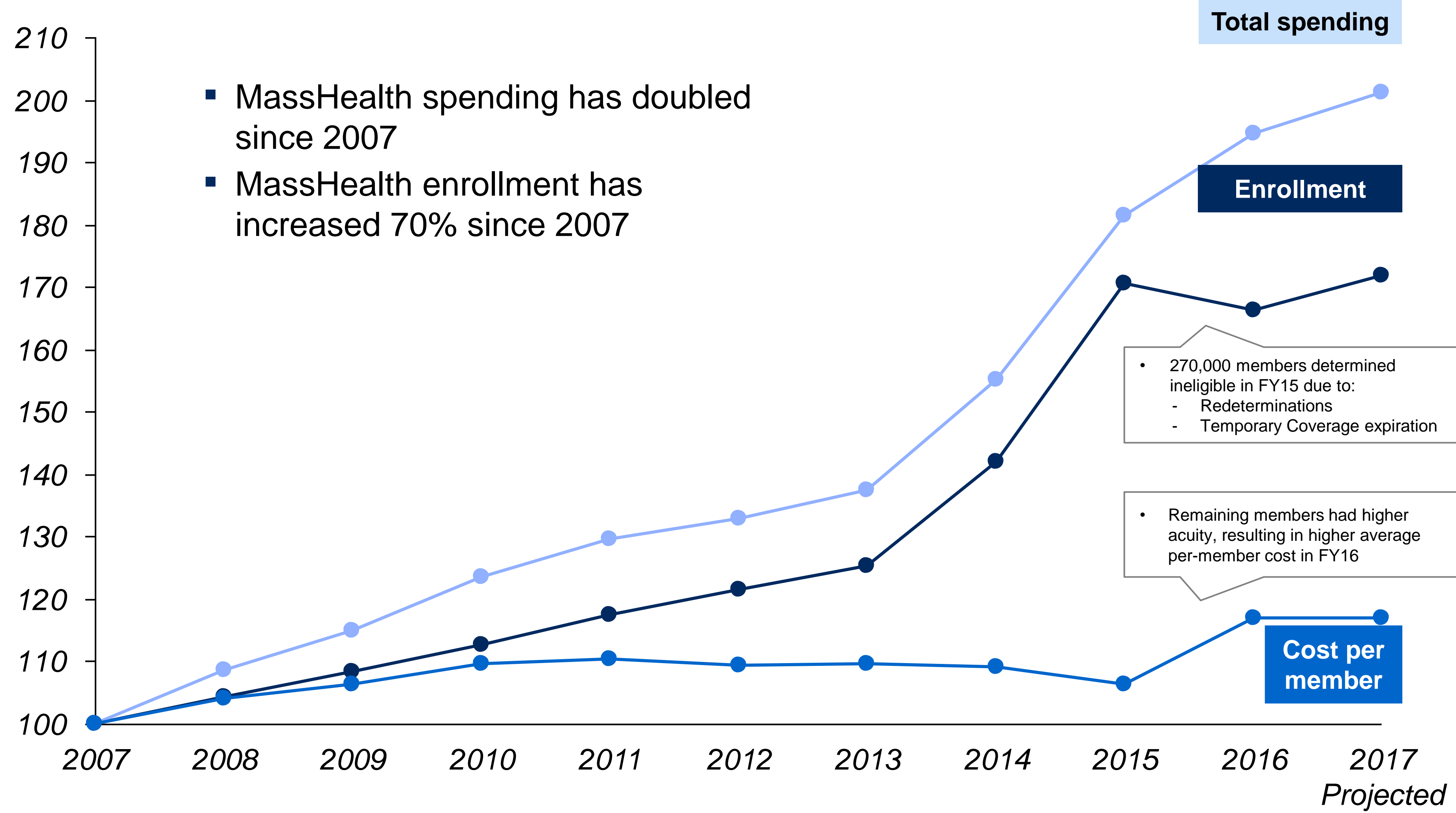
- **Massachusetts had to make changes in our insurance market to conform to the ACA**. **Those changes created unintended consequences impacting employer-sponsored insurance** (ESI). Since 2011:
  - Almost half a million lives have shifted from commercial ESI into public coverage
  - The percentage of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

Four Massachusetts Insurance Market Reforms

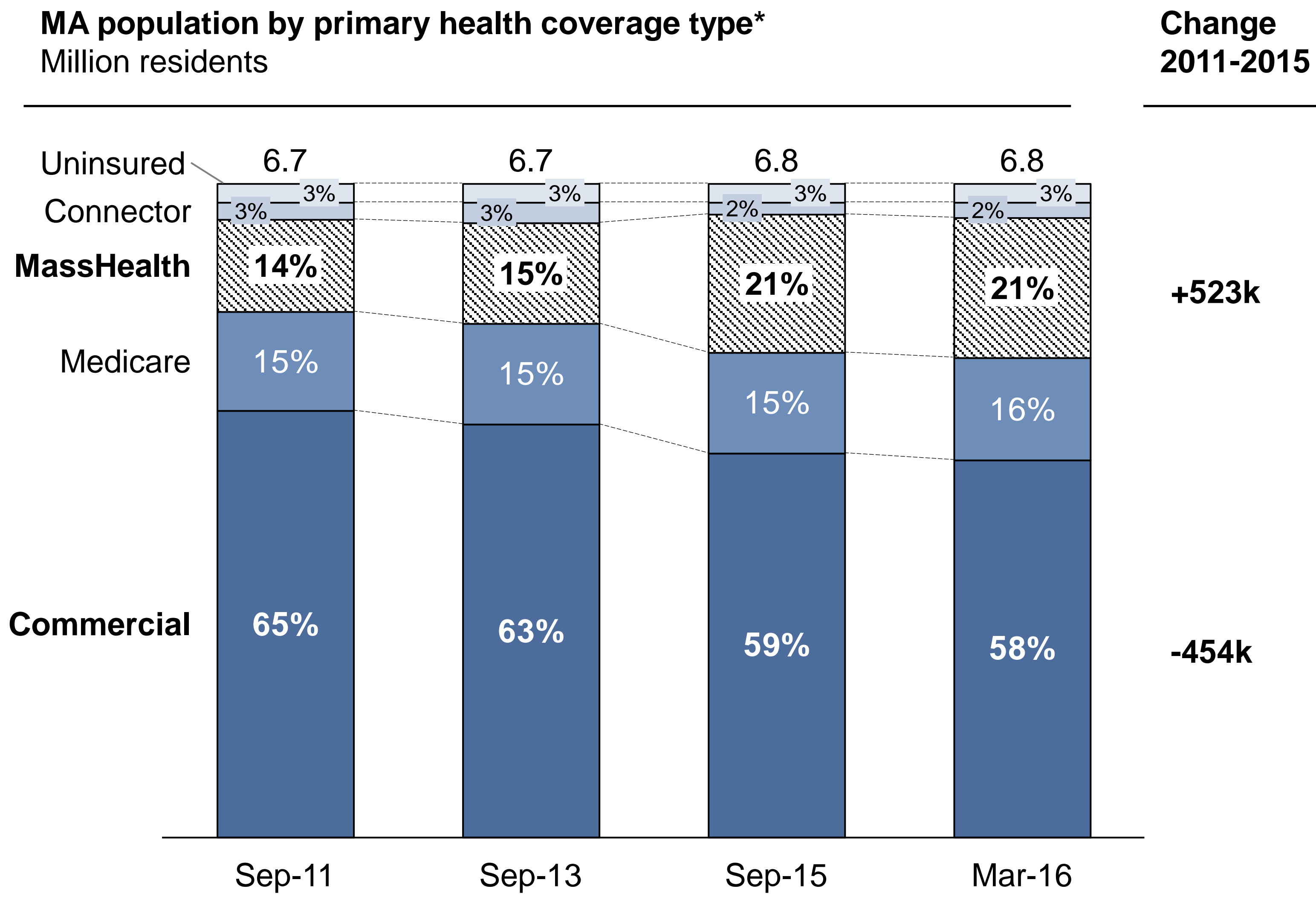
- To protect taxpayers and ensure the sustainability of the MassHealth program, we propose a multi-faceted approach to manage spending growth at MassHealth and in the commercial health insurance market
  1. **Affordability:**
     - Establish a **cap on growth rates for certain health care providers**; **eliminate certain facility fees** that insurers and consumers pay to hospital systems; **institute a five-year moratorium on new insurance mandates**; **implement additional transparency** and offer **new employer options through the Connector**
  2. **Flexibility:** Submit a federal waiver for relief from ACA employer mandate to simplify health care administration burden for employers
  3. **Reinstate Ch. 58 principle of employer contribution to universal coverage** for employers with 11 or more FTEs
  4. **Continue controls for MassHealth sustainability and program integrity**, such as:
     - Strengthen controls for program integrity, including implementing a Third Party Administrator to manage long term services and supports, and other cost avoidance and recovery measures to control fraud, waste, and abuse
     - Restructure MassHealth into integrated, accountable care models through the 1115 waiver
     - Align certain CarePlus benefits with commercial plans

Why is MassHealth enrollment growing?

Enrollment drives 85% of MassHealth growth in FY17



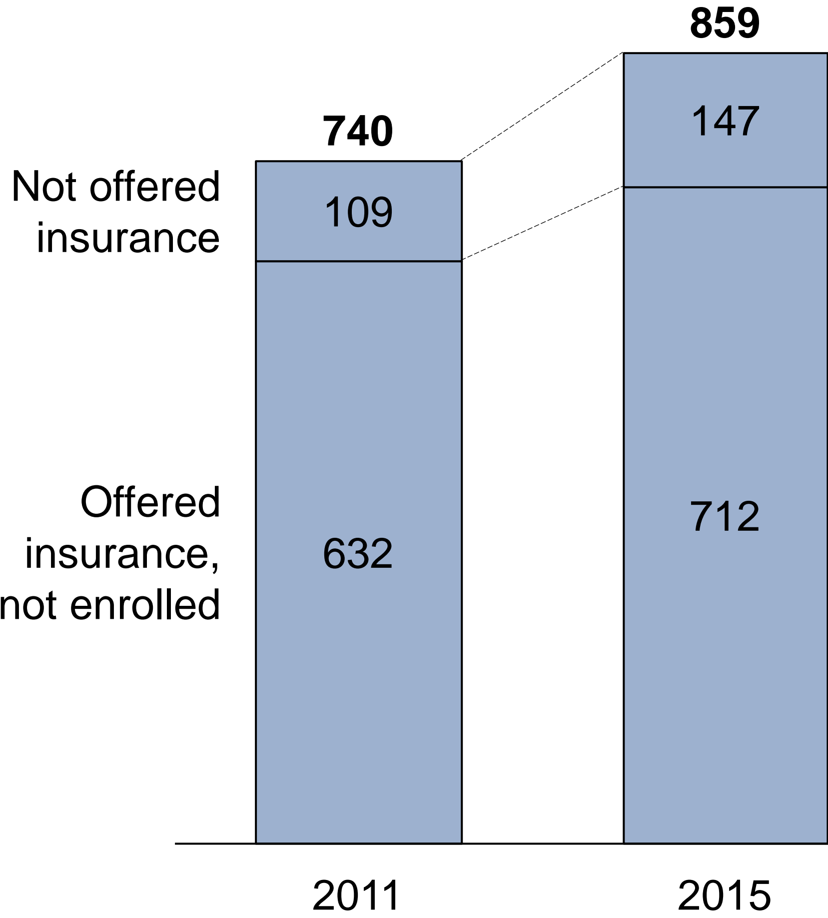
MassHealth enrollment growth has been driven by a shift of MA residents from commercial coverage to public coverage



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

Source: CHIA

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



Change 2011-2015

+118k

+38k

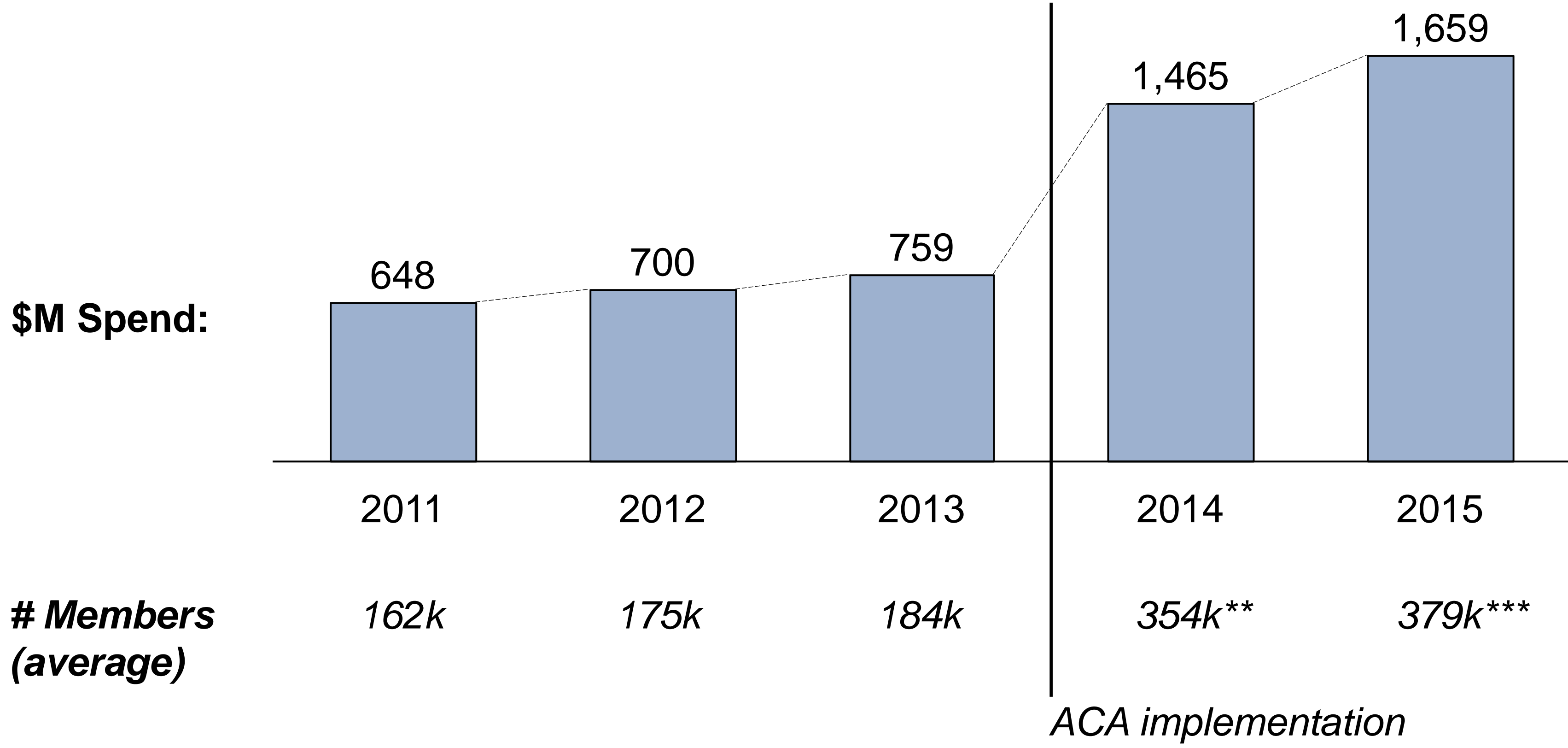
+80k

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

Source: Medical Expenditure Panel Survey / Insurance Component

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

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



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

* Only employees, dependents not included

** Includes 81k temporary MH members / $179M spend

*** Includes 15k temporary MH members / $11M spend (no temp members after Q1 2015)

Source: MA Department of Revenue; MassHealth

Insurance market trends driven by multiple factors since 2013

Rising healthcare costs

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

Increased access to subsidized public coverage

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

Changes in regulatory landscape

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

Demographic trends

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

* CHIA
** ESI = Employer Sponsored Insurance

Four insurance market reforms

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

Health care affordability: 5 components

1. Capping rate growth for certain health care providers

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

Health care affordability: 5 components (cont.)

2. Rebalancing away from facility-based care

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

3. Moratorium on new coverage mandates

- 5-year moratorium on new health insurance coverage mandates

Health care affordability: 5 components (cont.)

4. Transparency

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

5. New employer options through the Connector

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

** Health Reimbursement Account*

Federal flexibility

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

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

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

Reinstate Ch. 58 principle of employer contribution

- Reinstate Ch. 58 principle of employer contribution to universal coverage for employers with 11 or more FTEs
- Updated parameters:
  - Employer Contribution is $2,000 per FTE*, if owed (excludes temporary employees such as seasonal workers and interns)
  - Adequate coverage from an employer is defined as $4,950 for full time employees (>35 hours/ week) for employer-sponsored insurance, or a contribution to a defined benefit plan such as an HRA ($4,950 or another amount as determined by DOR). No additional requirement for spouses/ dependents
  - Employee uptake threshold is 80% of FTEs
- If an employer offers adequate coverage and at least 80% of FTEs take coverage, no Employer Contribution is required
- If an employer offers adequate coverage but less than 80% of FTEs take coverage, the Employer Contribution is only applied to the difference between the # of FTEs on coverage and 80%
  - Example: if 65% of FTEs uptake, the Employer Contribution only applies to 15% of FTEs (80% - 65%)
- DOR will issue regulations, in consultation with EOHHS
- If the ACA employer mandate is implemented, employers will be credited for any federal penalties before being assessed for their Employer Contribution.
- Effective date: Plan renewal dates after January 2018

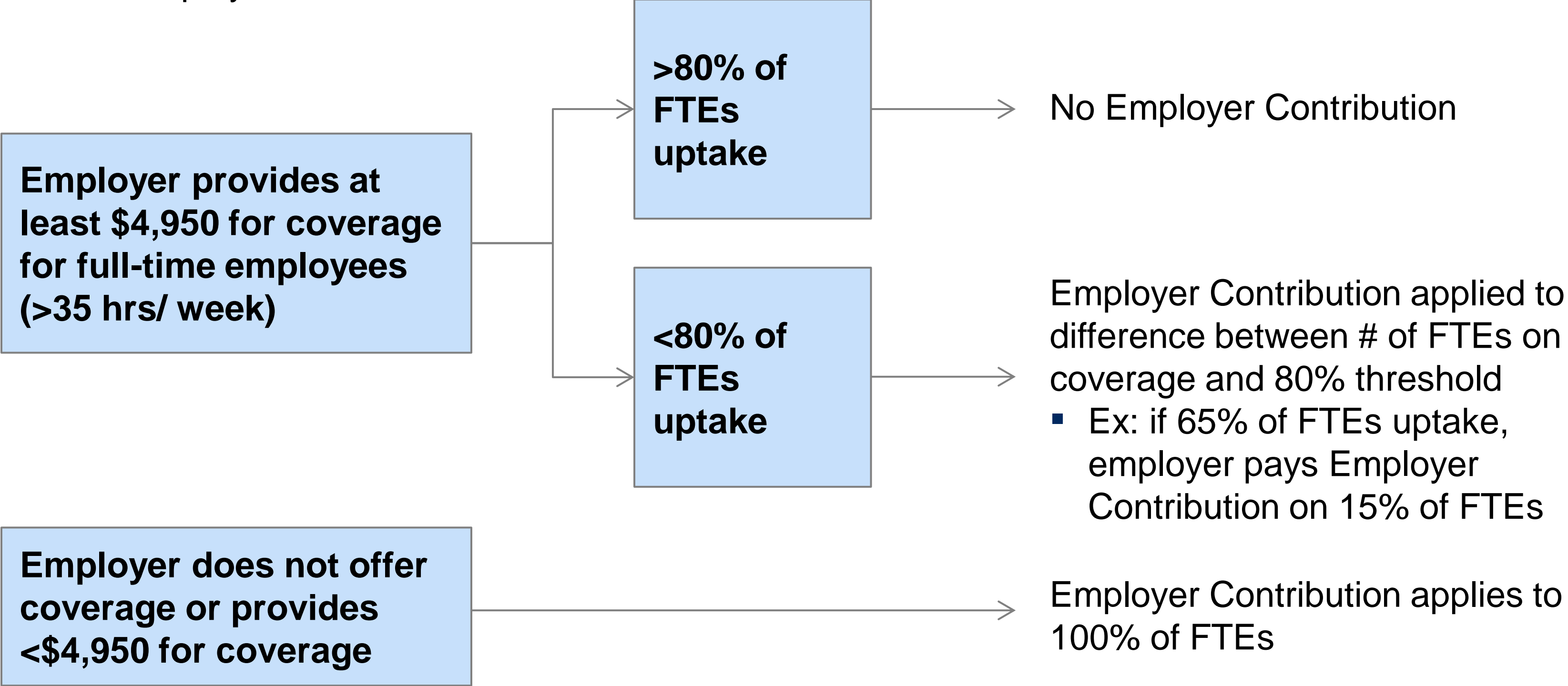
**FTEs calculated as the total number of employee hours per quarter / 500, for employers with at least 1 month tenure, with a maximum of 500 hours counted per employee. This formula avoids incenting employers to shift more full-time to part-time employees*

Reinstate Ch. 58 principle of employer contribution: how it works

Updated Chapter 58

Threshold for adequate coverage from an employer

Uptake threshold:



Uptake rate = *# of employees on coverage* / *Total # of FTEs* (FTEs defined as total number of employee hours per quarter / 500, for employers with at least 1 month tenure, with a maximum of 500 hours counted per employee)

Reinstate Ch. 58 principle of employer contribution: example

Each employer has 20 FTEs (Full Time Equivalents):
- 18 full-time employees (18 FTEs)
- 4 part-time employees (2 FTEs)

	Employer 1	Employer 2	Employer 3
Employer offer of coverage	$6,000 (85% of premium) for full-time employees	$5,000 (70% of premium) for full-time employees	Does not offer coverage
Employees enrolled	16 full-time	14 full-time	--
Uptake rate	80% (16 / 20 FTEs)	70% (14 / 20 FTEs)	0%
Current cost	$96,000	$70,000	--
Applicable FTEs*	0 FTEs	2 FTEs (10% of 20)	20 FTEs
Employer Cont. (EC) ($2,000 x applicable FTEs)	**$0**	**$4,000**	**$40,000**
Total cost incl. EC	**$96,000**	**$74,000**	**$40,000**
Total cost per FTE (total divided by 20 FTEs)	$4,800	$3,700	$2,000

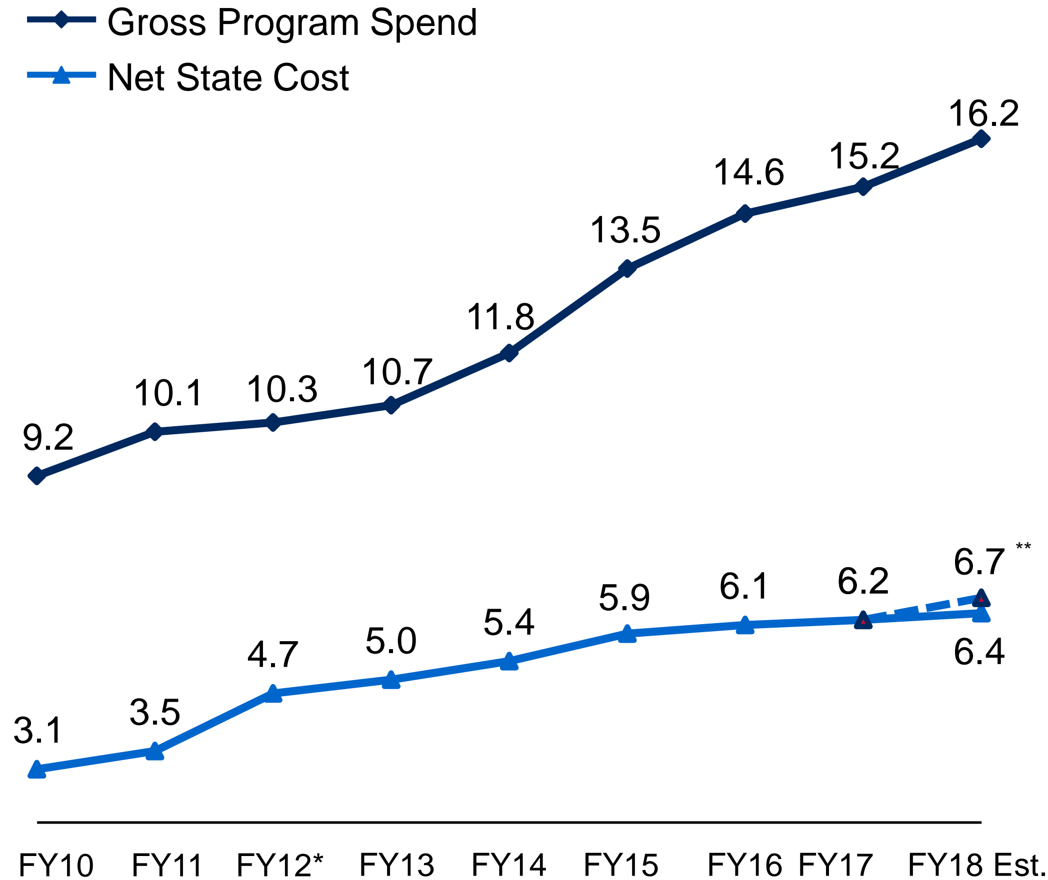
* FTEs required to meet 80% uptake threshold

MassHealth sustainability and program integrity: overview

- We are committed to a sustainable, robust MassHealth program that meets the needs of the 1.9 million (or 1 in 4) residents of the Commonwealth on MassHealth
- 85% of MassHealth growth has been driven by enrollment growth ($600M in FY18)
- The administration has reduced spending from historical double-digit growth to single digit annual growth;
  - 15% Gross Program spend in FY15
  - 8.5% Gross Program spend in FY16; 3.8% Gross Program spend in FY17
- This slowing of trend is the result of strengthened management of the program:
  - Fixing eligibility systems and completing redeterminations
  - Curtailing unrestrained growth in long-term services and supports
  - Instituting new audits, authorizations, and controls to limit inappropriate spending
  - Securing a five-year federal 1115 waiver that will restructure MassHealth toward Accountable Models of Care
- MassHealth will also better align its CarePlus benefits with commercial insurance coverage by eliminating non-emergency transportation (except for SUD) and glasses/contacts

MassHealth sustainability and program integrity: we have reduced spending from historical double-digit growth to single-digit annual growth

MassHealth Program Spending
$ billions



Compound Annual Growth Rate

FY10-13	FY13-15	FY16	FY17 Est.	FY18 Est.
5.1%	12.5%	8.5%	3.8%	**6.6%**
16.9%	9.2%	3.1%	1.7%	*(7.3%)*** **2.3%**

Note: Actuals through FY16. Excludes ELD Choices spending. Net numbers include NF assessment revenue.
** Commonwealth lost >$1B in federal revenue with sunset of American Recovery and Reinvestment Act (ARRA)*
*** Excluding Insurance market reforms*