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DIVISION OF INSURANCE

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JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

Fallon Community Health Plan, Petitioner,
v.
Division of Insurance, Respondent

Docket No. R2010-07

FINAL AGENCY DECISION

I. PROCEDURAL HISTORY

Fallon Community Health Plan ("Fallon") on March 1, 2010, filed with the Division of Insurance ("Division") proposed rates for all small group products offered or renewed in the Massachusetts merged market on or after April 1, 2010 ("proposed 2010 rates"). The filing was made pursuant to 211 CMR 43.00 *et seq.* as amended on an emergency basis on February 10, 2010 ("the Emergency Regulation").[1] The Commissioner of Insurance ("Commissioner") reviews rates for small group products offered or renewed in the Massachusetts market pursuant to G.L. c. 176G § 16, which provides in pertinent part as follows:

> The subscriber contracts, rates and evidence of coverage shall be subject to the disapproval of the commissioner. No such contracts shall be approved if the benefits provided therein are unreasonable in relation to the rate charged, nor if the rates are excessive, inadequate or unfairly discriminatory. Classifications shall be fair and reasonable.

On April 1, 2010, after the Division deemed the filings complete (see 211 CMR 43.08), the Health Care Access Bureau ("Bureau") in the Division notified Fallon by letter that its proposed 2010 rates for small group products were disapproved ("Disapproval Letter").

[1] All references and citations in this Decision to any section or subsection of 211 CMR 43.00 *et seq*. are to the Emergency Regulation that was promulgated on February 10, 2010. The Emergency Regulation governs all aspects of this hearing.

On April 12, Fallon requested a hearing on the disapproval pursuant to 211 CMR 43.08.[2] The Bureau represented the Division in the hearing; the Office of the Attorney General participated as an intervenor. Susan L. Donegan, Esq., Jean F. Farrington, Esq. and Stephen M. Sumner, Esq. were designated as presiding officers for the hearing. The Commissioner delegated final authority for the Division's decision to Presiding Officer Donegan.

II. FINDINGS OF FACT, ANALYSIS, DISCUSSION AND CONCLUSIONS ABOUT THE REASONS FOR DISAPPROVAL STATED IN THE DISAPPROVAL LETTER

The Disapproval Letter enumerated several specific reasons for the Division's conclusion that Fallon's proposed 2010 rates were "unreasonable in relation to the benefits provided and excessive." G.L. c. 176G, § 16. Each reason specified was identified as an independent basis for disapproval of Fallon's proposed 2010 rates. Fallon's burden in this *de novo* proceeding is to prove that each of the reasons for disapproving its proposed 2010 rates as stated in the Disapproval Letter is incorrect.[3]

References to the evidentiary record for the findings of fact that follow identify support for each finding, but are not necessarily exhaustive or exclusive. "I Tr." refers to the transcript

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[2] Our jurisdiction over Fallon's appeal of the Disapproval Letter arises from the last paragraph of 211 CMR 43.08, which provides as follows:

> If the Commissioner disapproves a filing, he shall notify the HMO in writing no later than the effective date of the rates or changes, and he shall state the reason(s) for the disapproval. The HMO may request a hearing on the disapproval to be held within 30 days of the notice by filing a written request with the Division of Insurance 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. The HMO may not implement the disapproved rates, or changes at any time unless the Commissioner reverses the disapproval after a hearing or unless a court vacates the Commissioner's decision.

[3] Previously we have ruled that the issues to be addressed in this hearing were limited to those identified in the Disapproval Letter, but that with respect to those issues the hearing on the Commissioner's disapproval is *de novo*. We also ruled that the issues in this hearing were limited to the reasons given in the Disapproval Letter, but would be looked at anew by us. Accordingly, the parties were allowed in this hearing to offer evidence beyond that considered by the Division in the initial staff review that resulted in the rate disapproval, so long as it was relevant and material to the reasons for disapproval stated in the Disapproval Letter. We will review the evidence produced by the parties independent of the conclusions reached based on the Division's staff review. See pages 14-15 of the *Decision on the Scope and Nature of the Hearings*, filed on April 30, 2010, in this docket and others. The Division's arguments about *judicial branch* deference to the expertise of the Commissioner of Insurance are inapposite to the context of this decision-making process, the result of which will constitute the final agency decision of the Division of Insurance, as affirmed by the Commissioner's designee.

of testimony given on May 26, 2010; "II Tr." refers to the transcript of testimony given on May 27, 2010.

A. Disapproval Letter Reason 1(a): Differing Rates of Reimbursement

"Fallon's Filing contains proposed 2010 rates that are unreasonable and excessive because Fallon's Filing fails to demonstrate that Fallon is paying providers differing rates of reimbursement solely based on the criteria identified in 211 CMR 43.08(10). . . . a) Fallon's Filing fails to illustrate how Fallon is paying providers differing rates of reimbursement solely based on (a) quality of care, (b) mix of patients, (c) geographical location at which care is provided, or (d) intensity of services provided, as identified in 211 CMR 43.08(10)." Exhibit 1, p. 2.[4]

Introduction

The Disapproval Letter states that a reason for disapproval of Fallon's proposed 2010 rates ("Disapproval Letter Reason 1(a)") was Fallon's failure to demonstrate that it pays different reimbursement rates to similarly situated providers ("differential reimbursement") based solely on quality of care delivered, mix of patients, geographical location at which care is provided, and intensity of services provided; four bases that are articulated in 211 CMR 43.08(10) ("the four articulated Regulatory bases"). 211 CMR 43.08(10) required Fallon to provide the following documentation in its filing (emphasis added):

> (10) If the HMO 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.

Findings of Fact:

1. Fallon's differential reimbursements are not based solely on the four articulated Regulatory bases; it considers other factors. Joint Exhibit 2, ¶ 31.

2. Fallon pays providers differing rates of reimbursement because of numerous factors that come into play in negotiating with providers, including the following:

[4] References to Exhibits are to the Final Exhibit List dated June 29, 2010.

(a) quality of care delivered,

(b) mix of patients,

(c) geographic location,

(d) intensity of services (the mix of services provided to plan members),

(e) the types of services that a provider offers,

(f) the number of specialists that a provider includes,

(g) risk-sharing arrangements,

(h) customer preferences,

(i) Fallon's market leverage or lack of leverage, and

(j) provider market leverage.

Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 10; Joint Exhibit 2, ¶¶ 10, 12, 16, 19, 20, 31, 32; II Tr. 22, 26, 49-51, 53-54, 151.

Quality of Care Delivered

3. Fallon evaluates providers on the basis of quality using nationally standardized and accepted metrics, and Pay for Performance programs for hospitals and physician groups reward providers for achieving specific target rates on selected clinical performance metrics. Joint Exhibit 1, Appendix to Actuarial Memorandum, Question 10.

Mix of Patients

4. Patient mix, attention to the general health of a provider's patients, can affect negotiated rates, because sicker patients tend to use more services and more intense and expensive services. Joint Exhibit 2, ¶ 18.

5. Generally, tertiary care facilities and teaching hospitals have sicker patient populations than others. Joint Exhibit 2, ¶ 18.

6. Facilities with a sicker patient mix, such as tertiary facilities, tend to demand greater reimbursement from health plans. Joint Exhibit 2, ¶ 18.

7. Fallon nevertheless includes tertiary facilities in its Direct Care network to be competitive with other plans and because employers and members want access to such providers. II Tr. 16-17; Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 10.

8. Boston-area tertiary facilities and specialist physicians are able to extract higher reimbursement levels from Fallon because they know that Fallon must include them in its network in order to be attractive to health care consumers and to be competitive with other HMOs. Joint Exhibit 2, ¶ 20; Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 10.

Geographic Location

9. Lower rates generally can be negotiated by Fallon in areas where there is a large concentration of providers as compared with areas that are geographically isolated and where there are fewer qualified providers. Joint Exhibit 2, ¶ 19.

10. Fallon has to ensure that it has under contract sufficient providers covering the range of services offered through its HMO products, and located in the geographic areas where current and prospective members reside. Joint Exhibit 2, ¶ 3.

11. Some providers are geographically isolated and therefore must be included in Fallon's network in order for Fallon to be able to market its products within the region. II Tr. 151-152.

12. Fallon historically has been able to exercise more negotiating leverage with providers in the Worcester area and central Massachusetts, compared with other parts of the Commonwealth, due in part to the concentration of Fallon's enrollees in central Massachusetts. Joint Exhibit 2, ¶¶ 19, 20.

13. In areas where Fallon has a high market share, and where there are more providers, such as in the Worcester area and central Massachusetts, it has greater ability to negotiate lower prices. Joint Exhibit 2, ¶¶ 19, 20.

14. From time to time, Fallon may expand to new geographic markets, where Fallon does not yet have a substantial number of members, and, in those situations, Fallon has less leverage in negotiating rates with the providers in those markets. Joint Exhibit 2, ¶ 19.

15. Fallon has less negotiating power in the Boston metropolitan area, especially with the larger tertiary and teaching facilities, and with the larger provider systems that include these tertiary facilities. Joint Exhibit 2, ¶ 20.

16. Fallon's payment levels depend in part on geography, because some geographic regions simply have higher costs, and these are reflected in the rates that providers in those regions demand. Joint Exhibit 2, ¶ 19.

17. Provider rates tend to be higher in eastern Massachusetts, where labor and overhead costs are higher than in central Massachusetts. Joint Exhibit 2, ¶ 19.

18. Fallon nevertheless must include certain Boston-area tertiary facilities and specialist physicians in order to have a viable network for its members. Joint Exhibit 2, ¶ 20.

Intensity and Types of Services Provided and Specialists

19. Fallon has to ensure that it has under contract sufficient providers covering the range of services offered through its HMO products, and located in the geographic areas where current and prospective members reside. Joint Exhibit 2, ¶ 3.

20. Tertiary care facilities and teaching hospitals have higher overhead, newer and more complex technology, more staff and, often, residency programs. Joint Exhibit 2, ¶ 18.

21. Tertiary care facilities and teaching hospitals may offer specialized services such as transplant services, neonatal intensive care units, or trauma units with higher costs due to specialized equipment, staffing needs and accreditation requirements. Joint Exhibit 2, ¶ 18.

22. These services are more expensive than those services offered in typical community hospitals. Joint Exhibit 2, ¶ 18.

23. Boston-area tertiary facilities and specialist physicians are able to extract higher reimbursement levels from Fallon because they know that Fallon must include them in its network in order to be attractive to health care consumers and competitive with other HMOs. Joint Exhibit 2, ¶ 20; Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 10.

24. Fallon must include certain Boston-area tertiary facilities and specialist physicians in order to have a viable network for its members. Joint Exhibit 2, ¶ 20.

Risk-sharing Arrangements

25. Whenever possible, Fallon has tried to encourage providers to accept fixed price reimbursement rather than percent of charge reimbursement. Joint Exhibit 1, Response to Objection Letter, Response 8.

26. Fallon utilizes different types of risk-sharing arrangements, including "capitated" arrangements in which Fallon pays a physician organization a basic monthly amount for each member who chooses a physician within that organization as his or her primary care physician. Joint Exhibit 2, ¶ 23.

27. In capitation and other risk-sharing arrangements, the physician organization typically is at risk for the costs of all physician services provided to a member. Joint Exhibit 2, ¶ 23.

28. In some cases, physician organizations share with Fallon in the cost of other services for the members, such as hospital services, which motivates the physician organization to effectively manage the member's care, to avoid unnecessary hospitalization and to manage the duration of hospital stays. Joint Exhibit 2, ¶ 23.

29. This arrangement provides the physician organization with strong incentives to manage care with attention to quality, efficiency and elimination of unnecessary services. Joint Exhibit 2, ¶ 23.

30. Capitation and other risk-sharing arrangements benefit the members, the provider and Fallon, and ultimately result in lower utilization and therefore lower premiums. Joint Exhibit 2, ¶ 24.

31. For many years, Fallon has had capitation and other risk-sharing arrangements with the Fallon Clinic, its largest physician provider organization in Central Massachusetts, under which Fallon provides a capitated payment per member per month for most members who choose Fallon Clinic physicians as their primary care physicians. Joint Exhibit 2, ¶ 25.

Customer Preferences

32. Both individuals and employer groups demand that Fallon provide options that include access to every doctor and hospital, including local providers, as well as access to larger tertiary systems. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 10.

33. Diversity of providers within a Fallon network is one of the most important factors Fallon's customers ask for, and without a broad network Fallon would not be competitive with other health plans. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 10.

34. If an employer requests that Fallon recruit a particular provider into the network, Fallon will attempt to do so in order to sell policies. II Tr. 53-54.

35. The consumer marketplace and the brokers that control a large segment of that market require a payor such as Fallon to have certain providers in their network in order to sell successfully in the Massachusetts marketplace. II Tr. 151.

36. Fallon may have to pay higher rates to a provider because, in order to be successful in the marketplace, it needs to have that provider in its network. II Tr. 49-51.

37. Fallon has to include Boston tertiary facilities within its network if it is going to be successful and to sell business to employer groups, which have indicated to Fallon that its network needs to include those facilities. II Tr. 22.

38. Marketplace realities mean that Fallon sometimes has no choice but to contract with higher cost providers, including Boston tertiary providers and geographically isolated higher cost facilities, even though these providers have more market leverage in negotiating, in order to offer employer groups a comprehensive network that is attractive and accessible to all of their employees. Joint Exhibit 2, ¶ 10; II Tr. 19.

39. For many employers, the availability of a broader network plan, like Fallon's Select Care product, that offers members a greater choice of providers, is a very important factor in choosing a health insurance company, and without the broader network plan, Fallon would not be competitive in the market. Joint Exhibit 2, ¶ 10.

Fallon's Market Leverage or Lack of Leverage

40. Market leverage is a significant factor in negotiating provider rates. II Tr. 150.

41. Fallon historically has been able to exercise more negotiating leverage with providers in the Worcester area and central Massachusetts, compared with other parts of the Commonwealth, due in part to the concentration of Fallon's enrollees in central Massachusetts. Joint Exhibit 2, ¶¶ 19, 20.

42. In areas where Fallon has a high market share, and where there are more providers, such as in the Worcester area and central Massachusetts, Fallon has a greater ability to negotiate lower prices. Joint Exhibit 2, ¶¶ 19, 20.

43. Fallon has less negotiating power in the Boston metropolitan area, especially with the larger tertiary and teaching facilities, and with the larger provider systems that include these tertiary facilities, but Fallon nevertheless must include certain Boston-area tertiary facilities and specialist physicians in order to have a viable network for its members. Joint Exhibit 2, ¶ 20.

Provider Leverage or Power

44. Market leverage is a significant factor in negotiating provider rates. II Tr. 150.

45. Provider leverage impacts Fallon's ability to negotiate lower rates and to link reimbursement with the quality of service. Joint Exhibit 2, ¶ 20.

46. Some providers, because of unique financial circumstances, may be unable and unwilling to accept reimbursement rates as low as others. Joint Exhibit 2, ¶ 21.

47. Fallon may have to pay higher rates to a provider because, in order to be successful in the marketplace, it needs to have that provider in its network. II Tr. 49-51.

48. The breadth or type of services that a provider offers and the size or number of sites that the provider can deliver in one negotiated deal may give it market clout. II Tr. 152-153.

49. Provider brand name or reputation contributes to provider market clout even though brand name does not necessarily indicate that a provider delivers higher quality medical services. II Tr. 153-154.

50. Geographic location may, by itself, provide greater negotiating leverage to certain providers. Joint Exhibit 2, ¶ 19.

51. Fallon has to ensure that it has under contract sufficient providers covering the range of services offered through its HMO products, and located in the geographic areas where current and prospective members reside. Joint Exhibit 2, ¶ 3.

Analysis, Discussion and Conclusion

52. Boston-area tertiary facilities and specialist physicians are able to extract higher reimbursement levels from Fallon because they know that Fallon must include them in its network in order to be attractive to health care consumers and competitive with other HMOs.

53. The Emergency Regulation does not characterize the four articulated Regulatory bases as the exclusive bases for justifying differential reimbursement; to the contrary, the Emergency Regulation explicitly acknowledges (by the language "including, but not limited to")

that the four articulated Regulatory bases constitute less than all the possible valid or reasonable grounds for paying similarly situated providers different rates of reimbursement.[5]

54. The Disapproval Letter, in disapproving Fallon's proposed 2010 rates for failing to base differential reimbursements solely on the four articulated Regulatory bases, overlooks the Emergency Regulation's acknowledgment that other valid reasons may support such differential reimbursements.

55. Because of factors such as the quality of care delivered, mix of patients, geographic location, intensity of services (the mix of services provided to plan members), the types of services that a provider offers, the number of specialists that a provider includes, the use of risk-sharing arrangements, member and employer preferences and expectations concerning a comprehensive network of providers, Fallon's market leverage or lack of leverage, and the economic realities of provider market leverage, Fallon has no realistic option in the merged market but to reimburse providers of similar services at different rates based on reasons beyond the four articulated Regulatory bases.[6]

56. *Conclusion*: Fallon has illustrated and proved that there are valid reasons that explain and justify its differential reimbursements to providers; accordingly, the disapproval of Fallon's proposed 2010 rates based on Disapproval Letter Reason 1(a) is **REVERSED**.

B. Disapproval Letter Reason 1(b): Renegotiating Rates of Reimbursement

"Fallon's Filing contains rates that are unreasonable and excessive because Fallon's Filing . . . fails to show that Fallon has taken adequate steps to renegotiate rates of

[5] The Regulation acknowledges that there are *valid* or *reasonable* reasons for differential reimbursement other than, or in addition to, the four articulated Regulatory bases. The concerns of the Division as stated on pages 12-13 of the *Brief of the Division of Insurance* filed on July 19, 2010, about the possibility of justifying differential reimbursement based on illegal reasons are unfounded.

[6] The Bureau's argument about the "intrinsic worth" of healthcare services (see pages 13-14 of the *Brief of the Division of Insurance* filed on July 19, 2010) disregards the economic realities of the healthcare marketplace. Each healthcare provider is free to decide what reimbursement the provider is willing to accept in exchange for providing a service to a subscriber of an HMO. Positing a hypothetical "intrinsic worth" for a healthcare service, such as surgery, does not consider such things as provider reputation, provider experience and provider specialty, all of which are considered by many, if not most, consumers of healthcare services. If subscribers of an HMO want access to a provider, the HMO must reach an accord with that provider about the reimbursement rate at which that provider is willing to perform services for its subscribers. Market forces, including "name brand" and subscriber expectations, influence both the HMO and the provider in the process of reaching an agreement about rates of reimbursement.

> *reimbursement to providers. . . . b) Fallon's Filing fails to show that Fallon has taken adequate steps to renegotiate rates of reimbursement to health care providers. The Division requested additional information from Fallon related to its renegotiation of existing contracts with its network of providers. The additional information provided to the Division does not demonstrate that Fallon has decreased its provider costs by renegotiating its existing contracts with providers."* Exhibit 1, p. 2.

Introduction

The Disapproval Letter states that a reason for disapproval of Fallon's proposed 2010 rates ("Disapproval Letter Reason 1(b)") was Fallon's failure to demonstrate that Fallon had taken adequate steps to "renegotiate" rates of reimbursement to providers and had not demonstrated that it had decreased its provider costs by renegotiating its existing contracts with providers.

Findings of Fact:

57. G.L. c. 176*O*, § 15(j) provides that: "No carrier shall make a contract with a health care provider which includes a provision permitting termination without cause. A carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment."

58. 211 CMR 52.12(5) provides that: "Contracts between carriers and health care providers shall state that neither the carrier nor the provider has the right to terminate the contract without cause."

59. 211 CMR 52.12(6) provides that "Contracts between carriers and health care providers shall state that a carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment."

60. Fallon's provider contracts do not allow Fallon unilaterally to reopen rate of reimbursement negotiations. Joint Exhibit 2, ¶ 11; II Tr. 193.

61. Providers are under no legal or contractual obligation to Fallon to reopen existing contracts. Joint Exhibit 2, ¶ 34.

62. Fallon's provider contracts allow for reimbursement rate negotiation at various points in time. Joint Exhibit 2, ¶ 10.

63. Fallon has provider contracts that come up for negotiation throughout the year. II Tr. 67.

64. Some of Fallon's major provider contracts with hospitals and physician groups are negotiated annually. Joint Exhibit 2, ¶ 10.

65. Other Fallon provider contracts are multi-year agreements. Joint Exhibit 2, ¶ 10.

66. Multi-year agreements often are advantageous, because they lower Fallon's administrative costs, allow Fallon to lock-in reimbursement rates, and therefore make the unit cost component of trend more stable. Joint Exhibit 2, ¶ 10.

67. Fallon's multi-year contracts typically are for periods of two to three years. Joint Exhibit 2, ¶ 10; II Tr. 67.

68. The time required for Fallon to negotiate an agreement with a provider can vary greatly, depending in part on the size and complexity of the provider organization. Joint Exhibit 2, ¶ 15.

69. Normally contract negotiations can take anywhere from three months to a year. II Tr. 44.

70. Reaching an agreement with a large or complex provider organization can take from six months to a full year. Joint Exhibit 2, ¶ 15.

71. Once agreement is reached, it normally takes two months for Fallon to implement the contract terms on Fallon's claims system. Joint Exhibit 2, ¶ 15.

72. Fallon filed its April 1 Rate Submission on March 1, 2010. Joint Exhibit 2, ¶ 26; II Tr. 192-193.

73. At the time Fallon filed its April 1 Rate Submission (March 1, 2010), approximately 42% of Fallon's hospital and 13% of its physician 2010 contracts, as measured by total provider reimbursement, had been set, within a range of increase of 4%-6%. Joint Exhibit 2, ¶ 26.

74. Fallon received an objection letter from the Division on March 9, 2010 ("March 9 objection letter"), requesting details about what it had done to reopen and renegotiate provider contracts. Joint Exhibit 2, ¶ 26; II Tr. 192-193.[7]

[7] The March 9 objection letter in numbered paragraph 8 stated: "Please provide details on all the efforts your company has made to reopen existing contracts and renegotiate existing rates so that they would be held to the CPI for medical care services." Joint Exhibit 1.

75: The March 9 objection letter required a response by March 11, two days later. Joint Exhibit 1.

76. Fallon answered the March 9 objection letter on March 11, 2010, explaining that Fallon had approached providers and that none of them had agreed to reopen its contract with Fallon. Joint Exhibit 1, Response to Objection Letter, Response 8; Joint Exhibit 2, ¶ 26; II Tr. 192-193.

77. After the emergency regulations became effective (February 10, 2010), and before the Disapproval Letter was issued, Fallon attempted, through telephone communication, to renegotiate its contracts with its top 15 providers (hospitals and physician groups), which furnish approximately 80% of the volume of services covered and paid by Fallon. Joint Exhibit 1, Response to Objection Letter, Response 8; Joint Exhibit 2, ¶¶ 26, 34, 35, Internal Exhibit 2; II Tr. 43-44.

78. Not one of Fallon's top 15 providers would agree to presently renegotiate its contract with Fallon. Joint Exhibit Response to Objection Letter, Response 8; Joint Exhibit 2, ¶¶ 26, 34, 35, Internal Exhibit 2; II Tr. 43-44.

79. Out of Fallon's top 15 provider contracts, it received the following responses: (1) no provider agreed to reopen the contract now; (2) 42.19% of the hospital and 13.39% of the physician PO and/or IPA providers did not agree to reopen the contract, and will discuss new terms when the contract renews; (3) 8.76% of the hospital and 17.78% of the physician PO and/or IPA providers already had agreed to 2010 contracts at New England Regional Medical CPI increase (3% or less); (4) 40.69% of the hospital and 63.88% of the physician PO and/or IPA providers currently are in negotiations and (5) no response was received from 8.36% of the hospital and 4.95% of the physician PO and/or IPA providers. Joint Exhibit 1, Response to Objection Letter, Response 8; Joint Exhibit 2, ¶¶ 34, 35, Internal Exhibit 2.

Analysis, Discussion and Conclusion

80. The Massachusetts Managed Care Reform Law of 2001, codified as G.L. c. 176*O*, and 211 CMR 52.12(5) require that all provider contracts contain a provision that the contract cannot be unilaterally terminated by a health plan or a provider without cause.

81. The Emergency Regulation does not impose an obligation on an entity such as Fallon to *re*negotiate its existing contracts with medical providers.[8]

82. The Division's interest in having Fallon renegotiate its provider rates does not, in and of itself, constitute an adequate cause that would allow Fallon to terminate or threaten to terminate its provider contracts.

83. Fallon's efforts to renegotiate its providers contacts, contacting its top 15 providers by letter, was reasonably adequate under the circumstances given the short timeframe for renegotiation that Fallon faced.

84. The overwhelmingly negative reaction that Fallon received to its contact renegotiation initiative from its major providers reasonably justified forgoing what likely would be further fruitless efforts by Fallon with them or with the remainder of Fallon's providers.[9]

85. *Conclusion*: Fallon has established the legal as well as practical barriers to reopening its existing provider contracts and the contracting and marketplace realities that limit its ability to do so, and has adequately described its efforts, despite these realities, to renegotiate rates of reimbursement to providers, and its inability to achieve results, despite its efforts, within the short time in which the Division expected results. Each of the following reasons constitutes, in itself, an independent and sufficient basis for reversing the disapproval of Fallon's proposed 2010 rates for Disapproval Letter Reason 1(b): (1) the time period within which the Division expected Fallon to secure reimbursement rate reductions from its providers in order to reduce its projected medical claim costs was unreasonable because it did not reflect the multi-year nature of provider contracts, the length of time required to negotiate contracts or the negotiating leverage of providers; (2) Fallon made reasonable efforts to try to renegotiate its provider contracts, and (3) 211 CMR 52.12(5) imposes limits on amending or terminating provider contracts.

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[8] At page 19 of the *Brief of the Division of Insurance* filed on July 19, 2010, the Division asserts that "Fallon has failed to meet it obligation to negotiate responsibly of behalf to its members." Disapproval Letter Reason 1(b), however, is based on a failure to *renegotiate* provider contracts within a very limited time period.

[9] The Division in the *Brief of the Division of Insurance* filed on July 19, 2010, criticizes as inadequate Fallon's contacting of its top 15 providers by letter, arguing that there was no evidence of follow-up efforts by Fallon. Given the short timeframe for renegotiation that Fallon faced, and the likely futility of contacting a second time providers that already had declined to reopen contracts, we find that Fallon's efforts were adequate under the circumstances.

Accordingly, the disapproval of Fallon's proposed 2010 rates based on Disapproval Letter Reason 1(b) is **REVERSED**.

C: Disapproval Letter Reason 2: Contribution To Surplus

> *"Fallon's Filing contains rates that are unreasonable and excessive because Fallon's rates were developed with a contribution-to-surplus load, and the rates include a contribution-to-surplus load* [2.5%]*, that is not within 0% to 1.9% which the Division finds to be a reasonable range for the contribution-to-surplus load."* Exhibit 1, pp. 2-3.

Introduction

The Disapproval Letter states that a reason for disapproval ("Disapproval Letter Reason 2") was that Fallon's contribution to surplus load of 2.5% was not within 0% to 1.9%, which the Division decided was a reasonable range for the contribution to surplus load.

Findings of Fact:

86. The Disapproval Letter states that a reasonable range for contribution to surplus is 0% to 1.9%. Exhibit 1.

87. Generally, a rate is not actuarially adequate if it does not cover the sum of the projected costs of covering medical claims, administrative costs, and a reasonable contribution to surplus. Joint Exhibit 3, ¶ 6; Joint Exhibit 17, ¶ 4; I Tr. 43-45.

88. No Massachusetts HMO, including Fallon, has "excess capital" as that term is generally understood. Petitioner's Exhibit 8, e-mail dated April 30, 2010, 3:42 PM, from Robert Dynan [Deputy Commissioner for Financial Analysis, Director of the Financial Surveillance Department of the Division of Insurance and CPA] to Joseph G. Murphy [Commissioner of Insurance].

89. Fallon's contribution to surplus load takes into account a number of factors, including the higher rate of adverse selection (individuals buying insurance when they get sick or anticipate medical needs, and dropping their insurance when it is no longer needed), the higher relative risk of defaulting (which relates to small employers and individuals having a greater risk of nonpayment of premium), protection for events that cause adverse claims experience across the board (such as the swine flu or H1N1), the need to build reserves in order to invest in the

business, and the need to ensure an adequate risk based capital ratio. Joint Exhibit 4, ¶ 5; I Tr. 66-67.

90. Fallon must consider its reserve levels when establishing a contribution to surplus load; in its pricing, Fallon always wants to contribute to its surplus for health plan infrastructure purposes and to maintain adequate reserve levels. Joint Exhibit 4, ¶ 6.

91. A contribution to surplus is important to ensure adequate capital and reserves, one measure of which is the risk based capital ratio (discussed below). Joint Exhibit 17, ¶ 16.

92. The contribution to surplus load is necessary to allow for the increased likelihood of individual members and small groups defaulting on their premiums. Joint Exhibit 17, ¶ 16.

93. A result of health care reform in Massachusetts was the merging of the small group market and the individual market for health insurance ("merged market"). Joint Exhibit 3, ¶ 7; Joint Exhibit 4, ¶ 4.

94. The merged market has existed since July 2007. II Tr. 124, 126.

95. The merged market has greater inherent risks than other commercial markets. Joint Exhibit 4, ¶ 5; Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 7.

96. The individual segment of the merged market has greater risks than the small group segment of the merged market. Joint Exhibit 4, ¶ 5; Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 7.

97. The appropriate level of contribution to surplus differs for large and small groups, as there are greater risks inherent in the merged market. Joint Exhibit 16(g), Tr. 8-9.

98. Fallon's merged market contribution to surplus reflects the greater risks inherent in the merged market compared with large groups. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 7.

99. Because the merged market has significantly greater risk, it is particularly important to build into rates a reasonable contribution to surplus allowance for products in the merged market. Joint Exhibit 17, ¶ 16.

100. The inherent risks of the merged market are taken into account in Fallon's contribution to surplus. II Tr. 124-125, 129.

101. The merged market experiences greater volatility due to demographic changes during a rating period, and this is an inherent risk of the merged market. Exhibit 1, Appendix to Actuarial Memorandum, Response 7.

102. Small employers and individuals have a greater risk of non-payment of premium, and this is an inherent risk of the merged market, and the contribution to surplus load is necessary in part to allow for the increased likelihood of individual members and small groups defaulting on their premiums. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 7; Joint Exhibit 17, ¶ 16.

103. The inherent risks of the merged market include adverse selection (anti-selection) and people jumping in and out of coverage, and the purchase of individual policies by people who are covered under an employer's self-funded plan but wish to acquire benefits that are not covered by that plan. II Tr. 124-125.

104. Adverse selection occurs when, as the size of a group decreases and includes individuals, opportunities to select the plans that are most advantageous for each member increase. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 7.

105. Adverse selection also occurs when individuals buy insurance, or richer plans, only when they get sick or anticipate greater medical costs, thereafter dropping their insurance or reducing coverage when they are well. Joint Exhibit 17, ¶ 16; I Tr. 62-63, 66-67.

106. Fallon has observed an anti-selection pattern in the merged market. I Tr. 139.

107. The results of anti-selection in terms of utilization are reflected in Fallon's historical data used in the trend analysis. I Tr. 142.

108. Fallon's claims costs for individuals who have coverage for a time, drop the coverage for some period, and then return are higher than Fallon's average claim costs. I Tr. 141.

109. Fallon's anti-selection factor is considered in connection with the contribution to surplus because contribution to surplus is intended to help Fallon maintain its ability to cover its obligations to policyholders, both short-term and long-term. I Tr. 142-143.

110. Fallon's contribution to surplus of 2.5% of premium in its proposed 2010 rates is necessary to make provision for the degree of anti-selection prevalent in the merged market. Joint Exhibit 17, ¶ 16; I Tr. 62-63, 66-67.

111. The merged market accounts for approximately 32% of Fallon's total commercial membership; whereas the merged market accounts for only between 20% and 23% of the total commercial membership of the other three largest health insurance plans in Massachusetts. Joint Exhibit 4, ¶ 4.

112. The individual segment of the merged market accounts for 4.7% of Fallon's commercial membership, whereas the individual segment only accounts for between 0.5% and 3.1 % of the total commercial membership of the other three largest health insurance plans in Massachusetts. Joint Exhibit 4, ¶ 4.

113. Because Fallon has a higher percentage of its membership in the merged market, and specifically in the individual segment of the merged market, Fallon's contribution to surplus load may need to be higher for Fallon than for other plans. Joint Exhibit 4, ¶ 5.

114. Fallon's April 2009 merged market rates were significantly inadequate to cover actual costs and Fallon lost money on the merged market in 2009. Joint Exhibit 17, ¶¶ 19 and 18.

115. Fallon incurred significant losses in the merged market in 2009 due to inadequate pricing of its merged market products in 2009. Joint Exhibit 18, ¶ 1[10]; Joint Exhibit 3, ¶ 7.

116. Fallon estimates that its 2009 rates were approximately 12.2% inadequate; *i.e.*, that its April 2009 rates needed to be 12.2% higher than they actually were to cover the cost of claims actually incurred for its book of business. Joint Exhibit 17, ¶¶ 9 and 21.

117. Fallon's historical loss ratios in the individual and small group markets that make up the merged market have shown great variability over the past several years, and have generally been significantly higher than Fallon's targeted loss ratios. Joint Exhibit 17, ¶ 16.

118. Fallon's proposed 2010 rates included a contribution to surplus load of 2.5% of the premium, which was unchanged from April 1, 2009, even though a recent actuarial analysis

[10] We found this opinion of Robert Dynan, CPA, to be persuasive, regardless of whether it is his personal opinion or an opinion *ex cathedra* by the Deputy Commissioner for Financial Analysis and Director of the Financial Surveillance Department of the Division of Insurance.

showed a range of 3% to 5% would be appropriate for a contribution to surplus for Fallon's merged market. Joint Exhibit 4, ¶ 3; I Tr. 78.

119. Even though Fallon lost money on the merged market in 2009, Fallon's proposed 2010 rates were set purely to cover the actual anticipated medical costs for the year going forward, administrative costs, and a reasonable contribution to surplus. Joint Exhibit 17, ¶ 18.

120. Risk Based Capital ("RBC") is a system used by insurance regulators, including the Massachusetts Division of Insurance, to evaluate the adequacy of insurer's reserves and, ultimately, their solvency. Joint Exhibit 17, ¶ 16.

121. Massachusetts law requires insurers to maintain certain reserve levels, as measured by a risk-based capital calculation, and Fallon's RBC at the end of 2009, which measures an insurer's reserves and risk of insolvency, was 271%, which was lower than that of any other major health plan operating in Massachusetts. Joint Exhibit 4, ¶ 7; Joint Exhibit 17, ¶ 16; Internal Exhibit 2, p. 10.

122. When compared with 2008, Fallon's RBC decreased by 27% in 2009. Joint Exhibit 4, ¶ 7.

123. In Fallon's case, it is important that its premium rates make some contribution to reserves to keep its RBC from falling below appropriate levels. Joint Exhibit 17, ¶ 16.

124. In part because of the inadequate pricing of its premium rates for merged market business in 2009, which pricing has an effect into 2010, Fallon projects additional losses in 20l0, which likely will further lower its RBC. Joint Exhibit 17, ¶ 16.

125. In 2010, Fallon needs to increase its reserve and RBC levels. Joint Exhibit 18, ¶ 2[11].

126. Based on Fallon's financial circumstances, Fallon requires a reasonable contribution to surplus, which may need to be higher than for certain other health plans. Joint Exhibit 18, ¶ 3[12].

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[11] See note 10, *supra*.

[12] See note 10, *supra*.

127. A maximum 1.9% contribution to surplus for Fallon's merged market rates would be inadequate because of the volatility and significantly greater variability and risk in the merged market, and Fallon's relatively low RBC. Joint Exhibit 17, ¶ 33; I Tr. 148.

128. A contribution to surplus of 2.5% is actuarially justifiable for Fallon's merged market products. Joint Exhibit 17, ¶ 31; I Tr. 148.[13]

129. A contribution to surplus *in excess of 2.5%* would be actuarially justifiable for Fallon's merged market products. I Tr. 148.

130. A contribution to surplus *below 2.5%* is not actuarially justifiable for Fallon's merged market products. I Tr. 148.

131. Fallon made a business decision to keep the contribution to surplus load for 2010 at 2.5% for Fallon's merged market products, the same level as in the previous year.[14] I Tr. 139.

Analysis, Discussion and Conclusion

132. A rate is not adequate, from an actuarial and regulatory perspective, if it does not cover the sum of the projected costs of covering claims, administrative costs, and some contribution to reserves/surplus.

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[13] We are mindful that Fallon in Response 7 to the Division's Objection Letter stated that "It is critical for the long term financial health of Fallon Community Health Plan that we be able to charge reasonable premium rates in the marketplace that will yield a 1.5%-2.5% margin." Joint Exhibit 1, Fallon's Response to Objection Letter, Response 7. See also Joint Exhibit 1, letter from W. Patrick Hughes, Fallon's Interim President and Chief Executive Officer, stated in a March 1, 2010, to Kevin Beagan, Deputy Commissioner and Director of the Health Care Access Bureau of the Division (same). The Division argues that these statements are an acknowledgment by Fallon that a 1.5% contribution to surplus for its merged market plans would be reasonable, a percentage within the 0% to 1.9% range that the Division stated was reasonable (see ¶ 86, *supra*). (It should be kept in mind that the Division rejected Fallon's filing because its contribution to surplus exceeded a particular range.) The Division's position fails to acknowledge that the statements did not specify a particular margin for Fallon's *small group products in the merged market*; rather, they identified a range of margins for Fallon's products. For example, while Fallon includes a 2.5% annual margin for its small group products, it includes a 2% annual margin for its large group business. Joint Exhibit 16(g), Tr. 6. Because the merged market has greater inherent risks than other commercial markets, it is not surprising that the appropriate contribution to surplus load for Fallon's merged market products is at the high end of the range stated by Fallon.

[14] The Division argues at pages 22-23 of the *Brief of the Division of Insurance* filed on July 19, 2010, that the 2.5% contribution to surplus load is merely a business decision by Fallon, and not the mathematical result of actuarial analysis, and therefore is unreasonable. This argument fails to appreciate that Fallon's actuarial analysis supported a *higher* number. This means that a 2.5% load could be inadequate, but is no support for finding that it is excessive or unreasonable because excessive. Furthermore, the Division rejected Fallon's filing because its contribution to surplus exceeded a particular range; not because of inadequate mathematical justification.

133. It is important to build into rates a reasonable contribution to surplus allowance, particularly for products in the merged market, because the merged market has significantly greater risk, including a higher rate of adverse selection and a higher relative risk of defaulting.

134. Fallon's April 2009 merged market rates were inadequate to cover actual costs and Fallon lost money on the merged market in 2009.

135. When compared with 2008, Fallon's RBC decreased by 27% in 2009.

136. Massachusetts law requires insurers to maintain certain reserve levels, as measured by a risk-based capital calculation that gauges an insurer's reserves and risk of insolvency, and Fallon's RBC of 271% at the end of 2009 was lower than that of any other major health plan operating in Massachusetts.

137. The higher percentage of Fallon's membership in the merged market, and specifically in the individual segment of the merged market, impacts Fallon's contribution to surplus load, and justifies, from both an actuarial and regulatory perspective, a higher load for Fallon than would be appropriate for other plans.

138. In Fallon's case, it is important that its premium rates make some contribution to reserves to keep its RBC from falling below appropriate levels.

139. In 2010, Fallon needs to increase its reserve and RBC levels.

140. *Conclusion*: Fallon's 2.5% contribution to surplus load in its proposed 2010 rates is not excessive in light of Fallon's specific circumstances and appropriately reflects the inherent risk characteristics of the merged market; accordingly, the disapproval of Fallon's proposed 2010 rates based on Disapproval Letter Reason 2 is **REVERSED**.

D: Disapproval Letter Reason 3(a): Rates Of Premium Increase Compared With The Increase In The New England Regional Medical CPI

"Fallon's Filing contains rates that are unreasonable and excessive because Fallon's overall assumed trend, viewed as a combination of utilization and contracted rates of reimbursement to providers, has increased at a rate that is significantly higher than the rate of change in the 2009 Consumer Price Index for medical care services for the New England Region ('Medical Care Services CPI'). Further, Fallon's overall assumed trend is not within 100% to 150% of Medical Care Services CPI, which the Division finds to be

> *a reasonable range for this trend. . . . Medical Care Services CPI is 5.1%. Fallon's assumed trend increase is, at 11.3%, substantially higher than Medical Care Services CPI. Fallon's filing fails to demonstrate a reasonable correlation between its assumed trend, or its overall unit cost and projected utilization, and the Medical Care Services CPI. . . . Fallon's filing fails to demonstrate a reasonable correlation between its assumed trend, or its overall unit cost and projected utilization, and the Medical Care Services CPI. . . . a) Fallon's Filing indicates that Fallon's contracted rates of reimbursement to providers (also referred to as 'unit costs') have increased at a rate that is significantly higher than the level of the increase in Medical Care Services CPI."* Exhibit 1, p. 3.

Introduction

The Disapproval Letter states that a reason for disapproval ("Disapproval Letter Reason 3(a)") was that Fallon's overall assumed trend, viewed as a combination of utilization and contracted rates of reimbursement to providers, has increased at a rate that is significantly higher than the rate of change in the New England Regional Medical CPI and, furthermore, that Fallon's overall assumed trend was not within 100% to 150% of the New England Regional Medical CPI, which the Division found to be a reasonable range for this trend.

Findings of Fact:

141. Unit cost (contracted rate of reimbursement to providers), which is passed through to subscribers through premiums, is one of the bigger drivers that, with utilization and intensity of services, have caused premium rates to go up over the past few years. II Tr. 27-28.

142. The change in the cost of medical care encountered by the *Massachusetts* health plans studied averaged more than 11% annually during the period 2002-2006 according to "Trends in Health Care Claims for Fully-Insured Health Maintenance Organizations in Massachusetts, 2002-2006," an Oliver Wyman report to the Health Care Access Bureau of the Massachusetts Division of Insurance released on September 19, 2008 ("Wyman report"). Joint Exhibit 13.

143. The actual trends in medical costs experienced by Fallon between two twelve-month periods (October 1, 2001 to September 30, 2008 and October 1, 2008 to September 20,

2009), adjusted for the effect of benefits changes by customers, virtually all of which involved benefit reductions, was 14.8% for the merged market and at or near 11.0% for all insured markets. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 4.

144. The U. S. Bureau of Labor Statistics issues a Consumer Price Index for medical care services for the *New England region*, which, for purposes of this review, includes Boston, Massachusetts; Brockton, Massachusetts; Nashua, New Hampshire; Maine; and Connecticut ("New England Regional Medical CPI"). Exhibit 1, p. 3, n. 10.

145. In preparing for provider negotiations, Fallon considers a variety of factors, including a variety of available financial information and utilization data pertaining to the particular type of provider with whom Fallon will be negotiating, and the New England Regional Medical CPI is one of those factors. Joint Exhibit 2, ¶ 13.

146. The use of inflationary indexes is just one of many considerations used by Fallon to evaluate a provider and to develop an acceptable range of rates under which Fallon will enter into a contract with a provider. Joint Exhibit 2, ¶ 36.

147. In preparing for provider negotiations, Fallon targets rate increases for each major provider using the New England Regional Medical New England Regional Medical CPI and other publicly available information, such as the Division of Health Care Finance and Policy hospital cost information, Medicare 403 reports and American Hospital Association Reports, as factors to be considered in identifying its targeted rate increases. II Tr. 70-74.

148. Although Fallon uses the New England Regional Medical CPI as an element in its negotiations with providers, Fallon gives it no greater weight than any of the other factors that it uses. II Tr. 71-72.

149. The New England Regional Medical CPI includes costs for items and services not covered by Fallon. Joint Exhibit 17, ¶ 36, Internal Exhibit 5.

150. The New England Regional Medical CPI measures only unit costs increases, whereas Fallon's overall assumed trend is a composite of (1) projected increases in unit costs of medical procedures, which is based on the rates of reimbursement set by Fallon's provider contracts; (2) projected increases in utilization, or the rate at which medical procedures are

consumed; and (3) projected increases in intensity, or the mix of services provided to plan members. Joint Exhibit 17, ¶¶ 12, 36, 37 and 38.

151. It would be improper to evaluate the reasonableness of Fallon's entire trend factor by referring to just one component; *i.e.*, unit costs. Joint Exhibit 17, ¶ 37.

152. The New England Regional Medical CPI is backwards looking, while Fallon's unit costs are forward looking. Joint Exhibit 17, ¶ 38.

153. The New England Regional Medical CPI measures only past expenses and does not reflect projections about future costs. Joint Exhibit 17, ¶ 36.

154. There is no correlation between the projected increases in Fallon's costs of covered services and the New England Regional Medical CPI, and applying some arbitrary lower factor not supported by analysis of the data would not be actuarially sound and could result in an inadequate rate. Joint Exhibit 17, ¶¶ 36, 40.

155. Generally, a rate is not actuarially adequate if it does not cover the sum of the projected costs of covering medical claims, administrative costs, and a reasonable contribution to surplus. Joint Exhibit 3, ¶ 6; Joint Exhibit 17, ¶ 4; I Tr. 43-45.

156. A result of health care reform in Massachusetts was the merging of the small group market and the individual market for health insurance ("merged market"). Joint Exhibit 3, ¶ 7; Joint Exhibit 4, ¶ 4.

157. The merged market has greater inherent risks than other commercial markets, and the individual segment of the merged market has greater risks than the small group segment. Joint Exhibit 4, ¶ 5.

158. The advent of the merged market in Massachusetts has resulted in complexities that have required adjustments in how HMOs, including Fallon, underwrite and price future claims for future health care services for this now-merged market. Joint Exhibit 3, ¶ 7.

159. Fallon's historical loss ratios in the individual and small group markets that make up the merged market have shown great variability over the past several years, and have generally been significantly higher than Fallon's targeted loss ratios. Joint Exhibit 17, ¶ 16; I Tr. 136.

160. The observed variability in the merged market is greater than the variability observed in other markets. I Tr. 138.

161. Fallon's April 2009 merged market rates were significantly inadequate to cover actual costs and Fallon lost money on the merged market in 2009. Joint Exhibit 17, ¶¶ 19 and 18.

162. Fallon incurred significant losses in the merged market in 2009 due to inadequate pricing of its merged market products in 2009. Joint Exhibit 18, ¶ 1[15]; Joint Exhibit 3, ¶ 7.

163. Fallon's estimated 2009 operating losses in its merged market business was $15.3 million; it suffered consolidated operating losses of approximately $38.1 million in 2009. Joint Exhibit 3, ¶ 9.

164. Fallon estimates that its 2009 rates were approximately 12.2% inadequate; *i.e*., that its April 2009 rates needed to be 12.2% higher than they actually were to cover the cost of claims actually incurred for its book of business. Joint Exhibit 17, ¶¶ 9 and 21.

165. Because Fallon's previous year's rate (April 2009) was inadequate, capping a current rate at an increase that might seem reasonable for other plans may actually result in a new rate for Fallon in April 2010 that again is inadequate. Joint Exhibit 17, ¶ 21.

166. Applying the New England Regional Medical CPI, even at l50% of the New England Regional Medical CPI (or 7.7%) to Fallon's inadequate 2009 rate does not reflect the increases needed to get Fallon's rate to the level at which that rate would cover actual projected medical claims and administrative costs, and therefore, in Fallon's case, would not be actuarially sound because it would result in an inadequate 2010 rate. Joint Exhibit 17, ¶ 37.

167. Merged market rates for Fallon's products based on a rate increase limited to 7.7% above Fallon's April 2009 rates would not be adequate or actuarially sound using appropriate actuarial standards, and would result in significant losses to Fallon on contracts effective on and after April 1, 2010. Joint Exhibit 3, ¶ 15.

168. Limiting Fallon to a 7.7 percent rate increase would have an extremely negative effect on Fallon's risk-based capital ratio. I Tr. 69.

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[15] See note 10, *supra*.

169. Holding Fallon's 2010 rates to a 7.7% increase over its inadequate 2009 rates threatens Fallon's long-term financial viability. Joint Exhibit 17, ¶ 23.

170. If Fallon's rates were increased only by 7.7% over 2009 rates, Fallon would suffer a merged market loss of revenue of approximately $23 million on an annual basis, which would reduce Fallon's RBC by approximately 62 percentage points, representing a significant and serious impact on Fallon's RBC position. Joint Exhibit 4, ¶ 8.

171. The Division of Insurance required Fallon to quantify the projected financial impact of several rate scenarios for its combined merged market, community rating by class business, and partially credible business. Joint Exhibit 3, ¶ 13.

172. The rate scenarios the Division requested were (1) capping premium rate increases at 10% over April 2009 levels, (2) capping increases at 5% over April 2009 levels, and (3) holding rates at April 2009 levels. Joint Exhibit 3, ¶ 13.

173. Projections showed anticipated net *losses* for Fallon in 2010 of approximately $39 million at a 10% rate increase over April 2009 levels, $47 million at a 5% rate increase over April 2009 levels, and $57 million at a 0% increase over April 2009 levels, with significant losses continuing in 2011. Joint Exhibit 3, ¶ 13.

174. In Fallon's case, limiting its trend factors to l50% of the increase in the New England Regional Medical CPI would result in an inadequate rate that would fail to cover projected medical and administrative costs for the merged market population, let alone those projected costs and a reasonable contribution to surplus. Joint Exhibit 17, ¶ 41.

175. Fallon estimates that the loss ratio for merged market business with April 2009 effective dates for the twelve-month period April 2009 through March 2010 was 97.6%. Joint Exhibit 17, ¶ 9.

176. April business represents approximately 42% of Fallon's total calendar year 2009 premium for the merged market; accordingly, these deficiencies had a significant negative impact on Fallon's finances in 2009, and helped contribute to a significant operating loss. Joint Exhibit 17, ¶ 9.

177. The Disapproval Letter's approach of applying a 7.7% increase to last year's rates, regardless of whether those rates were adequate, ignores Fallon's actual base period claims experience. Joint Exhibit 17, ¶ 21.

178. A premium rate cannot be determined to be excessive or unreasonable, from an actuarial perspective, based on the percentage increase over the prior year's rate, particularly where, as with Fallon's proposed 2010 rates, the prior year's rates were significantly inadequate. Joint Exhibit 17, ¶ 21.

179. Looking at a percentage increase, as opposed to the actual rate, is a flawed methodology, from an actuarial perspective, for determining whether a rate is excessive or unreasonable and leads to flawed results. Joint Exhibit 17, ¶ 21.

180. The Division's methodology, focusing on the percentage increase rather than on actual base premium rates could result in not disapproving the proposed rate for a more expensive plan but disapproving the proposed rate for a similar, less expensive plan.

181. The flawed results that can occur when percentage increase, as opposed to the actual rate, is used as a measure for disapproval include the following examples. Fallon's proposed 2010 rates, which were disapproved by the Commissioner, are lower than the revised rates for substantially similar products that were submitted by one competitor, Aetna, and were approved by the Commissioner. Aetna's approved rate for its A-1O plan ($570.85) is 25.9% higher than for Fallon's disapproved Select Care Premium Saver Value I plan ($453.26) even though, when the plans are adjusted to account for slight differences in benefit levels, Aetna's rate is approximately 26.5% higher. Aetna's approved rate for its C-I0 plan ($364.33) is 5.0% higher than Fallon's disapproved Select Care Choice 2000 plan ($346.83) even though, when the plans are adjusted for differences in benefit levels, Aetna's rate is 7.4% higher. These Aetna and Fallon plans were compared because they are the most comparable in benefit design (*e.g.*, copays and deductibles). Joint Exhibit 17, ¶ 19, Internal Exhibit 3.

Analysis, Discussion and Conclusion

182. G.L., c. 176G, §16, requires that a carrier's rates shall not be "inadequate."

183. The requirement of G.L. c. 176G, §16, that a carrier's rates shall not be "inadequate" means that rates must be adequate to meet the costs that a *particular* HMO, in this case Fallon, can expect to actually occur.

184. Trend must be developed and evaluated for each HMO based on its own data; applying an external trend such as the New England Regional Medical CPI as the sole criterion for evaluating the overall assumed trend is improper from both actuarial and regulatory perspectives.

185. The New England Regional Medical CPI is backward-looking (*i.e.*, it looks at past costs) whereas rates are set prospectively; therefore, it is improper to use the New England Regional Medical CPI as a benchmark for determining whether a projected trend is reasonable because it does not accurately reflect the reasonably expected future costs to Fallon and therefore is an inappropriate metric for evaluating Fallon's proposed premium base rate increases.

186. Although Fallon uses the New England Regional Medical CPI as an element in its negotiations with providers, this is distinct from relying upon it to develop a premium rate.

187. Although the New England Regional Medical CPI may constitute some measure of the costs of medical care commodities and medical care services to consumers in the New England Region, it has no bearing or relevance to the actual or anticipated costs of health care claims to Fallon, which has a specific group of consumers, and applying an arbitrary lower factor not supported by analysis of the data would not be actuarially sound and could result in an inadequate rate.

188. The New England Regional Medical CPI is inappropriate as a basis for evaluating Fallon's premium rates because it does not accurately reflect claim costs and administrative costs of Fallon.

189. The New England Regional Medical CPI is an inappropriate benchmark by which to evaluate Fallon's estimate of medical cost trend because the New England Regional Medical CPI measures increases in certain costs encountered by all consumers and therefore is not a relevant measure of the actual or anticipated costs of covered health care claims for members in Fallon's merged market health plans.

190. A premium rate cannot be determined to be excessive or unreasonable based on the percentage increase over the prior year's rate, particularly where, as with Fallon's proposed 2010 rates, the prior year's rates were significantly inadequate.

191. Looking at the percentage increase, as opposed to the actual rate, is a flawed methodology for determining whether a rate is excessive or unreasonable and leads to flawed results.

192. The Disapproval Letter's approach of applying a maximum 7.7% increase to last year's rates ignores Fallon's actual base period claims experience.

193. In Fallon' case, limiting its trend factors to l50% of the increase in the New England Regional Medical CPI would result in an inadequate rate that would fail to cover projected medical and administrative costs for the merged market population, let alone those projected costs and a reasonable contribution to surplus.

194. Limiting Fallon's April 20l0 merged market rate increases to 7.7% over its inadequate 2009 rates would result in significantly inadequate rates for April 2010, and therefore would be inconsistent with G.L. l76G, § 16, the legal basis for disapproving HMO rates.

195. Capping Fallon's 2010 rates at an increase of 7.7% over its prior year's rates is not actuarially sound, does not comply with applicable actuarial standards, and the resulting rates for 2010 would be inadequate, and would result in significant financial losses in the merged market for Fallon.

196. The Division's methodology, focusing solely on the percentage increase rather than on actual base premium rates has resulted in not disapproving the proposed rate for higher priced plans offered by Aetna but disapproving the proposed rate for similar, lower priced Fallon plans.

197. *Conclusion*: Fallon has proved that using the percentage increase of the New England Regional Medical CPI as the sole criterion for deciding whether to disapprove Fallon's proposed 2010 rates is incorrect for the following reasons, each of which constitutes, in itself, an independent and sufficient basis for reversing the disapproval of Fallon's proposed 2010 rates for Disapproval Letter Reason 2(a): (1) the New England Regional Medical CPI is purely a backward-looking measure of past expenses and does not measure or forecast future costs; (2) the New England Regional Medical CPI does not measure costs that are comparable to the costs

of Fallon's prospective claims, (3) focusing solely on the percentage increase, to the exclusion of the resultant premium number permits anomalous results, with another company's premiums that are higher that Fallon's proposed premiums for comparable products not being disapproved while Fallon's were disapproved; (4) using a metric external to Fallon as the sole factor to determine whether Fallon's proposed 2010 rates are excessive violates actuarial and regulatory principles and thereby contravenes the statutory requirement that rates must be adequate; accordingly, the disapproval of Fallon's proposed 2010 rates based on Disapproval Letter Reason 2(a) is **REVERSED**.

E: Disapproval Letter Reason 3(b): Inadequately Controlling Utilization

"Fallon's Filing contains rates that are unreasonable and excessive because Fallon's overall assumed trend, viewed as a combination of utilization and contracted rates of reimbursement to providers, has increased at a rate that is significantly higher than the rate of change in the 2009 Consumer Price Index for medical care services for the New England Region ('Medical Care Services CPI'). Further, Fallon's overall assumed trend is not within 100% to 150% of Medical Care Services CPI, which the Division finds to be a reasonable range for this trend. . . . Medical Care Services CPI is 5.1%. Fallon's assumed trend increase is, at 11.3%, substantially higher than Medical Care Services CPI. Fallon's filing fails to demonstrate a reasonable correlation between its assumed trend, or its overall unit cost and projected utilization, and the Medical Care Services CPI. . . . b) Fallon's Filing fails to demonstrate that Fallon is adequately controlling utilization, or adjusting its practices in order to control utilization, in a manner that is sufficient to maintain claims costs at a reasonable level or that, when combined with unit cost, results in an assumed trend that is within the range of reasonableness, i.e. 100% to 150% of Medical Care Services CPI." Exhibit 1, p. 3.

Introduction

The Disapproval Letter states that a reason for disapproval ("Disapproval Letter Reason 3(b)") was that Fallon's Filing fails to demonstrate that Fallon is adequately controlling utilization, or adjusting its practices in order to control utilization, in a manner that is sufficient to maintain claims costs at a reasonable level or that, when combined with unit cost, results in an

assumed trend that is within the range of reasonableness, *i.e.*, 100% to 150% of the change in the New England Regional Medical CPI.

Findings of Fact:

198. Cost containment was not addressed by 211 CMR 43.00 *et seq*. prior to its emergency amendment effective February 10, 2010.

199. The Emergency Regulation, *inter alia*, required Fallon to include in its filing "[a] detailed description of all cost containment programs of the HMO to address health care delivery costs and the realized past savings and projected savings from all such programs." 211 CMR 43.08(9).

200. Fallon describes its cost containment initiatives at length in Response 9 of its Appendix to the Actuarial Memorandum included with its rate filing (Response 9").[16] Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9; Joint Exhibit 4, ¶ 10, Internal Exhibit 1. Response 9 is attached as Appendix A to this Decision.

201. Fallon's cost containment activities address the cost of care across five major areas within the organization:

(a) unit cost (focused on contracting strategy, pharmacy costs and revenues),

(b) utilization (focused on utilization management, case management and disease management efforts),

(c) fraud and abuse (focused on prevention, identification and recovery)

(d) payment policy (focused on reimbursement policy and pre-payment claims edits) and

(e) benefit design (focused on benefit designs, exclusion and tiered network).

Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9; Joint Exhibit 4, ¶ 10, Internal Exhibit 1.

202. Fallon implements new initiatives and adjusts its practices on an ongoing basis. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9.

203. One aspect of cost containment is utilization management. I Tr. 99.

[16] See Joint Exhibit 1, Chet Lewandowski's April 1, 2010, Fallon Rate Filing Report to Kevin Beagan: "The actuarial memorandum provided a lengthy list of cost containment programs undertaken by Fallon."

204. Utilization refers to the rate at which medical procedures are used. Joint Exhibit 1, Chet Lewandowski's April 1, 2010 Fallon Rate Filing Report to Kevin Beagan.

205. Fallon's Cost of Care Team, co-chaired by Fallon's Senior Vice President/Chief Medical Officer and its Vice President of Medical Economics, works to eliminate or minimize duplicative, unnecessary, or inappropriate care. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9; Joint Exhibit 4, ¶ 10, Internal Exhibit 1.

206. Fallon in Response 9 summarized the Cost of Care Team's utilization management efforts relating to, among other areas, inpatient hospital services, laboratory services, and radiology services. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9; Joint Exhibit 4, ¶ 10, Internal Exhibit 1.

207. Fallon has introduced programs and provider audits to reduce non-medically necessary care such as overuse of diagnostic imaging, sleep studies, high cost implants and drugs. Joint Exhibit 1, Response to Objection Letter, Response 8.

Analysis of Producers

208. Fallon relies on certain public information and its own data to assess providers' cost structures and their ability to efficiently provide and manage care. Joint Exhibit 2, ¶ 13.

209. The public information includes, for example, the Division of Health Care Finance and Policy annual hospital cost reports, Medicare cost reports, and Medicare and Medicaid fee schedules. Joint Exhibit 2, ¶ 13.

210. For providers who are already participating in Fallon's networks, Fallon analyzes their actual historical claims data for its members who use these providers, to measure utilization and costs. Joint Exhibit 2, ¶ 13.

211. Fallon's analysis focuses on, among other factors, the providers' (1) rates of admissions and inpatient days, (2) average length of stay, (3) ambulatory surgery, laboratory, and radiology utilization, and (4) pharmacy costs. Joint Exhibit 2, ¶ 13.

212. For providers new to its network, Fallon's analysis is based on a selection of claims data from participating providers analogous to that particular provider's type, size, makeup, and pertinent regional characteristics. Joint Exhibit 2, ¶ 13.

213. For physicians Fallon also considers (1) utilization estimates based on the DXCG methodology (a severity tool adjustment that normalizes different medical groups) and the Group Insurance Commission methodology for evaluating physician quality and efficiency, and (2) their administrative and management fees; Fallon also assesses the provider's willingness and ability to accept a risk-based reimbursement structure. Joint Exhibit 2, ¶ 13.

214. By analyzing this information, Fallon can better determine how efficient the hospital or physician group is as compared to others in managing their costs, and in managing the care of its members. Joint Exhibit 2, ¶ 13.

215. If the data shows that a particular provider organization is less efficient at providing and managing care than others, Fallon typically uses that data in an effort to negotiate a lower rate of increase in reimbursement. Joint Exhibit 2, ¶ 14.

216. Fallon seeks to understand what providers are doing to become more efficient, and to work with them towards that goal. Joint Exhibit 2, ¶ 14.

217. Fallon works closely with the Fallon Clinic to establish disease management programs and other cost containment programs to help Fallon control costs. II Tr. 42.

Pay For Performance

218. Fallon has pay-for-performance programs in place that help control utilization in areas such as laboratory tests, radiology, generic prescriptions, hospital admissions, and length of stay, by reimbursing providers whose performance is better than average when measured by utilization. II Tr. 30; Joint Exhibit 1, Response to Objection Letter, Response 8.

219. The lack of market power with respect to non-Worcester hospitals impacts Fallon's ability to introduce pay for performance programs and its ability to negotiate reimbursement rates. II Tr. 141-142.

220. Of Fallon's total physician reimbursement, 80% to 82% is based on pay for performance. II Tr. 142.

Risk-sharing Arrangements

221. Whenever possible, Fallon has tried to encourage providers to accept fixed pricing rather than percent of charge reimbursement. Joint Exhibit 1, Response to Objection Letter, Response 8.

222. Fallon utilizes different types of risk-sharing arrangements, including "capitated" arrangements in which Fallon pays a physician organization a basic monthly amount for each member who chooses a physician within that organization as his or her primary care physician. Joint Exhibit 2, ¶ 23.

223. In capitation and other risk-sharing arrangements, the physician organization typically is at risk for the costs of all physician services provided to a member. Joint Exhibit 2, ¶ 23.

224. This arrangement provides the physician organization with strong incentives to manage care with attention to quality, efficiency and elimination of unnecessary services. Joint Exhibit 2, ¶ 23.

225. In some cases, physician organizations share with Fallon in the cost of other services, such as hospital services, for the members, which provides an economic incentive for the physician organization to effectively manage the member's care, to avoid unnecessary hospitalization and to manage the duration of hospital stays. Joint Exhibit 2, ¶ 23.

226. For many years, Fallon has had capitation and other risk-sharing arrangements with the Fallon Clinic, its largest physician provider organization in Central Massachusetts, under which Fallon provides a capitated payment per member per month for most members who choose Fallon Clinic physicians as their primary care physicians. Joint Exhibit 2, ¶ 25.

227. Capitation and other risk-sharing arrangements benefit the members, the provider and Fallon, and ultimately result in lower utilization and, therefore, lower premiums. Joint Exhibit 2, ¶ 24.

228. Fallon anticipates that increases in its capitation and risk-sharing arrangements will decrease medical costs in the merged market. II Tr. 127.

Savings

229. Fallon's utilization control efforts and cost containment programs produce savings in the merged market and have helped minimize the increase in utilization. II Tr. 126.

230. Fallon accounts for savings from its cost containment programs, such as those described in Response 9, when actual savings can be reliably measured and projected from experience.[17] Joint Exhibit 1, Actuarial Memoranda.

231. Fallon quantified savings associated with its cost containment programs in its filing.[18] Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9; Joint Exhibit 4, ¶ 10, Internal Exhibit 1.

232. All of Fallon's Cost of Care initiatives implemented in 2009-2010 and the several initiatives that are scheduled for completion in 2010 have, or will have, an impact on decreasing Fallon's HMO health care delivery costs. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9; Joint Exhibit 4, ¶ 10, Internal Exhibit 1.

233. Fallon estimates to have saved $4.7 million in 2009, and projects savings of $5.8 million in 2010, through its cost of care programs for its commercial business. Joint Exhibit 1, Appendix to Actuarial Memorandum, Response 9.

234. The combined cost containment efforts of Fallon's Utilization Management Department results in an *aggregate savings* of $2.50 for every dollar that Fallon spends. II Tr. 121-122; Joint Exhibit 16, page 23 of transcript of November 9, 2009 in Docket No. G2009-07.[19]

235. Fallon realized *aggregate medical spending savings* of $2.31 saved for every $1.00 spent from Fallon's activities in controlling pharmacy services, including prescription

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[17] See Joint Exhibit 1, Chet Lewandowski's April 1, 2010 Fallon Rate Filing Report to Kevin Beagan: "Fallon does not incorporate cost savings into its pricing until the actual savings are realized."

[18] See Joint Exhibit 1, Chet Lewandowski's April 1, 2010 Fallon Rate Filing Report to Kevin Beagan: "The company also quantified the savings associated with these cost containment programs."

[19] We found the statements by Dr. Elizabeth C. Malko, M.D., Fallon's Senior Vice President and Chief Medical Officer, adopted as findings of fact in this decision, to be more persuasive on the issue of the return on investment that Fallon expects from its cost containment efforts than the testimony on this point by Todd Michael Bailey, Fallon's Vice President of Underwriting, Actuarial and Medicare Reimbursement. See II Tr. 122-123. Mr. Bailey describes Dr. Malko as having "extensive experience in cost containment" (II Tr. 123, ll. 18-19) and as "*the* expert in looking at the cost containment" (II Tr. 123, ll. 8-9; emphasis added). Mr. Bailey, furthermore, misstated Dr. Malko's statement on November 9, 2009 in Docket No. G2009-07, when Mr. Bailey testified that "Dr. Malko has stated, for every $2.50, we [Fallon] are willing to put up a dollar." Dr. Malko's actual statement was as follows: "The combined efforts of our [Fallon's] Utilization Management Department results in an *aggregate savings* of $2.50 for every dollar that we [Fallon] spend." Joint Exhibit 16, page 23 of transcript of November 9, 2009 in Docket No. G2009-07 (emphasis added).

management tools such as quantity limits, prior authorizations, criteria and step therapy edits. Joint Exhibit 16, page 24 of transcript of November 9, 2009 in Docket No. G2009-07.

236. Fallon realizes *aggregate savings* of $1.50 saved for every $1.00 spent from Fallon's Case Management and Disease Management Programs. Joint Exhibit 16, page 23 of transcript of November 9, 2009 in Docket No. G2009-07.

Conclusion

237. *Conclusion*: Fallon has adequately described its cost containment programs, documented its realized cost savings from its cost containment efforts and proved that its cost containment programs, including its utilization programs, are adequate in organizational structure, commitment by senior staff, scale, effectiveness and responsiveness, and has shown that it adjusts its practices to control utilization by implementing new programs; accordingly, the disapproval of Fallon's proposed 2010 rates based on Disapproval Letter Reason 3(b) is **REVERSED**.

III. ORDER

The disapproval in the April 1, 2010 Disapproval Letter is **REVERSED**; Fallon's proposed rates for all small group products offered or renewed in the Massachusetts merged market on or after April 1, 2010 are **NOT DISAPPROVED**.

Filed: August 6, 2010

_____
Jean F. Farrington
Presiding Officer

_____
Stephen M. Sumner
Presiding Officer

AFFIRMED
August 6, 2010

_____
Susan L. Donegan
Designee of Commissioner of Insurance

This Decision constitutes the final agency decision of the Division of Insurance and may be appealed to the Superior Court pursuant to G.L. c. 30A, § 14.

APPENDIX A

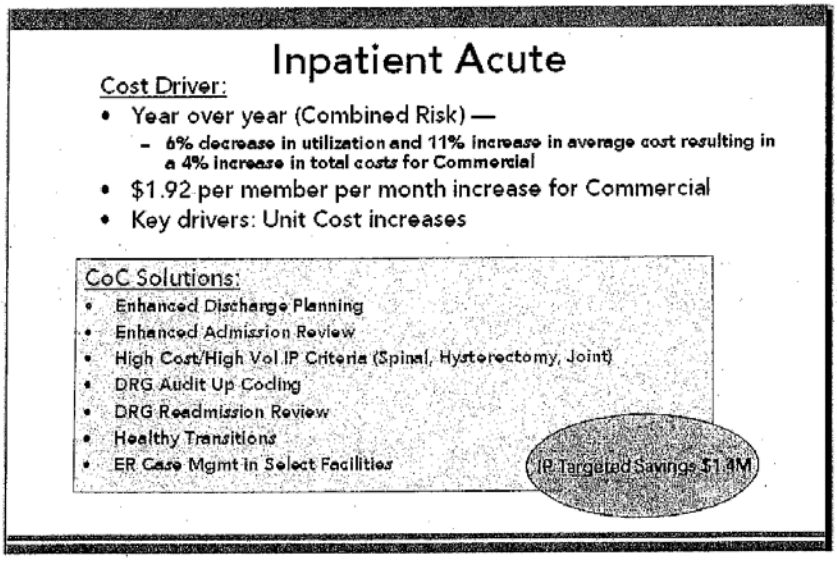
Appendix to Actuarial Memo; Division of Insurance Rate Filing; 211 CMR 43.08: Premium Rates

9) A detailed description of all cost containment programs of the HMO to address health care delivery costs and the realized past savings and projected savings from all such programs.

In order to maintain premiums, copayments, cost shares, and deductibles at affordable levels, FCHP continually works to contain the cost of care; that means eliminating or minimizing duplicative, unnecessary, or inappropriate care. It also means supporting those initiatives and activities that improve the quality of care. These directives are the focus of the FCHP Cost of Care Team.

The fundamental principle under which this team designs, builds and implements programs to achieve cost containment is based on the principle of delivering the right care to the right patient in the right setting without duplication, errors, or gaps in care, resulting in the most effective care and the best outcomes for our members.

The Cost of Care Team monitors cost drivers and implements programs targeted to reduce medical expense; some examples of our focus on drivers of cost are summarized in the following slides.



Appendix to Actuarial Memo; Division of Insurance Rate Filing; 211 CMR 43.08: Premium Rates

Laboratory/Pathology

Cost Driver:

- Year over year (Combined Risk) —
  - **a 23.3% increase in costs for Commercial**
- $4.59 per member per month increase for Commercial
- Key drivers for Commercial: genetic testing and vitamin D testing

CoC Solutions:

- CMIPA UMASS Lab Contract
- Prior authorization for genetic testing
- HLA Testing payment policy
- Additional projects TBD based on further analysis

Lab Targeted Savings $702k

Radiology

Cost Driver:

- Year over year (Combined Risk) —
  - **a 16.1% increase in costs for Commercial**
- $3.89 per member per month increase for Commercial
- Driver: Increased use of high cost radiology procedures, including MRI, CT scans, PET, and nuclear cardiology.

CoC Solutions:

- Nuclear cardiology cost sharing
- Radiology Utilization Management program

Radiology Targeted Savings $1.4M

Appendix to Actuarial Memo; Division of Insurance Rate Filing; 211 CMR 43.08: Premium Rates

FCHP cost containment activities address the cost of care across five major areas within the organization:

- Unit cost: focused on contracting strategy, pharmacy costs and revenues
- Utilization: focused on utilization management, case management and disease management efforts
- Fraud and Abuse: focused on prevention, identification and recovery
- Payment Policy: focused on reimbursement policy and pre-payment claims edits
- Benefit Design: focused on benefit designs, exclusions, and tiered network.

The following table describes the individual Cost of Care initiatives implemented by FCHP in 2009-2010, as well as several initiatives (shown in *italics*) that are scheduled for completion in 2010. All initiatives have, or will have, an impact on decreasing HMO health care delivery costs.

Initiative Name	Description	Area of focus	Project Objective
Radiology Management full UM Program	Program to provide true utilization management for all outpatient MRI/MRA, CT/CTA, PET and nuclear cardiology imaging studies	Utilization	Improve the overall quality of high-tech radiology services and ensure appropriate use of such services
Enhanced Discharge Planning	Initiative focused on ensuring planning for member discharge begins upon admission and that barriers to discharge are addressed timely.	Utilization	Improve the overall quality of patient stay in- facility and ensure length of stay is optimized.
Sleep Apnea Utilization Management Program	Program to provide sleep diagnostic and therapy management	Utilization	Improve the overall quality of sleep services and ensure appropriate use of such services
Enhanced Admission Review	Initiative to review requested service against physician's orders at the time of member admission to acute facility	Utilization	Ensure admission meets criteria and matches doctor's orders
Healthy Transitions Program –	Pilot program that aims to decrease avoidable readmission rates by ensuring all necessary follow-up care is scheduled, the member's PCP is provided with the discharge summary, and patient education relative to their new drug regimen or tests occurs within 5 days of member discharge from acute facility to home.	Utilization	Improve overall quality of life for high-risk patients post discharge and decrease avoidable readmissions

Appendix to Actuarial Memo; Division of Insurance Rate Filing; 211 CMR 43.08: Premium Rates

Initiative Name	Description	Area of focus	Project Objective
Genetic Testing Prior Authorization	Program of prior authorization for elective genetic testing based on FCHP medical policy.	Utilization	Decrease unnecessary and not covered Genetic Testing
DRG Readmission Review Process	Process to review and potentially deny payment for re-admissions to the same facility within 7 days of discharge with the same or similar/related diagnosis	Utilization	Decrease medical expense by not paying for readmits where appropriate
Infusion Program for IVIG	Program to outreach to members who are undergoing facility-based administration of IVIG infusion services and offer home-based infusion services	Utilization	Increase member quality of life and satisfaction while decreasing cost of IVIG
NICU Levelling Program	Program to reduce NICU costs by identifying appropriate NICU levels per criteria for applicable per diem payments	Utilization	Reduce NICU medical expense
NICU Case Management Program	Program to assign visiting case managers to families with infants in NICUs and to continue case management support post-NICU	Utilization	Provide needed support to families with NICU infants and reduce unnecessary ER visits and INPATIENT admissions post-NICU
Hysterectomy Inpatient Criteria	Clarify FCHP inpatient criteria on Hysterectomy admissions	Utilization	Reduce Inpatient medical expense
Spinal Inpatient Criteria	Clarify FCHP inpatient criteria on Spine admissions	Utilization	Reduce Inpatient medical expense
Joint Inpatient Criteria	Clarify FCHP inpatient criteria on Joint admissions	Utilization	Reduce Inpatient medical expense
Transition of ESRD and Kidney Transplant members to Medicare (COB)	Initiative to ensure that members undergoing dialysis or kidney transplant are enrolled in Medicare and transitioned to Medicare as primary for COB at the appropriate time as dictated by CMS regulations	Benefit Design	Support ESRD members' enrollment in Medicare in order to apply Medicare COB rules for ESRD and Kidney Transplant members
Benefit Change on PPIs (Proton Pump Inhibitors)	Benefit change for PPI drugs based on the over-the-counter availability for Prevacid, a popular Proton pump inhibitor (PPI) used to treat heartburn, gastrointestinal reflux disease	Benefit Design	Decrease Rx costs

Appendix to Actuarial Memo; Division of Insurance Rate Filing; 211 CMR 43.08: Premium Rates

Initiative Name	Description	Area of focus	Project Objective
Human Leukocyte Antigen (HLA) Testing Payment Policy	Payment Policy to clarify and correct billing for HLA state-mandated testing	Payment Policy	Reduce medical costs associated with HLA and genetic testing
Anesthesia Payment Policy	Payment policy to clarify and correct billing for Anesthesia services	Payment Policy	Reduce overall medical expenses for anesthesia services
Multiple Imaging Procedure Reduction Payment Policy	Payment policy to clarify and correct payment of radiology multiple procedures –based on CMS model	Payment Policy	Reduce medical costs related to radiology
Pre-Admission Testing Payment Policy	Payment policy to align billing practices with CMS and local payer marketplace rules re: costs for pre-admission testing being included in inpatient reimbursement – DRG, per diem, or case payment.	Payment Policy	Reduce annual medical expenses for pre-admission testing
Maximum Unit Limitations Payment Policy	Payment Policy to align FCHP maximum unit edits with CMS MUE (Medically Unlikely Edit) code list when appropriate.	Payment Policy	Reduce overall medical expenses for claims billed with medically unlikely units
Cardiology Payment Policy	Payment policy to clarify and correct payment of E&M codes when billed by the same provider on the same date of service as a cardiac stress test	Payment Policy	Reduce medical expense for Cardiology services
Transportation Payment Policy	Payment policy to clarify and correct payment of transportation services	Payment Policy	Reduce medical expense for not medically necessary transportation
Global Obstetrics Services Payment Recovery	Document and monitor/recover overpayments for services that are included in the OB Global reimbursement	Fraud and Abuse	Reduce OB medical expense by recovering payments that were paid separately instead of globally
High Dollar Pharmacy Claims Audit	Audit of High Cost Pharmaceuticals billed on medical claims	Fraud and Abuse	Reduce overall medical expense for Rx
Implantables Audit	Audit at specific Hospitals where the contract does not require an additional payment for implantables	Fraud and Abuse	Reduce medical expense for implantables
Renal Services	Audit of Renal Services for	Fraud	Reduce medical

Appendix to Actuarial Memo; Division of Insurance Rate Filing; 211 CMR 43.08: Premium Rates

Initiative Name	Description	Area of focus	Project Objective
Audit	commercial members with ESRD	and Abuse	expense for Renal Services
DRG Up coding Audit	Audit of All hospitals that pay with a DRG payment methodology and have a billed amount of $10,000 or greater or are paid at 50% or more of billed charges	Fraud and Abuse	Reduce overall medical expense
Targeted OP Facility Claims Review	Audit of OP surgical claims with billed amt of $2500.00 to $4999.99.	Fraud and Abuse	Reduce Outpatient surgery medical expense
New contract with CVS Caremark (Pharmacy Benefits Manager)	New contract	Unit cost	Reduce Rx costs
New contract with Image Consultants for Radiology	New contract	Unit cost	Reduce medical expense for radiology services
New CMIPA UMASS Lab Contract	New contract	Unit cost	Reduce medical expense for Lab services
New DME Contract with Lakeview Medical	New contract	Unit cost	Reduce medical expense on DME services
IMRT for Breast Cancer Medical Policy	Clarify FCHP Medical Policy on the treatment of Breast Cancer using IMRT	Unit cost	Reduce medical expense on radiology services
Lyme Disease Medical Policy	Clarify FCHP Medical Policy on treatment for Lyme Disease	Unit cost	Reduce Rx costs
ER Case Management in Select Facilities	*Program to install case managers in ER dept of select hospitals in order to offer home health or SNF services as appropriate to members not meeting criteria for inpatient admission*	*Utilization*	*Reduce Inpatient medical expense*
4th Tier	*Program to design a 4th tier to*	*Unit cost*	*Reduce Rx costs*

Appendix to Actuarial Memo; Division of Insurance Rate Filing; 211 CMR 43.08: Premium Rates

Initiative Name	Description	Area of focus	Project Objective
Pharmacy	*the pharmacy benefit that can be offered to commercial employer groups to save Rx expenses*		
Specialty Pharmacy Ambulatory Infusion Center and Site of Service Prior Auth Program	*Program to develop ambulatory infusion center and implement program to prior authorize infusions based on site of service*	*Utilization*	*Reduce infusion facility costs*
Modifier 78 for Outpatient Surgery Payment Policy	*Payment policy to clarify and correct billing for outpatient surgery claims with modifier 78. Modifier 78 is used to report - return to the operating room for a related procedure during the postoperative period*	*Payment Policy*	*Reduce Outpatient Surgery medical expense*
Modifier 59 on colonoscopies/ endoscopies Payment Policy	*Payment policy to clarify and correct billing for claims for multiple colonoscopy/ endoscopy procedures with modifier 59. Modifier 50 is used to report multiple procedures.*	*Payment Policy*	*Reduce outpatient medical expense*
Buy up to Brand (Rx)	*Benefit offered to employer groups where member pays generic copay plus the difference between brand and generic*	*Benefit*	*Reduce Rx costs*
Optimize Refill Language (Rx)	*Change to refill language so that member cannot refill until 75% of Rx is used. Decreases allowed refills per year from 18 to 14.*	*Unit cost*	*Reduce Rx costs*

FCHP estimates to have saved $4.7M in 2009 and projects savings of $5.8M in 2010 through its cost of care programs for our commercial business.