The Massachusetts Universal Coverage Initiative

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Brief Overview

MA Aimed to Achieve Universal Coverage through Medicaid Expansions, Mandates, and Insurance Market Reforms

Coverage Expansions	Individual Mandate and Employer Penalties	Insurance Market Reforms
Expanded Medicaid program to children with family incomes between 200-300 percent FPL	Individuals over 18 must have credible coverage Penalty = ½ premium cost for the lowest-cost Health Connector-certified insurance plan	*Reforms enacted prior to April 2006:* • Guarantee issue • Community rating (2:1) for age and geography • Limits the use of pre-existing conditions
Offer subsidized insurance through CommCare to residents with incomes between 100-300 percent FPL (provided by Medicaid managed care plans)	Employers with 11 or more FTEs must offer health insurance and pay at least 33% of premium cost or have 25% enrolled Penalty = $295 per worker per year	Created insurance exchange, the Connector, which administers CommCare and CommChoice Exchange open to individuals and employees of small businesses (<50 FTEs)

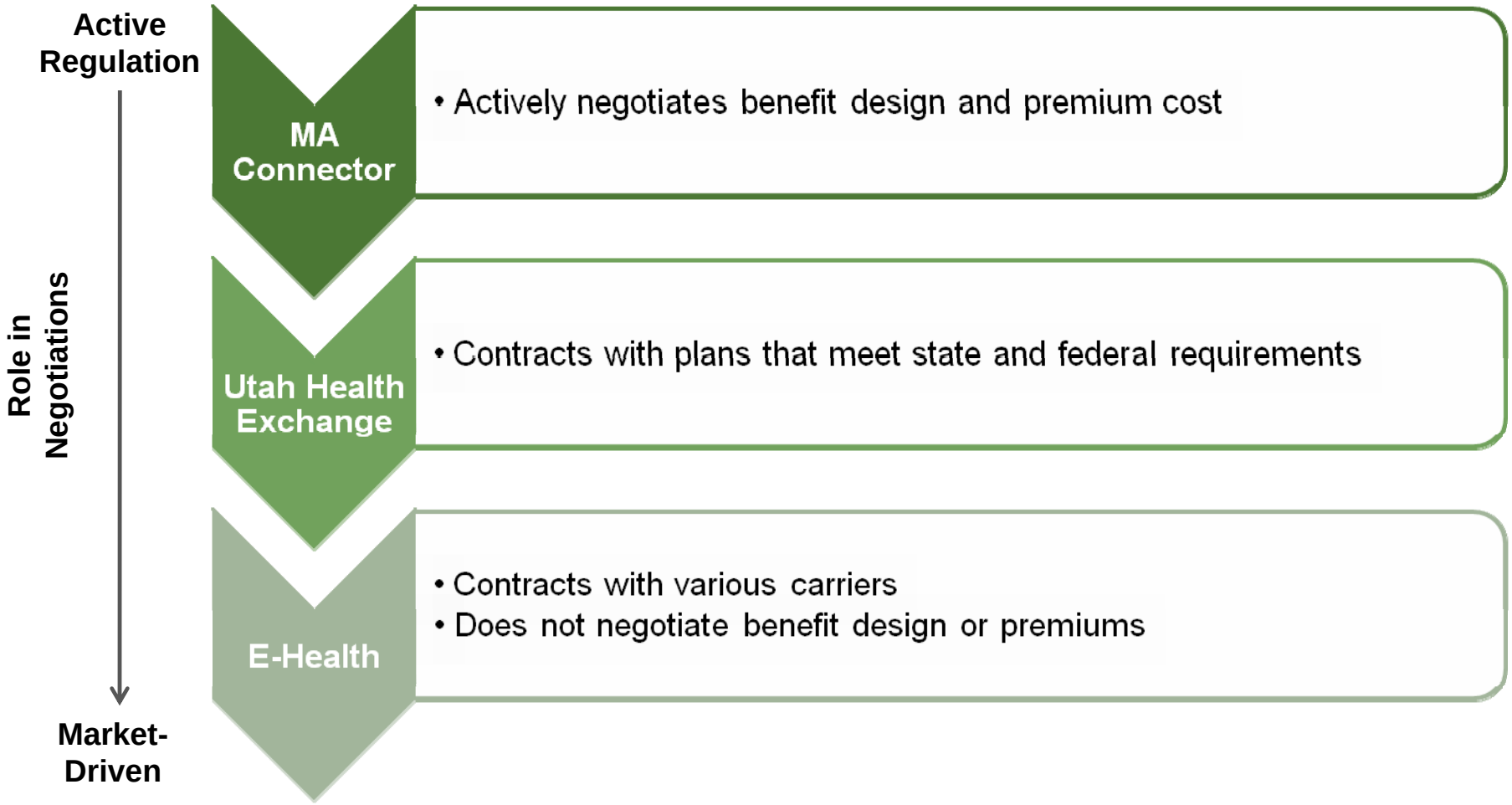
Reform in Massachusetts shares several key elements with federal proposals.

Although Massachusetts Offers One Model for Reform, the State Differs in Several Key Ways from the Nation

- **Insurance Market Reforms:** Already required guarantee issue (1 of 6 states) and modified community rating (1 of 7 states) in non-group market
- **Uninsurance Rate:** Only 10% of MA residents were uninsured in 2006, compared to 16% nationwide and a high of 25% in TX
- **Income:** High per-capita income (5th in the US) resulted in fewer residents qualifying for subsidies
- **Employer Offer Rate:** Higher employer offer rates pre-reform
- **Uncompensated Care Pool:** Already allocating significant funds towards uncompensated care, which was redirected toward reform
- **Bipartisan Cooperation:** History of operating with a Democratic legislature and a Republican governor

How is enacting health reform different in Massachusetts?

Existing Exchange-Like Models Take Varying Approaches to Carrier Negotiations



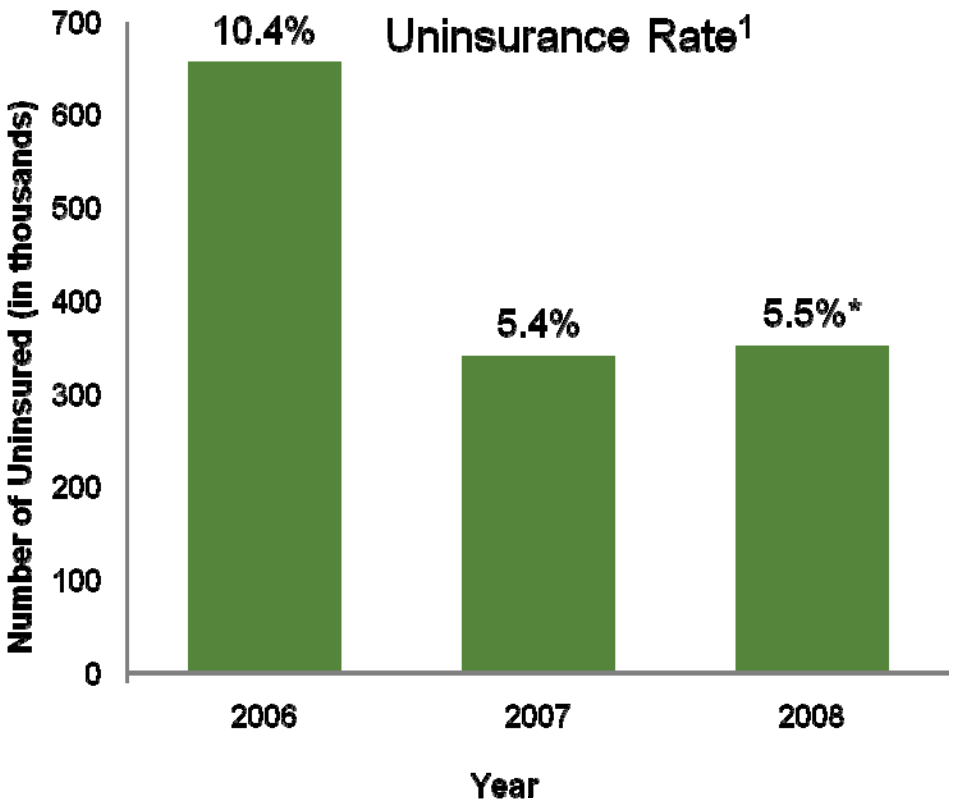
The Contributory Program Allows Small Groups to Purchase Coverage Through the Connector

- **History:** MA legislation authorized the Connector to facilitate coverage for both individuals and small businesses in the state
  - » The Connector delayed implementation of the small group enrollment because of the complexity of this market
- **Pilot Program:** As of 2009, small groups (<50 workers) can enroll in a Commonwealth Choice Contributory Plan on a pilot basis
  - » Policies must be sold to small groups by a pilot broker
  - » Employers select a contribution level (minimum of 50%), a coverage tier, and a benchmark plan
  - » Employees can select either the Benchmark Plan or another available Commonwealth Choice plan within the same plan benefit tier
  - » The Connector only offered HMO plans in 2009. In 2010, one PPO will be offered
- **Limited Enrollment:** To date, only 42 small businesses and 145 enrollees have enrolled through the pilot program

Why has enrollment been so limited? How important is plan choice to enrollees? How can the state overcome administrative challenges of enrolling small groups?

Lessons Learned

1. Even with an Individual Mandate, Not Everyone Will be Covered



- Improved continuity of coverage
- Some legal immigrants insured

- 352,000 individuals remain uninsured
- 76,000 exempt from the mandate
- Who is left?

» Younger (60% under 40) and healthier individuals

» Illegal immigrants

What can we learn from looking at the uninsured population in Massachusetts?

[1] US Census Bureau Health Insurance. "Current Population Survey, Annual Social and Economic Supplement, 2009" (September 2009). http://www.census.gov/hhes/www/hlthins/hlthins.html
*The state reports a 2.7% uninsurance rate for 2008.

2. Insurance Coverage Does Not Ensure Access

Early Gains

- Working-age adults (ages 18-64) more likely to report a usual place to go when sick[2]
- Reported an increased likelihood of having any doctor visit by 5.1%[2]

Setbacks in 2008

- 25% of adults with public coverage reported being denied services because of their insurance compared to 7% of those with private coverage[2]
- Lack of access to primary care – significant media coverage of long wait times to see PCPs

How can reform address both coverage expansion and accessibility simultaneously?

[2] Long, Sharon and Paul Masi. "Access and Affordability: An Update on Health Reform in Massachusetts." Health Affairs. (May 2009)

3. Expanded Coverage May be Less Generous than ESI

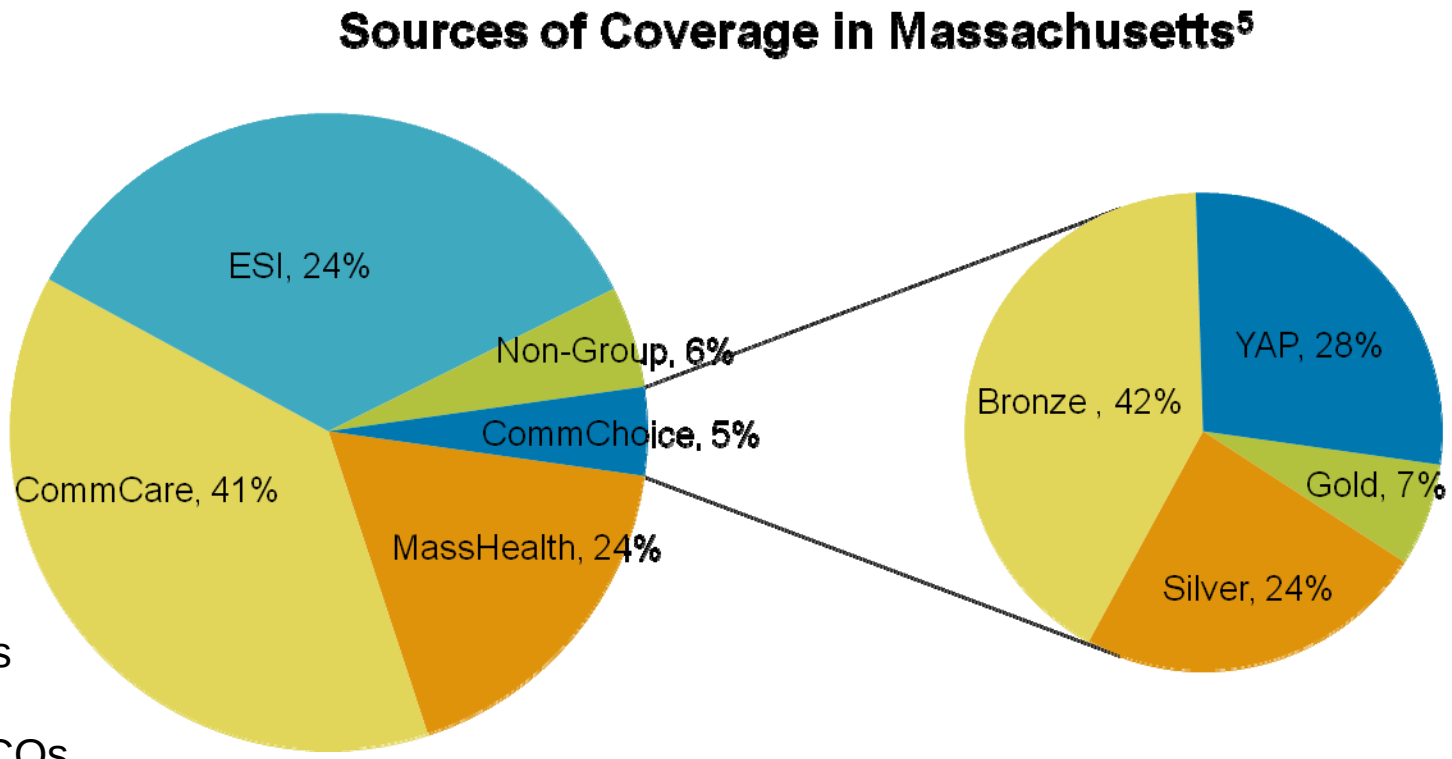
Insurance Plan	Actuarial Value
Typical ESI (HMO)[4]	93%
FEHBP Blue Cross- Blue Shield Standard Option (PPO) [4]	87%
Gold[3]	86.6%
Typical ESI (PPO)[4]	80.0% - 84%
Medicare Parts A, B and D[4]	76%
Silver[3]	73.4% - 77.0%
Bronze[3]	59.7% - 53.2%
Most Popular Non-Group Plan Offered by Aetna in CT	50%

- Gold plan = highest premiums; lowest OOP cost sharing
- Bronze = lowest premiums; highest member cost sharing
- The Connector offers only HMOs plans. In 2010, a PPO will be offered

What implications do these actuarial values have for the state's gains in terms of coverage expansion?

[3] The Massachusetts Commonwealth Health Insurance Connector: Seal of Approval Recommendations. (2009)
[4] Peterson, Chris. "Setting and Valuing Health Insurance Benefits." Congressional Research Service. (2009)

4. Most People Have Purchased Private Coverage Outside the Connector; Inside, Enrollees Choose Low Cost Options



- CommCare offered plans from four Medicaid MCOs

Why did individuals choose to enroll in plans through the non-group market outside of the exchange? Why was enrollment concentrated in the lowest cost CommChoice plans?

[5]The Massachusetts Commonwealth Health Insurance Connector Authority. "Report to the Massachusetts Legislature: Implementation of Health Care Reform Fiscal Year 20009" (October 2009). https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Executive%2520Director%2520Message/Connector%2520Annual%2520Report%25202009.pdf.

5. Expansion of Public Coverage Did Not Result in "Crowd Out"

- **The employer penalty is nominal relative to the cost of contributing to coverage**
  - » Cost of Contributing to Coverage: Approximately $1,344
    - Mandate: Contribute 33% towards premium
    - 2008 average premium through ESI = $4,704
  - » Penalty: $295 annually per worker

- **However, enrollment in ESI grew following reform**
  - » Enrollment in private insurance has grown by more than 140,000 individuals
    - 96,000 (~70%) enrolled through their employer[6]

Are there enough incentives to prevent "crowd out" from occurring in the future?

[6]The Massachusetts Commonwealth Health Insurance Connector: Facts and Figures. (2009)

6. Debate Continues Surrounding Mandate Compliance and Penalty Amount

- Individual mandate penalties must be high enough to prevent adverse selection
  - » Penalty: 50% of premium cost towards least expensive Connector plan
- 95% compliance rate at the end of calendar year 2007, half of previously uninsured individuals purchased coverage
  - » Many of remaining uninsured are deemed exempt
- Some evidence of churning in the market
  - » Could be signs of adverse selection – individuals only buying coverage when they need it
  - » May also be caused by people moving between other sources of coverage (e.g., ESI, Medicaid)

Will individuals comply with mandate or instead purchase coverage only in anticipation of use of care?

7. Public/Political Support Has Been Crucial For Successful Implementation

Public Awareness and Education Campaigns

- Public Information Unit
- Civic/Corporate Partnerships
- Educational outreach

Bipartisan Support

- History of bipartisan cooperation eased passage and supported implementation

Strong Public Support

- 77% of residents support providing subsidized coverage[7]
- 71% agree that the law has been successful at reducing the number of uninsured[7]

How does the national landscape differ in terms of public and political support?

[7]Harvard School of Public Health: Poll Shows Strong Support for MA Health Reform Law. (2008)

8. Short-Term Cost Issues Surprised and Challenged Policymakers

- Spending substantially surpassed initial budget projections
- Several factors contributed to higher spending in early years of the program:
  - » Number of uninsured residents underestimated
  - » Adverse selection into Commonwealth Care
  - » Lower than expected revenues from mandates due to slower implementation timeline
  - » Reforms did not address payment reform or cost containment
- Cost estimates were an educated guess at best

How can reform accurately project costs and prepare for uncertainty?

9. Rising Healthcare Costs Undermine Affordability Gains

- The state continues to struggle with long term cost containment challenges
- Premium increases continue to impact affordability
  - » Number of adults reporting difficulty paying medical bills rose by 1.7% in 2008
  - » Number of adults spending 10% or more of family income on OOP health care costs rose in 2008, especially among low-income families
- The Connector has avoided large increases in premiums by re-bidding and reducing benefits
  - » CommChoice limited premium increases to 5 percent in 2009
  - » However, premiums were often controlled by reducing benefits and increasing cost sharing

Is the Massachusetts program sustainable? How can reform bend the cost curve to ensure affordable coverage?

10. Reforms Have Been Expensive to Implement & Costs Will Continue to Grow without Reductions in Spending

- From 2006 to 2010, Massachusetts spending on health care increased by $707 million
  - » About half of the spending was paid for with federal funding
  - » Premium subsidies and Medicaid expansions have driven cost increases
  - » State costs are directly tied to increasing healthcare costs
- Connector start-up costs were $25 million in 2006
  - » The Connector is now financially self-sustaining by requiring participating insurers to pay a fee (4.5% of total premiums in CommChoice)

Is this model financially feasible for other states?

Next Steps: Massachusetts Shifts Focus to Cost

- Massachusetts has successfully expanded coverage to nearly all residents, but costs continue to be a challenge
  - » Created Special Commission on the Health Care Payment System to "investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care"

Recommendations of the Special Commission

- Global payment system with adjustments to reward accessible and high quality care
- Global payments prospectively compensate providers for all or most of the care that patients receive over a contract period
  - Bases payment amounts off of past cost experience and an actuarial assessment of future risk (related to patient demographics and known medical conditions)