Enhancements to the Massachusetts Health Insurance Rate Review Practice: Promoting Transparency and Protecting Massachusetts Consumers

a) Current Health Insurance Rate Review Capacity and Process

General health insurance rate regulation information

In the Commonwealth of Massachusetts insurance companies are licensed and regulated by the Division of Insurance under M.G.L. c. 175. Health maintenance organizations (HMOs) are licensed and regulated under M.G.L. c. 176G and regulation 211 CMR 43.00. Non-profit hospital service corporations (Blue Cross) and medical service corporations (Blue Shield) are organized and regulated under M.G.L. c. 176A and M.G.L. c. 176B respectively. In addition, the individual market and the small group market are regulated together (the merged market) under M.G.L. c. 176J and regulation 211 CMR 66.00. Certain closed individual plans continue to be regulated under M.G.L. c. 176M and regulation 211 CMR 41.00.

Merged Market (individual and small group markets combined)

Individual plans and small group plans are combined and regulated together under M.G.L. c. 176J and 211 CMR 66.00. Premiums are adjusted community rated and must be established according to the following:

- The group base premium rates may not exceed two times the group base premium rate that could be charged by a carrier to the eligible small group or eligible individual with the lowest group base premium rate for that rate basis type within that class of business in that group's or individual's geographic area.
- The carrier must develop a base premium rate for each rate basis type and may develop and use one or more of the following rate adjustment factors, provided that together the adjustments fall within a range between 0.66 and 1.32. Factors include age, industry rate, participation-rate, wellness program rate, and tobacco use rate.
- The carrier may apply additional factors that would apply outside the 0.66 to 1.32 equivalent rate band. Factors include benefit level, area rate, rate basis type [single, two adults, one adult and child(ren), family], group size, and intermediary discount.
- The carrier may not charge a premium rate based on the eligible individual's or eligible small business' health status, duration of coverage, or actual or expected claims experience.
- The carrier must annually file with the Division an actuarial opinion that the carrier's rating methodologies and rates comply with the requirements of M.G.L. c. 176J and 211 CMR 66.00.

Effective in 2010, HMOs and Blue Cross Blue Shield must submit proposed small group base rates for all small group products at least 90 days prior to the proposed effective date(s) according to 211 CMR 43.00.

Large Group Market

Effective in 2010, HMOs and Blue Cross Blue Shield must submit proposed large group base rates for all products at least 90 days prior to the proposed effective date(s) according to 211 CMR 43.00.

Closed Individual Plans

Individual guaranteed issue plans issued prior to the merging of the individual and small group market continue to be regulated under M.G.L. c. 176M and 211 CMR 41.00. These plans may establish premiums considering the following:

- The carrier may establish an area rate adjustment for each different geographic region that must range from .80 to 1.20.
- The carrier may establish an age rate adjustment which may range from 0.67 to 1.33.

In reviewing the submitted rates, the Division computes an average adjusted composite rate for each type of closed guaranteed issue health plan and calculates the standard deviation for the submitted adjusted composite rates. A rate filing will be subject to further review if it is determined that the adjusted composite rate filed by the carrier exceeds the average adjusted composite rate for that type of guaranteed issue health plan or closed guaranteed issue health plan by more than two standard deviations and the proposed composite rate also exceeds 110% of the carrier's current composite rate for the plan. The carrier may adjust the rate proposal based on the review.

Information Technology (IT) and systems capacity

The Division currently participates in the System for Electronic Rate and form Filing (SERFF). All filers are required to transmit all rate filings via SERFF.

No other use is made of IT systems at this time in the review of rate filings and no further use had been contemplated prior to the development of this grant proposal.

Consumer Protections

Rate filings are public record and available for public viewing upon completion of the internal review. The Massachusetts Public Records Law, M.G.L. c.66, sections 10(a) and (b) and c.4, section 7(26)(a-s), provides that all records made or received by an agency are public, unless they fall within one of the specifically enumerated exemption to the public records law. M.G.L. c.4, section 7(26)(d), commonly known as the deliberative process exemption, provides an exemption from disclosure for materials that if disclosed prematurely would taint the deliberative process, and applies to matters within an ongoing deliberative process. The Division of Insurance invokes this exemption for all rate filing during the internal review period. At such time as the review has been completed, all materials relative to the review of the rate filing become public record. Access to public documents at the Division of Insurance is available by appointment during business hours each day.

- *Are summaries of rate changes offered in plain language for consumers?*

The Division does not at this time provide any summaries of rate changes.

- *How much advanced notice is given to consumers prior to proposed rate changes? Are consumers provided with official comment periods to review and comment on proposed rate changes?*

The Division does not at this time provide an official comment period on rate review and rate changes.

Existing Rate Hearing Processes

Under Massachusetts law, the Division has the authority to disapprove the insured health plan rates offered in Massachusetts by Blue Cross and Blue Shield of Massachusetts, Inc. (M.G.L. c. 176B, § 4) and licensed Health Maintenance Organizations (M.G.L. c. 176G, § 16) if the rates are unfairly discriminatory, excessive, inadequate or unreasonable to the benefits provided.

On the regulatory front, in February 2010, Governor Patrick directed the Division to issue an emergency regulation, 211 C.M.R. 43.00, requiring carriers to file their proposed small group rates at least 30 days in advance starting with the with April 1, 2010 effective dates. Prior to this change, carriers filed their proposed rates on their effective date. This exercise required the carriers to file little more than an Excel spreadsheet with the Division. There was no opportunity for the Division to review these proposed rates before they became effective. Carriers are now required to file substantial documentation to support their proposed rates.

Under this new regulatory structure, in early March, the carriers filed their proposed base rate changes. These ranged from 6% at the low end to a high of 34%. Again, these are base rates. When you factor in the statutorily allowed rating factors (geography, group size, age, etc., these rates can be considerably higher). After reviewing the information DOI actuaries received from the carriers for the rate filings with April 1 effective dates, it was determined that in the vast majority of cases, the carriers failed to meet the statutory threshold that rates not be excessive or unreasonable in relation to the benefits provided.

Under this regulatory scheme, the carriers have the option to appeal those disapprovals through an adjudicatory hearing process before independent hearing officers at the Division. The Attorney General's Office also has the option intervene in those hearings. Additionally, the carriers may resubmit modified rate filings at any time for consideration by Division technical staff.

As the carriers file rates quarterly, on June 1, DOI received proposed rates for the July 1 quarter. Division technical staff is currently reviewing those rates and determining if any of those rates should be disapproved.

Consumer Inquiries and Complaints

The Consumer Services Section (CSS) of the Massachusetts Division of Insurance handles all manner of consumer inquiries and complaints through a phone hotline and through a formal complaint process. During 2008 and 2009 combined, approximately 52,000 calls came in to the CSS phone hotline. Nearly 15,000 of these calls involved some sort of question or inquiry regarding a health insurance product or health insurer. Another 2,600 calls are actual complaints about health insurance. Among those 2,600 complaint calls, the most common reasons were: Denial of Claim; Coordination of Benefits; Delays;

Coverage; and, Further Consumer Education. Complaints regarding the rates or premiums for group or individual coverage were infrequent during this two year period.

During the same time, CSS handled nearly 3,300 formal written complaints against insurance companies and producers. Approximately 750 of those formal complaints concerned health insurance. The vast majority of these health insurance complaints involved some sort of claims issue such as a denials, delays or coordination of benefits. Another common complaint among individual products is marketing issues such as misrepresentation. Complaints involving rates amounted to less than 1% of all health complaints and consisted of billing issues rather than complaints about underlying rates.

For the Division of Insurance, most complaints regarding health insurance rates in the individual or small group market come in as individual letters to the Commissioner or complaints to legislators that are forwarded to the Division. During 2008 and 2009, the Division handled approximately 100 such inquiries. These communications universally involve either individuals or owners of very small businesses who have endured a series of large rate increases for their individual or small group health insurance policy. They all relate stories of repeated rate increases each of which is much higher than the rate of inflation. These consumers frequently decide to scale back coverage as an initial strategy for dealing with the rate hikes, but they then face similar increases on the scaled back coverage the following year. By the time they contact their legislator or the Division, they have reached the outer limit of their ability to absorb increases for minimum creditable coverage.

The relatively small number of these direct complaints on health insurance rates is due in part to the pathways of communication used by the Division of Insurance. Our consumer hotline and formal complaint process are designed to assist consumers with a solvable problem or provide a referral to an appropriate agency. The inability to afford basic health insurance is not a problem the CSS can effectively "solve." Most consumers faced with unaffordable insurance premiums understand that the Division does not simply set a price for each consumer. That being said, the Division needs the stories, ideas and feedback from consumers in the individual and small group markets – the people who directly pay for the cost of their health coverage. We presently do not have a sufficient social media presence that can elicit meaningful data from this segment of the health insurance market. The addition of an employee dedicated to marketing activities on health insurance issues and information could raise the Divisions profile among the consumers who can offer the most information to us about their insurance experience.

<u>Resources and Capacity for Reviewing Health Insurance Rates - Budget and Staffing</u>

The Division of Insurance has a budget of $12.761 million for FY2010. It is estimated that the Division will be responsible for revenue of approximately $32.550 million for this period.

The Health Care Access Bureau within the Division of Insurance is responsible to monitor access to and the affordability of insured health coverage in Massachusetts. The Health Care Access Bureau has a budget of $1.1 million for FY2010. It is estimated that the Division will only be able to expend approximately $700,000 of this budget during the fiscal year. The budget is fully funded by assessment on the insured health industry within Massachusetts. There is no specific breakdown of resources segregating the review of the individual/small group markets from all other health insurance markets.

Qualifications for Rate Review Staff

The Health Care Access Bureau is statutorily composed of a deputy commissioner, an actuary, a researcher and a finance expert

The Deputy Commissioner is a 15 year DOI supervisor of health coverage with Masters in Public Health and Public Policy

The Actuary is a Fellow of the Society of Actuaries with over 25 years of experience in the life and health fields.

The Researcher has 5 years of experience in the insurance industry with a Masters degree in Business Administration.

The Finance Expert is a CPA with over 25 years of experience in the review of health carriers' financial systems.

Due to hiring freezes, the DOI has not been able to hire additional staff and relies on external actuarial firms with Fellows of the Society of Actuaries from large and small consulting firms knowledgeable about the Massachusetts market participating in the reviews.

- *If available, provide the total number of health insurance rate filings that are received for the individual and/or group markets (annually and/or monthly), and the average amount of time that is required to complete the review process.*

During the April 2010 process, health carriers submitted filing materials that pertain to 274 small group base rates. It is anticipated that the Division will get at least this number of filings each quarter or filings for over 1000 base rates per year. Based on the initial reviews, and not building in the cost of rate hearings, the average review could take 5 hours per base rate.

b) Proposed rate review enhancements for health insurance

Expanding the scope of current review and approval activities

Under Massachusetts law, the Division of Insurance has the authority to disapprove the insured health plan rates offered in Massachusetts by Blue Cross and Blue Shield of Massachusetts, Inc. (M.G.L. c. 176B, § 4) and licensed Health Maintenance Organizations (M.G.L. c. 176G, § 16) if the rates are unfairly discriminatory, excessive, inadequate or unreasonable to the benefits provided. Following the promulgation of emergency regulatory changes to 211 CMR 43.00 and the issuance of Bulletin 2010-05 in February 2010, the Division implemented procedures to collect rate filing information for small group plans beginning March 1, 2010 for rates effective April 1, 2010. Regulations have been slightly modified since that time to extend the review period to 90 days for rates intended to be effective on and after October 1, 2010. Our Division is continuing to seek legislative changes that would extend the Division's review authority to all types of insured health plans and to change the standards that would apply to the rate review process.

During March 2010, the Division shifted internal resources to review the April 1, 2010 small group filings and disapproved 235 out of 274 small group base rates. Following this disapproval, members of Division staff have been actively involved in administrative rate hearings to review the disapproval decisions. These hearings are expected to not be complete until later this summer. While these hearings are going on, the Division's staff and consulting actuaries are actively reviewing submitted rate filings intended to be effective July 1, 2010. These reviews and hearings have only been in place for three months, but they have already created substantial shifts in the use of Division resources away from the regulation of other items. The cost of such reviews are expected to increase by fourfold over the next fiscal year as this is applied to a full year's worth of rate filings and to an expanded array of products, including large group rates and those offered by insurance companies.

It is estimated that this will require approximately $150,000 of additional legal support to work on the new regulatory tools and participate in the hearings that are associated with any disapprovals.

In addition to the company-by-company rate reviews, the Division's Health Care Access Bureau has commissioned actuarial studies of Massachusetts market conditions and structures to evaluate the cost drivers that are leading to the insured health plan rate increases. Recognizing that Massachusetts' carriers' medical loss ratios are in the 85-90% range, the Division is aware that much of the rate increase pressure is due to increased use of services and the use of more expensive services. The Division has devoted a large share of its health care budget to study drivers so that it may contribute to the debate about ways to best impact the increase in health costs.

It is estimated that this will require approximately $250,000 of additional support to examine utilization, technology and unit cost trends in the overall market to evaluate their impact on the cost of coverage in the market.

<u>Improving Rate Filing Requirements</u>

In its initial March 2010 review, the Division was only able to do a quick analysis of the claim cost trends, administrative expenses and contribution of surplus needs of those companies filing small group health insurance rates. Based on our first review, we are aware that we in the Health Care Access Bureau need to expand the array of materials that we collect from filing companies that explore the detailed actuarial basis for the requested rate increases. Working with external actuaries, we intend to examine the materials that will zero in on individual company rate factors and develop the tools to question the assumptions that companies are using to develop rates. We do intend to develop new tools that will require companies to separate claims trends and administrative costs into standardized buckets so that we can track spending in certain areas and we do intend to devote additional research to evaluate company positions on contributions to surplus and investment income. We also expect to develop internal models that will assist actuaries to evaluate utilization forecasts.

It is estimated that this will require approximately $100,000 of contracted actuarial support to conduct the analysis and develop the new tools for us to collect and review the rate filings in a more in-depth manner.

<u>Enhancing Rate Review Process – Staffing</u>

In its initial March 2010 review, the Division was only able to do a quick analysis of 274 small group rate increase filings intended to be effective April 1, 2010. In order to conduct this one review, the Division hired 2 external actuarial firms to assist in the review of the rates at a cost of over $50,000. It is anticipated that the cost of conducting the review of rates intended to be effective July 1, 2010 will also cost this amount.

It is estimated that this will require approximately $400,000 of additional contracted actuarial support to conduct the reviews necessary for the next fiscal year, especially if we expand the scope of each review and look at more than small group rate filings.

Enhancing Rate Review Process-IT Capacity

In its initial March 2010 review, the Division was only able to do a quick analysis of the claim cost trends, administrative expenses and contribution of surplus needs of those companies filing small group health insurance rates. Based on our first review, we are aware that we in the Health Care Access Bureau need to expand the array of materials that we collect from filing companies that explore the detailed actuarial basis for the requested rate increases. Working with external actuaries, we intend to examine the materials that will zero in on individual company rate factors and develop the tools to question the assumptions that companies are using to develop rates. We do intend to develop new tools that will require companies to separate claims trends and administrative costs into standardized buckets so that we can track spending in certain areas and we do intend to devote additional research to evaluate company positions on contributions to surplus and investment income. We also expect to develop internal models that will assist actuaries to evaluate utilization forecasts.

It is estimated that this will require approximately $50,000 in consultant work to pay for enhanced and standardized methods to collect rate review information so that it can be aggregated and effectively reviewed by actuarial staff. This will improve the reliability of information collected from filing companies and standardize the materials that are reviewed by the internal and external actuaries reviewing submitted rate filings.

Enhancing Consumer Protection Standards

It is estimated that this will require approximately $50,000 in consultant work to improve the transparency of information on the Division's website associated with the rates of all the products that are available in the market.

c) Reporting to the Secretary on Rate Increase Patterns

During the April 2010 process, health carriers submitted filing materials electronically that would allow us to report on the majority of the identified data elements. We are aware that we in the Health Care Access Bureau need to expand the materials and data that we collect from the companies as part of the rate filings. In addition, we will need to expand our reporting capabilities so that we can develop an automated process to provide the noted data to the Secretary. Working with the Division's IT staff, we intend to improve our IT systems to allow us to capture and report on the noted data elements, and also to allow for more robust internal analysis of the rate filings received from the companies. We will also need to work with our IT staff to create a process to collect and report on the aggregate data for rate filings in each market segment in an efficient manner. It is estimated that this will require

approximately $50,000 of additional IT support and system development to provide data on the health insurance rate trends.