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Selection in Massachusetts' Commonwealth Care Program: Lessons for State Basic Health Plans

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) allows for each state to develop a Basic Health Plan, which would enroll individuals with family income below 200 percent of the federal poverty level (FPL) who are ineligible for Medicaid. The Basic Health Plan would operate independently of the state's health insurance exchange, and it would receive separate federal financing equal to the subsidies that enrollees would have received if they had been enrolled in an exchange plan.

Risk selection is a major concern for states as they plan exchanges and decide whether to develop a Basic Health Plan. The enrollment of many previously-uninsured individuals into the exchange might disrupt the commercial insurance market. If a state's exchange attracts individuals who are less healthy than current commercial enrollees and risk adjustment is imperfect, adverse selection could raise premiums in the exchange and drive unsubsidized enrollees to seek coverage outside the exchange. In turn, this would leave fewer participants over whom to spread the administrative costs of operating the exchange and perhaps fewer health plans willing to participate in the exchange.

A Basic Health Plan could help buffer the exchange from adverse risk by separately pooling and financing the medical risk of low-income adults. However, if the Basic Health Plan itself experiences adverse selection, enrolling only those who need care, states may find it difficult to finance the program through federal subsidies alone.

CommCare is a separate health plan that serves low-income adults ineligible for Medicaid, much like a Basic Health Plan under the ACA.

In 2006, Massachusetts enacted health care reform legislation that became the fundamental model for the ACA. Massachusetts' reforms included the creation of the Commonwealth Care Program, or CommCare. CommCare is a separate health plan that serves low-income adults ineligible for Medicaid, much like a Basic Health Plan under the ACA. Massachusetts' health care reforms are widely viewed as successful, and CommCare has been an important component of their success. By 2008, just 5 percent of adults filing personal income tax returns lacked health care coverage at any time during the year (Massachusetts Health Connector and Department of Revenue 2010). By the end of 2008, CommCare covered nearly 40 percent of newly insured residents.

While CommCare initially experienced adverse selection, risk selection improved over time as Massachusetts implemented its individual mandate, increased the level of income at which adults qualified for full subsidies, and auto-enrolled eligible adults from the state's Uncompensated Care Pool.

CommCare's experience offers important lessons for states considering whether to form a Basic Health Plan, especially with regard to the health status and health service use of individuals likely to enroll. While CommCare initially experienced adverse selection, risk selection improved over time as Massachusetts implemented its individual mandate, increased the level of income (to 150 percent of poverty) at which adults qualified for full subsidies, and auto-enrolled eligible adults from the state's Uncompensated Care Pool.

If other states are similarly successful in encouraging relatively healthy low-income adults to enroll, a Basic Health Plan might enroll adults with similar or less medical need than adults currently enrolled in commercial individual coverage—although probably higher-risk than those (at higher incomes) who would newly enroll in commercial coverage through the exchange. This prospect, coupled with the potential for significant administrative costs as many enrollees transition to and from Medicaid, could challenge states expecting to finance the Basic Health Plan only with federal funds.

THE COMM CARE PROGRAM

CommCare is a subsidized market model of coverage for low-income adults. Adults with household income at 300 percent FPL or less may enroll in CommCare if they have no affordable offer of employer coverage and are ineligible for coverage in MassHealth (Medicaid), Medicare, Tricare, or certain other insurance programs. CommCare is offered through the Connector, Massachusetts' flagship health insurance exchange, but only in CommCare plans can eligible individuals obtain subsidies to offset all or part of the cost of their premiums. CommCare fully subsidizes premiums for adults with income below 150 percent of FPL and partially subsidizes premiums for those with income from 150 to 300 percent FPL, who in general are subject to Massachusetts' individual mandate.

CommCare opened in late 2006. That year, it served only eligible adults with income below 100 percent FPL who were auto-enrolled from the state's Uncompensated Care Pool (UCP) program and fully subsidized. In January 2007, CommCare opened enrollment to all eligible adults below 300 percent FPL. In the first half of the year, enrollees with income above 100 percent FPL were required to pay part of the cost of premiums. A full subsidy was extended to enrollees up to 150 percent FPL in July 2007, and individuals in this higher income group were then also auto-enrolled from UCP.

Since the first enrollees were auto-enrolled from the UCP, it is not surprising that, from the start of the program, CommCare enrollment was concentrated among adults with income below 150 percent FPL and, therefore, eligible for fully subsidized premiums either initially or within months of enrollment. Enrollment of these adults grew rapidly

throughout 2007 (when many were auto-enrolled) and stabilized in early 2008. Other adults (those eligible for a partial subsidy in all months of enrollment, or eligible for a full subsidy in some months and a partial subsidy in others as their income changed) entered the program more slowly but accounted for nearly one-third of all enrollees by December 2008.

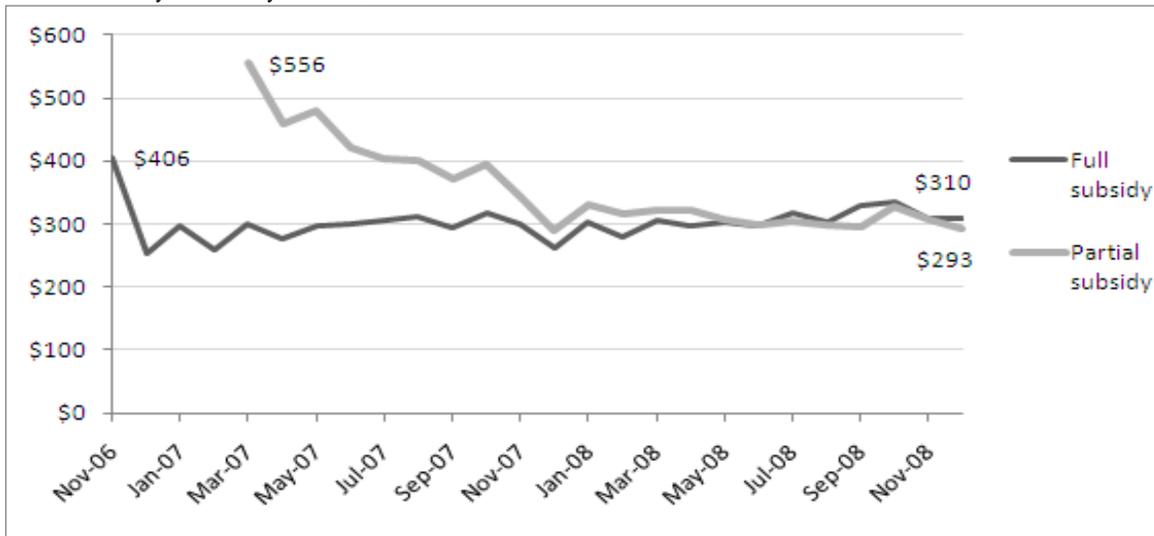
RISK SELECTION IN COMM CARE

Both the demographics of adults who enrolled in CommCare at the start of the program and their average medical cost indicate that the program initially experienced adverse selection. Compared with the entire pool of eligible individuals, CommCare enrollees were older.¹ This was particularly true for higher income enrollees eligible for only a partial subsidy, who were less likely to be young adults aged 18-24 and more likely to be adults aged 45-64 compared with all adults eligible to participate in the program (enrolled or unenrolled).

More favorable risk selection occurred with greater enrollment in CommCare: despite fast growth in enrollment from 2007 to 2008 (especially among older adults only eligible for a partial subsidy), average monthly medical cost for the program as a whole changed very little. Among full-subsidy enrollees, average monthly medical cost increased among those with income at or below 100 percent FPL, but it fell among enrollees from 101 to 150 percent FPL. Among partial-subsidy enrollees, average medical cost fell by 17 percent. By December 2008, average monthly medical cost was less for partial-subsidy enrollees than for full-subsidy enrollees, even though partial-subsidy enrollees were on average older (Figure 1).

¹ The pool of eligible individuals was defined as Massachusetts residents who were working-age adults living in households below 300 percent FPL and not enrolled in Medicare, Medicaid, TRICARE, or employer-based insurance. This definition may slightly overstate the actual pool of residents eligible for CommCare, in that it included individuals who may have been eligible for coverage from these sources but not enrolled.

Figure 1. Monthly Medical Cost per Member among Commonwealth Care Enrollees by Subsidy Level, 2006-2008



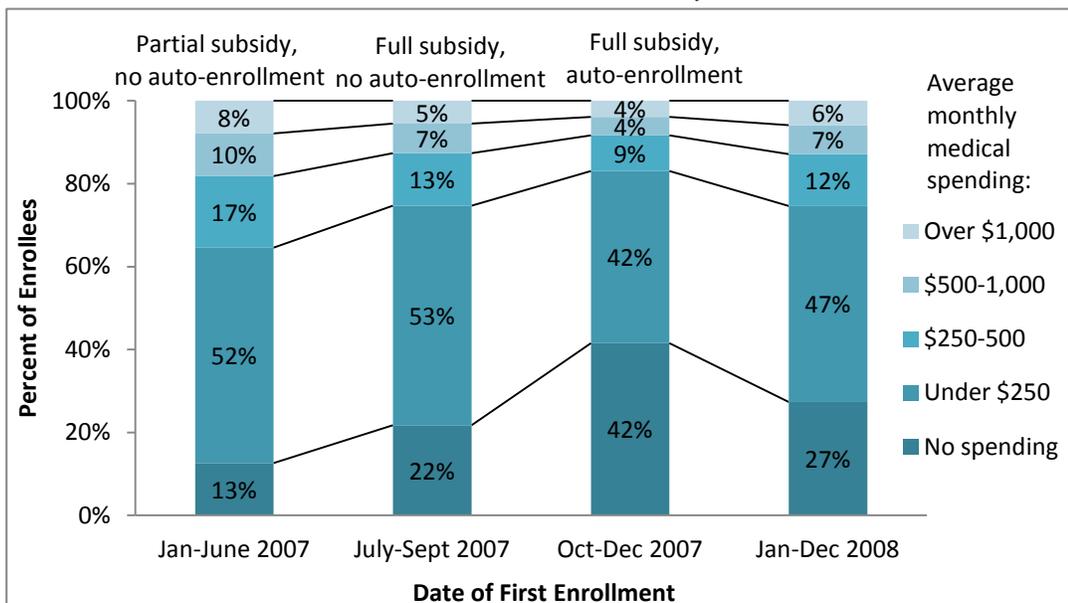
Source: Mathematica Policy Research tabulations of Commonwealth Care claims and enrollment data.
 Note: Estimates exclude the 10 percent of enrollees who moved between partial and full subsidies in 2007 and 2008 due to changes in income, categorized as mixed-subsidy enrollees. The levels of expenditures for these enrollees generally fell between the levels of expenditures for full- and partial-subsidy enrollees.

Auto-Enrollment and Subsidy Effects

Greater subsidies and auto-enrollment can significantly affect risk selection in programs like CommCare—and in CommCare risk selection improved (Figure 2). After July 2007, when premiums were eliminated for enrollees with income from 100 to 150 percent FPL, new enrollees were nearly twice as likely as current enrollees to use no covered services in the first six months, and those that did use services were more likely to incur relatively low average costs.

From October to December 2007, when UCP users were auto-enrolled, 42 percent of new enrollees in this income group incurred no medical cost in the first six months, and just 4 percent were very high-cost (with medical costs averaging more than \$1,000 per month). In 2008 (after UCP was closed), new enrollees continued to cost less than those who had been enrolled since early 2007, but they were not as low cost as those who first entered the program when auto-enrollment occurred.

Figure 2: Average Monthly Medical Cost in the First Six Months of Enrollment: Commonwealth Care Enrollees at 100-150% FPL by Date of First Enrollment, 2007-2008



Source: Mathematica Policy Research tabulations of Commonwealth Care claims and eligibility data.

Note: Estimates include individuals with income from 100 to 150 percent FPL when first enrolled.

Disenrollment from CommCare

In any insurance program, adverse selection will occur if individuals enroll only when they need medical care. However, even when adverse selection does not occur at initial enrollment, it can occur over time if healthy individuals are more likely than those with health problems to drop coverage. There is some evidence that, since Massachusetts implemented its health insurance reforms, commercially insured individuals have been less likely to remain in the same insurance plan for an entire year. The greater frequency of lapsing from insurance plans following reform contributed to carriers' perceptions that "hit and run" enrollment was contributing to adverse selection and led to legislation limiting open enrollment for individuals in private plans.

In CommCare, about one-third of enrollees left their selected plan within a year, with partial-subsidy enrollees (36 percent) somewhat more likely to leave than full-subsidy enrollees (31 percent). Older enrollees were more likely to remain enrolled than young adults, indicating the potential for lapses to contribute to adverse selection. However, unlike in the commercial market, those who remained enrolled in CommCare for longer periods of time had much lower average medical costs: those who stayed in the program longer than three months were nearly half as costly as those who lapsed within three months. Thus, disenrollment patterns actually improved program risk over time.

In contrast to what may motivate short-stay enrollment in the commercial market, in CommCare the large proportion of enrollees who stay in the program for short periods is more likely due to volatile income and, therefore, to changes in eligibility. One study found that, from January 2008 to April 2009, a monthly average of nearly 8,100 CommCare enrollees—about two-thirds of those leaving CommCare each month—transitioned to MassHealth or Massachusetts' Health Safety Net (HSN) program (Seifert et al. 2010).

Risk in CommCare Compared with the Commercial Market

Notwithstanding the fact that CommCare enrollees were much older than the population eligible to enroll, they were much younger than adults enrolled in commercial coverage with individual policies. Twenty-one percent of CommCare enrollees were aged 18 to 24 (versus 13 percent of commercially insured adults),

reflecting the much younger ages especially of those qualifying for a full subsidy. Nevertheless, full-subsidy enrollees—specifically, those at or below 100 percent FPL—used more inpatient hospital care than commercially insured adults, while higher-income full-subsidy enrollees and partial-subsidy enrollees (although older on average) used slightly less hospital care than commercially insured adults.

Despite their higher rate of hospital use, average medical cost (per member per month) among full-subsidy enrollees was at least one-third less than among commercially insured individuals, due to lower provider payment rates in CommCare. While CommCare carriers' payment rates from 2006 to 2008 were higher than Medicaid, they were much lower than commercial insurance payment rates. Had CommCare not been served by MassHealth plans with payment rates below commercial rates, the per-member cost of the program might have been much greater and the effects of adverse risk selection among very low-income enrollees, in particular, more apparent.

LESSONS FOR OTHER STATES

Program Design

Despite evidence of some initial adverse selection in CommCare, at least three aspects of CommCare's reform environment may have helped offset risk in the program. First, Massachusetts' individual mandate—which was put into place to discourage adverse selection and gaming of guaranteed issue—apparently encouraged healthy adults subject to the mandate to enroll in CommCare with just partial subsidies for coverage. Second, auto-enrollment of low-income adults who had been UCP users appears to have been an important source of relatively low-risk enrollment in CommCare. Third, the availability of a full subsidy encouraged low-cost users and nonusers to enter and remain in the program—especially when accompanied by auto-enrollment.

However, changes in eligibility (presumably due to unstable family income) appear to have been a key source of short-stay enrollment in CommCare. Others have noted the likelihood under national reform that many low-income individuals enrolled in health insurance exchanges are likely to transition between the exchange and Medicaid during a year (Sommers and Rosenbaum 2010). Evidence from CommCare

suggests that the most costly individuals may also be the most likely to transition between programs.

Impacts on the Commercial Market

The entry of many low-income individuals into the commercial insurance offers significant potential for disruption in that market. While the ACA offers commercial health plans several layers of protection (including temporary reinsurance and risk corridor programs, as well as state risk adjustment), states might consider whether separate risk pooling might be a preferred strategy in the long term.

By enrolling many low-income individuals in relatively poor health in CommCare's separate risk pool, Massachusetts appears to have helped buffer the commercial insurance market from some effects of the state's health care reforms. CommCare's highest-cost enrollees (those with income below 100 percent FPL) will become eligible for Medicaid under the ACA. For higher-income enrollees, Massachusetts must decide whether to establish a Basic Health Plan or transition them into the Connector. In fact, hospital and physician service use among these enrollees was ultimately not very different from that among commercially insured individuals—suggesting that their medical cost might also be similar if payment rates were comparable.

Other states might do well also to consider whether low-income individuals newly entering the commercial market might present much higher medical risk than individuals who are currently insured in that market or who are otherwise likely to enroll under the ACA's individual mandate. If so, they might pool and finance the medical risk of low-income adults separately, as Massachusetts did, by establishing a Basic Health Plan. This strategy could benefit the commercial market by diverting individuals who might represent not only higher medical cost, but also much higher administrative cost due to changes in their eligibility for Medicaid.

Financing and Operating a Basic Health Plan

Massachusetts' experience with CommCare provides lessons for the financing and operation of a Basic Health Plan, particularly one that would attract adverse risk and high administrative cost. With respect to program financing, differences in the expected medical and administrative costs of Basic Health Plan enrollees compared with the costs of exchange enrollees are crucial considerations in gauging the potential adequacy of federal funding. While the Basic Health Plan might substantially reduce its average medical cost and improve the likelihood that federal funding would be sufficient by paying providers Medicaid rates, more widespread use of Medicaid rates may be problematic, especially if the state is also substantially expanding Medicaid coverage under the ACA. States that expect higher medical and administrative cost for enrollees in the Basic Health Plan would want federal funding to consider both factors when estimating what enrollees otherwise would have been charged for exchange coverage and, therefore, the premium tax credit they would have received.

CommCare's experience also offers lessons for other states with respect to the operation of a Basic Health Plan. In particular, having the same carriers that participate in Medicaid also serve the Basic Health Plan could greatly help ease transitions for low-income residents who move between the exchange and Medicaid during the year. However, states might have additional or alternative options to manage frequent transitions between programs or among plans that would serve a Basic Health Plan, including a minimum enrollment period in Medicaid. Similarly, if allowed in federal regulation, a minimum period of enrollment in the Basic Health Plan could help manage frequent transitions into the exchange. Finally, once-annual open enrollment in the Basic Health Plan might encourage residents to remain continuously enrolled while eligible.

ABOUT SHARE

The State Health Access Reform Evaluation (SHARE) is a national program of the Robert Wood Johnson Foundation (RWJF) that aims to provide evidence to policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. More information about SHARE is available at www.shadac.org/share.