



COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
One South Station • Boston, MA 02110-2208
(617) 521-7794 • <http://www.mass.gov/doi>

DEVAL L. PATRICK
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TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

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ECONOMIC DEVELOPMENT
BARBARA ANTHONY
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AND BUSINESS REGULATION
JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

Bulletin 2010-05

TO: Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA)
FROM: Joseph G. Murphy, Commissioner of Insurance
DATE: February 10, 2010
RE: Small Group Rates Submitted by BCBSMA

The purpose of this Division of Insurance (Division) Bulletin is to instruct BCBSMA to file all small group health coverage rate increases or changes to small group rating factors, as defined in M.G.L. c. 176J, with effective dates on or after April 1, 2010, at least 30 days before their effective dates. Filings are subject to the Commissioner's disapproval if the benefits and rates do not meet the requirements of M.G.L. c. 176B, § 4. A submission shall not be deemed filed until it is complete.

I. Rate Filing

A filing is not complete unless it contains an actuarial memorandum and all of the following documentation:

- (a) Three years of historic claims payment experience, shown separately for each year and differentiating among:
- a. Inpatient hospital care;
 - b. Outpatient hospital care, with separate experience for:
 - i. Radiological/laboratory/pathology costs; and
 - ii. All other outpatient costs;
 - c. Health care provider charges for:
 - i. Medical and osteopathic physicians;
 - ii. Mental health providers; and
 - iii. All other health care practitioners;
 - d. Supplies; and
 - e. Outpatient prescription drugs.
- (b) Three years of historic utilization experience, shown separately for each year and differentiating among:
- a. Inpatient hospital care;

- b. Outpatient hospital care, with separate experience for:
 - i. Radiological/laboratory/pathology costs; and
 - ii. All other outpatient costs;
 - c. Health care provider charges for:
 - i. Medical and osteopathic physicians;
 - ii. Mental health providers; and
 - iii. All other health care practitioners.
 - d. Supplies; and
 - e. Outpatient prescription drugs.
- (c) Trend factors differentiating among:
- a. Inpatient hospital care;
 - b. Outpatient hospital care, with separate experience for:
 - i. Radiological/laboratory/pathology costs; and
 - ii. All other outpatient costs.
 - c. Health care provider charges for:
 - i. Medical and osteopathic physicians;
 - ii. Mental health providers; and
 - iii. All other health care practitioners;
 - d. Supplies; and
 - e. Outpatient prescription drugs.
- (d) The actuarial basis for all trend factors, including all relevant studies used to derive the factors;
- (e) All non-fee-for-service payments to providers, differentiating among:
- a. Inpatient hospital care;
 - b. Outpatient hospital care, with separate experience for:
 - i. Radiological/laboratory/pathology costs; and
 - ii. All other outpatient costs;
 - c. Health care provider charges for:
 - i. Medical and osteopathic physicians;
 - ii. Mental health providers; and
 - iii. All other health care practitioners.
 - d. Supplies; and
 - e. Outpatient prescription drugs.
- (f) Administrative expense load factors, including an explanation of all changes to any administrative expense loads that were used in the prior period's rates and where changes in administrative expenses may be caused by regulatory requirements or efforts to contain health care delivery costs;
- (g) Contribution-to-surplus load factors, including an explanation of all changes to the contribution-to-surplus load factor that are caused by regulatory requirements or other external events;
- (h) The anticipated loss ratios for the one year period during which rates will be in effect;

- (i) A detailed description of all of BCBSMA's cost containment programs to address health care delivery costs and the realized past savings and projected savings from all such programs; and
- (j) If BCBSMA intends to pay similarly situated providers different rates of reimbursement, a detailed description of the bases for the different rates including, but not limited to:
 - a. Quality of care delivered;
 - b. Mix of patients;
 - c. Geographic location at which care is provided; and
 - d. Intensity of services provided.

II. Change to Rating Factor

A filing of a change to any small group health plan rating factor is not complete unless it contains all of the following documentation:

- (a) A description of the exact rating factor that has changed and the reasons for such change;
- (b) A signed actuarial opinion as set forth in 211 CMR 66.90: *Appendix A* that the carrier's rating methodologies and rates comply with the requirements of M.G.L. c. 176J and 211 CMR 66.00;
- (c) A detailed description of the method used to derive the changed factors, including a description of the data sources and assumptions used; and
- (d) If the company is modifying its benefit level rate adjustment, the filing must include an actuarial demonstration that the ratio of the actuarial value of the benefit level, including the health care delivery network, of one health benefit plan as compared to the actuarial value of the benefit level of another health benefit plan, measured on the basis of a census that is representative of Massachusetts eligible individuals and eligible small businesses for that carrier; and

If the Commissioner disapproves a filing, he shall notify BCBSMA and state the reason(s) for the disapproval. BCBSMA may request a hearing on the disapproval to be held within 30 days of the notice by filing a written request with the Division for a hearing within 15 days of its receipt of such notice. The Commissioner shall issue a written decision within 30 days after the conclusion of the hearing. BCBSMA may not implement the disapproved rates, or disapproved changes to rating factors, at any time unless the Commissioner reverses the disapproval after a hearing or unless a court vacates the Commissioner's decision.

If you have any questions about this Bulletin, please contact Kevin Beagan, Deputy Commissioner, Health Care Access Bureau, at (617)521-7323 or Kevin.beagan@state.ma.us.