MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

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What are Employers & Consumers Buying?

Approximately 4.26 million Massachusetts residents are enrolled in commercial health insurance coverage. The majority of individuals with commercial health insurance in the state obtain coverage through an employer. Between 2011 and 2014, the proportion of Massachusetts employers offering health insurance remained steady at 76%, notably higher than the 55% national average; 73% of benefit-eligible Massachusetts employees enrolled in their employer health plans in 2014.[i] Increasingly, Massachusetts employers and consumers are moving toward PPO products offering a broad choice of network providers, or alternatively, into high performance network HMO products. The market is also seeing a significant increase in the number of individuals covered under self-insured plans. **The changes taking place in the market are driven by three main factors: choice, flexibility and cost.** MAHP's latest On Point examines the current trends in the marketplace and the factors contributing to these changes, including state and federal policies affecting employers' health care costs, and outlines a series of steps policymakers should consider to make health care more affordable.

Choice: HMO v. PPO

The majority of privately insured individuals obtain health insurance coverage through one of two types of products, a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO). HMO products offer a network of providers and generally require members to coordinate care utilizing in-network providers and obtain referrals to specialists through a primary care physician. An HMO product provides coverage for out-of-network care if services are not available within network, in accordance with state law. Conversely, a PPO product identifies a network of "preferred providers," but allows members to obtain coverage outside of the network with higher levels of cost-sharing. These products also do not typically require enrollees to select a primary care physician.[ii] Therefore, PPO products offer employees more flexibility in choosing which providers to see for care and treatment.

KEY ELEMENTS OF HMO PRODUCTS

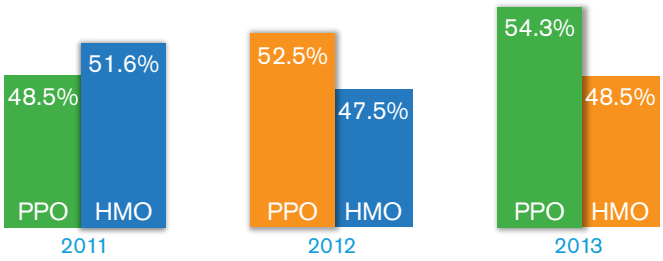
- The member chooses a Primary Care Physician (PCP) within a network and the PCP coordinates the medical care of the member, including referrals to specialists.
- Members can only go to in-network providers, unless they receive an out-of-network referral from their PCP.
- Coverage for out-of-network care is permitted if services are not available within network.
- Typically, the premium and cost-sharing are lower for HMO products than PPO offerings.

KEY ELEMENTS OF PPO PRODUCTS

- No PCP selection is required; members can choose to go to any network provider.
- Referrals by PCPs are not required in order to see specialists in the network and members can go to non-network providers, usually with additional cost-sharing.
- Provides greater access to providers and more flexibility for employers and employees when some employees or dependents are located in other states and cannot easily access in-network providers.
- Premiums are typically higher because of the flexibility.

The Center for Health Information and Analysis' *2014 Annual Report on the Massachusetts Health Care Market* found that nearly 55 percent of the commercial population is enrolled in a PPO or other non-restrictive network product, up from 48.5 percent in 2011. Likewise, the Attorney General's April *2013 Examination of Health Care Cost Trends and Cost Drivers* report noted that "Purchasers have increasingly moved to PPO products, including self-insured PPO products, and away from fully-insured HMO products."

Among the top reasons employers often provide for choosing a PPO is that these plans allow them to offer their employees additional choice of providers, which is particularly useful when employees have existing physician relationships, work for several days or weeks out-of-state, or have dependents that may live out-of-state and cannot be limited to a network with Massachusetts-only providers.[iii]



Flexibility: Fully-Insured v. Self-Insured

Employers that offer health insurance benefits finance those benefits in one of two ways: they contract with a health insurance company to cover the claims for benefits for their employees and dependents, referred to as fully-insured plans, or they provide health benefits directly to employees with the employer's own funds through a self-insured arrangement. The terms of eligibility and covered benefits in a self-insured plan are similar to those found in a typical fully-insured policy; however, the federal Employee Retirement Income Security Act of 1974 ("ERISA") exempts self-insured plans from most state insurance rules.

KEY ELEMENTS OF FULLY-INSURED PLANS

- The employer pays a premium to the health plan, which assumes the financial responsibility for paying for medical treatment, behavioral health services, prescription drugs and other necessary health services for the employer's workers and their dependents, shielding the employer from financial exposure due to unexpected increases in utilization, catastrophic events or public health crises.
- Premium rates are fixed for a year, based on the number of employees enrolled in the plan each month, and only change during the year if the number of enrolled employees in the plan changes.
- Plans are subject to state insurance rules, including mandated benefits.

KEY ELEMENTS OF SELF-INSURED PLANS

- The employer acts as its own health plan, assuming the financial responsibility for the medical services of its employees and their dependents by paying their medical claims directly.
- While there are potential savings if medical costs are lower than expected, the employer may face higher financial exposure if more services than anticipated are used.
- Self-insured plans often contract with a health plan or a third party entity to administer health care claims.
- Plans are not subject to state insurance rules or state-imposed mandated benefits due to ERISA preemption.

Where Individuals & Employers Access Coverage

Employers with up to 50 employees that seek fully-insured coverage for their employees must purchase products through the state's small group market. Individuals who do not have access to employer-sponsored coverage choose plans from the individual, or non-group, market. Actuarial analysis shows that average claims costs for the individual market are significantly higher than those for the small group market. The difference can be attributed to an older average subscriber age and a much lower number of children covered in the individual market, and also to a higher average morbidity.[iv] With the enactment of Chapter 58 of the Acts of 2006, Massachusetts is the only state to have effectively "merged" its small group and individual markets, meaning that the claims experience and anticipated risk for individuals and small business employees is combined and health plans must rate products offered to individuals and small groups the same. As a result, small businesses subsidize a portion of the cost of coverage for individuals enrolled in Massachusetts plans. According to a 2010 study by the state's Division of Insurance, the cost of the merger for small businesses was estimated to be 2.6 percent or 1.1 percent to 1.6 percent higher than the 1.0 percent to 1.5 percent impact that had been projected prior to the merger.[v]

Large companies typically self-insure, providing them with the ability to avoid or place limitations on certain mandates and other state insurance requirements. Due to their size, small and midsize businesses typically purchase fully-insured products, although there has been a steady migration of these businesses moving to self-insured coverage over the last several years. Nearly 60 percent of commercially insured individuals in Massachusetts were enrolled in a self-insured plan in 2013, a significant increase from 49 percent in 2011.[vi] The nationwide percentage of covered workers who are enrolled in plans that are either partially or completely self-funded mirrors the state's experience.[vii] The requirement under the Affordable Care Act that states expand their small group markets to include mid-sized groups with 51 to 100 employees no later than January 1, 2016 may lead many more small and mid-sized employers to self-insure.[viii, ix]

58% of Privately Insured Individuals are in a Self-Insured Health Plan

Cost: State & Federal Rules Affecting Coverage Options

For Massachusetts employers, the two most important factors in determining the coverage to offer to their employees are cost and flexibility in plan design.[x] For fully-insured employers, cost is the key deciding factor when purchasing coverage for their employees, while flexibility to create plan options that meet their needs is the most important factor for self-insuring employers in Massachusetts.[xi] State and federal policy has a significant impact on the cost of coverage, affecting employers' benefit decisions, and includes:

State Mandated Benefits

Mandated benefits in Massachusetts increase the cost of health insurance coverage. In Massachusetts, state law mandates that fully-insured health plans provide coverage for nearly 49 specific services, treatments, supplies and practitioners.[xii] Since 2006, 14 new mandated benefits have been passed in Massachusetts. The statewide cost of mandated benefits is more than $1.4 billion annually.[xiii]

The average impact to an insured individual is $29.49 per member per month, and this total does not include the costs associated with state-required benefits enacted more recently, including the diagnosis and treatment of autism and expanded substance abuse treatment.[xiv] Various state reports have estimated that the cost of state mandated benefits account for anywhere between 7¢ and 12¢ of every premium dollar.[xv, xvi]

The cost of state mandated benefits falls primarily on fully-insured companies as they are required to cover them. While some self-insured plans may choose to cover certain mandated benefits, they are excluded from state laws that impose additional costs. Due to preemption of ERISA, self-insured plans are not required to cover state mandated benefits. This exemption offers self-insured employers generous control over the particular benefits they cover for their employees, and this flexibility allows these businesses the option of reducing their health care costs substantially. The Division of Insurance's Summary of 2013 Membership in Employment Sponsored Self-Funded Health Benefit Plans found that a dozen state mandated benefits were not covered by more than 90 percent of self-funded plans in 2013.[xvii] As more employers self-insure, state laws mandating specific types of benefits and services affect an increasingly smaller portion of the privately insured marketplace.

7¢–12¢ of every premium dollar is spent on mandated benefits

Expanded Benefits Under the Affordable Care Act

Enactment of the Patient Protection and Affordable Care Act (ACA) placed considerable new regulatory constraints on the products that can be offered to individuals and small businesses. These design restrictions have significantly increased the cost of care.[xviii] The ACA mandates coverage of 10 broad categories of care services, referred to as Essential Health Benefits, including treatments that had previously not been typically covered, such as pediatric dental care and commercially-marketed weight loss programs. The ACA also eliminated annual dollar limits on these benefits, and created annual caps on the member's share of costs, specifically the total deductible, copayments, and coinsurance that an individual member is responsible for in a given year of coverage. Simultaneously, the ACA established a metallic tier framework for differing benefit levels, requiring that all products fit within one of four narrow bands of allowable values based on a ratio of what a member pays versus what a health plan pays. Through an expansion of health care benefits and a restriction on member cost-sharing, the ACA has resulted in restricted flexibility for innovative plan design and increased premiums for consumers and employers.

Administrative costs and regulatory restrictions associated with the ACA are also making the cost of health care coverage more expensive for Massachusetts employers and consumers.[xix] Among the current and pending changes:

Restrictions on Rating Factors

As part of the 2006 Health Care Reform Law, Massachusetts merged the individual and small group markets, resulting in small employers subsidizing individuals. The law permitted the continuation of the state's small group rating factors, allowing rates to be adjusted based on a limited number of factors including the size of the employer, its industry, and whether it was participating in a wellness program. Inclusion of the state's rating factors was a critical component to mitigate some of the impact the merger had on small employers. The ACA eliminates most of the state's important rating factors, permitting only the use of family structure, geographic area, age, and tobacco use. In March 2013, the federal government granted the state a transitional waiver to phase out the existing state rating factors over a three-year period (later extended to four). In 2015, Governor Baker requested that Massachusetts be allowed to freeze rating factors at their current levels; this freeze was approved by the federal government in June of 2015 for one additional year. While the elimination of the Commonwealth's rating factors will vary from group to group, it will result in extreme premium increases for a significant number of Massachusetts small employers as the costs associated with these changes will be in addition to increases in medical trend. A July 2013 report by Wakely Consulting examining the potential financial impact that the changes in the rating rules will have on employers found that there will be wide variation, including significant increases for some small businesses as the rating factors decrease and are eliminated altogether.[xx]

MASSACHUSETTS RATING FACTORS

1. Family size (rate basis type in MA)
2. Geographic rating area
3. Age
4. Tobacco use
5. Industry
6. Participation rate
7. Wellness
8. Group size factor
9. Use of an intermediary
10. Group purchasing cooperative
11. Benefit level

AFFORDABLE CARE ACT (ACA) PERMITTED RATING FACTORS

1. Family size (rate basis type in MA)
2. Geographic rating area
3. Age
4. Tobacco use

Expansion of the Small Group Market

The ACA requires states to expand their small group markets to include groups with 51 to 100 employees no later than January 1, 2016. As groups with 51 to 100 employees renew or purchase new coverage, they will be subject to all federal regulations governing the small group market, including those related to benefit coverage, cost-sharing requirements and premium rating restrictions. These mid-size employers, and their employees and dependents, will be pooled with all insured individuals in the state's merged market for rating purposes. It is anticipated that reclassifying this market segment will lead to higher premiums for these mid-sized employers as they will be subject to more stringent actuarial value standards, cost-sharing limits, and essential health benefit requirements, as well as state rating rules that have not historically applied to them.[xxi, xxii] Further, expanding the small group market will reduce choice for groups of 51 to 100, which have had greater flexibility in benefit design than groups of one to 50. As a result, these employers will be unable to keep their coverage when they renew in 2016 and will be left with fewer coverage options, which could lead many of these employers to self-insure. In April 2015, Governor Baker requested that Massachusetts be allowed to continue to maintain the state's small group definition to avoid rate increases and further market disruption. This request is still pending.

ACA Fees & Taxes

The ACA imposes a number of new fees and taxes on health plans. The ACA established an annual fee on health plans – the so-called Health Insurance Tax – based on each plan's premiums to help fund federal subsidies that lower-income individuals receive towards the purchase of insurance. For 2015 and 2016, the total assessed is $11.3 billion annually; this number increases to $14.3 billion in 2018 and grows each year thereafter.[xxiii] From 2014 through 2023, the tax will cost Massachusetts residents and businesses an estimated $3.85 billion to $3.89 billion.[xxiv] Because this fee does not apply to self-insured enrollees, the financial burden shifts to smaller employers and individuals who continue to purchase fully insured coverage and must shoulder the cost of a statutorily-fixed level of fees. As more groups move to the self-insured market, the cost of the Health Insurance Tax will increase for those that remain in the fully-insured market. A comprehensive analysis estimates that premiums will increase on average by 2.8 percent to 3.7 percent by 2023, or several thousand dollars per enrollee over a 10-year period beginning in 2014.[xxv] The ACA also requires health plans to transfer millions of dollars annually to cover mandatory risk adjustment charges. These assessments create further incentive for small employers to self-insure their health benefits coverage as a means of avoiding these fees. Finally, the ACA mandates that health plans, along with self-insured employers, make payments totaling $25 billion over a three-year period into a reinsurance pool to offset the costs of high-risk individuals, and establishes an excise tax on more generous employer-sponsored health plans, referred to as the "Cadillac Tax." This tax is equal to 40 percent of the cost of benefits that an employer provides to employees above a prescribed threshold. The imposition of a broad premium tax on health plans, as well as unanticipated assessments for reinsurance and risk adjustment, contributes to the increasing cost of health care in the Commonwealth.

The ACA's Health Insurance Tax will cost Massachusetts residents and businesses nearly $4 Billion.

Risk Adjustment

The ACA established three risk mitigation and market stabilization programs — the Risk Corridors program, the Reinsurance program and the Risk Adjustment program ("3Rs") — to offset concerns about adverse selection, stabilize premiums and encourage issuers to participate in the market in the wake of the ACA. The 3Rs are new to the Massachusetts market as of 2014 (Risk Corridors and Reinsurance) and 2015 (Risk Adjustment), and will have a significant financial impact on health plans. As an example, while risk adjustment is intended to help stabilize the marketplace as states implement the market reform rules, it may have the opposite effect in Massachusetts. The state's long-standing requirements around guaranteed issue and modified community rating, the existence of a merged market and an individual mandate, and a relatively low rate of uninsured residents, make it unlikely that the Commonwealth would face the same uncertainty as other states. However, the significant transfer payments required under risk adjustment may have the unintended consequence of limiting competition and eliminating innovative product designs, leading to higher costs and fewer options for employers and consumers.

Solutions – Making Health Care More Affordable for Massachusetts Businesses

The rising cost of health care is a major barrier to economic growth in Massachusetts. Legislative and regulatory efforts in the Commonwealth and in Washington, D.C. should focus on measures to make health care more affordable for employers and the workers they cover. Approaches that state and federal policymakers should consider include the following:

1. Adopt Governor Baker's request for a permanent extension of the state's current rating factors

The federal government recently approved Governor Baker's request for an extension of the current transition period to permit the Commonwealth to continue using the state's specific rating factors through 2017. Federal policymakers should allow for a permanent waiver that permits the state's current rating factors to continue for all merged market offerings to protect small businesses from significant increases should they be eliminated altogether.

2. Adopt Governor Baker's request for a waiver from the federal small group definition

Governor Baker's April 27, 2015 letter included a request that the state maintain its current small group definition of one to 50 employees. A waiver from this provision of the ACA is needed to avoid the significant premium increases and loss of product options to employers and federal policymakers should approve this request.

3. Support mandated benefit reform

Nearly 80 mandated benefits bills requiring coverage of specific levels or types of treatment or screenings have been filed in the current legislative session. While well-intentioned, mandated benefits fall disproportionately on small businesses, adding to the costs of coverage for these employers and exacerbating the challenge they face in finding affordable options. State policymakers should institute a robust moratorium on new mandates to avoid increasing costs for small businesses and apply the state's mandate review law to regulatory agencies.

4. Oppose legislative and regulatory proposals that increase costs for employers offering coverage in the merged market

The number of employers seeking to self-insure is growing at a rapid rate, with many smaller employers now looking at this option as a way to avoid state mandates, assessments and special interest legislation that drives up health care costs. Legislative leaders and the Governor should not adopt mandates, assessments or special interest legislation that will increase costs for employers in the merged market. Bills establishing rates for ambulances, observation stays, and emergency department boarding should be swiftly rejected and left to private negotiation. Likewise, legislative or regulatory efforts to take away essential managed care tools that ensure appropriate utilization of medical services should not be adopted. Instead, the Governor and legislative leaders should encourage evidence-based practice by providers and reject policies that are not based on supporting data and outcomes.

5. Monitor Risk Adjustment and evaluate the methodology to ensure a robust and competitive health insurance market

Massachusetts is the only state utilizing an alternative methodology to calculate the payments and charges health plans will be subject to for purposes of reimbursement for high-cost utilizers. The state should undertake a comprehensive review of the methodology to gain a detailed understanding of its effect on the market.

Endnotes

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