



January 19, 2016

Commissioner Daniel R. Judson
First Deputy Commissioner Gary Anderson
Deputy Commissioner, Health Care Access Bureau, Kevin Beagan
Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118-6200

Re: AIM Letter of testimony relative to 2016 second quarter small group rates

Dear Commissioners,

On behalf of Associated Industries of Massachusetts and our 4,500 members across the Commonwealth, we would like to thank you for the opportunity to submit our comments relative to 2016 second quarter small group rates. We are encouraged by the Division's decision to hold this hearing, the first of its kind, to allow health insurance consumers a clearer understanding of the factors affecting second quarter 2016 small group rates.

AIM recently celebrated its 100th anniversary, and produced [*AIM's BluePrint for the Next Century*](#),¹ speaking with hundreds of business owners; managers; elected officials; economists; academics; journalists; high school teachers; students; and labor unions with the goal of collecting ideas for ensuring that the Bay State remains a global economic powerhouse.

A common theme across these groups is a concern over the ever-increasing cost of health insurance. Massachusetts employers and consumers currently pay the highest health insurance premiums in the country, and the elimination of state ratings factors, skyrocketing prescription drug costs, and the implementation of other burdensome provisions of the Affordable Care Act are adding to these already high costs.

Our employer members struggle to manage rising costs with virtually no control over the pricing options available to them. Although base rates in 2016 have increased by an average of 6.3%, some small employers are experiencing premium increases ranging anywhere from 10% to 30%. Small and medium sized employers typically cannot self-insure – an option for larger businesses – and thus must bear the costs of providing health care coverage with little flexibility and few cost-saving options available. This also places the employees at these companies at a financial disadvantage compared to their counterparts at large employers.

As small businesses, in particular, struggle to keep up with rising costs, they believe they have little to no control over the prices handed to them by insurers. Part of this frustration stems from the complexity of health insurance and the almost insurmountable task for employers of compiling the necessary cost and quality data to make informed decisions. Employers are already taking an active role, making changes within their workplace to realize any possible savings while still

¹ <http://blog.aimnet.org/aim-issueconnect/topic/blueprint-for-the-next-century>

preserving benefits for their workers. Thus, the Division's focus on transparency in rate filing is welcomed by those businesses served by small group plans.

The state's role in monitoring the industry's progress toward cost containment is vital. If the market fails, then it is appropriate for the state to get the market, in this case health carriers, back on track. The threat of government action can be the impetus for market change. Health providers, insurance companies and employers are working together to change the way consumers pay for medical care. But much more needs to be done to ensure quality and affordable care is available across the Commonwealth.

One way to ensure this important goal is achieved is for the Division to require rate filings that reflect increased cost savings to be passed directly on to employers and their employees. As a timely example, Congress and the President recently approved a suspension of the health insurance tax for calendar year 2017, a tax that has been passed on to employers through higher premiums. When this tax was implemented in 2014, health carriers emphasized the disproportionate cost impact – and resulting premium increase – on Massachusetts resulting from our already higher enrollment and premiums. Thus, we now anticipate a direct, corresponding savings to our members in the form of premium reductions.

Therefore, we urge the Division to require health carriers to include this cost savings in not just their second quarter rates, but also retrospectively in adjustments to their first quarter small group rates. Massachusetts employers acknowledge the need for effective and well-managed regulation that ensures the health and welfare of society without weakening the financial underpinnings of the job market.

Given what we have learned since 2012, and the changes happening in the market today, Massachusetts should set aggressive targets regarding health care cost containment. With total health care expenditures exceeding the cost growth benchmark and reaching 4.8% growth in 2014, we know definitively that Massachusetts is not yet doing enough.

Our Commonwealth stands at a pivotal moment in the health care cost containment and has the opportunity to establish an environment that will result in sustainable and meaningful changes to the health care market for health care consumers.

Thank you for taking AIM's position into consideration. Should you have any questions please feel free to contact me directly at 617-262-1180.

Sincerely,

A handwritten signature in black ink, appearing to read "Katherine E. Holahan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Katherine E. Holahan
Associate Vice-President for Government Affairs

The purpose of the first-ever informational hearings that occurred yesterday is to provide interested persons the opportunity to provide comment on the 2nd quarter 2016 small group health insurance rate filings.

I sat through all 7 hours of yesterday's hearings and have several comments.

First, the obvious issues:

45 Days: Mr. Beagun explicitly recited the State's duty and obligation to approve or disapprove quarterly rate filing no later than 45 days before the effective date of those rates, but I want to be extremely clear in my observation that this is an *imperative*. When DOI does not meet the 45 day deadline the world of small group health insurance is thrown into complete chaos. Insurers cannot inform their customers and brokers of increases. Brokers cannot obtain competing quotations for their customers. Small employers cannot budget their second largest expense after payroll—GROUP HEALTH INSURANCE PREMIUMS. —Enough said!

Health Insurance Inflation: General inflation continues at just about 2% held down by steadily decreasing oil prices. Good news except for the fact that health insurance rate increases for 2nd quarter are many times this 2% figure. I'm sure I didn't copy down all the figures from yesterday's reports from insurers, but I'm quite sure I heard that 2nd quarter rates will rise by as little as a fraction of a percent to as much as 12-13% from the major insurers. If I were to multiply the rate increase by each insurer's market share in MA I'd guess the overall increase works out to 7-8%. That's 3 ½ to 4 times general inflation!

Unsustainable?, Irrational?, Unhealthy?—Sure! All those things and more.

As I plow through my small-group customers' renewals I am seeing the frayed edges of the fabric of our economy. Every year rate increases are countered with a few innovative strategies from insurers and a much more important transfer of cost to employees in the form of higher deductibles, copayments and—returning from the past—*co-insurance*. The ACA sets maximum out of pockets at [say the full numbers!==>] \$6550/\$13,100 for 2016. Most covered workers would need years to pay off medical care debts of this size. We call this "protection" but it amounts to guaranteed financial ruin for almost anyone with a serious medical problem.

I think about this problem every day. The solutions I see call for:

- Doctors to be relieved of burdens not directly related to care so they can spend 20 minutes with a patient instead of 10.
- They call for patients—in non-emergency situations--to be required to get education about each unit of treatment being prescribed: to know the efficacy of a drug and—less importantly--its dizzyingly numerous, possible side-effects; to understand that a surgical procedure may resolve an ailment, but may not increase the quality of life or postpone death.
- They call for insurers to become less important as our nation mopes toward health care for all. In the words of one of yesterday's insurance company speakers: "These [claims] aren't *losses*, they are *costs*." No one in this room thinks of his or her mortgage payment or rent as a "loss" only as a "cost" of having a roof overhead. Why should the cost of

healthcare be different? We don't have insurance policies that cover certainties, like haircuts or rent, but we do have insurance policies that cover routine annual medical exams. We don't need an insurance company for this!

Now for the not-so-low-hanging fruit I plucked from yesterday's grinding testimony.

Risk Adjustment Mechanism: The ACA contemplated significant disruption in the markets for health insurance and addressed them in many different ways. I am *not an expert on this subject and have so far done only superficial research on it*, but The Risk Adjustment Mechanism appears to be a well-intentioned attempt at a "Robin Hood" strategy to *steal from the rich* insurers lucky enough to attract healthy new customers under the ACA and *give to the poor* insurers saddled with the more expensive customers with medical problems. Yesterday's hearings produced 2 classes of insurers:

- Those who were silent on the subject of the impact of Risk Adjustment ***because they are on the receiving end of these Adjustments***, and
- Those who made absolutely clear the impact of Risk Adjustment on their 2nd quarter 2016 rate filings ***because they are having to pay very substantial amounts to their competing insurers***

From yesterday's presentations by insurers I see two important lessons.

First, the apparent complexity of the issue is so great that, at least in the case of one insurer, the future effect of Rate Adjustment is so unpredictable that the insurer decided not to include it in its 2nd quarter rate filing. From what I believe I heard yesterday that means that this insurer has set next quarter's increase at about 7%, but Rate Adjustment could increase that figure by 7% or *decrease it* by about the same amount. Can you imagine how you would deal with an airline that offered you a \$500 fare to Cancun, but only after you got to Mexico, at the baggage claim carousel, made a public announcement that there would be an additional \$500 fee to retrieve your bags?

The uncertainty surrounding the Rate Adjustment Mechanism is at least as important as the impact of its *magnitude*. One insurer testifying yesterday said that its Rate Adjustment amount exceeded the total amount of its premium income. This was an extreme example and was not representative of the statements from the other insurers who are on the wrong end of the Robin Hood scheme. But those other insurers clearly indicated that Risk Adjustment is having a large impact on their 2nd quarter filings. As I listened to all this I began to think that—if allowed to careen along—Risk Adjustment could cause the prices of policies issued by all but the largest insurers to make their plans non-competitive resulting in a serious decrease if not complete elimination of competition in health insurance in Massachusetts.

Can we fix this? Maybe.

The ACA is an enormously complex law that has still not benefited from a technical corrections bill. It seems to me that the United States Congress is not likely to fix the Rate Adjustment Mechanism anytime in the next year or two at least.

But I have an idea!

Under the *federal* ACA, if the Rate Adjustment Mechanism calculation calls for Insurer A to pay Insurer B ONE DOLLAR, use Massachusetts law to refund 50 cents to Insurer A. This would not be a tax increase because the amounts involved would simply represent a halving of the amounts due under the ACA. And it seems to me that it should be easy to administer. Of course, I could be irretrievably wrong. But I've not heard any other ideas.

Drugs: Here I am again: talking about drugs.

Big Pharma spends more money lobbying congress than any other industry segment in the US.

America is one of only a few "advance" countries that permits direct-to-consumer advertising of prescription medications.

Medicare and Medicaid—where more is spent per capita on drugs than in any other segment of health care—are forbidden to negotiate prices with drug manufacturers.

What's wrong with this picture?

I wish I could suggest a solution that would be effective as well as politically feasible, but the only one I can think of involves educating the drug-buying public in an effort to counteract the effect of Big Pharma's lobbying and TV's seductive portrayal of the effects of the latest and most expensive drugs.

There!

I've provided my "oral comment" on 2nd quarter filings.

I hope I've helped.

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January 19, 2016

Commissioner Daniel R. Judson
MA Division of Insurance
1000 Washington St., 8th Floor
Boston, MA 02118

Re: Public Hearing on 2nd Quarter 2016 Small Group Health Insurance Rate Filings

Dear Commissioner Judson:

On behalf of Health Care For All, thank you for the opportunity to provide written comments on the proposed small group health insurance rate filings. Health Care For All is a non-profit advocacy organization that is the voice of consumers and patients, working to make health care in Massachusetts more accessible, more affordable and higher quality.

We are pleased that the Division of Insurance (Division) is taking public comments on the proposed small group rate filings. The Division has a substantive responsibility to the consumers in the Commonwealth and a public comment process represents an opportunity for direct consumer input into the rate approval process. Under Chapter 288 of the Acts of 2010, the Division was granted expanded authority to disapprove proposed rates that are excessive or unreasonable. The state can consider consumer costs (out-of-pocket and share of premiums), network adequacy, provider pricing, executive compensation, and affordability in the rate review process. We strongly believe that transparency provides for more efficient operation of the market, improved decision-making and better care, and that the public has the right to a complete understanding of the operation of the health care system that is so vital to every resident of our Commonwealth.

We commend the Division for taking modest steps toward increased transparency for premium increases, as we have been calling for a more transparent process for rate filings for a number of years. Specifically, we have advocated that health carrier rate filing information for the proposed rates for the merged market be disclosed to the public prior to the rates being approved. The rate filing information should include both the hard data the carrier and its actuary uses to justify the proposed rates and the assumptions, estimates and projections made to justify the rates. We have requested that the initial proposed rate filings and the approved rate filings be made publically available on the Division's website, along with a consumer-friendly summary of the proposed and final rates. Every carrier should further submit hard data on health care quality, cost and utilization as part of the rate filing process, which provides helpful information to form a baseline to evaluate insurers' efforts to contain costs and improve quality of care.

We would like to note, however, that while the purpose of the public hearing was to increase transparency by affording all interested parties an opportunity to provide comments relating to the Division's review of 2nd quarter 2016 small group health insurance rate filings, the Division did not release any information to the public on the proposed rate filings or carrier justifications prior to the hearing. With a lack of publically available information on the proposed rates in advance of the hearing, it has been challenging, if not virtually impossible, to conduct an informed review and analysis of the proposed rates and the carriers' justifications. For a comment to be meaningful, one must have access to all of the information on which the proposed increase is based. In particular, one must understand the underlying hard data and the assumptions, estimates, and projections the actuary makes to determine the rate. Without access to these elements, the public cannot possibly evaluate the reasonableness and potentially challenge proposed health insurance rate increases. At least 12 states, including Colorado, California, Connecticut, Maine and Oregon, make all rate filing information public in an effort to increase transparency and public participation in the rate review process. We very much hope that the Division takes steps to improve this process in the future so that the public truly has an opportunity to be a part of this important process.

Despite not having any official information from the Division, we listened with interest to the testimony presented during the public hearing. What we heard was proposals for significantly higher premium increases overall:

- Blue Cross Blue Shield of MA proposed that overall rates go up a bit over 4%;
- Tufts Health Plan filed for an increase of almost 5% between their two plans;
- Health New England filed for an 8.3% average increase;
- Harvard Pilgrim Health Care is proposing an almost 14% increase, combining their two entities;
- Fallon Health is looking for an increase of over 12%; and
- United HealthCare hopes to raise its rates by 13%.

The carriers advanced several justifications for the proposed increases, including reasons such as passing on the costs of rising drug prices, including both specialty drugs and generics; increased utilization of health care services and prescription drugs with increased coverage under the federal Affordable Care Act; and the federal risk adjustment program, which requires insurers with healthier members to make payments to insurers with sicker members in order to share the risks and cost of insuring people with a lot of medical needs. While some have been critical of this program, we believe that in at least in concept the program can help set a level playing field by protecting plans that have enrolled a disproportionate number less healthy and more costly members.

We are extremely disappointed to see that the proposed rates for this year are much higher than those approved in 2015, and that some have even reached the double digits. These premium increases must also be taken in the context of increased cost-sharing such as copays, coinsurance and deductibles. According the most recent Center for Health Information and Analysis (CHIA) Annual Report on the Performance of the Massachusetts Health Care System, Massachusetts continues to see increased enrollment in high deductible health plans – which are now 19% of the commercial market – and increased consumer cost-sharing, which rose by 4.9% in 2014 while benefit levels remained constant. We hear from consumers on a daily basis about their struggles to pay for increasing health care costs, both in the form of increasing premiums and out-of-pocket costs.

Several of the plans testified at the hearing about their strategies to reduce cost growth, including better care coordination, case management and education around wellness strategies. These are important, positive steps that should be welcomed. However, we think more can be done to improve efficiency and work with providers in their networks to focus on prevention and other proven strategies that keep patients healthier. We recommend that insurers include a detailed description of these efforts in their rate proposals, which should provide enough detail to enable an independent evaluation of the adequacy of an insurer's cost containment strategy. In future filings, we hope that information about insurers' cost containment efforts is integrated with enhanced cost and quality metrics to ensure that the data is presented in detail sufficient to create meaningful accountability.

There are also a number of policy options that the state could implement to address rising health care costs. For example, health plans should promote value-based care, such as through value-based insurance design (VBID), which aligns patient cost sharing with value. Making it easier for consumers to access cost-effective treatments would reduce the need for expensive acute care. Research shows that certain medications and services for chronic conditions such as hypertension, high cholesterol, diabetes, asthma, depression, and HIV/AIDS are considered "high value," because they provide large health benefits with comparatively low costs. The health system should therefore encourage patients to use these treatments, instead of imposing high co-pays and deductibles that discourage adherence to prescribed treatments and lead to further complications and expensive emergency services and hospitalizations. Removing barriers to essential, high-value health services is often cost-neutral to implement and even potentially cost-saving in the long term.¹ We are supporting legislation that would take the first steps to implement VBID in Massachusetts health insurance design.

We are also supporting initiatives to address rising costs of prescription drugs. A prescription drug cost transparency bill currently pending in the Legislature would promote transparency of prescription drug pricing, and let the public and the state understand the components of pricing by drug manufacturers – including the cost to manufacture the drug, research costs, advertising expenses, and what the company charges in other countries. With this information, one can make an assessment if the price being charged is fair and reasonable.

The Legislature has additionally taken action to reduce drug costs by funding an evidence-based prescriber education program called "academic detailing," which focuses on the therapeutic and cost-effective utilization of prescription drugs, supporting prescribers to make decisions based on balanced research data rather than biased promotional information. The program improves providers' clinical decision making and controls costs over time, countering the influence of drug companies that promote the most expensive new drugs. The legislature appropriated \$500,000 for this program in the FY16 budget. We were disappointed to learn recently that the Governor had eliminated all funding for this program as part of the 9C cuts.

We furthermore need increased investment in prevention and wellness focused on population health. Preventing illness and keeping us healthy in the first place is the most effective way to improve our overall health. Health plans should play an active role in moving the health care system to focus not just on individuals, but on the health of the population.

¹Lee, Joy L., et al. "Value-Based Insurance Design: Quality Improvement But No Cost Savings." *Health Affairs* 32, no. 7 (July 2013): 1251-1257. *Academic Search Premier*, EBSCOhost (accessed June 29, 2015).

We hope the Division will consider the rates filed for the upcoming quarter as just the start of the process. We urge the Division to carefully scrutinize the proposed rates, examining closely the reasons given for rate increases, and making sure carriers make maximal effort to control cost increases.

Thank you for the opportunity to submit comments regarding the 2nd quarter 2016 small group health insurance rate filings. If you have any questions regarding these comments, or need more information, please contact Alyssa Vangeli at avangeli@hcfama.org or 617-275-2922.

Sincerely,

A handwritten signature in black ink, appearing to read "Alyssa Vangeli". The signature is written in a cursive, flowing style.

Alyssa R. Vangeli, Esq., MPH
Senior Health Policy Manager



January 12, 2016

Daniel R. Judson, Commissioner
Division of Insurance
1000 Washington Street
Boston, MA 02118

Dear Commissioner Judson:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 17 health plans that provide coverage to 2.6 million Massachusetts residents, I am writing with regard to the Division's Informational Session on the Second Quarter 2016 small group health insurance rate filings. We share the concerns that many have expressed about the impact rising health care costs are having on individuals and small businesses and have been long proponents of increased transparency in the health care system. To that end, we appreciate the opportunity to offer our comments to the Division as part of its informational hearings to discuss the factors contributing to premium increases.

Keeping health care affordable is *the* challenge facing all of us in the health care system and our member plans have been working to bend the cost trend. While the Center for Health Information and Analysis' 2015 *Annual Report on the Performance of the Massachusetts Health Care System* found that the state exceeded the cost benchmark in 2014, commercial health plans kept their costs below the state benchmark. As the Center's report noted, "The vast majority of premium dollars (89%) were used to pay for member medical care in 2014," and also noted that less than six (6) cents of every premium dollar used to cover health plans' general administrative expenses and surpluses accounted for only two hundredths of a penny in 2014.

As you are aware, Massachusetts has the country's most stringent standards on how the premium dollar is spent, requiring that a minimum of 88 percent is allocated to medical care in the small and non-group markets. This is well above the 80 percent level established in the Affordable Care Act (ACA) and any amount below the state standard must be returned to individuals and small businesses.

Further, state law significantly restricts the amount of funds that may be allocated to administrative expenses and limits health plan profits to no more than 1.9 percent in the small and non-group markets. Health plans in Massachusetts operate on extremely thin margins. In recent years many health plans have operated at or around break-even, with some experiencing financial losses. While our member health plans will not file their 2015 financial results with the Division until next month, based on a survey of their preliminary results, we expect many of them to have experienced financial losses last year.

Our member health plans recognize that rising health care costs are a challenge to individuals and small businesses and they have worked aggressively and diligently to limit their rate increases. Nevertheless, it is an unfortunate fact that medical costs continue to rise in the Commonwealth.

With nearly 90 percent of the premium dollar spent on services that benefit and support patients, including doctor visits, diagnostic tests, prescription drugs, and hospital stays, health insurance premiums and medical costs are inextricably linked. The rates that our member health plans have filed reflect the cost of care, and our comments focus on the major factors driving premium increases, which include the following:

- Care in Massachusetts is being delivered in the highest priced settings
- Increases in prescription drug costs
- Costs associated with the Affordable Care Act (ACA)

Care in Massachusetts is being delivered in the highest priced settings

In Massachusetts, health care is most often delivered in higher priced settings and high priced providers continue to draw significant patient volume. As the Attorney General's September 2015 *Examination of Health Care Cost Trends and Cost Drivers* report noted, higher priced hospitals have increased their share of discharges statewide over time. In its inaugural report in 2010, the Attorney General's office found that from 2005 to 2008 the share of discharges across the state at higher priced hospitals increased. Since then, from 2009 to 2014, higher priced hospitals' share of inpatient discharges have continued to increase.

These findings are consistent with other state agencies' reports, which have shown that more and more patient volume is concentrated in higher-priced settings for both inpatient and outpatient services. For example, the Health Policy Commission's 2013 *Annual Cost Trends* report found that in the 10 years between 2002 and 2012, the proportion of the state's total inpatient discharges from teaching hospitals and the other hospitals controlled by systems with a major teaching hospital grew from 60 percent to 68 percent. The Commission's 2014 *Annual Cost Trends* report found that the proportion of inpatient discharges from academic medical centers grew slightly, from 36 percent in 2009 to 37 percent in 2012, while the percentage of discharges from community hospitals dropped from 47 to 46 percent.

Likewise, multiple reports from the Center for Health Information and Analysis have found that patient volume is more concentrated in higher-priced settings. The Center's 2012 relative price report and its 2013 *Annual Report on the Massachusetts Health Care Market* found that high-priced hospital and physician groups (those with prices higher than the network median) received 80 percent of total payments. Likewise, in its 2013 reports, the Center found that in 2011 and 2012, providers in the highest price quartile of each payer's network accounted for more than 50 percent of total payments, while those in the lowest quartile only received six (6) percent of total payments, reflecting the fact that patient volume is more concentrated in higher-priced settings.

Increases in prescription drug costs

While breakthrough medications offer tremendous clinical benefits for patients, the cost of prescription drugs has increased significantly in recent years. The Center for Health Information and Analysis' 2015 *Annual Report on the Performance of the Massachusetts Health Care System* found pharmacy spending grew by roughly 13 percent from 2013 to 2014, driven by an unprecedented 31 percent increase in spending on specialty medications. Further, PricewaterhouseCoopers' Health

Research Institute June 2014 medical cost trend report estimated that while only four (4) percent of patients use specialty drugs, those medications account for 25 percent of total drug spending nationwide.

The increase in prescription drug costs is not restricted to specialty drugs. According to the Institute for Healthcare Informatics' study – *Medicine Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014* – total spending on U.S. medicines increased 10.3 percent in 2014, up from a 3.2 percent increase in 2013. The sharp increase in spending in 2014 was driven by new brands, lower impact from expiring patents, and increases in the list prices of branded medicines. Likewise, the cost of generics has also increased significantly in recent years, adding to the increase in prescription drug spending.

Costs associated with the Affordable Care Act (ACA)

While the ACA has had a profound impact on expanding coverage for Massachusetts residents and millions of Americans, regulatory restrictions and fees and assessments associated with the ACA are also making the cost of health care coverage more expensive for Massachusetts employers and consumers.

For example, the ACA established an annual fee on health plans – the so-called Health Insurance Tax – based on each plan's premiums to help fund federal subsidies that lower-income individuals receive toward the purchase of insurance. For 2016, the total assessed is \$11.3 billion annually and increases to \$14.3 billion in 2018, growing each year thereafter. From 2014 through 2023, the tax will cost Massachusetts residents and businesses an estimated \$3.85 billion to \$3.89 billion, increasing premiums on average by 2.8 percent to 3.7 percent by 2023.

Further, the risk adjustment program required under the ACA was intended to stabilize the marketplace during the initial years of ACA implementation, avoiding adverse issues as states implement the market reform rules (guaranteed issue, the individual mandate and modified community rating) by redistributing funds from health plans with lower-risk members to those with higher-risk enrollees. This is not the case for Massachusetts. The state's long-standing requirements around guaranteed issue and modified community rating, the existence of a merged market and an individual mandate, and a relatively low rate of uninsured residents, made it unlikely that the Commonwealth would face the same uncertainty as other states. Unfortunately, the implementation of risk adjustment has had the opposite effect for Massachusetts, requiring the transfer of millions of premium dollars among health plans and directly contributing to premium increases for employers and consumers.

Thank you for providing us with an opportunity to offer our comments on the factors contributing to premium increases. If you or members of your staff have any questions or need additional information, please do not hesitate to contact MAHP at 617-338-2244.

Sincerely,



Lora Pellegrini
President & CEO