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MAHP OnPoint: Impact of the COVID-19 Pandemic on Health Plans and Hospital Finances in Massachusetts

The COVID-19 pandemic has had a historic impact on the health care sector at both the state and federal levels, impacting health care utilization and spending in 2020 and beyond. With decreased utilization caused by state and federally mandated closures of in-person care, many hospitals, and providers experienced revenue losses while many health plans experienced lower than predicted claims costs resulting in unexpected surplus.

In Massachusetts, however, federal and state funding buffered losses for hospitals and providers, while strict statutory and regulatory requirements for premium spending offset surplus for health plans. As the Commonwealth begins to return to a new normal, this OnPoint provides insight into the impact of the COVID-19 pandemic on health plan and hospital finances, as well as the existing legal framework regulating health plan profits, and offers recommendations to policymakers to further align oversight of hospital finances with existing health plan oversight.

COVID-19: Federal and State Funding to Hospitals and Providers

According to the 2020 National Health Expenditures Highlights report, the United States experienced a 9.7% increase in national health care spending, bringing spending to $4.1 trillion for 2020. This growth was primarily driven by increased federal spending in response to the pandemic — including financial assistance through the Provider Relief Fund ($122 billion in 2020) and the Paycheck Protection Program (PPP) ($53 billion in 2020) and increased federal public health spending ($114.9 billion) — issued to providers to make up for lost revenue and spending for vaccine development, COVID-19 testing, and health facility preparedness.[1]

COVID-19 Relief Funds Reporting

MAHP engaged a consultant to track the COVID-19 relief funds distributed to Massachusetts hospitals and non-hospital providers (providers hereafter). In addition to the $2.6 billion reported by Massachusetts hospitals to CHIA, additional federal relief funding in the form of accelerated payments, and increased reimbursement rates raised the total amount of relief to $4.4 billion for hospitals. Federal and state policymakers also gave $3.1 billion to providers in form of direct funds, accelerated payment program, and loans or grants. Figure 1 below provides a comparison of funds reported under CHIA report and MAHP report for Massachusetts hospitals and providers.

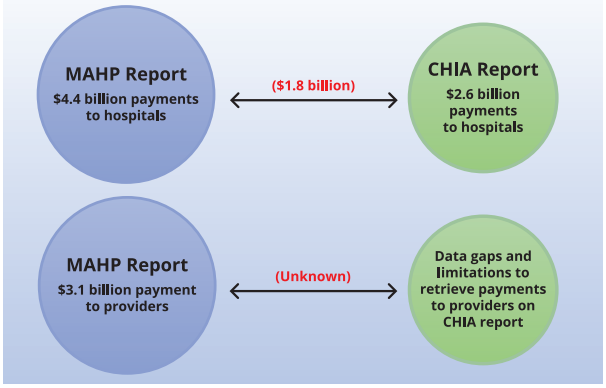

Figure 1: MAHP analysis of COVID-19 relief funds to hospitals and providers reported under CHIA and MAHP report.

Massachusetts, however, saw a decrease of 2.4% in health care spending, falling below the health care cost growth benchmark of 3.1% established in accordance with the state's 2012 health care cost containment law. In 2020, health care expenditures totaled $62.6 billion, or $8,912 per capita. The 2020 total health care expenditures figure does not include funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, PPP, or other federal funding related to COVID-19, as these dollars were distributed on a fiscal year schedule rather than the calendar year period on which the benchmark is assessed. However, the figure does include $495.3 million in MassHealth supplemental payments for COVID-19 relief.[2]

The COVID-19 pandemic significantly affected health care utilization in Massachusetts. In 2020, decreases in medical spending were largely attributed to a drop in utilization due to patient hesitancy to receive in-person care, a shift in care to telehealth delivery, and multiple federal and state directives intended to maintain needed hospital bed capacity and reduce infection transmission. These directives included Governor Baker- approved Department of Public Health orders issued at the beginning and during the governor's declared state of emergency on March 10, 2020, which ceased or restricted nonessential elective procedures for 10 months in 2020.[3]

Acute care hospitals in Massachusetts were faced with a rapid influx of COVID-19 patients, while they also were experiencing an increase in behavioral health boarding. Health plans experienced major impacts in 2020 from the effects of COVID-19 on health care utilization as well as shifts from employer-based commercial coverage to MassHealth, due to the significant loss of employment and financial instability of Massachusetts residents.[4] Since the early days of the COVID-19 pandemic, the entire health care system, together with federal and state officials, worked collectively to protect individuals, families, and businesses during an unprecedented public health crisis.

Health Plans Actions During the COVID-19 Crisis

MAHP member plans were committed to providing comprehensive care and coverage to their members through regulatory and voluntary efforts, including:

- Coverage of the costs of COVID-19 tests, treatment, and vaccines without cost-sharing.
- Coverage of telehealth for COVID-19 and non-COVID-19 encounters.
- Dedicated phone lines for sharing COVID-19 information with consumers.
- Implementation of more than 50 Division of Insurance and MassHealth bulletins providing administrative flexibilities, including but not limited to suspension of prior authorization, grace periods for premium payments, and expediting credentialing.

MAHP member plans operating in Medicaid and Medicare developed member support tools, including connecting them to needed services like medication delivery, meal delivery, and transportation; adjusting in-home visits; and coordinating with home care partners to meet members' needs.

MAHP member plans also provided community support during the pandemic, distributing over $10 million to community organizations, first responders, and frontline workers.

Health Plan and Hospital Finances

Reports from the Center for Health Information and Analysis (CHIA), the Health Policy Commission (HPC), and the Division of Insurance (DOI) have provided insights into the impact of COVID-19 on health care organizations' finances. To provide a deeper dive into the financial health across health care organizations in the state, this paper analyzes total margin across five years, including pre- and post-pandemic experience. Total margin is a key financial performance measure that reflects the excess or shortfall of total revenues in total expenses, presented as a percentage of total revenue. As outlined by CHIA, total margin measures the overall profitability of an organization.

Health Plan Profit Margins

In 2020, health plans reported lower medical spending, primarily due to decreased utilization of non-COVID-19 care, resulting in an anomalous profit of 2.49%. As the state experienced a rebound in utilization of non-COVID-19 medical care — in addition to COVID-19-related costs, greater behavioral health utilization, and investment income losses — health plans reported 2021 profitability close to that of pre-pandemic years. See Figure 2.

	2017	2018	2019	2020	2021
Health Plan Median	1.88%	1.71%	0.58%	2.49%	1.02%

Figure 2: Five-year analysis of Massachusetts health plans' profitability.[5] *Source: DOI's health plans annual financial statements.*

Strict Regulatory Requirements for Health Plan Profits

There are strict state and federal requirements for health plan profits, including a cap on contributions to surplus and federal and state medical loss ratio (MLR) requirements.

State and federal laws include **MLR provisions** that require fully insured health insurance plans to spend a certain percentage of premiums on medical care and limit the portion of premium dollars that can be spent on administration, marketing, and profit. The Affordable Care Act requires health plans in the individual and small group markets to spend at least 80% of premiums on claims and quality improvement; the MLR threshold for large group plans is 85% of premiums.

Massachusetts imposes even more stringent rules, requiring health plans to spend 88 cents of every premium dollar on health care services. If a health plan does not meet these thresholds, it is required to issue premium rebates to members. Rebates ensure that no health plan can make excessive surplus or profits or spend too much on administration. Health plans' MLR was 87% in 2020, resulting in the issuance of $58 million in premium rebate checks to individuals and employers in Massachusetts.[6] These MLR premium rebates, issued in 2021, were driven largely by the impact of the COVID-19 pandemic on health care utilization and spending during the 2020 plan year.

MLR premium rebates are calculated based on a three-year retrospective average. Therefore, consumer premium rebates over the coming years will "level out" the anomalous surplus from 2020. For 2022, the premium rebates will be calculated based on a health plan's claims experience in 2019, 2020, and 2021 as compared to the premiums collected in 2021. According to a recent Kaiser Family Foundation report, insurers are estimated to issue $1 billion in premium rebates nationally this year.[7]

In addition to rebates, Massachusetts state law requires that if a health plan's surplus exceeds 1.9% of premiums, premium rates filed by the health plan may be disapproved as excessive by the DOI. Surplus is typically directed into health plan reserves, which is money set aside to pay for unanticipated claims costs to ensure that hospitals and providers are paid.

Separate and distinct from both MLR and surplus requirements, state and federal regulators utilize an additional tool known as the **risk-based capital (RBC) formula** to assist them in the financial analysis of health plans.

While surplus represents the difference between assets and liabilities, the RBC formula is used to establish a minimum amount of capital appropriate for a health plan to support its overall business operations in consideration of its size and risk profile. The RBC ratio is determined by dividing surplus by a factor-based index called the "authorized control level," which is calculated using information from a health plan's balance sheet and income statement, which then is put into a formula prescribed by the National Association of Insurance Commissioners (NAIC). RBC is a point-in-time estimate — it is not forward looking, nor does it measure liquidity risk. For example, a health plan may have a receivable that is recorded as an asset, but the receivable is not expected to be paid for another six months.

On the national level, a majority of health plans have RBC over 1,000%, with close to 40% of health plans reporting an RBC between 1,000% and 10,000%.[8] Massachusetts state law requires that if health plans' RBC ratio exceeds 700%, they are required to submit to a hearing before the DOI.[9] The median RBC level in Massachusetts for MAHP member plans has hovered between 350% and 550% for the past five years, and health plans are required to comply with stringent RBC reporting requirements under 211 CMR 20.00.[10] See Figure 3.

Health Plans	2017	2018	2019	2020	2021
Risk-Based Capital Ratio (Median)	405%	357%	380%	491%	516%

Figure 3: MAHP analysis of RBC ratio for five years for MAHP member plans.[11] *Source: DOI's health plans annual financial statements.*

RBC is intended to be a minimum regulatory capital standard, requiring health plans with higher amounts of risk to hold higher amounts of capital, protecting the plan against insolvency, ensuring sufficient capital to pay unanticipated claims, and allowing the plan to develop new products, invest in new technology, and comply with new regulatory requirements. With MLR rebate and surplus requirements, health plans in Massachusetts are prevented from making excessive profits or surplus.

Hospital Profit Margins

The influx of federal and state COVID-19 relief funds to hospitals provided financial stability during and after the COVID-19 pandemic. In 2020, hospitals reported operating margin losses because of state-ordered closure of elective surgeries and of COVID-19 costs; however, these losses were largely buffered by federal and state relief funding. In 2021, the hospitals saw a rebound in profits that surpassed the profit margins from pre-pandemic levels for most of the cohorts, primarily driven by increased utilization and COVID-19 relief funds. See Figure 4.

	2017	2018	2019	2020	2021*
Hospital Median	**3.2%**	**4.5%**	**3.5%**	**2.6%**	**5.4%**
Academic Medical Center	2.0%	5.0%	3.1%	4.2%	6.3%
Teaching Hospital	3.5%	6.3%	8.6%	4.8%	6.7%
Community Hospital	2.6%	2.1%	5.6%	1.4%	7.1%
Community High-Public Payer	4.5%	4.8%	3.0%	4.0%	5.2%

Figure 4: Five-year analysis of hospital profit margins.12 *Source: CHIA's hospital and health system financial performance reports.* https://www.chiamass.gov/hospital-financial-performance/

In 2021, aggregate total operating revenue for Massachusetts hospitals increased by $2.8 billion (9.0%), while aggregate net patient service revenue, the most significant component of operating revenue, increased by $3.5 billion (14.6%) when compared to the prior fiscal year. Aggregate expenses increased $2.5 billion (8.0%) in FY 2021 as compared to FY 2020.[13]

Unlike the stringent MLR and RBC ratio requirements placed on health plans, there are **no regulatory requirements or controls placed on hospital profit or surplus margins.** There are also opportunities to improve transparency of hospital finances. Historically, reporting of hospital audited financial statements was inconsistent. The state should ensure that reporting is complete and consistent across all entities, including amending reporting requirements to enable policymakers and interested stakeholders to understand financial performance for each individual entity.

When financial reports are consolidated across multiple entities or when reporting categories are broad, financial performance can be obscured, intentionally or unintentionally. Finally, while information on financial performance by payer is collected as part of the HPC's Annual Cost Trends Hearings, it has not been widely or routinely collected for all Massachusetts hospitals. This information should be added to CHIA's annual data collection and reporting on hospital finances.

State Oversight Requirements

Health plans and hospitals comply with state regulatory requirements promulgated by several state agencies including but not limited to the Division of Insurance, the Center for Health Information and Analysis, the Health Policy Commission, MassHealth and the Health Connector. Figure 4 below highlights current state regulatory requirements on health plans, and hospitals.

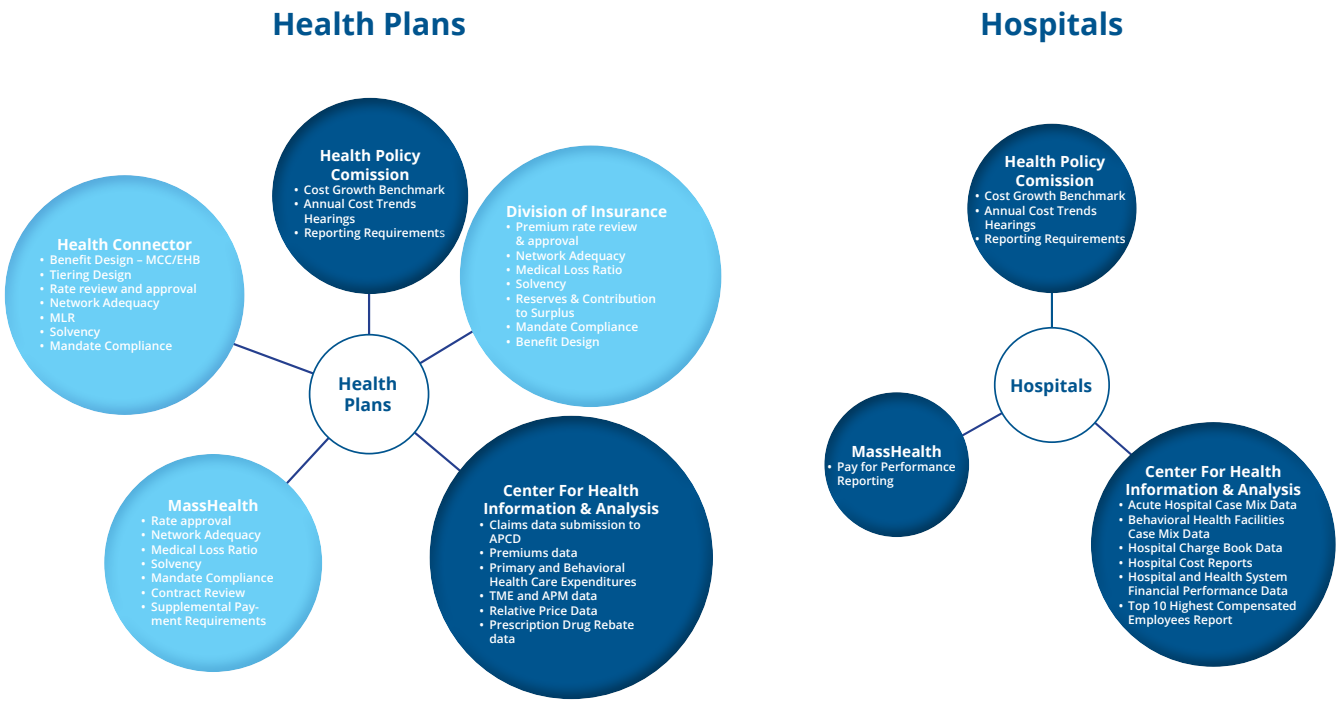

Figure 5: MAHP Chart on state oversight requirements for health plans and hospitals.

Recommendations

As our state adjusts to a new normal and policymakers consider legislation and policy changes to address both the growing health needs of the population and rising health care costs, MAHP strongly encourages consideration of the following recommendations for oversight of health plans and hospital finances:

- **Monitor health plan finances:** Health plans in Massachusetts are extensively regulated entities, and no other actor in the health care sector faces similar restrictions. MAHP encourages policymakers to continue to closely monitor health plan finances through the existing stringent federal and state regulatory requirements governing health plans' MLR rebates, surplus limits, and RBC totals, which reflect a complete and comprehensive financial picture of Massachusetts health plans.
- **Monitor hospital finances:** MAHP also encourages close monitoring of hospital spending and surpluses, including of hospital-owned provider organizations and the flow of funds between these entities. While there are no regulatory requirements or controls placed on hospital profit or surplus margins, MAHP encourages policymakers to closely monitor hospital spending trends, including federal and state COVID-19 relief funds, administrative flexibility, and regulatory changes that reflect a complete financial picture of Massachusetts acute hospitals and health care systems. Additionally, hospital reporting requirements should be updated to improve the consistency and accuracy of the financial information that is reported in order to enable policymakers and others to assess the financial health of our health care delivery system. It is critical that we understand not just the aggregate contribution to total health care expenditures but also each individually licensed acute care hospital's contribution to growth in total medical expense by market segment, including commercial, Medicaid, and Medicare.

- **Continued reporting on COVID-19 relief funds:** During the COVID-19 pandemic, CHIA provided timely reporting of hospital finances, which included analysis of federal and state COVID-19 relief funds, and MAHP supports the continued reporting of these funds. Additionally, MAHP supports improved state reporting requirements, which ensure details of all federal and state relief — including regulatory changes and flexibilities that enhance hospital finances awarded to Massachusetts hospitals and health systems, non-hospital providers, and provider organizations — are fully transparent, reported, and analyzed.
- **Require reporting on hospital labor costs:** As labor costs rise and health care staffing shortages continue, hospital labor costs are skyrocketing. According to a Definitive Healthcare report, average national hospital contract labor expenses rose to $4.59 million in 2020 as hospitals faced labor challenges and high labor costs.[14] The HPC should monitor and report on Massachusetts hospital labor costs and trends and include comparisons with other states where we compete for labor.

Health care organizations, including hospitals and health plans, continue to face the consequences of the COVID-19 pandemic, including the impact of inflation on ever-growing health care prices. While financial, operational, and other challenges, such as workforce shortages, increased patient acuity and demand due to deferred care, these organizations are dedicated to rigorously working to fulfill the growing needs of the patients and families of the commonwealth.

Footnotes

1. Centers for Medicare & Medicaid Services, Historical. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical

2. Annual report on the performance of the MA Health Care System (March 2022). CHIA. https://www.chiamass.gov/annual-report/

3. Declaration of State of Emergency to Respond to COVID-19: https://www.mass.gov/news/declaration-of-a-state-of-emergency-to-respond-to-covid-19. Orders of the Commissioner of Public Health: March 15, 2020; May 18, 2020; June 24, 2020; December 7, 2020; and recission of previous orders March 21, 2021.

4. Impact of COVID-19 on the MA Health Care System: Interim Report. Health Policy Commission (2021). https://www.mass.gov/doc/impact-of-covid-19-on-the-massachusetts-health-care-system-interim-report/download

5. The total margin analysis includes median of 11 health plans. This includes Allways Health Partners, BCBSMA Inc., BCBS HMO Blue, Boston Medical Center Health Plan, Fallon Health, Health New England, HPHC Inc., Tufts Associated HMO, Tufts Health Public Plans, and United Health Care of New England.

6. Centers for Medicare and Medicaid, *MLR Refunds by State and Market for 2020*. October 21, 2021. Available at https://www.cms.gov/files/document/2020-rebates-state.pdf

7. Ortaliza, J., Amin, K. & Cox, C. (2022). Data Note: 2022 MLR Rebates. https://www.kff.org/private-insurance/issue-brief/data-note-2022-medical-loss-ratio-rebates/

8. NAIC Financial Data Repository, *Aggregated Health Plan Risk-Based Capital Data 2020 Data*. June 30, 2021. Available at https://content.naic.org/sites/default/files/inline-files/2020%20Health%20RBC%20Statistics_as%20of%202020-06-30.pdf

9. Chapter 176O, Section 21(d) Submission by carrier of annual comprehensive financial statement. https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176O/Section21

10. 211 CMR 20: Risk-Based Capital (RBC) for insurers. https://www.mass.gov/regulations/211-CMR-20-risk-based-capital-rbc-for-insurers

11. The RBC analysis includes median of nine health plans. These are *Allways Health Partners, Boston Medical Center Health Plan, Fallon Health, Health New England, HPHC Inc., Tufts Associated HMO, Tufts Health Public Plans, United Health Care of New England.*

12. The 2021 CHIA statewide median includes median of 49 acute hospitals. For all previous years, the data includes median of all 61 acute hospitals as reported under CHIA. For 2021 figures:
    — All academic medical centers and community hospitals included
    — Missing data for three teaching hospitals (Saint Vincent Hospital, Steward Carney Hospital, and Steward St. Elizabeth's Medical Center)
    — Missing data for nine community HPP hospitals (Athol Hospital, Heywood hospital, MetroWest Medical Center, Morton Hospital, Nashoba Valley Medical Center, Steward Good Samaritan Medical Center, Steward Holy Family Hospital, Steward Norwood Hospital, and Steward Saint Anne's Hospital)
    Source: FY21 MA acute hospital health system performance preliminary report https://www.chiamass.gov/assets/Uploads/mass-hospital-financials/2021-annual-report/FY21-MA-Acute-Hospital-Health-System-Performance-Preliminary-Report.pdf

13. *Id* at iv.

14. Top 20 hospitals by highest contract labor expenses. Definitive Healthcare (2022). https://www.definitivehc.com/resources/healthcare-insights/hospitals-by-highest-contract-labor-expenses