An Interim Report Card on Massachusetts Health Care Reform

Part 3: Administrative Efficiency

No. 55
March
2010

A Pioneer Institute White Paper

by Amy M. Lischko and Kristin Manzolillo

PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

Pioneer's Mission

Founded in 1988, Pioneer Institute is a non-partisan public policy think tank committed to keeping Massachusetts economically competitive and to strengthening the core values of an open society. To inspire market-driven policy reforms, Pioneer promotes individual freedom and responsibility and limited, accountable government. The Institute has changed the intellectual climate in Massachusetts by commissioning timely and rigorous academic studies from leading scholars. Pioneer injects new ideas into the public debate through forums and lectures, transcripts, the media, and outreach to legislators, business groups and the general public.

Pioneer's Centers

■ **This paper is a publication of the Center for Economic Opportunity**, which seeks to keep Massachusetts competitive by promoting a healthy business climate, transparent regulation, small business creation in urban areas and sound environmental and development policy. Current initiatives promote market reforms to *increase the supply of affordable housing*, *reduce the cost of doing business*, and *revitalize urban areas*.

The **Center for School Reform** seeks to increase the education options available to parents and students, drive system-wide reform, and ensure accountability in public education. The Center's work builds on Pioneer's legacy as a recognized leader in the charter public school movement, and as a champion of greater academic rigor in Massachusetts' elementary and secondary schools. Current initiatives promote *choice and competition, school-based management, and enhanced academic performance in public schools.*

The Shamie Center for Better Government seeks limited, accountable government by promoting competitive delivery of public services, elimination of unnecessary regulation, and a focus on core government functions. Current initiatives promote *reform of how the state builds, manages, repairs and finances its transportation assets as well as public employee benefit reform.*

Pioneer Institute is a tax-exempt 501(c)3 organization funded through the donations of individuals, foundations and businesses committed to the principles Pioneer espouses. To ensure its independence, Pioneer does not accept government grants.

An Interim Report Card on Massachusetts Health Care Reform

Part 3: Administrative Efficiency

Amy M. Lischko
Kristin Manzolillo

Contents

Foreword	1
Introduction	2
Background	3
Scorecard Metric 1: Premiums and Medical Loss Ratios in Small and Non-Group Market Compared to Large Group Market	3
Scorecard Metric 2: Competition and Adverse Selection	8
Scorecard Metric 3: Insurance Distribution Costs	12
Conclusions	13
About the Authors	14
Endnotes	15

FOREWORD

In Massachusetts and across the country, the Commonwealth's health care reform has taken on an exaggerated "persona"; for some, it embodies all that is evil about government intrusion into health care markets; for others, it exhibits all the virtues of government action.

The simple fact is that the reform is an experiment. It is likely to succeed on some fronts and fail on others. Given the early stage of our 2006 reform, we are now only starting to gain access to data on outcomes, and the series of years covered is often inadequate to making judgments.

State-level experimentation is needed to test and ultimately to drive the national debate on health care reform. As occurred with welfare reform in the eighties and nineties, robust experimentation allowed federal officials to draw important lessons from the successes and failures of a number of states as they sought a thoughtful national welfare reform bill.

It is undeniably premature to enact a reasoned national-level solution based on Massachusetts' or other state experiments. They have yet to be evaluated. In a field as complicated as health care, where government involvement is already considerable and where states have historically played a defining role, we need a sensible debate based on facts.

That's where the *Interim Report Card* series of reports come in. Our *Report Card* series is the first attempt to provide a comprehensive assessment of the Massachusetts Health Care Reform Act. In January, we released an assessment of the reform's impact on access to care. The second chapter, released in February, focused on the sustainability and fairness of the financing model employed. The cost and quality of care will be dealt with in the fourth and final installment in this series.

Pioneer has not yet taken a position on the reform act. We seek first to understand and measure its performance empirically. Only after publication of the *Report Card* series will we begin suggesting fixes and formulating a comprehensive position. The tone and substance of current federal proposals does not remotely resemble the quality of dialogue we need.

James Stergios

INTRODUCTION

On April 12, 2006, Chapter 58 of the Acts of 2006, entitled "An Act Providing Access to Affordable, Quality, Accountable Health Care" was passed, reforming the Massachusetts health care system. The goals of the legislation were to make health insurance affordable to most every resident and establish mechanisms to help control health care inflation.[1]

Key components of the reform included employer and individual requirements, a small Medicaid expansion, the creation of a state-subsidized insurance program and an insurance exchange, and the merging of the non-group and small group insurance markets.[2] Although the Massachusetts reform has expanded insurance coverage to many of the state's uninsured, the success of other aspects of the reform has yet to be comprehensively evaluated. While much data has been collected on the reform's impact, not all information has been gathered and evaluated in such a manner to provide an inclusive review of the reform.

As an alternative to analyzing the reform's impact on isolated issues, in January 2009 the Pioneer Institute proposed a framework for evaluating the reform.[3] The framework focuses on an evaluation of four key areas:

- Reduction of barriers to access
- Equitable financing, based on ability to pay
- Administrative efficiency
- Cost-effective quality.

Specific metrics to evaluate each of the above areas were proposed in order to conduct a comprehensive review of Chapter 58. This quantitative outcomes approach can help highlight what has and has not worked well as a part of the Massachusetts reform, and can help guide policymakers on the latest reform efforts.

This report is the third in a series of four. The focus of this report is on administrative efficiency. This report will evaluate questions such as: Have there been efficiencies realized by merging the small group and individual markets? Has a competitive market within the Connector been established and if so, has it helped to constrain growth in premium rates? What has been the experience administering the Connector and Commonwealth Care? How do plan administrative costs compare before and after reform? The analysis will be organized by the three Scorecard Metrics presented in Figure 1.

No new data collection was performed to conduct this evaluation. Rather, a systematic approach was taken to evaluate available data. Unfortunately, good data are not readily available for all of the proposed scorecard metrics. When this situation occurred, several different pieces of data were synthesized to arrive at a conclusion. A grade was assigned to each of the scorecard metrics as follows:

A = Excellent performance, high level of certainty that the goal has been achieved.

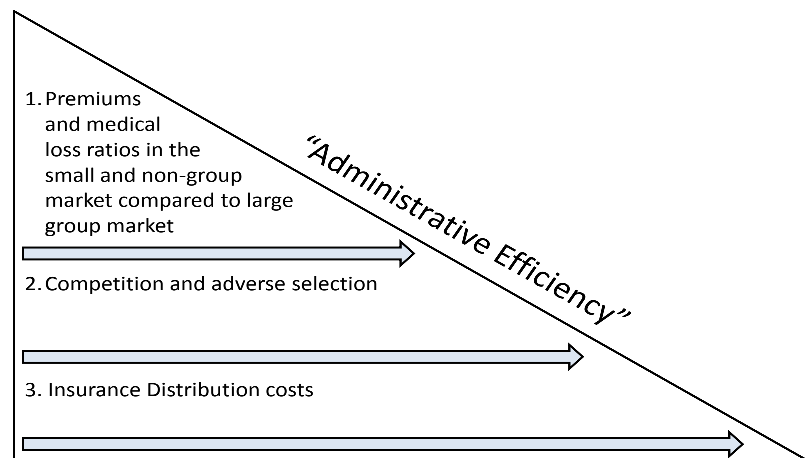
B = Good performance, moderate level of certainty that the goal has been achieved.

C = Mixed results, the available evidence is inconsistent, more research is needed.

D = Poor performance, a high level of certainty that the goal has not been achieved.

I = Current evidence is insufficient to assess whether the goal has been achieved.

Figure 1: Administrative Efficiency Metrics



BACKGROUND

Several components of Chapter 58 deal specifically with the administrative efficiency of health care reform as follows:

- **Establishment of the Commonwealth Health Insurance Connector**: The Connector was created by Chapter 58 of the Acts of 2006 as an independent quasi-governmental agency to implement key elements of the Massachusetts health reform law. The Connector serves many integral functions including management of both "Commonwealth Care" and "Commonwealth Choice" programs. The Connector was designed to assist both individuals and businesses in acquiring health care coverage through these programs, but also facilitates execution of the overall health reform law.
- **Creation of Commonwealth Care Program**: A new program called "Commonwealth Care Health Insurance Program," (CCHIP) was established by the legislation. This program provides subsidies towards the purchase of private health insurance products for adults with incomes below 300% of the Federal Poverty Level (FPL). Full subsidies are available for those with incomes less than 150% of the FPL with sliding scale subsidies available between 150 and 300% of the FPL.
- **Creation of Commonwealth Choice Program**: A new non-subsidized program called "Commonwealth Choice Health Insurance Program," was established by the legislation. This program facilitates choice and the purchase of health insurance for eligible individuals and small groups.
- **Merging of small group and non-group markets**: The legislation required the merging of the individual and small group insurance markets to create one risk pool with one set of rate bands to facilitate lower costs for individuals purchasing insurance without employer subsidies.

SCORECARD METRIC 1: PREMIUMS AND MEDICAL LOSS RATIOS IN SMALL AND NON-GROUP MARKET COMPARED TO LARGE GROUP MARKET

Scorecard Metric 1 is comprised of two different components. The first component measures premiums for individuals and small groups before and after reform to determine whether the reform was successful at lowering costs for these purchasers of health insurance. The second component examines medical loss ratios (MLRs) over the same time period to determine whether any "efficiencies" in carrier administration occurred due to the merging of the non-group and small group markets.

One important component of the reform was the merging of the non-group (individual) and the small group (1-50 employee) markets. This feature was included in the legislation because it was deemed more advantageous to spread the risk of individuals purchasing in the non-group market across a larger risk pool. In addition, it was viewed by some to be more equitable to *all* individuals without access to employer sponsored health insurance. Prior to the reform, a person who was a "sole proprietor" could purchase insurance in the small group market as a "group of 1," while a person who worked for an employer but did not have access to employer sponsored insurance was required to purchase in the non-group market. At the time the reform was passed, rates in the non-group market could exceed those in the small group market by as much as 40% for the same or similar product.

Moreover, product choice was also much more limited in the non-group market. Chapter 58 required that a formal study be conducted to estimate the impact of this market merger on rates. This study concluded that non-group rates would decrease by as much as 25% and small group rates would see small increases of

between 1 to 4%.[4] However, given that there were a fair number of assumptions that went into these estimates, it is important to examine what was the actual impact of the market merger on individual and small group rates, as well as to compare premium trends with those of the large group market over time.

Figure 2 below compares annual premium rates for an individual purchasing a single policy before and after the merging of the small group and non-group markets. Because rating depends on a number of factors, primarily age and geography, the data used here assume a single person aged 25 living in the Boston area. It is important to note that directly comparable data before and after the market merger are not available as benefits have changed somewhat over time. The standard policy in 2006, however, did include similar features as a "gold" Commonwealth Choice policy post reform.

Historical premium data are not readily available from the Division of Insurance (DOI) and thus these data were from a snapshot in time taken on December 1, 2006 and recently reported elsewhere.[5]

Figure 2: Average Annual Massachusetts Individual Premiums, 2006 - 2010

Plan	2006	2008	2010	Projected 2010[1]
HMO Blue	$528	$470	$510	$718
Harvard Pilgrim Health Care	$507	$441	$460	$690
Neighborhood Health Plan	$436	$343	$369	$593
Tufts	$710	$378	$426	$966

Source: Data for 2006 from DOI, available on December 1, 2006.
Data for 2008/2010 from MA Connector, Gold plans for 25 year old living in Boston
[1]2006 rates increased by 8% trend each year.

One cannot directly compare what rates would have been for individuals had reform not merged the markets, as it is very possible that the risk pool enrolled in these products could have changed. However, column four of Figure 2 presents projected premium rates for the non-group market if an average year-to-year trend in premium rate increases of 8% is assumed.

These results show that rates for individuals purchasing insurance in the non-group market have decreased dramatically post-reform. Premium rates in 2010 for a 25-year old purchasing a plan with comparable benefits to those available in 2006 were somewhat lower. And, perhaps more importantly, the difference in actual 2010 premium rates from those projected (had the merger not taken place) ranged from 40-60% (not including Tufts Health Plan – which did not have any significant non-group membership in 2006).

Without actual claims experience it is difficult to isolate and measure the independent effects of the merger versus the changes that may have occurred in the risk pool due to the individual mandate. Because it was presumed that the individual mandate would encourage some healthier people to enter this risk pool, it is likely that some small lowering of rates would have occurred even without the market merger.

The question of whether small group rates increased to compensate for these decreases as expected is another area of inquiry. Small business premiums were also a recent focus of a series of hearings at the DOI.[6] Figure 3 presents individual average (median) premium rates for small and large groups pre and post reform as reported from a survey of employers conducted by the Division of Health Care Finance and Policy (DHCFP). These survey data show the increase in median monthly premiums for small groups from 2007 to 2009 was about 6% per year while for large employers the average increase in rates over the same period was 5%. These premium changes do not take into consideration

any change in benefits during this time period. Figure 4 presents the same data for family plans. For family plans the picture is somewhat different, with small firms' median premiums increasing 12% since 2007 and large firms' median premium costs increasing only 5%.

The DOI also collected and reported premium data from carriers for Health Maintenance Organizations for 2008 and 2009.[7] These data more closely resemble the discrepancy found in small and large firms' family premium increases, with increases for small groups ranging from a low of 5.8% (Health New England) to a high of 14.02% (BCBS of MA); and smaller increases for large firms ranging from 6.2% (Health New England) to 11.9% (Harvard Pilgrim Health Care and Connecticare).

It is not clear why there are larger differences for family rates than for individual rates when assessing increases among small and large firms. A recent report released by DHCFP provides some additional information regarding rate increases for small and large firms.[8] This analysis found that from 2007 to 2008 adjusted premiums for small firms were only slightly higher (5.8%) than for mid-size or large groups (4.8% and 5.4% respectively).

The second component of this scorecard metric includes analyzing the MLR of carriers before and after reform. A MLR is the ratio of medical expenditures to insurance premiums. It should be noted that historically, problems exist with using the MLR as a measure of efficiency.[9] Although over the years the National Association of Insurance Commissioners (NAIC) has sought to standardize the accounting principles behind the calculation of the MLR, many policymakers believe that problems remain when assessing this metric over time and across carriers.[10]

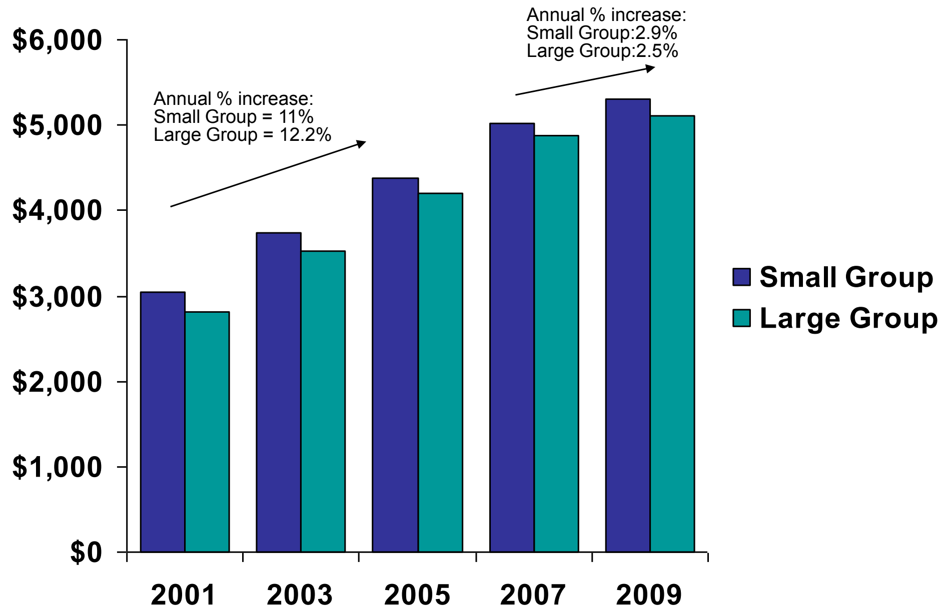
In general, high MLRs are perceived to be better for consumers since a higher percentage of the premium is being spent on medical care instead of administrative costs. This is especially true in a state where nonprofit insurers are in the majority and are not seeking to make profits. However, a high ratio can be achieved either through a large numerator (high medical expenditures) or through a small denominator (low insurance premiums). This fact, coupled with the knowledge that these ratios can be easily manipulated by carriers, makes it difficult to put much confidence in the use of the MLR as a valid indicator of efficiency.

Figure 6 presents MLRs for carriers operating in the Commonwealth before and after reform. From these data, it appears that some carriers have seen a small increase in their MLRs post reform. As noted earlier, it is difficult to understand why this increase in MLR occurred. It could be that insured people are seeking more medical care or that premiums were set lower.

Another benchmark for measuring efficiency is to simply observe the ratio of administrative costs to premium, or the administrative expense ratio. The DHCFP has been monitoring this ratio for plans operating in Massachusetts since the merging of the markets in 2007. Figure 7 presents results for the administrative expense ratio across carriers. These results suggest that administrative costs have remained steady for most plans since the merger of the markets in Massachusetts although small changes are noted in both directions for certain plans. In particular, an increase in the administrative expense ratio is observed for the largest plan in Massachusetts, Blue Cross and Blue Shield of Massachusetts. However, a recent report released by the DHCFP[11] reported that administrative expenses for all carriers grew more slowly from 2006-2008 than in previous years with per member per month increases of 2.5% in 2007 and 1.4% in 2008. That report also noted a high merged market MLR (88.1%) which the authors attributed to a 112% MLR on individuals in 2008.

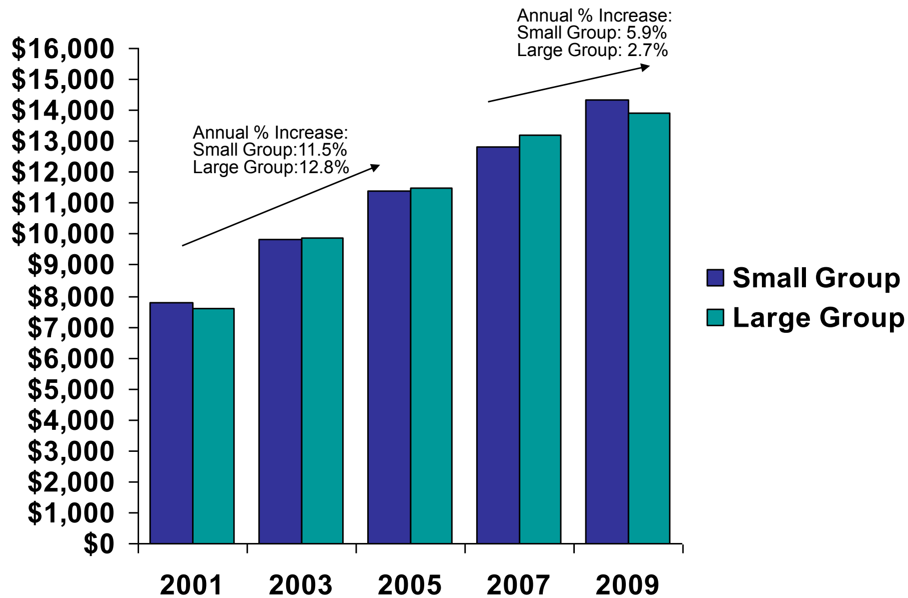
In summarizing data used for this scorecard metric, it can be concluded that rates for individuals purchasing in the non-group market were reduced dramatically due to the market merger. Although premium increases for small and large

Figure 3: Individual Premium Rates for Small and Large Groups, 2001 - 2009



Source: DHCFP Massachusetts Employer Survey

Figure 4: Family Premium Rates for Small and Large Groups, 2001 - 2009



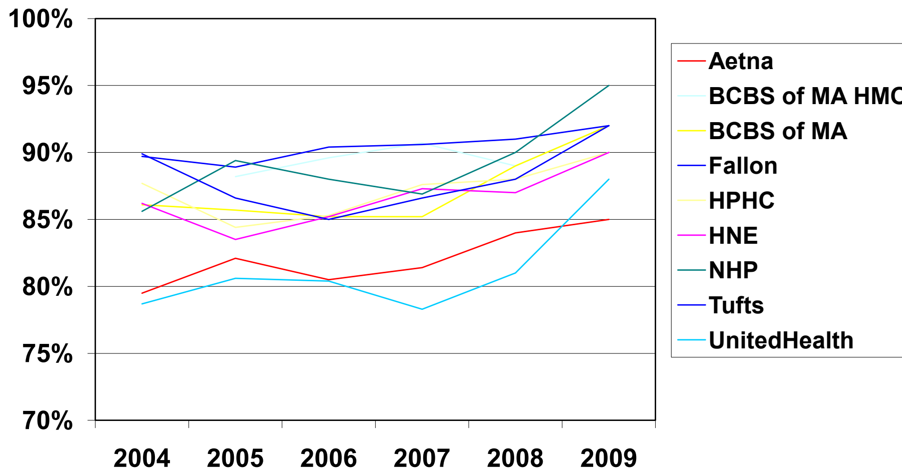
Source: DHCFP Massachusetts Employer Survey

Figure 5: HMO Premiums for Small and Large Groups, 2008 and 2009

Carrier	Small Group 08	Small Group 09	Large Group 08	Large Group 09
BCBS MA	$348.57	$397.44	$331.83	$364.55
Harvard	$400.82	$437.73	$380.17	$425.24
Neighborhood Health Plan	$413.06	$461.98	$396.62	$443.59
Tufts	$385.90	$420.24	$382.49	$414.31
Connecticare	$332.83	$366.94	$353.48	$395.46
Health New England	$381.38	$403.57	$340.60	$361.77
Fallon	$315.49	$358.23	n/a	n/a

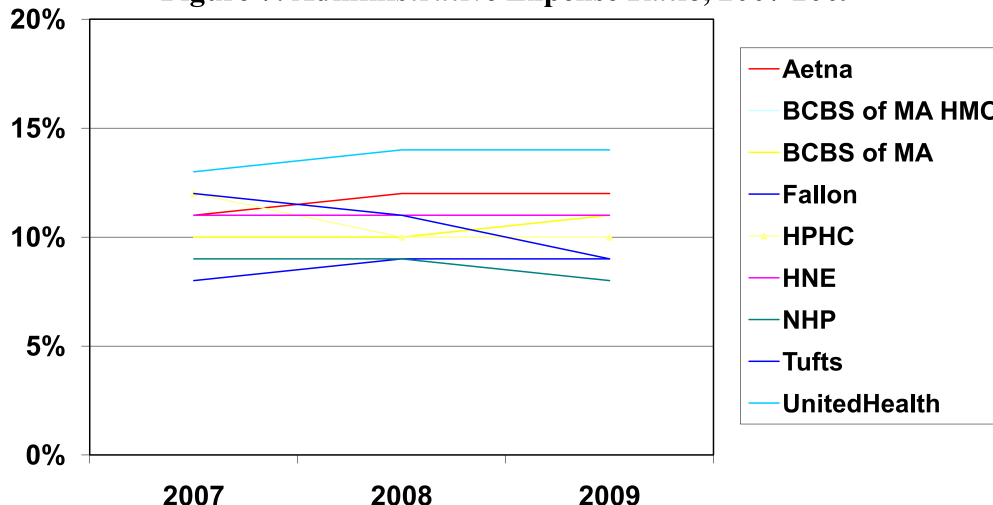
Source: HMO rates accessed from DOI on January 12, 2010 http://www.mass.gov/Eoca/docs/doi/Consumer/HMO/pmpm_increase.pdf. In cases where a carrier has more than one HMO plan, the lowest cost plan is shown here.

Figure 6: Medical Loss Ratios for Massachusetts by Carrier, 2004 – 2009



Source: (2004-2007) Giesa, K, Fritchen, B and Armstrong, S, Analysis of Administrative Expenses for Health Insurance Companies in Massachusetts, 2008. (2008-2009) http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_nov_09.pdf2009 is first 6 months only

Figure 7: Administrative Expense Ratio, 2007-2009



Source: (2004-2007) Giesa, K, Fritchen, B and Armstrong, S, Analysis of Administrative Expenses for Health Insurance Companies in Massachusetts, 2008. (2008-2009) http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/key_indicators_nov_09.pdf2009 is first 6 months only

employers are similar for individual premiums, rate increases for family premiums have increased at a greater rate (for small groups) than those observed for larger groups. In addition, some of the data provide evidence that the market merger may have reduced administrative costs overall for carriers but led to increases in administrative costs for the carrier with the highest market penetration (BCBS of MA).

It will be important to monitor median rates and the range of rate increases closely. It may be important to analyze family rates more closely to determine why the rate of increase was greater in small firms. Large annual increases cannot be sustained year after year especially with a declining economy. Smaller firms may experience much more volatility in their rates from year-to-year than larger firms and the state may want to explore approaches for smoothing these increases in addition to addressing the overall issue of increasing costs.

This Scorecard Metric earns a grade of B as there is a moderate level of confidence that the goal of reduced premiums for individuals due to the market merger occurred and some modest increases in efficiency.

Overall grade for Scorecard Metric 1: B

SCORECARD METRIC 2: COMPETITION AND ADVERSE SELECTION

The next scorecard metric was intended to assess adverse selection and competition in the market before and after reform. Because data measuring this issue are not yet available and Massachusetts included a number of features in its law to avoid adverse risk selection, as described below, this scorecard metric does not include direct measurement of the first component.

Massachusetts employed several techniques to avoid overall adverse selection, that is, that only sick people purchase health insurance while healthy individuals remain outside the insurance system. First, the non-group and small group markets were merged, as noted earlier, which lowered rates for individuals purchasing insurance without an employer subsidy. This action alone would presumably encourage more healthy people to purchase insurance. Second, the law's individual mandate required people obtain health insurance if affordable, thereby increasing the likelihood that healthy people would also join both the subsidized and non-subsidized insurance pools.

There are not a lot of data available yet to assess whether healthier people were more likely to remain uninsured under reform. In Chapter 2 of this series, it was noted that people remaining in the Safety Net Program[12] appear healthier than those who were being served by the Uncompensated Care Pool (UCP) prior to reform, suggesting that sicker people may have been more likely to enroll in the program.

In the private market there is some evidence of risk selection as well. Recent data cannot confirm or refute this concern but carriers have reported that the relatively higher MLRs in the individual market post-reform provide some evidence that individuals who need care may be purchasing insurance at the time of need and then dropping coverage.[13] Under the merged market rules, individuals can purchase insurance at any time during the year. Although carriers are permitted to impose a six month waiting period on their entire book of business, no insurers have done so.

Finally, in addition to the above general issues of adverse selection, some also worried about selection into the Connector as this was one of the failings of earlier attempts at purchasing pools.[14,15,16] The law, however, required that rating rules be the same whether purchasing insurance from the Connector or directly from the carrier to avoid selection into or out of the Connector. To mitigate risk selection among the carriers

inside the Connector, the staff and Board of the Connector devised a tiered approach for enrolling small groups. The Contributory Plan, as it is called, allows small employers with 50 or fewer full-time employees to subsidize their employees' purchase of health insurance through the Choice program. An employer must select a level of plan for their employees (Gold, Silver or Bronze), and agree to pay at least 50% towards the employee premium (and meet carrier participation rules). Employees can then take that base employer contribution and select any carrier's plan within the tier of coverage selected by the employer. They may not buy a product outside the tier selected by their employer. Because of these implementation decisions, there is less chance of risk selection across carriers.

Analyzing the adverse selection issue further requires a sophisticated claims-based analysis. A study funded by the Robert Wood Johnson Foundation is currently underway to assess the issue of adverse selection in the Massachusetts marketplace using de-identified claims data from both Commonwealth Care and the private market.[17] Another study is also being conducted on the private market by the Division of Insurance. Until those results are in, it is difficult to fully assess this component of scorecard metric 2.

It is important to evaluate whether the reform has been successful in increasing competition in the individual and small group markets. It is widely acknowledged by policymakers that good competition among carriers is based on price and quality of the plan and not on plans competing by selecting better risk. Competition is measured here by: 1) examining whether any new carriers have come into the marketplace and, 2) assessing whether existing carriers are competing in a meaningful way over price and quality. This scorecard metric will examine how much, if any, product innovation has been brought to the market and whether the model implemented by the Connector provides individuals and small groups with an attractive alternative for purchasing health insurance. The focus of this analysis will be on the private insurance market.

On or after July 1, 2007 (the time the markets were merged) all small group benefit plans offered by carriers were made available to eligible individuals. No new carriers have yet to offer insurance in the private marketplace, however, the number of options for individuals has increased exponentially. That is because before reform (from 1997-2007) health carriers were allowed to offer only two types of standardized non-group health plans. One plan offered by a carrier was required to include, at a minimum, a standard set of benefits and cost-sharing levels. Carriers were allowed to offer one alternate plan which typically excluded prescription drugs.

Post reform, there is no limit to the *number* of plans a carrier may offer to individuals. However, individuals are now required to have insurance that meets minimum creditable coverage standards.[18] Some may view these requirements as limiting choice for individuals. According to the DOI website over 150 product choices are available to individuals and small groups from 12 different carriers.[19] This seems to be a sufficient number of carriers and products for adequate competition to occur.

Commonwealth Choice benefit plans are offered both inside and outside the Connector to individuals, and to small groups on a pilot basis. However, not all plans offered outside the Connector are also offered inside the Connector. The Connector limits the number of carriers and plans sold through its distribution channel. In 2010, for example, only 6 carriers with up to 9 benefit plans each have been approved for sale through the Connector. The Connector developed its own "seal of approval" process through which plans offered must meet higher standards in terms of benefit levels than those already in place for the state's overall insurance market. The Connector conducted focus groups with consumers purchasing in the non-group market and found that consumers generally

wanted fewer, more meaningful product choices. That, in combination with the Board members' overall belief that standardization is important in a managed-competition environment, prompted the Connector to reduce the number of options available to consumers through the Connector this year.

Before the market merger, the non-group market was dominated by one carrier, BCBS of MA, which held nearly three-quarters of the non-group market (see Figure 8). Harvard Pilgrim Health Care was second with a little over 15% of the market. While current numbers are not available to assess market share for individuals purchasing in this market, looking just at products sold through the Connector in 2009 an entirely different picture emerges. Four carriers, BCBS of MA, Harvard Pilgrim Health Care, Neighborhood Health Plan and Fallon Health Care hold almost equal shares of the market.

Figure 9 shows that the distribution of enrollment among carriers has changed over time for individuals purchasing through the Connector. In addition, people who enroll through the Connector seem to favor lower cost options or (bronze pans) as shown in Figure 10. While it is impossible to discern the health status of those enrolling via the Connector, what is evident is that consumers are selecting lower cost options when they purchase through the Connector. Presumably this is because they can make comparisons across plans.

It should be noted, however, that not all consumers are purchasing insurance via the Connector when given the opportunity. Out of nearly 84,000 individuals purchasing coverage without an employer subsidy (not including young adult plans), fewer than one-quarter are choosing to enroll in plans via the Connector. About half of all new purchasers are purchasing through the Connector, including about 5,000 young adults who are purchasing plans only available through the Connector. It is unclear why so many individuals are choosing to purchase directly from the carrier.

Additional information is necessary to determine whether individuals are enrolling in the same products available in the Connector or whether they are enrolling in different products which are only available outside the Connector. Enrollment data by plan should be more readily available by the DOI to track these important trends.

The small employer model, which has only been in a pilot phase during calendar year 2009, has enrolled an insignificant portion, thus far, of the snall group market. The Connector plans to target the mini-employer market this year in the hopes of enrolling more small employers to its distribution channel. The Connector may also open the pilot phase of the contributory product to all brokers. Thus far, employers overall have seen very little value in the Connector as a distribution channel. A recent survey of employers found that only 37% were even familiar with the Health Connector.[20]

The Connector's experience with individual purchasers provides some evidence of a market shift and greater competition among carriers. However, if consumers and small employers continue to purchase products offered outside the Connector with greater frequency than inside, the Connector's role in stimulating competition in the overall marketplace may be diminutive and changes may need to be made to their model to move the overall market in any meaningful way.

Data on adverse selection is not yet in and overall evidence that the reform has increased competition in the Massachusetts marketplace is small. However, some competition is apparent in the Connector and therefore this scorecard metric earns a score of B.

Overall grade for Scorecard Metric 2: B

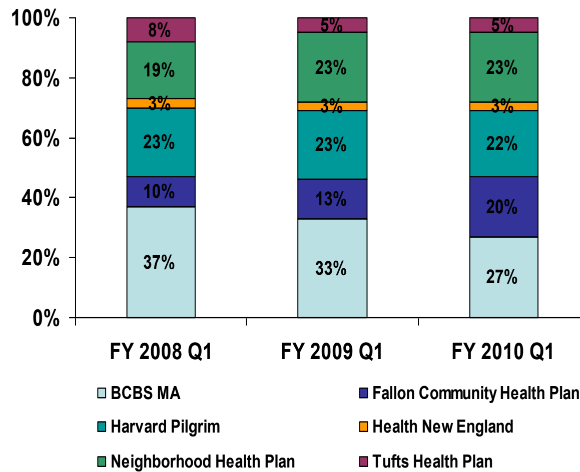
Figure 8: Non-Group Market Share, 2005 and 2010

Carrier	Total Guaranteed Issue Membership Share 2005 [1]	Commonwealth Choice Connector 2010 [2]
BCBS MA	72.2%	26%
Harvard	15.7%	27%
Neighborhood Health Plan	<1%	22%
Tufts	1.7%	6%
Health New England	.9%	3%
Fallon	3.1%	16%

Source: [1]DOI, Guaranteed Issue Nongroup Membership, 12/31/05 [2]MA Health Connector, January Board meeting, includes YAP members

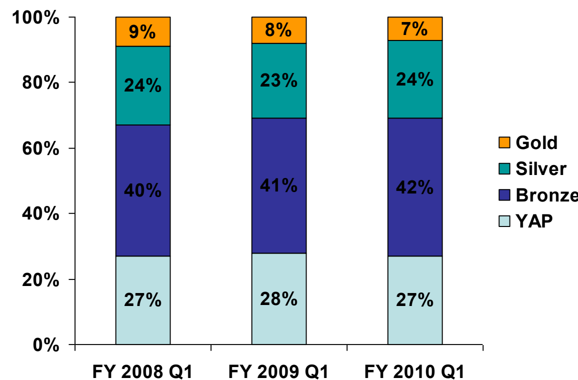
---

Figure 9: Connector Commonwealth Choice Enrollment by Carrier, FY 2008 –FY 2010



Sources: MA Health Connector, Quarterly Ops Report, October 8, 2009; MA Health Connector, Quarterly Board Operations Report, October 17, 2008; MA Health Connector, Commonwealth Choice Progress Report, October 11, 2007

Figure 10: Connector Commonwealth Choice Enrollment by Benefit Level, FY 2008 –FY 2010



Sources: MA Health Connector, Quarterly Ops Report, October 8, 2009; MA Health Connector, Quarterly Board Operations Report, October 17, 2008; MA Health Connector, Commonwealth Choice Progress Report, October 11, 2007

SCORECARD METRIC 3: INSURANCE DISTRIBUTION COSTS

The last scorecard metric for this chapter assesses the distribution costs of insurance in Massachusetts pre- and post-reform. The Connector was established, in part, to reduce the administrative costs for individuals and employers purchasing health insurance. This scorecard metric will evaluate the costs of the Commonwealth Care Health Insurance program as a percentage of total costs and in comparison to Medicaid. The distribution costs of Commonwealth Choice will also be compared to the distribution costs of private insurance plans in Massachusetts.

Some have argued that exchanges can facilitate substantial reductions in administrative costs incurred by employers and insurers.[21,22] However, purchasing cooperatives have rarely yielded significantly lower administrative costs for employers, employees and insurers. Lower administrative costs are observed in large employer groups and in large groups such as the Group Insurance Commission (GIC) but the reasons that these groups have lower administrative costs are not necessarily transferable to exchanges overall. Some policymakers believe that cutting out the middleman or agent (broker) can save administrative costs. However, if the Connector eliminated the broker role, it would need to devise and pay for its own marketing capabilities and provide a similar level of customer service to employers and individuals.

The experiment in Massachusetts is complicated by the fact that the Connector distribution channel exists side-by-side the other distribution channels, requiring carriers to maintain their own broker and customer service capabilities while some of these functions are duplicated within the Connector. Thus, the addition of the Connector likely added some administrative costs to the system overall.

Per the enabling legislation, the Connector can charge an administrative fee on premiums for administration of both the Commonwealth Care and Commonwealth Choice products. Because the Commonwealth Care program is exclusive to the Connector, the administrative fee does not need to mirror that in other programs. The administrative fee applied to Commonwealth Care premiums began at 5%, decreased to 4.5% in its second year of operation, and were lowered again to 4% in years 3 and 4. This decrease is expected because as premiums increase some fixed costs remain constant.

The administrative fee applied to Commonwealth Choice premiums needs to coincide with distribution costs charged outside the Connector as the overall premium rates are not permitted to vary. These costs have remained at 4.5%.

Using data provided by the Connector from its annual audit (Figure 11) it was found that the administration of the overall program (including Commonwealth Care and Commonwealth Choice) is about 4.2% of its costs. According to a recent publication by Kaiser Family Foundation, public Medicaid programs' administrative costs average around 7%.[23] Another study found administrative expenses for Medicaid programs to average about 8.8% of the premium.[24] This is not exactly a fair comparison, however, since most Medicaid programs still maintain some fee-for-service element which requires greater administrative overhead.

From available data it can be concluded that the Connector is efficient at operating the Commonwealth Care and Choice plans compared to the costs of administering Medicaid plans. However, there is an element of redundancy in a number of tasks both in the management of Commonwealth Care and Commonwealth Choice product distribution. The Connector's overall administrative budget exceeds $30 million per year. Moreover, there are additional costs to the system for parties interacting with various state agencies including the state Medicaid agency, the

Figure 11: Health Connector Administration Fees Compared to Total Operating Expenses, FY 2008 and Q1-Q3 2009

	Commonwealth Care and Commonwealth Choice					
	Average # of Members[1]	Total Administration Fee[2]	Administration Fee PMPM	Total Operating Expenses[3]	Operating Expenses PMPM	Administration Fee as % of Operating Expenses
FY 2008	173,941	$29,944,479	$14.35	$653,910,383	$313.28	4.6%
Q1 - Q3 2009	184,503	$35,447,532	$16.01	$837,925,299	$378.46	4.2%

Sources: [1]MA Health Connector, Quarterly Ops Report, October 8, 2009; MA Health Connector, Quarterly Board Operations Report, October 17, 2008; [2]Commonwealth Health Insurance Connector Authority, Financial Statements and Required Supplmentary Information, June 30, 2009 and 2008, prepared by KPMG LLP; [3]Commonwealth Health Insurance Connector Authority, Financial Statements and Required Supplmentary Information, June 30, 2009 and 2008, prepared by KPMG LLP

Connector, and the DOI. These additional costs are difficult to quantify.

Sources:
[1] MA Health Connector, Quarterly Ops Report, October 8, 2009; MA Health Connector, Quarterly Board Operations Report, October 17, 2008
[2] Commonwealth Health Insurance Connector Authority, Financial Statements and Required Supplmentary Information, June 30, 2009 and 2008, prepared by KPMG LLP
[3] Commonwealth Health Insurance Connector Authority, Financial Statements and Required Supplmentary Information, June 30, 2009 and 2008, prepared by KPMG LLP

Commonwealth Care could have been administered through the state's Medicaid program since many of the functions are more or less the same. While some additional capabilities would have been necessary to address program differences, it would have undoubtedly been less costly than the added infrastructure costs of an entirely new organization.

Regarding Commonwealth Choice, with just under 25,000 members as of January 2010,[25] the Connector has not yet been able to gain administrative efficiencies within the commercial market. The Connector recently announced their plans to partner with the Small Business Service Bureau (SBSB) to offer the private "mini-group" market (1-5 employees) a lower cost alternative. Through this effort the Connector hopes to decrease administrative costs for the very small businesses while also increasing the number of non-subsidized lives covered in the Connector. By enrolling these employers into the Connector, the administrative fee charged to carriers will be reduced from 4.5% to 3.5%, with the hopes of passing the savings on to the small employer. This effort should be monitored closely to determine if administrative efficiencies are gained.

Although the Connector is managing the programs it oversees efficiently, this new infrastructure has added administrative costs to the overall health care system in Massachusetts. Because there is no evidence yet of a reduction in administrative costs for the system as a whole, the overall grade for this scorecard metric is a C.

Overall grade for Scorecard Metric 3: C

CONCLUSIONS

Overall, the framework and scorecard metrics proposed by the Pioneer Institute were somewhat useful in summarizing the effects of the Massachusetts Health Care Reform around Administrative Efficiency. In some cases, additional data are necessary to form conclusions.

First, the market merger was successful at reducing rates for individuals purchasing health insurance on their own without the help of an employer's subsidy. Premium rates for individuals were reduced dramatically post reform. From available data, post-reform rate increases for small employers are no higher than pre-reform increases although for small employers, volatility of rate increases still remain a problem. New data provide some evidence that the market merger *reduced* overall administrative costs for carriers.

Second, evidence that the reform has increased competition in the Massachusetts marketplace is weak. Although some competition is apparent

within the Connector, there are not yet enough lives purchasing through this entity to have a significant impact on the overall market.

Finally, although the Connector is efficient at managing the programs it administers, the overall additional costs of this new structure need to be considered. Policymakers in other states may want to consider whether the infrastructure costs of a Connector-like structure outweigh the benefits it conveys.

Overall, the scorecard for administrative efficiency earns a B. There is some evidence that these aspects of reform have worked to improve efficiencies in the system overall. It will be important to monitor these metrics moving forward to determine if further efficiencies can be gained.

The next and final report in Pioneer's *Interim Report Card* series will evaluate cost-effective quality and will attempt to answer the following questions: Has the Health Care Quality and Cost Council effectively transmitted data to users? Has the Health Care Access Bureau at the DOI improved quality and value through transparency? Has the Health Disparities Council identified and reduced disparities?

About the Authors:

Amy M. Lischko has over fifteen years of experience working for the Commonwealth of Massachusetts, most recently as Director of Health Care Policy and Commissioner of the Division of Health Care Finance and Policy under Governor Romney. Dr. Lischko holds a doctorate degree in health services research from Boston University and was one of the key authors of the administration's health care reform proposal.

Kristin Manzolillo is currently an MPH candidate at the Tufts University School of Medicine. She received her undergraduate degree in community health and history from Tufts University. Upon graduation, Kristin spent two years at a human capital consulting firm, where she engaged in health and welfare benefit design and strategy development on behalf of large employers.

About Pioneer:

Pioneer Institute is an independent, non-partisan, privately funded research organization that seeks to change the intellectual climate in the Commonwealth by supporting scholarship that challenges the "conventional wisdom" on Massachusetts public policy issues.

Endnotes

1. The Health Care Quality and Cost Council, established via Section 16K of the law, was tasked with developing health care quality improvement and cost containment goals.

2. Weissman, JS, and Bigby, J. Massachusetts Health Care Reform – "Near-Universal Coverage at What Cost?" *New England Journal of Medicine*, October 21, 2009, 361 (121): 2012 -2015.

3. Miltenberger M, and Poftak S. Massachusetts *Healthcare Reform: A Framework for Evaluation*. Policy Brief, Shamie Center for Better Government, Pioneer Institute, January 2009.

4. http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf, accessed January 2010.

5. http://commonhealth.wbur.org/nancy-turnbull/2008/09/individual-market-reforms-data-for-a-few-more-powerpoint-slides-by-nancy-turnbull/#more-626, accessed January 2010.

6. www.mass.gov/?pageID=ocasubtopic&L=5&L0=Home&L1=Government&L2=Our+Agencies+and+Divisions&L3=Division+of+Insurance&L4=Health+Plan+Informational+Hearings&sid=Eoca, accessed January 2010

7. http://www.mass.gov/Eoca/docs/doi/Consumer/HMO/pmpm_increase.pdf, accessed January 2010.

8. Welch, D, Oliver Wyman Actuarial Consulting, Inc. *Premium Levels and Trends in Private Health Insurance Plans*, February 2010.

9. Robinson, James C. "Use and Abuse of the Medical Loss ratio to Measure Health Plan Performance," *Health Affairs*, Volume 16,(4) 1997.

10. Ibid.

11. Welch, D, Oliver Wyman Actuarial Consulting, Inc. *Premium Levels and Trends in Private Health Insurance Plans*, February 2010.

12. Lischko, Amy M, Manzolillo, Kristin, *An Interim Report Card on Massachusetts Health Care Reform Part 2: Equitable and Sustainable Financing*, No. 51, February 2010

13. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/cost_trends_files/part2_priv_health_ins_premium_trends.ppt

14. Wicks, E.K. et al. March 2000. "Barriers to Small-Group Purchasing Cooperatives" *Economic and Social Research Institute*: accessed November 2005: http://www.esresearch.org/Documents/HPC.pdf

15. Curtis, Richard et al. 2001. "Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?" *Health Affairs* 20(1): 164-168.

16. Wicks, E.K. 2002. "Health Insurance Purchasing Cooperatives" *The Commonwealth Fund*: accessed November 2005: http://www.cmwf.org/usr_doc/wicks_coops.pdf

17. Evaluation of Risk Selection in Market-Based State Programs, PI- Deborah Chollet, Co-PI Amy Lischko, Funded by the State Health Access Reform Evaluation Project, RWJF.

18. Minimum creditable coverage must include prescription drug coverage, 3 regular doctor visits and check-ups for an individual or 6 for a family before any deductibles, caps the deductible at $2,000 for an individual or $4,000 for a family each year, caps out-of-pocket spending for non-Rx health services at $5,000 for an individual or $10,000 for a family each year if you have a deductible or co-insurance) and does not cap total benefits for a sickness or for each year. For more detail see: https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/956%2520CMR%25205%252000%2520Final%2520Regulations-Official%2520103108.pdf

19. http://www.mass.gov/?pageID=ocaterminal&L=5&L0=Home&L1=Consumer&L2=Insurance&L3=Health+Insurance&L4=Health+Care+Access+Bureau&sid=Eoca&b=terminalcontent&f=doi_Consumer_css_health_smlindgroup&csid=Eoca, accessed January 2010.

20. http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/10/mes_results_2009.ppt, accessed January 2010.

21. Holahan J and Blumberg L, "Massachusetts Health Care Reform: A Look at the Issues," *Health Affairs* 25 (web Excl): w432-w443. 2006

22. McDonough, J, Roaman, B, Phelps, F, Shannon, M. "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* 25 (web Excl)w420-w431, 2006.

23. http://www.kaiserhealthnews.org/Stories/2009/July/01/Medicaid-True-or-False.aspx, accessed January 2010

24.http://www.news-medical.net/news/20091014/Core-administrative-costs-in-Medicaid-plans-decreases-by-1425-in-2008-SEER-study.aspx

25. https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520Board%2520Meeting%2520January%252014%252C%25202010/CommChoice%2520Board%2520Presentation%2520-%252001%252014%252010_DRAFTv5%2520Pres%2520%2520Version1%2520FINAL.ppt#3, accessed January 2010.

Recent Pioneer Publications

Beyond Demographic Destiny: An Analysis of Massachusetts Minority and White Student Achievement Gaps, White Paper, March 2010

Heading Down: The Loss of Massachusetts Headquarters, White Paper, March 2010

An Interim Report Card on Massachusetts Health Care Reform Part 2: Equitable and Sustainable Financing, White Paper, February 2010

Failure to Thrive: Job Creation and Loss in Massachusetts: 1990-2007, White Paper, January 2010

An Interim Report Card on Massachusetts Health Care Reform Part 1: Increasing Access, White Paper, January 2010

Debunking the Myths About Charter Public Schools, Policy Brief, January 2010

Drawing Lessons: Different Results from State Health Insurance Exchanges, Policy Brief, December 2009

85 Devonshire Street, 8th Floor, Boston, MA 02109 T: 617.723.2277 | F: 617.723.1880 | www.pioneerinstitute.org