Member Migration and Plan Choice in Massachusetts

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Agenda

1. Introductions.
2. History
3. Current Study
4. Member response
5. Discussion.

Commonwealth of Massachusetts

Population: 6.5 million
Second highest average per capita income in the US ($51,500 in 2010).
Home to 65 universities and colleges (Harvard; MIT; BU; BC; etc.)
Home to many famous medical facilities: Mass General; Brigham & Womens; Dana-Farber Cancer Institute, etc.

Prior to passage of reform in 2005, Massachusetts had the lowest rate of uninsured in the US (9%). After reform, fell to 2-3%.

History and Accomplishments

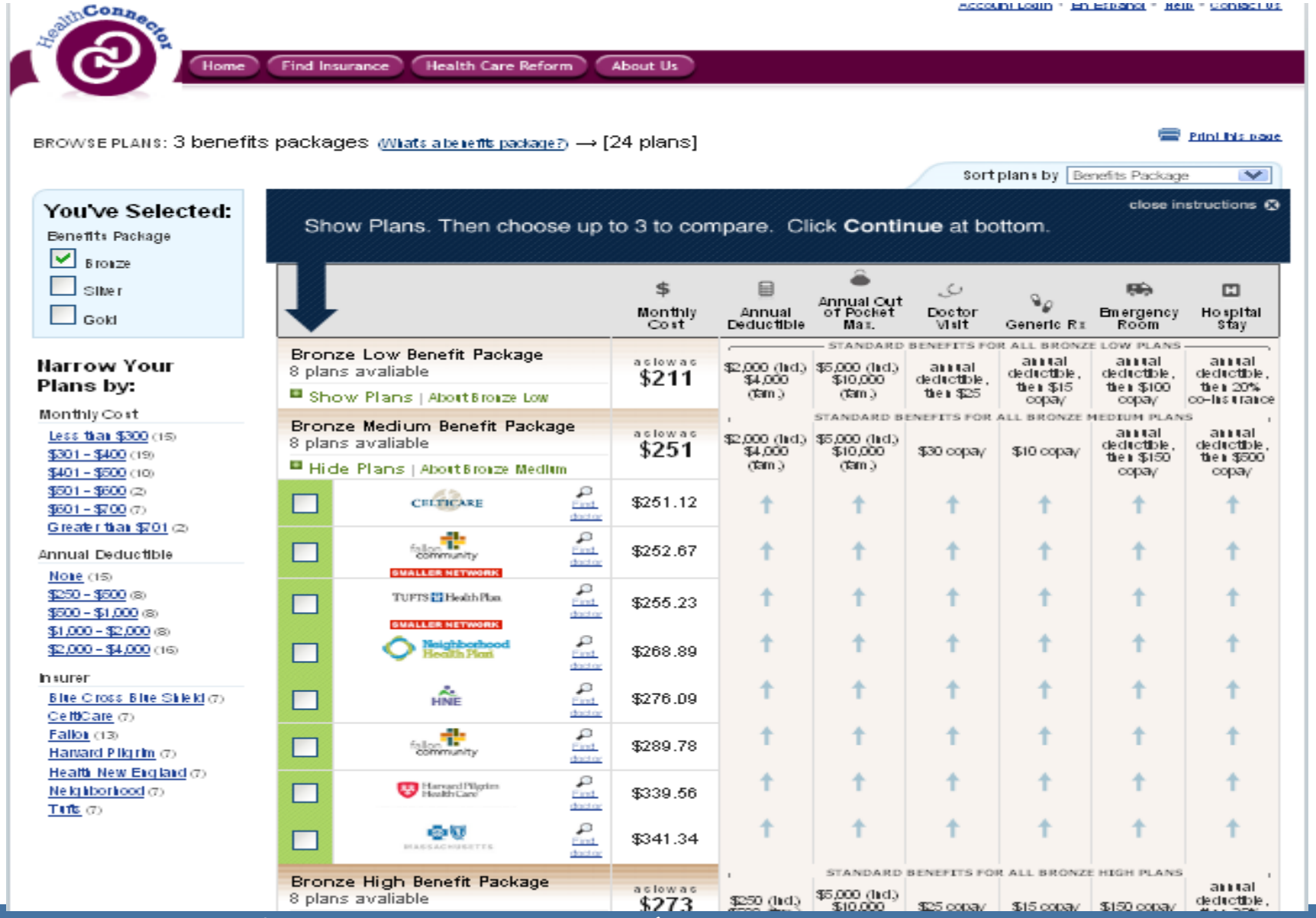
Programs: Key Features

Unlike the ACA which is a unitary program, Massachusetts operated 2 separate and distinct programs (in addition to Medicaid):

Key Features of different Massachusetts programs

PROGRAM	ELIGIBILITY	SUBSIDIZED/ UNSUBSIDIZED	BENEFIT PLANS	ADMINISTRATION
Comm Choice	18+; Income > 300% FPL; no affordable ESI	Unsubsidized	Commercial; 3 benefit tiers (G/S/B)	Connector contracts with "seal of approval" commercial insurers
Comm Care	100% ≤ Income ≤ 300% FPL and not eligible for a MassHealth program	Subsidized (sliding scale)	Medicaid-type co-payments; contributions vary by income category	Connector contracts with Medicaid Managed Care Organizations
MassHealth (Medicaid)	Income ≤ 100%; pregnant; Children <18 etc.	Subsidized	Medicaid-type co-payments; non-contributory	MassHealth (EOHHS) contracts with MMCOs and also administers Fee-for-Service program

Mass 2.0: Standardized Products



Affordability Schedule

for Single Person: Monthly Premium

Annual Income	Mass 2013 Affordability Scale	% of Income
$0 - $11,496	$0	0%
$11,497 - $17,244	$0	0%
$17,245 - $22,980	$40	2.4%
$22,981 - $28,728	$78	3.6%
$28,729 - $34,476	$118	4.5%
$34,477 - $40,195	$178	5.7%
$40,196 - $45,554	$239	6.7%
$45,555 - $51,639	$331	8.2%
$51,640 - $56,273	$359	8.0%
$56,274	10% of income	

Same as Commonwealth Care Premium Schedule

Results

Newly-insured populations as a result of Massachusetts reform

MassHealth *		252,000	
-Pre-reform categories			190,000
- Expansion categories			62,000
Commonwealth Care**		206,394	
Commonwealth Choice**		41,788	
- Individual			36,742
- Small group			5,046
Other Commercial enrollment***		42,212	
TOTAL		542,394	
* at 12/2010			
** at 6/30/2013			
*** Authors' estimates using QCC data			

Age Distribution and Capitation Rates

Age distribution of Commonwealth Care enrollees vs. Massachusetts Population

TOTAL	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	Massachusetts Population*
18-26	35.8%	29.1%	25.5%	25.8%	23.8%	19.3%	17.2%	19.9%
27-39	20.9%	23.0%	23.5%	22.0%	22.0%	23.5%	24.9%	25.8%
40-49	17.8%	19.6%	20.3%	19.5%	19.3%	19.6%	19.9%	23.3%
50+	25.5%	28.3%	30.7%	32.7%	34.9%	37.6%	38.0%	31.0%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Average Commonwealth Care Capitation rates FY 2007-13

	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
Capitation Rate	$354.07	$351.62	$400.70	$396.36	$426.71	$403.95	$356.21
Rate Trend		-0.7%	14.0%	-1.1%	7.7%	-5.3%	-11.8%

Study of Massachusetts Reform

- Began 2009;
- Sponsored by the Commonwealth Fund and the Society of Actuaries.
- Recently completed.
- Study of member plan choice is part.

Member Plan Choice

The average capitation rates fluctuated significantly by year; rates charged by individual MCOs fluctuated even more. The Connector adopted a lowest-bid rate strategy, charging consumers who chose more expensive plans in a particular region the difference between the rate of their chosen plan and that of the lowest-priced plan (in addition to the basic member contribution) consumers in those plan types that charged contributions were faced with year-to-year fluctuations in their contributions. Members generally responded to these price signals. We analyzed the price elasticity of demand for a particular plan in response to the change in that plan's contribution rate, relative to all other plans in the particular plan type.

Elasticity of response to a change in price is defined as $\frac{\partial y/y}{\partial p/p}$ or the relative change in enrollment (y) divided by the relative change in price (p).

Data

Data for this study came from the Massachusetts Quality & Cost Council, an all-payer database established under Chapter 58 (2006). QCC data includes all covered lives except Medicare.

	QCC/MassHealth data Member Months				
FY	Commercial	Commercial*	Medicaid	Commonwealth Care	Commonwealth Choice
2007	40,611,239	33,217,502	13,706,431	711,203	-
2008	41,094,756	32,577,385	14,207,179	2,309,819	37,582
2009	34,829,932	30,018,412	14,165,600	2,175,009	90,082
2010	29,057,070	29,057,070	13,409,365	2,011,326	167,268
2011	10,981,720	10,981,720	6,543,438	955,660	80,514

Member Choice

Member subsidies are administered by charging members a net premium. Separate models were developed for each of plan types IIA, IIB, IIIA and IIIB; because there is little difference between the models for the alternatives within Types II and Type III, we have combined these models in this analysis.

Members are categorized by income level into Plan Types as follows:

Type I < 100% FPL Non-contributory.

Type IIA 101% - 150% Non-contributory*. } Combined for reporting

Type IIB 151% - 200% Contributory.

Type IIIA 201% - 250% Contributory. } Combined for reporting

Type IIIB 251% - 300% Contributory.

Member Choice - Example

BMC Health Plan Member Contributions and Rank (Plan Type IIB)
Income 150% to 200% of FPL)

Fiscal Year	Member Contribution (monthly)	% Change	Relative Change	Rank
2007	$35.00	n/a	n/a	1
2008	$39.00	11.4%	-1.7%	1
2009	$50.44	29.3%	22.2%	3
2010	$58.91	16.8%	-9.3%	3
2011	$91.00	54.5%	39.7%	5
2012	$40.00	-56.0%	-62.2%	1
2013	$40.00	0.0%	2.2%	1

Model

The following linear model was applied within contributory Plan Type:

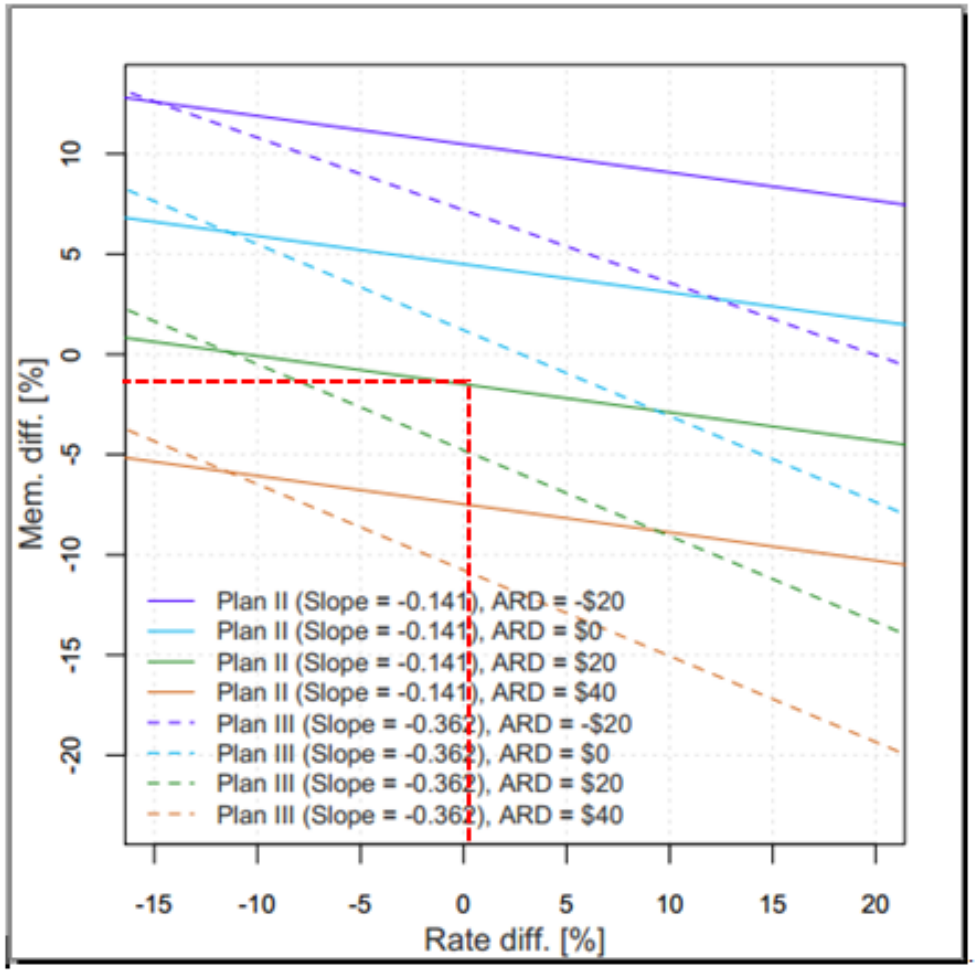
Relative Change in Member enrollment $_i$ =
$\alpha + \beta_1$ Relative Change in Member contribution rate $_i$ + β_2 Year
β_3 Absolute Change in Member contribution rate $_i$ +
β_4 Absolute Member contribution rate $_i$ + ε_i

where i refers to the i-th MCO (BMC; CeltiCare; Fallon; Network Health and Neighborhood Health) and the $\varepsilon_i \approx$ i.i.d. N(0,1). (The error terms, ε_i, are identical and independently distributed random variables, normally distributed with mean 0 and Variance σ^2.)

A number of regression models were developed using Mallows' M estimator, one of a class of robust regression approaches, to limit the effect of outliers.

Results

Figure 5.4 Graphical Representation of Member Response Models



An example of interpretation of the figure is as follows:
The green solid line represents an absolute rate difference of $20. The response of members to a 1% increase in relative rates is -0.141 (or -0.14% decrease for a 1% increase), irrespective of the percentage rate difference. If the ARD is 0% (although the MCO has increased its rate in absolute terms, the increase is equal to the average for all MCOs in that plan Type and therefore its relative rate increase is 0%) we can expect the plan to lose a small percentage of its membership (about 1%).

Results

1. Price elasticity of demand for the more heavily-subsidized plans (Plan Types IIa and IIb that cover individuals between 100% and 200% of FPL) is low and is estimated at -0.14 (lower than elasticity reported in the literature for employer plans). This elasticity implies that for a one percent increase in relative member contribution, a plan will lose 0.14% of its enrollment.

3. Price elasticity for less-subsidized plans (Plan Types IIIa and IIIb that cover individuals between 200% and 300% of FPL) is -0.36; i.e for each 1% increase in price relative to the average of all plans, the plan can expect to lose about 0.36% of its membership.

4. Price elasticities are lower than those reported in the literature for employer plans.

Lessons for State Exchanges

- The largest sub-population to gain insurance was those citizens already eligible for Medicaid who had not previously enrolled. This will prove costly (50% match) and in the future as Federal financing (inevitably) decreases.
- The risk profile of the newly-enrolled is a critical factor.
- The newly-insured tended to be relatively older than the Massachusetts population as a whole, particularly after the extension of parental coverage to age 26 which reduced the number of young enrollees.
- Younger enrollees are under-represented (following the ACA).
- A conclusion from the risk profile analysis of Massachusetts insureds is that there are different sub-populations within the newly-insured, and these populations have different experience and will behave differently. For a state operating an exchange it will be important to identify and manage the mix and utilization of sub-populations.

Lessons for State Exchanges

- Close management of the financial aspects of the exchange is important. Massachusetts achieved very good, stable financial results with the average capitation rate paid to participating MCOs varying very little over seven years (although with volatility within this period) by following an active negotiating strategy and working closely with the MCOs.
- The "3-Rs" as practiced in Massachusetts made a minor contribution to the financial stability of the program.
- Members will move between plans in response to changes in relative member contributions but are less sensitive than employee populations. This is particularly so for the more heavily-subsidized populations.

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