MASSACHUSETTS HIGH DEDUCTIBLE HEALTH PLAN MEMBERSHIP

CHIA's *2015 Annual Report on the Performance of the Massachusetts Health Care System* profiled overall membership and cost trends in the Massachusetts market from 2012 to 2014. This brief provides additional coverage and cost details[1] on High Deductible Health Plan (HDHP) membership in the Commonwealth.[2]

HIGH DEDUCTIBLE HEALTH PLAN ENROLLMENT CONTINUES TO INCREASE

In 2014, nearly one-in-five (19%) Massachusetts commercial market members—or 846,000 contract-lives[3]—were enrolled in an HDHP, an increase of three percentage points (+146,000 contract-lives) from the prior year.[4] **(Figure 1)** Growth was driven by Massachusetts' largest payer and largest employers: Blue Cross Blue Shield of Massachusetts accounted for 60% of Massachusetts' new HDHP enrollees; and 74% of new HDHP enrollees received coverage from firms with more than 100 employees. Massachusetts' smaller employers, however, continued to have the highest rates of HDHP enrollment.

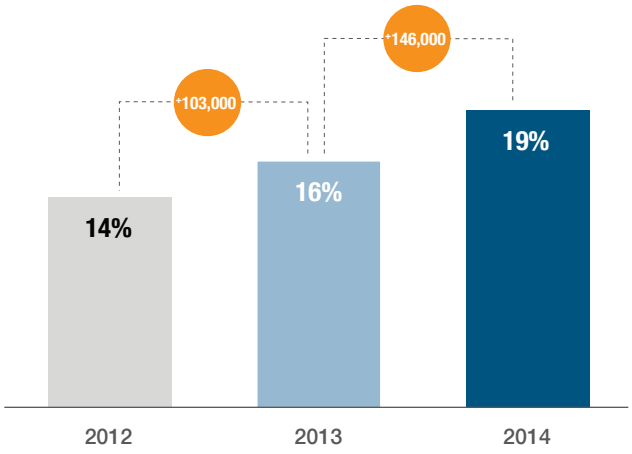
More than half (52%) of individual health insurance purchasers and 43% of those receiving coverage through employers with 50 or fewer employees were enrolled in HDHP plans.[5] **(Figure 3)** Massachusetts' Cape Cod and Islands region, with its high concentration of small businesses, also had particularly high HDHP penetration (25%).[6] **(Figure 2)**

Members of national payers United Healthcare and CIGNA, and Massachusetts payer, Fallon Health, were more often enrolled in an HDHP than those covered by other payers.[7]

HDHP MEMBERS HAVE LOWER PREMIUMS BUT PAY MORE OUT-OF-POCKET

HDHPs offer employers and employees lower up-front health insurance premiums[8] in exchange for potentially higher employee cost-sharing later.[9] In 2014, the average Massachusetts premium for an HDHP enrollee was $82 per member per month (PMPM) less (-18%) than for a non-HDHP enrollee.[10] **(Figure 4)** Between 2013 and 2014, HDHP member premiums also grew more slowly (+1.3%) than both non-HDHP premiums (+3.4%) and inflation (+1.6%).[11]

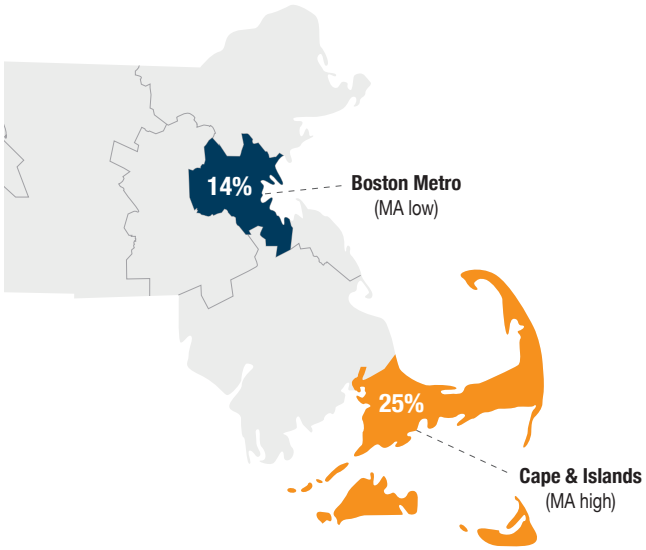
1 **HDHP Enrollment, 2012-2014**



Source: CHIA payer-reported data.

Notes: Based on MA contract-membership, which may include non-MA residents. HDHPs defined by IRS individual plan standards. See technical appendix.

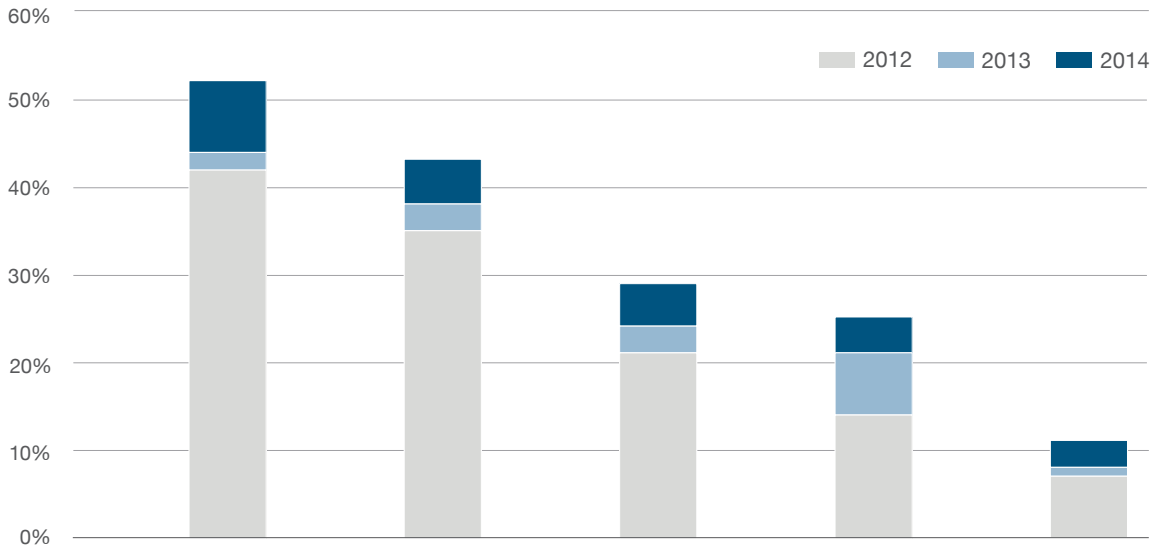
2 **HDHP Enrollment by Region, 2014**



Source: CHIA payer-reported data.

Notes: Regional analyses done using three-digit zip code data, aggregated to regions by DOI small group rating regulations. Self-insured data for CIGNA and United excluded.

3 HDHP Enrollment by Employer Size, 2012-2014



	Individual Purchasers	Small Group (1-50)	Mid-Size Group (51-100)	Large Group (101-499)	Jumbo Group (500+)
HDHP Members (2014)	**42,000**	**233,000**	**82,000**	**182,000**	**308,000**

Source: CHIA payer-reported data.

Notes: Based on MA contract-membership, which may include non-MA residents. HDHPs defined by IRS individual plan standards. See technical appendix.

However, HDHP members were responsible for paying almost twice as much in average cost-sharing than non-HDHP enrollees ($75 PMPM vs. $39 PMPM).[12] HDHP member cost-sharing also grew slightly faster than non-HDHP member cost-sharing from 2013 to 2014 (+2.9% vs. +2.2%).[13]

HDHP MEMBERS HAD LOWER HEALTH CARE SERVICE COSTS

In 2014, the overall cost for HDHP enrollees' health care services was, on average, notably lower (-13%) than for non-HDHP enrollees, a difference that remained after controlling for certain demographic factors tied to health care utilization.[14] HDHP enrollees averaged $407 PMPM in allowed claims, compared to $467 PMPM for non-HDHP enrollees. Lower average claim dollars may indicate reduced member service utilization, unobserved health status differences, and/or increased price-awareness by enrollees, patterns consistent with recent studies.[15] Evidence remains mixed on whether lower costs may be sustained long-term and whether the reduced spending comes at the expense of necessary care.[16] ■

For questions on this brief, please contact Kevin Meives, Senior Health System Policy Analyst, at (617) 701-8208 or at Kevin.Meives@state.ma.us.

4 HDHP Premiums and Cost-Sharing PMPM, 2014

	HDHP Members	Non-HDHP Members	Difference *Dollars*	Difference *Percentage*
Premiums	$378	$460	-$82	-18%
Cost-Sharing *(Allowed - Incurred)*	$75	$39	$36	94%
Total Avg. Member Cost *(Premiums + Cost-Sharing)*	**$453**	**$499**	**-$46**	**-9%**

Source: CHIA payer-reported data.

Notes: Referenced premium includes premium-equivalent values. Self-insured data for CIGNA and United excluded.

Additional Data:

Allowed Amt.	$407	$467	-$61	-13%
Incurred Amt.	$331	$428	-$97	-23%

Notes

[1] Contract member data provided by 11 Massachusetts commercial payers. See technical appendix.

[2] HDHPs defined by IRS standards for individual plan deductibles: $1,200 in 2012; $1,250 for 2013 and 2014. Plans by this definition alone may not meet all IRS HDHP qualifications. See technical appendix.

[3] Results for Massachusetts' 4.4 million contract-members, including individual purchasers. Premiums are set based upon these contract-populations, though not all members under these contracts may reside in Massachusetts.

[4] According to HRET/Kaiser Family Foundation's 2015 Employer Health Benefits Survey, Massachusetts HDHP adoption rates were in-line with national averages—20% in 2014—though specifications differed slightly.

[5] HDHP membership was more common in fully-insured (29%) than self-insured (12%) employers, though the difference for employers with more than 100 employees was minimal.

[6] According to the US Census' Statistics of US Businesses, as of 2012, 54% of employees in Cape and Islands were employed by a firm with under 100 employees, as compared to 32% in the rest of Massachusetts (county-based analysis).

[7] In 2014, 33% of United Healthcare's membership was reported to be in a HDHP, as was 29% of Fallon's and 28% of CIGNA's. For comparison, BCBS of MA, Massachusetts' largest private commercial payer, had 18% of its membership in HDHPs.

[8] Includes premiums and premium-equivalents.

[9] To help offset increased employee out-of-pocket spending, employers may offer Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs). HRAs are established and funded solely by employers. HSAs are established by employees and may or may not receive contributions from employers. According to Kaiser Family Foundation's 2014 Employer Benefits Survey, approximately two-thirds of employees with official HDHPs were enrolled in an "HSA-qualified" plan; the remainder had an HRA. Of those with an HSA-qualified plan, approximately three-quarters received employer contributions in 2014, averaging $1,006 for individual coverage and $1,744 for family coverage. Expense offsets from these employer-based reimbursement arrangements are not accounted for in CHIA data.

[10] Fully-insured cost measured by annual premium; self-insured cost measured by annual premium-equivalent. Results were scaled to full benefits net of MLR rebates, unless noted. See technical appendix.

[11] Inflation measured by the Consumer Price Index (CPI) for the Boston Metro area.

[12] Average member cost-sharing includes members who had little to no cost-sharing in a given year, as well as members who may have experienced significant medical costs. Not health-status adjusted.

[13] The Congressional Research Service found that HDHP members filed fewer medical claims, but that filed claims were larger, resulting in "a more variable (and uncertain) claims experience."

[14] The demographic and rating factor data that CHIA collected suggests that age, gender, and geographic differences did not account for the lower costs of HDHPs. However, a RAND analysis found that healthier employees were more likely to enroll in HDHPs or CDHPs (i.e., HDHPs paired with HSAs or HRAs). Further, EBRI surveys reported that CDHP enrollees self-reported better health statuses.

[15] As reported in an Employee Benefit Research Institute (EBRI) brief, when a large employer switched all of its employees to a CDHP, per person medical spending decreased by $527 in the first year; subsequent years, however, saw smaller decreases relative to the control group. A recent National Bureau of Economic Research (NBER) study also found that upon offering CDHPs, employers saw a five percent reduction in total health spending in the subsequent three years relative to the spending of employers who did not offer CDHPs.

[16] A recent RAND study found that HDHPs reduced health care spending, but also reduced member use of covered preventive health care services. Another study found that members reduced their hospitalization utilization in year one of adoption, but experienced more hospitalizations in year two.

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