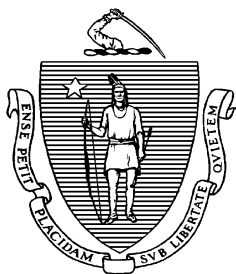


SMALL GROUP HEALTH PREMIUMS IN MASSACHUSETTS

**Report on Small Group Health Increases Based upon Information
Obtained in Hearings
Held between November 2, 2009 and January 14, 2010 and
Between March 1, 2010 and March 8, 2010**



**JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE
July 2010**

Acknowledgements

The enclosed report was prepared by staff reporting to the Commissioner, the Health Care Access Bureau, the Bureau of Managed Care and the Legal Division of the Massachusetts Division of Insurance (“Division”), including the following persons:

Nancy Schwartz, Bureau of Managed Care
Kevin P. Beagan, Deputy Commissioner, Health Care Access Bureau
Suzanne Bailey, Financial Expert, Health Care Access Bureau
Chet Lewandowski, Actuary, Health Care Access Bureau
Maryanne Walsh, Research Analyst, Health Care Access Bureau
Margaret Parker, Aide to the Commissioner
Erin Bagley, Counsel to the Commissioner, Legal Division
Susan L. Donegan, Hearing Officer and Counsel to the Commissioner, Legal Division

The report is primarily based on materials presented at the November 2, 2009 through January 14, 2010 informational hearings, additional information submitted outside the hearings by interested parties for inclusion in the docket for these proceedings and parallel special sessions examining group health purchasing cooperatives. The Division has not audited or otherwise verified the accuracy of the information presented.

Background information was obtained from statistical and other public reports produced by the Division of Insurance, Division of Health Care Finance and Policy, Commonwealth Health Insurance Connector Authority and the Office of the Attorney General as noted within the reports.

Any questions regarding the content or issues discussed in this report should be directed to Kevin Beagan, Deputy Commissioner of the Health Care Access Bureau, at (617) 521-7323 or Kevin.beagan@state.ma.us.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	v
I. INTRODUCTION	1
A. Informational Hearings	
B. Massachusetts Small Group Health Insurance Laws	
II. MARKET OVERVIEW	4
A. Health Plans' Shares of Small Group Market	
B. Characteristics of Massachusetts HMO Plans	
C. Small Group Business as a Proportion of Total Business	
D. Small Group Rate Changes	
E. Actuarial Review of Rates	
III. ADMINISTERING A HEALTH PLAN	9
A. Maintaining a Provider Network	
B. Reviewing Utilization Trends	
C. Developing Cost Containment Systems	
D. Paying Provider Claims	
E. Designing and Marketing Health Plans	
F. Answering Members' Questions and Complaints	
G. Calculating Benefit Plan Rates	
H. Controlling Health Plans' Finances	
I. Satisfying Regulatory Requirements	
J. Other Administrative Services	
K. Steps Taken to Address Administrative Costs	
L. Barriers to Lowering Administrative Costs	
IV. DEVELOPING PROVIDER NETWORKS	17
A. Networks –Negotiating for Providers to Deliver Care	
B. Health Plan – Provider Contracting	
C. Health Plan – Provider Rate Negotiations	
D. Health Care Provider Cost Increases	
E. Barriers to More Efficient Systems	
V. MANAGING NETWORKS AND PAYING CLAIMS	22
A. Paying Provider Claims	
B. Claims Administration Metrics	
C. Ongoing Efforts Leading to Changes in Utilization	
D. Barriers to More Efficient Systems	

VI.	UTILIZATION TRENDS AND COST CONTAINMENT	26
	A. Factors Leading to Changes in Utilization	
	B. Cost Containment Systems	
	C. Ongoing Efforts to Reduce Costs	
	D. Disease Management	
	E. Wellness and Health Management Programs	
	F. Provider Payment Incentive Programs	
	G. Barriers to More Efficient Systems	
VII.	DEVELOPING BENEFIT PLANS AND RATES	33
	A. Marketing to Members	
	B. Consumer Services	
	C. Design of Products	
	D. Barriers to Less Costly Products	
VIII.	DEVELOPING PREMIUMS	38
	A. Projecting Claim and Related Health Care Costs	
	B. Paying Administrative Expenses	
	C. Protecting Plan Solvency	
	D. Regulatory Oversight	
	E. Contribution to Surplus Adjustment	
	F. Development of Market and Group Level Premiums	
	G. Reasons for Small Group Premiums Being Higher than Larger Group Premiums	
	H. Small Group Rate Volatility	
	I. Adverse Selection Analysis of Rate Increases	
	J. Barriers to Lower Premiums	
IX.	POLICY OPTIONS	44
	A. Create More Affordable Small Group Products	
	B. Make Adjustments to Small Group Rating Rules	
	C. Control Small Group Market Overutilization	
	D. Eliminate Anti-Competitive Forces	
	E. Improve Claims Handling Process	
	F. Increase Transparency	
	G. Standardize Authorization Processes Across HMOs	
	H. Standardize Billing and Coding Processes Across HMOs	
	I. Standardize HMO Administrative Processes	
	J. Reduce Burdensome Administrative Processes	
	APPENDIX A – SMALL GROUP RATES FROM APRIL 2008 TO APRIL 2009	A-1
	ENDNOTES	B-1

EXECUTIVE SUMMARY

Massachusetts residents are blessed with some of the most technologically advanced hospitals, best trained health care practitioners and top ranked health insurance carriers in the nation. This can be one of the reasons, however, that health care costs and premiums can be high which can especially impact small businesses. Between April 2009 and April 2010, average small business health insurance rates increased by 12.4%. During the Division's hearings the state's HMOs described how they operate and the barriers that they face.

Findings

- The top HMOs (Blue Cross and Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan) cover 87% enrolled in HMOs; each is a local non-profit contracting with over 65 hospitals, 4,000 primary care doctors, and 16,000 specialists.
- On average, 85-89% of each premium dollar is spent on health care payments to hospitals and other health practitioners; the remaining amounts are devoted to administrative expenses or contributions to surplus.
- It is becoming more complex to administer plans due to
 - Provider networks: Network hospital and non-hospital providers have increased reimbursement demands to pay for technology, training and capital expansions, as well as to subsidize underpayments from government and other payers.
 - Employer products: Employers have increased demands to reduce benefit costs while maintaining the same level of health benefits and are exploring a wider array of cost-sharing and tiered network plans.
 - Regulatory constraints: Plans need to devote resources to design health plans and rates; respond to consumers; contract with providers; develop utilization review and cost containment programs, pay claims; report to financial and regulatory agencies; develop information technology systems to keep up with complexity.
- The increasing complexity causes inefficiency and raises costs
- Small group and large group premiums are both growing, but small group premiums are growing at a faster rate
 - Small group administrative costs are higher than those of large employers mostly because HMOs perform many more enrollment functions for small employers and need to spread certain account-level costs over a smaller pool of employees
 - Small group utilization is higher than utilization for large employers
 - Individuals are allowed to “jump into” coverage when they need it to pay for health services and “jump out” after treatment is provided
 - Large employers are much more likely to employ “health management” or wellness programs that address employees who are at risk of developing chronic health conditions.

Policy Options to Address Rising Health Insurance Costs

The following options were raised during the course of the hearings to help carriers decrease the costs of coverage to small employers

Create More Affordable Small Group Products

- Require marketing of plans through all distribution channels
- Require offer of one product that does not meet MCC levels
- Require offer of at least one selective network product
- Permit the offer of coverage through group purchasing cooperatives
- Permit health plans that exclude mandated benefits
- Permit carriers to offer at least one tiered benefit product where doctors may move from one benefit tier to another during the contract period
- Require a plan whose provider rates are capped (the “Affordable Health Plan” legislation)

Make Adjustments to Small Group Rating Rules

- Allow commissioner to adjust rating rules annually to eliminate duplicative or unwarranted costs
- Eliminate age-rate factors
- Cap the application of rating factors to reduce rate shock when group composition changes
- Smooth rating factors to reduce rate shock
- Allow carriers to offer wellness/tobacco use adjustments outside the permissible 2:1 band
- Require review of changes in the benefit level rate adjustment factor

Control Small Group Market Overutilization

- Create open enrollment period for individuals
- Require small employers to use wellness/smoking cessation programs
- Create a high-risk pool for those individuals with potentially expensive costs
- Require that small group products include higher incentives to use primary care providers
- Require regular reviews of existing mandates and repeal ineffective ones
- Institute a moratorium on mandated benefits
- Increase the individual mandate penalty and limit pro-rating of penalties

Eliminate Anti-Competitive Forces

- Prohibit noncompetitive provisions from being in contracts
- Prohibit tie-in deals in provider contract negotiations
- Limit profits of insurance and pharmacy companies
- Change facility licensing rules to prevent inflation of payments to satellite facilities

Improve Claims Handling

- Encourage providers filing claims on paper to use of administrators to file electronically
- Require carriers and providers to use electronic means to process all claims materials and to use Electronic Medical Records (EMRs) to store patient information
- Require carriers to penalize providers who do not file electronically or file inappropriate claims

Increase Transparency

- Increase DOI efforts to make health care costs more transparent
- Require reporting of complaint statistics
- Require reporting of detailed administrative expenses on supplemental financial statements
- Require reporting of all cost containment efforts

Standardize Authorization Processes Across HMOs

- Require carriers and providers to follow the same processes to authorize requests for service
- Require carriers and providers to use the exact same medical necessity criteria

Standardize Billing/Coding Processes Across HMOs

- Limit the look-back period for carriers to audit prior payments to providers
- Require all product benefits and cost-sharing to be the same

Require carriers to collect all copayments, deductibles and other cost-sharing

Standardize HMO Administrative Processes

Further standardize credentialing processes across plans
Prohibit carriers from transferring mental health care to carve-out organizations
Require all providers to accept global payments at some time in future
Require plans to penalize employers for filing retroactive changes to enrollment

Reduce Burdensome Administrative Processes

Make HMO licensing a biennial process
Require electronic submission of HMO licensing and accreditation filing materials
Eliminate requirement to notify insured that referrals are approved
Eliminate requirement that HMO evidences of coverage be sent in for DOI review
Eliminate requirement that HMOs put premium on documents to covered employees
Eliminate requirement that HMOs send annual provider directory to employers
Reduce rate filing requirements for closed nongroup health plans
Consolidate data reporting across state agencies to reduce duplicative reporting
Enact legislation to ease approval process for termination of closed plans

[intentionally left blank]

I. INTRODUCTION

At the most basic level, health plans provide, or arrange payment to providers for, covered services to insured individuals or employer groups. The delivery of health care, and the administration of health insurance coverage, has become more complicated over time because doctors, hospitals, and other providers have access to effective techniques and services that could not be imagined twenty years ago. We, as consumers of health care, expect our health plans to pay for these services when we need them.

The American market is more complex than other systems because of the level of choice. Large and small employers, employees and individuals can choose from a variety of health plans offering differing benefits, cost-sharing, and provider systems. The greater the choices, the more complicated the system - and its administration. As the complexity increases, higher costs and inefficiencies follow.

Beyond the differing level of health care benefits, Massachusetts residents expect the right to go to their choice of doctors and hospitals when they need them. Unlike many other states, the major Massachusetts health plans have created networks that include almost all of the same providers, whether they are high-cost or low-cost. Massachusetts residents have indicated in comments to the Division and complaints to health plans that a plan is inadequate if it does not have access to all of the providers that people want when they need them.

Over the past half-century, the government, private businesses, employers, consumer advocates and health plans have tinkered with the level of choices as to networks, have tried to implement point-of-service systems, tiered arrangements, and health savings accounts and have utilized managed care tools and consumer education in an attempt to impact choice and provide incentives for covered persons to get the appropriate level of care.

Health care costs and health premiums are continuing to rise at alarming levels, despite the actions described above. According to a report issued by Oliver Wyman for the Division,¹ “between 2002 and 2006, the total cost for medical services per insured member per month increased by 55%”² for an average increase of 11.6% per year. Some claim that costs have increased at a higher rate for small employers over the past few years, including an increase of 16.1% for claims used to derive April 2009.³

A. Informational Hearings

In August 2009, Governor Deval Patrick charged the Secretaries of Housing and Economic Development, Health and Human Services, and Administration and Finance to explore and evaluate all reasonable options to address the rising cost of health coverage impacting Massachusetts’ small businesses. The Secretaries detailed their agencies’ ongoing efforts and discussed the recommendations of the Health Care Quality and Cost Council, including the restructuring of the method of paying providers and the simplification of the administration of health care services.

On October 20, 2009, among other actions, Governor Patrick directed the Division to schedule informational hearings to examine health premium increases, concentrating on changes in

premium for small businesses and actions that health plans are taking to address costs. During this time, the Division invited each health plan offering products to small businesses, as well as hospitals and provider groups, to explain their systems and the reasons that they believe costs are increasing.

The Division held Introductory Hearings in the first week of November in Lowell, Springfield, Boston, Bridgewater and Worcester to listen to public comments on the topics and questions upon which the Division should concentrate. Over the next seven weeks, the Division instructed the 10 health plans⁴ participating in the Massachusetts small group health insurance market to respond to a series of questions regarding the following topics:

Week 1	Company Cost Containment Initiatives
Week 2	Health Benefit Design, Marketing and Administration
Week 3	Consumer Services, Financial Systems and Regulatory Affairs
Week 4	General Management Expenses and Claims Payment Systems
Week 5	Provider Contracting and Network Management
Week 6	Utilization Management and Claims Payment Trends
Week 7	Premium Development for Whole Plan and Small Groups

In addition to the health plan hearings, the Division invited Massachusetts hospitals and health care provider trade associations to present comments at several hearings between January 7, 2010 and January 12, 2010, or to submit written materials by January 22, 2010, detailing the rising costs from the perspective of the hospital and provider. The Division held a wrap-up session in Boston on⁵ January 14, 2010 for interested parties to submit any comments for review and held additional sessions in Hyannis, Boston, Pittsfield, Lawrence, Framingham and Fitchburg between March 1 and March 8, 2010 for interested parties to submit any additional comments for review. The Division, as directed by Governor Patrick, examined the information presented in the hearings to develop policy options to be considered for implementation in statute, benefit design, or administrative practices to mitigate the substantial annual increases that have impacted both the small businesses and the Massachusetts health insurance market overall.

B. Massachusetts Small Group Health Insurance Laws

Prior to the enactment of M.G.L. c. 176G, the Health Maintenance Organization (HMO) Act, and the promulgation of 211 CMR 66.00, the Division's small group health insurance regulation, health coverage for Massachusetts small employers (also referred to as "small groups" or "small businesses") was inconsistent, and frequently inadequate. Health plans could deny coverage to any small employer, non-renew at the end of a contract, set premiums based on the small group's prior or expected claims, and change benefits at any time. A small employer's rates could spike in any one year and be over four times that of a similarly situated small employer solely due to an employee's use of expensive medical services the prior year.

Beginning in 1992, small employers of one (self-employed individuals) to 25 eligible employees were guaranteed the right to buy the same coverage that a health plan would offer to other eligible employers in the small group health insurance market. The small group law was amended in 1996 to further extend the guarantee issue protections to employers with up to 50 eligible employees, and to remove an association group exemption⁶ that had previously allowed health plans to offer coverage only to members of an association. Because of the 1996 amendment, health plans were required to take all eligible employers and employees, with the right to apply a six-month pre-existing condition limitation or four-month waiting period on employees without prior creditable coverage.

Health plans offering small group coverage follow strict rating rules and cannot base any small group's rates on actual or expected health care costs. The rates offered to small groups cannot vary outside a 2:1 rating band (i.e., the rates of the most expensive group cannot be more than twice the rates of the least expensive group) and can only vary according to the following factors:

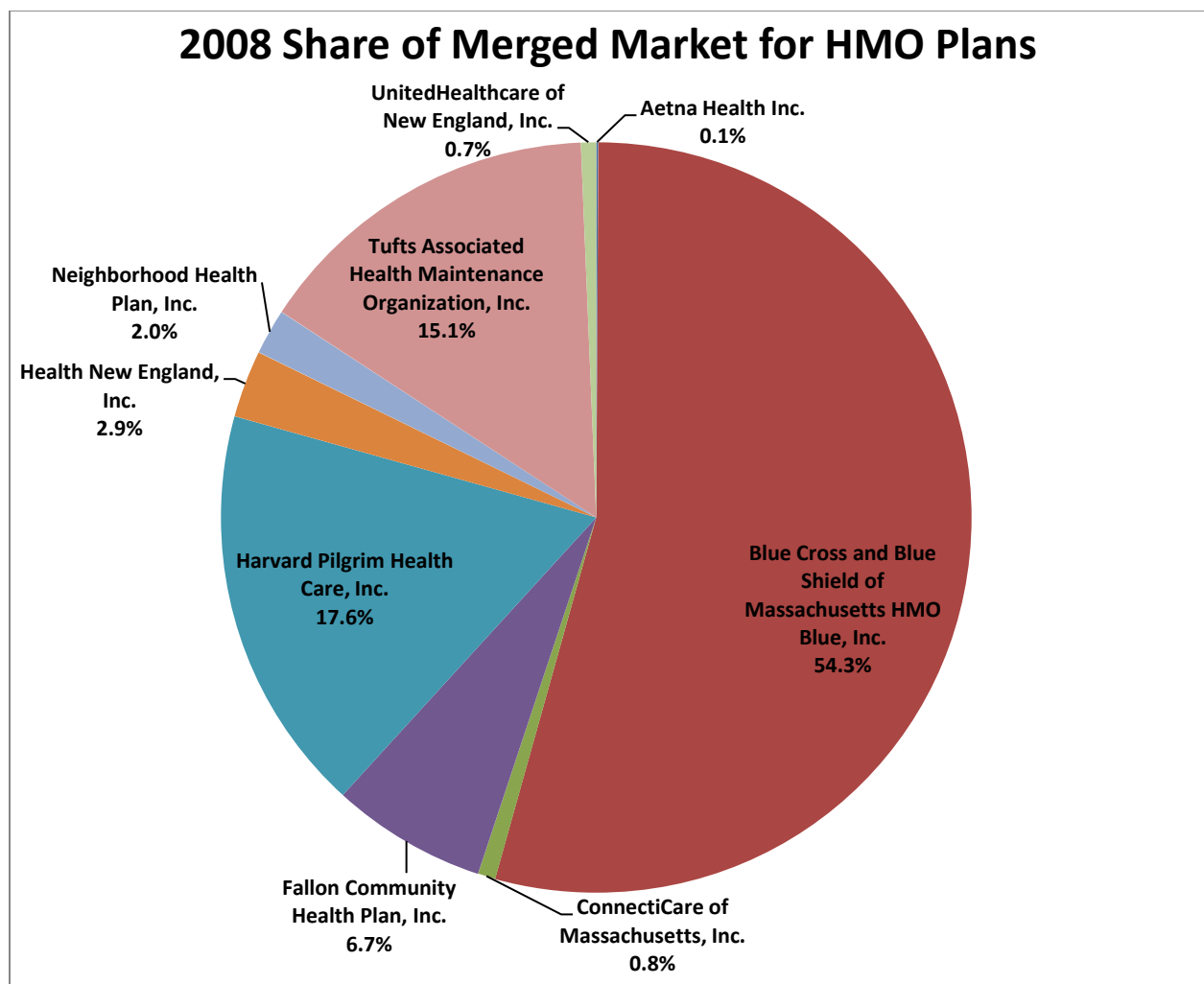
- the average age of the group's members;
- the group's industry or type of business;
- the size of the group;
- the proportion of employees who choose group health coverage;
- the geographic location of the group; and
- the actuarial value of plans' benefit differences.

The Massachusetts small group law changed again in 2006 as part of a comprehensive reform package that created a mandate for all Massachusetts residents to have adequate health coverage. Individuals, who previously had been guaranteed coverage under a separate rating pool, were merged into the small group market. The rating rules were also slightly modified to expand the group size rating adjustment and to permit carriers to rate groups based on tobacco use or wellness programs.

II. MARKET OVERVIEW

A. Health Plans' Shares of Small Group Market

According to reports developed by the Division, a total of 815,931 persons are covered under fully insured small group health insurance plans, including 72,513 individuals and 743,418 small business employers, employees and dependents, as of December 31, 2009. The Massachusetts market for small group health insurance is dominated by the state's HMOs, which account for 87% of the coverage. The remaining coverage is predominantly provided through Blue Cross and Blue Shield's non-HMO plan, the Assurant Health Insurance Companies, and closed plans with other commercial companies who are no longer offering new coverage in the Massachusetts market.



The statewide plans offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., Harvard Pilgrim Health Care, Inc. and Tufts Associated Health Maintenance Organization, Inc. account for over 85% of all HMO membership.

B. Characteristics of Massachusetts HMO Plans

The Massachusetts market is unique, as compared with other states, because it is dominated by Massachusetts-centered non-profit HMOs. The four largest health plans grew from regional health plans to statewide plans that operate, in a limited capacity, in other jurisdictions. Large national health plans with a substantial presence in other states, including United HealthCare of New England, Inc. and Aetna Health Inc., account for less than 1% of the Massachusetts small group health market.

Characteristics of Massachusetts HMOs in the Small Group Market (listed by size of HMO)

	For-Profit or Non-Profit	Statewide or Regional	Mass-Centered or National	Operating In Other States
Blue Cross and Blue Shield of MA, Inc.	Non-Profit	Statewide	Mass-Centered	National Ties
Harvard Pilgrim Health Care, Inc.	Non-Profit	Statewide	Mass-Centered	NH and ME
Tufts Associated HMO, Inc.	Non-Profit	Statewide Almost	Mass-Centered	RI
Fallon Community Health Plan, Inc.	Non-Profit	Statewide	Mass-Centered	None
Health New England, Inc.	For-Profit	Western Mass	Mass-Centered	None
Neighborhood Health Plan, Inc.	Non-Profit	Urban Areas	Mass-Centered	RI
ConnectiCare of Massachusetts, Inc.	For-Profit	Western Mass	Mass-Centered	CT
United HealthCare of New England, Inc.	For-Profit	Statewide	National	National
Aetna Health Inc.	For-Profit	Statewide	National	National

The four largest HMOs offer robust provider networks that include the vast majority of the hospitals, primary care providers and specialty care physicians available in Massachusetts.⁷

Providers within Contracting Network of Four Largest HMOs

	Acute Care Hospitals	Primary Care Physicians	Specialty Care Physicians
Blue Cross and Blue Shield of Ma, Inc.	66	6,166	19,402
Harvard Pilgrim Health Care, Inc.	73	4,127	17,667
Tufts Associated HMO, Inc.	86	7,116	16,654
Fallon Community Health Plan, Inc.	73	3,579	17,319

In general, the networks offer approximately the same access to hospitals and physicians throughout the state, although there are minor differences in the service delivery systems of the providers under contract in each plan. The health plans indicated in the health plan hearings that they do not compete based on access to provider, but instead, strive to have networks that are similar to their competitors so that the health plan will not lose any competitive position among the consumers in relation to the health plans.

C. Small Group Business as a Proportion of Total Business

The seven largest HMOs collected \$13.8 billion in revenue from all collected premiums and fees generated from serving self-funded accounts, between July 1, 2008 and June 30, 2009. Revenue generated from small group health plans in that one-year period accounted for \$3.2 billion.

Revenue 7/1/2008 through 6/30/09 in Millions of Dollars

	Insured - Small Group	Insured - All Other	Self-Funded	Government	Total
Blue Cross and Blue Shield of MA, Inc.	\$ 1,885	\$ 4,115	\$ 302	\$1,012	\$7,314
Harvard Pilgrim Health Care, Inc.	\$ 573	\$ 1,203	\$ 82	\$ 274	\$2,132
Tufts Associated HMO, Inc.	\$ 492	\$ 838	\$ 69	\$1,027	\$2,426
Fallon Community Health Plan, Inc.	\$ 196	\$ 343	\$ 5	\$ 514	\$1,058
Neighborhood Health Plan, Inc.	\$ 59	\$ 70	\$ 0	\$ 747	\$ 875
Health New England, Inc. ⁸	\$ 90	\$ 134	\$ 8	\$ 69	\$ 301
ConnectiCare of MA, Inc.	\$ 21	\$ 3	\$ 0	\$ 0	\$ 24
TOTAL HMOs	\$ 3,224	\$ 6,572	\$ 459	\$3,574	\$ 13,829

During the above-noted period, large group premium revenue accounted for almost half of all revenue generated by the health plans. Small group premium revenue was smaller, but still accounted for over 23% of total revenue. If government revenue is excluded from the table, small group premium revenue accounted for over 30% of all revenue.

Proportion of Total Revenue by Market Segment

	Insured - Small Group	Insured - All Other	Self-Funded	Government
Blue Cross and Blue Shield of MA, Inc.	25.8%	56.3%	4.1%	13.8%
Harvard Pilgrim Health Care, Inc.	26.9%	56.4%	3.9%	12.9%
Tufts Associated HMO, Inc.	20.3%	34.6%	2.8%	42.3%
Fallon Community Health Plan, Inc.	18.5%	32.4%	0.5%	48.6%
Neighborhood Health Plan, Inc.	6.7%	8.0%	0.0%	85.3%
Health New England, Inc.	29.9%	44.5%	2.7%	22.9%
ConnectiCare of MA, Inc.	87.3%	12.7%	0.0%	0.0%
	23.3%	47.5%	3.3%	25.8%

D. Small Group Rate Changes

Health plans in Massachusetts compete aggressively to maintain and grow their shares of the market. In the large group market, health plans rate based on experience, i.e., each large employer's prior and projected medical expenses compared to other large groups. In the small group market, health plans are required to base rates on the prior and projected medical expenses of the overall small group market with adjustments based on the age, industry, participation rate and location of the group.

In response to recent claims that small group rates are increasing more rapidly than those of the large group market, the Division looked more closely at the overall trends in April 2009. Based on that analysis, it appears that certain health plans increased rates more for small groups than for large groups. As illustrated below, Blue Cross and Blue Shield of Massachusetts HMO, Inc. raised the base rates for its two most populated small group plans by over 14%, while keeping increases for its large group plans to lower than 10%.

STATEWIDE HMOS - BASE RATES AS OF APRIL 2009

PLAN NAME	BCBS OF MA ⁽²⁾		HARVARD ⁽³⁾		FALLON ⁽⁷⁾		TUFTS ⁽⁵⁾	
	ENHANCED VALUE	VALUE PLUS	W6	W5	PLAN 1	PLAN 2	PLAN 1	PLAN 2
SMALL GROUP PMPM								
April-08	\$348.57	\$381.52	\$400.82	\$430.71	\$372.95	\$315.49	\$385.90	\$380.94
April-09	\$397.44	\$439.93	\$437.73	\$483.30	\$421.52	\$358.23	\$420.24	\$414.29
% INCREASE	14.0%	15.3%	9.2%	12.2%	13.0%	13.5%	8.9%	8.8%
PLAN NAME	NEW ENG. ENHANCED VALUE		NEW ENG. VALUE PLUS					
	VALUE	PLUS	W6	W5	PLAN 1	PLAN 2	PLAN 1	PLAN 2
LARGE GROUP PMPM								
April-08	\$331.83	\$363.76	\$380.17	\$406.31	NA	NA	\$382.49	\$381.55
April-09	\$364.55	\$399.67	\$425.24	\$446.23	NA	NA	\$414.31	\$412.80
% INCREASE	9.9%	9.9%	11.9%	9.8%	NA	NA	8.3%	8.2%
SMALL/LGE @ Apr. '08	105.0%	104.9%	105.4%	106.0%	NA	NA	100.9%	99.8%
SMALL/LGE @ Apr. '09	109.0%	110.1%	102.9%	108.3%	NA	NA	101.4%	100.4%

E. Actuarial Review of Rates

The Division opened a special examination in the summer of 2009 to examine whether small group health rates are increasing more rapidly than large group rates, including a review of the processes utilized by the four largest HMOs in the development of their base rates (the “Small Group Exam”).

The Small Group Exam found that between April 2008 and April 2009, base premium rates for the most populated plans of the four largest HMOs increased by 12.4% for small employers and by 9.8% for large employers. Based on this limited analysis, it appeared that:

- Claims payments were the biggest driver of premium rate changes.
 - Actual small employer claims increased by 16.1%
 - Actual large employer claims increased by 12.0%
- Administrative costs and contribution to surplus were also growing, but more slowly.
 - Small employer increased by 1.6%
 - Large employer increased by 6.1%
 - April 2009 administrative costs in April 2009 were 20% higher per member for small employers than for large employers because small employers have fewer employees sharing the costs

The analysis performed as part of the Small Group Exam also identified that the starting points for large and small groups were far apart. In the two-year claim payment period used to develop April 2009 rates, health plans paid an average of \$310.86 per member per month (\$3,730 per member per year) for claims for members of small employers. Health plans paid \$276.64 per member per month (\$3,319.68 per member per year) for claims for members of large employers. Members of small employers used more services or used services that cost more, for a total of 12.37% higher costs than those used by members of large employers in the same period.

The Division’s Small Group Exam could not, however, answer the question of why the costs are so different or what the factors or operations are, within a health plan, which may be leading to the cost differences. To that end, the Division conducted informational hearings to understand the way that health plans operate and to examine whether there are features of health plans products or operations that could be modified to lower overall costs for small employers.

As part of the hearings, the Division examined underlying themes that impact the structure of the Massachusetts health system, and the ways that health plans develop networks, negotiate rates of reimbursement, develop and market products to employers and assist covered persons to obtain promised benefits. The Divisions developed a list of policy options, presented at the end of the report, that correlate to the identified themes. The Division’s intent is to identify options that may be considered for action or further a more complete analysis in future hearings and examinations.

III. ADMINISTERING A HEALTH PLAN

Health plans spend between 10% and 15% of each premium dollar on costs to administer the health plan. Each HMO in the market employs staff devoted to developing and maintaining a health care delivery system that is offered along with the health benefits package presented to employers and eligible individuals. In order to understand the cost drivers impacting each health plan, the Division devoted seven weeks to hearings with each HMO to hear comments from the HMOs about how they carry out their necessary functions. The Division learned of the following:

Administrative Cost	BCBSMA	CtCare of MA	FCHP	HNE	HPHC	NHP	Tufts
Total Plan Design & Management	21.5%	48.5%	32.7%	36.8%	22.6%	9.6%	23.3%
Total Consumer Services	6.3%	6.0%	3.8%	17.5%	2.9%	5.5%	2.3%
Total Network Administration & Contracting	2.7%	5.3%	5.3%	4.3%	3.8%	4.1%	2.5%
Total Claims Administration	6.4%	5.2%	3.7%	9.3%	8.7%	2.4%	3.7%
Total Utilization Trends	0.1%	0.5%	1.0%	4.5%	0.4%	7.0%	1.0%
Total Cost Containment	21.4%	4.6%	10.1%	12.9%	11.8%	21.3%	12.5%
Total Rate Development	0.5%	1.2%	1.0%	1.5%	2.0%	1.4%	1.3%
Total Financial Systems	2.3%	0.9%	4.2%	4.6%	1.9%	8.0%	1.0%
Total Regulatory Affairs	0.1%	1.1%	2.5%	4.1%	3.2%	1.4%	0.4%
Total Other Administrative Costs	38.7%	26.7%	35.7%	4.5%	42.7%	39.3%	52.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

A. Maintaining a Provider Network

Over 95% of the fully-insured health plan coverage purchased in Massachusetts is in products that provide, or arrange for the delivery of, care through closed or preferred networks of health care providers. In order to market such products, health plans need to contract with sufficient numbers and types of providers to be able to market an adequate network of care in the service delivery area in which the health plan markets its products. Health plans need to attract providers, develop provider contracts, negotiate provider rates of reimbursement, credential providers and, once providers are approved, maintain systems to respond to provider questions and complaints.

Administrative Cost	BCBSMA	CtCare of MA	FCHP	HNE	HPHC	NHP	Tufts
Network Administration and Contracting	2.7% ⁹	6-8% ¹⁰	5.3% ¹¹	4.3% ¹²	3.8% ¹³	4.1% ¹⁴	2.5% ¹⁵

B. Reviewing Utilization Trends

Since 90% of each premium dollar is dedicated to provider payments, it is essential that health plans dedicate resources to monitor and review claims payments to identify utilization and unit cost changes that drive costs throughout the systems. Health plans must devote resources to developing trend reports and to monitoring the many different types of utilization to identify areas in which to devote additional cost containment or fraud-fighting efforts in the future.

Administrative Cost	BCBSMA	FCHP	HPHC	NHP	Tufts
Utilization Trends	0.1%	1.0%	0.4%	7.0%	1.0%

C. Developing Cost Containment Systems

Each health plan is expected to consistently invest administrative resources to evaluate its existing systems to provide, or arrange for the delivery of, care and design programs that will streamline administrative processes and reduce spending while also improving the delivery of services to patients.¹⁶ Many of the cost containment initiatives attempt to standardize processes among the several independent hospital and provider groups to coordinate the delivery of care dedicated to a patient so that medically necessary and appropriate care is provided with a minimum of service delivery disruption.

Administrative Cost	BCBSMA	CtCare of MA	FCHP	HNE	HPHC	NHP	Tufts
Cost Containment	21.4%*	5.0%	9.1%*	18.86%*	11.8%	21.3%*	12.5%**

* As reported in 2008 NAIC Filing Exhibit Analysis of Expenses and converted from dollars

** Reported as % of premium and converted

Each health plan develops its own cost containment system and, while some take similar approaches, a vast number of different plans and their initiatives have, at times, been criticized by the provider community for contributing to overall costs. The health plans characterized cost containment as fundamental to the health plan's operation, in some instances even if only to "bend" the trend where costs are increasing.¹⁷ In other words, health plans indicated that, without cost containment, certain costs would actually be rising at a higher rate than they do now.

D. Paying Provider Claims

Health plans need to maintain systems to receive, review, adjudicate and pay claims for covered services that are provided to covered health plan members. The systems must evaluate whether the services identified on the submitted claims meet the plan's medical necessity guidelines and are processed according to federal Health Information Portability and Accountability Act ("HIPAA") standards for uniform coding and billing. This claim information is not only used to pay bills, but also to keep track of the types and volume of claims payments processed for covered members. The carriers reported that there are no differences in claims-paying practices between large group and small group business.

Administrative Cost	BCBSMA	FCHP	HNE	HPHC	NHP	Tufts
Claims	6.4%	3.7%	4.2%	8.65%	2.4%	3.7% com 1.6% Med

E. Designing and Marketing Health Plans

HMOs and other insurance carriers market insured health benefit plans to employers and individuals. Health plans expend significant resources to develop, rate and market products; sell products and pay broker commissions; and manage employer group accounts.

Health plans participate in different markets because certain products may fill a niche, and health plans can provide differing products that purchasers will want to buy.¹⁸

Administrative Cost	BCBSMA	CtCare of MA	FCHP	HNE	HPHC	NHP	Tufts
Product Development & Marketing	6.0%	3.2%	8.8%	5.6%	6.1%	7.2%	6.5%
Sales	*%	44.3%	14.9%	21.7%	15.9%	2.0%	9.5%
Account Management	15.5%	2.3%	5.0%	9.4%	0.6%	0.4%	7.3%
Total	21.5%	49.8%	28.7%	36.7%	22.6%	9.6%	23.3%

* BCBSMA combines product development, marketing, and sales data.

As mandated benefits laws change or employers demand different benefit packages to respond to price pressures, the health plans evaluate the opportunities in the market¹⁹ and explore what can

be done, while balancing quality, simplicity and affordability in the design of products that employers will want to buy for their employees. Once designed, health plans need to pay for marketing and sales staff to present the product effectively to prospective accounts. Health plans' staff works to enroll members and ensure that health plan benefits are provided once the newly-marketed plan is purchased.

F. Answering Members' Questions and Complaints

Employers choose *which* health plan products are offered, but it is the employee, and the employee's dependents, that will use the health plan to cover needed services. Each health plan devotes administrative resources to ensuring that members understand the benefits in the product and the best way to obtain services. Health plans produce consumer guides, maintain internet sites, coordinate help lines and respond to complaints from individual consumers (or those representing them).²⁰ Each health plan is expected to maintain these resources to ensure that the plan is able to "fix" problems and fairly and consistently provide the benefits required. Over the past decade, health carriers have developed web-based tools that provide speedier answers at a lower cost than traditional telephone lines.

Consumer Services	BCBSMA	FCHP	HNE	HPHC	NHP	Tufts
Consumer Guides and Newsletters	2.4%	2.0%	***%	0.2%	2.9%	0.0%
Web-based Applications	0.5%	*%	***%	0.9%	0.1%	0.0%
Responses to Consumers	3.4%	1.8%	***%	1.8%	2.5%	2.3%
Total	6.3%	3.8%	***%	2.9%	5.5%	2.3%

* FCHP was not able to capture the expenses for Consumer Guides and Newsletters and Web-based applications separately, but the two together were 2.0 % of Administrative expenses.

** HNE does not capture the expenses for Consumer Guides and Newsletters, Web-based Applications, and Responses to Consumers at the level of detail requested.

G. Calculating Benefit Plan Rates

When a health plan calculates the insurance rate to be charged to individuals, small groups and large groups, this function is described as rate development. The rate calculation for an insured individual or group is calculated by a rate formula, which involves applying factors to a base rate expressed in terms of a per member per month dollar amount. The goal of the rate development function is to generate rates which are not inadequate. Adequate rates are sufficient to cover a plan's projected benefits and expenses, and to make a contribution to surplus.

Cost As % Total Administrative Expense	BCBSMA	FCHP	HNE	HPHC	NHP	Tufts
Product Development	0.5%	1.0%	NA	2.0%	1.4%	1.3%

H. Controlling Health Plans' Finances

Each health plan is responsible for processing billions of dollars in premiums and provider payments annually and is required to establish and maintain appropriate financial systems to account for all such accounts and responsibly protect the health plans' assets and solvency. Each plan employs systems that do the following:

- gather and report financial information,
- send bills to employers,
- collect and account for revenues,
- manage daily cash flow and treasury accounts,
- prepare for payment of taxes,
- budget and maintain financial controls,
- coordinate investment decisions,
- arrange for purchasing and payments to providers
- identify fraud and abuse, and
- advise on the strategic direction of the company.

Note: underwriting and actuarial systems, though included in the broad definition of financial systems were covered elsewhere in the hearings and addressed separately in this report.²¹

The health plan must maintain a financial system with strong controls to protect the health plans' assets and solvency, provide accurate reporting of financial information, and ensure compliance with applicable statutory and other requirements under applicable law. These systems are designed to ensure that the plan will be able to pay the claims of covered members.²²

Financial Systems	BCBSMA	FCHP	HNE	HPHC	NHP	Tufts
Financial Systems	1.0%	2.4%	5.3%	1.5%	7.0%	1.0%
Investment Management	*%	0.7%	0.4%	*%	0.0%	%
Audits/Exams	0.6%	*%	1.5%	0.4%	1.0%	*%
Total	1.6%	3.1%	7.2%	1.9%	8.0%	1.0%

* BCBSMA, FCHP, HPHC and Tufts do not separately capture the expenses for Investment Management and/or Audits and Exams as discrete functions.

I. Satisfying Regulatory Requirements

Each health plan operates according to standards established by state and federal regulators, and contracts with certain government payers. In order to maintain their licenses and contracts, plans are expected to consistently demonstrate that they are satisfying the appropriate regulatory standards and consumer protections, and each health plan is expected to dedicate resources to report and respond to said regulators. Although certain of the health plans have units dedicated to regulatory functions, support of this function is often company-wide, including staff from many various functional areas.

Regulatory Affairs	BCBSMA	FCHP	HNE	HPHC	NHP	Tufts
Monitor Legislative Regulatory Actions	0.1%	1.0%	*%	0.4%	0.6%	0.4%
Regulatory Reporting	*%	*%	*%	2.8%	0.8%	*%
Total	*%	*%	*%	3.2%	1.4%	*%

* BCBSMA, FCHP, HNE and Tufts do not capture the administrative costs for Regulatory Reporting at the level of detail necessary to report as a % of administrative expenses.

Health plans indicated that they need to devote resources to regulatory affairs due to frequent data requests for same or similar data from various regulators, constant changes in laws and regulations affecting their operations, and requests from financial regulators for SAS 70 audits (examinations of the company's controls over enrolling, billing and paying claims of members.) The plans claimed they produce hundreds of required regulatory reports responsive to the many regulators with authority/oversight of health plans in Massachusetts, including the following regulators:

- Division of Insurance
- Division of Health Care Finance and Policy
- Division of Medical Assistance (MassHealth)
- Commonwealth Health Insurance Connector Authority
- Department of Public Health
- Department of Revenue
- Executive Office of Health and Human Services
- Health Care Quality and Cost Council
- Office of Elder Affairs
- Office of Patient Protection
- Office of the Attorney General
- The federal Centers for Medicare and Medicaid Services
- The federal Internal Revenue Service

The health plans recommend developing a single repository of data in standardized formats, due to the inefficiency of responding to so many regulators with differing reports and processes.

J. Other Administrative Services

The health plans also reported expenses in the following functional areas. The health plans identify certain of these additional expenses in different ways.

Administrative Cost	BCBSMA	CtCare of MA	FCHP	HNE	HPHC	NHP	Tufts
IT	15.0%		13.6%	10.4%	20.48%	16.9%	20.5%
Facilities Mgmt	6.4%		2.9%	4.9%	3.5%		22.8%
Community Relations and Charitable			1.5%				.2%
Quality Programs			3.0%			1.4%	
H R	1.4%		2.0%	2.1%		2.1%	1.3%
Exec Office, Corporate Governance	2.6%		5.4%				
Premium Taxes and Other				3.4%	4.0%		1.5%
Legal	0.8%			1.7%	1.0%	.3%	.9%
Medical Policy	0.9%						
Lease and Depreciation				2.6%	8.0%		
Senior Care/Medicaid			2.1%				
Business Planning and Development						.9%	
Business Process Improvement						.5%	
Central Services						1.9%	
Credentialing						.4%	
Project and Process management						.3%	
Other					5.1%		
Total	12.1%		16.9%	14.7%	21.6%	7.8%	26.7%

K. Steps Taken to Address Administrative Costs

All of the health reported initiatives to reduce administrative costs over the past few years, including, but not limited to, the following:

- Blue Cross and Blue Shield of MA, Inc. reported that it: (1) reduced its employee incentive plan by 20%, (2) eliminated 2009 pay increases for all employees, (3) instituted a hiring freeze, (4) reduced employee benefits for all employees and (5) restructured its real estate strategy.
- HPHC reduced its FTEs and substantially cut its television advertising.
- ConnectiCare improved its claims processing efficiency by 15%, while improving its claims processing speed by 2%.
- Neighborhood reported that it: (1) provided free assistance to Community Health Centers to improve their efficiencies, (2) placed a freeze on hiring, (3) established a 24/7 nurse line to improve efficiency and (4) implemented a formal initiative to improve administrative efficiencies.
- Health New England developed tiered pharmacy copayments and step therapy programs.

L. Barriers to Lowering Administrative Costs

As reported by the health plans, barriers include:

- Increasingly complex benefit plan designs and provider payment arrangements create increased demands on the information technology systems of each plan. Many have had complete systems overhauls to handle the increased pressure to present information to employers, providers and regulators. Information technology services accounted for over 10% of each health plan's administrative budget.
- Although technology continues to facilitate the enrollment of health plan members, health plans continue to devote over 10% of administrative expenses to sales and account management activities to attract and keep employer accounts. As the market becomes more competitive among the health plans, they have dedicated resources to ensure that their employer accounts are satisfied with the product sold.
- Health plans must report to a dozen different state and federal regulatory agencies that require detailed reports on similar types of financial, utilization or membership. Staff resources are devoted to reports that are similar.
- Examples of unnecessary regulatory rules reported to increase administrative costs:
 - Renewal license application must be sent in every year
 - Provider directories must be sent in paper
 - Disclosure of premium must be sent to every member
 - Managed care law requires a paper document be sent to every member to notify them that a health care service has been approved by the plan
 - Burdensome process to close down old small group and nongroup plans
 - Rate filing process is unnecessarily burdensome

IV. DEVELOPING PROVIDER NETWORKS

A health plan's premiums are heavily dependent on its ability to manage its network costs. Administrative costs account for 10 cents of every premium dollar - this means that health plans pay out approximately 90 cents of every premium dollar to providers for services provided to members. If payments to providers increase, this directly impacts a health plan's need to increase the premiums it charges.

A. Networks – Negotiating for Providers to Deliver Care

Most health coverage in Massachusetts is written through closed network coverage offered by HMOs or preferred provider network plans offered by health plans that provide or arrange for the delivery of health care services. A "network" is a group of providers, hospitals and other medical care professionals that a health plan contracts with to deliver medical services to its members. Each Massachusetts health carrier offers an identical network of providers to both its large and small group accounts. Health plans do not determine their network based upon the size of the group purchasing coverage.

Network plans are generally less expensive than non-network plans since providers are willing to accept discounted fees to belong to the network and, in exchange, benefit from efficiencies provided through network management. An in-network provider is prohibited, by contract with the health plan and often by law, from charging the patient the difference between the billed charge and the payment negotiated under the contract with the health plan.²³ In addition, if a member receives services from an in-network provider, the deductible, coinsurance, and co-payment obligations are typically lower than if the member receives services from an out-of-network provider.

Currently, almost all of the health care providers in Massachusetts contract with each Massachusetts health plan and almost all of the Massachusetts health plans contract with almost all of the Massachusetts health care providers within their service area. Each health plan offers robust provider networks - with some offering 20,000 to 40,000 providers²⁴ - in order to be attractive to as many members as possible.

B. Health Plan - Provider Contracting

In Massachusetts, health plans do not own hospitals or other health practices; they contract with independent practitioners to provide services to covered members. There are no exclusive service contracts that require a provider to serve only the members of one health carrier. Each health plan contracts with many different health providers and each health provider contracts with many health plans.

As independent entities, no health plan is required to contract with any specific provider and no provider is required to contract with any specific health plans. In some geographic areas, however, only one hospital or provider group is available. The Division has not permitted

insured health plans to indicate that they offer comprehensive care in these service areas if the health plan has not secured a contract with the one hospital or provider group available.

When choosing whether to contract with each other, individual health carriers and providers evaluate whether the contract terms and the rates of reimbursement are acceptable based on their administrative practices and financial need. Once under contract, providers agree to follow the health plan's administrative practices when obtaining authorizations to provide services to members and submitting claims for reimbursement.

Provider contracts are comprehensive legal instruments that identify the explicit obligations of both the provider and the health plan regarding the delivery of services to health plan members and the method to compensate a provider for services. Although most health plans use "boilerplate" or standardized language²⁵ in contracts, there may be deviations if demanded by a provider and agreed to by a health plan, provided the differing terms are acceptable to the financial, medical management, operations, legal and regulatory staff of each side.²⁶

Smaller providers have indicated that they have little market power and are forced to accept the terms offered by health plans with little or no deviation. Larger or specialty facilities are alleged to have more market power with the health plans, because the health plans want to keep larger and prestigious providers in their networks and the provider groups have more latitude to demand customized terms. In addition to terms associated with administrative standards (*e.g.*, timeliness of reimbursement), the Division found that certain contract agreements have evolved to impact other contracts or the offering of certain products, including terms that:

- Tie rates of reimbursement or the right to renegotiate reimbursement based on levels of reimbursement from a third party;
- Require inclusion of all providers within a system, including, for example new satellite facilities of hospitals or provider groups;
- Require inclusion of all the services offered by the providers within a system; or
- Limit the offer of new types of insured products or allows a provider to opt out of certain products offered by a health plan.

The Division's Bureau of Managed Care reviews all health plan "boilerplate" contracts for compliance with the law²⁷, but it does not review final, individual contracts that may deviate from the boilerplate reviewed.

C. Health Plan - Provider Rate Negotiations

Providers are generally reimbursed after treating a patient for the services provided, but some are paid upfront – under a contracted "capitation" amount. The capitation amount is a payment for treatment that is independent of the services provided. Health plan-provider contracts specify rates of reimbursement and may include financial incentives based on the quality of care or adherence to best practices and procedures.

Health plans negotiate rates of reimbursement with each provider that differ based upon some of the following: the services offered, the quality of care provided, or the “market power” of the provider or payer. Some providers reported that they seek inflated reimbursement rates from health plans to offset underpayments from government payers. This is called cost-shifting.

The following were frequently cited as reasons why negotiating for reimbursement rates in health care is different than negotiating for services in other industries:

1. Payment is made by a third-party for a member’s use of services - not by the patient receiving treatment;
2. Levels of payment for identical services may vary dramatically based on the payer;
3. Payment is based upon pre-established billing codes entered upon a patient’s bill or claim that identify patient conditions and procedures performed during patient treatment;
4. The government is often the largest single payer and does not negotiate payment but simply defines the rules for payment upon which it will render compensation for services provided to its beneficiaries.²⁸

Prior to negotiating with providers, health plans assess key market conditions facing the provider (such as other forms of reimbursement available) and other provider-specific issues (such as plans for growth and expansion and market share). Depending on the size and type of provider – a large integrated delivery system and hospital versus a single physician contract for example²⁹ - negotiations can take up to a year as health plans make offers of rates of reimbursement and providers make counter-offers until an agreement is reached.³⁰ Most health plans offer multi-year contracts, usually a three-year term (some less, some “evergreen” or auto-renewal), and the health plans generally stagger their renegotiation schedules in order to avoid working on too many contracts at one time. Although some providers expressed an interest in shorter contract periods in order to be able to avoid being locked into unfavorable terms, most agreed that a staggered contract schedule is preferable so they are not involved in continuous contract negotiations.

Implicit in negotiations is the relative market power of providers versus the health plans. Health plans claim that providers with strong reputations, or who may be the lone provider in a geographic area, have leverage to negotiate higher rates because the health plan wants to keep these providers in their networks to remain competitive with other health plans.³¹ Smaller, less powerful providers indicated that they are not able to secure the same level of compensation. As identified on the website maintained by the Health Care Quality and Cost Council, geographically similar providers receive vastly different rates of reimbursement for similar procedures.

One provider claimed that this was partially due to another type of cost-shifting, in this case, among services within a hospital. This type of cost-shifting involves distributing some of the cost of expensive specialized units, such as burn units and neurosurgery services, to the charges for other services within the hospital. As one provider said, “[r]ather than charge outlandish prices for these services that are on standby, the costs of those types of things get spread across

all services, and it's one of the things that contributes to our prices being higher.”³² Despite such internal cost-shifting, the perceived inequity in market power perpetuates the disparity in rates of reimbursement and is considered a cost driver in negotiating contracts and maintaining provider networks.³³

Many of the health plans pointed to the need to move away from traditional fee-for-service models and endorsed a movement to a global payments system, as endorsed by the Governor's Payment Reform Task Force. A global payments system would fundamentally change the way that health care is reimbursed, and is described as allowing for a more orderly method of reimbursing providers with payment incentives to promote better care.³⁴

D. Health Care Provider Cost Increases

Health providers point to cost pressures to continue to deliver quality care through their practices and systems as the driver for a demanded rate increase. The providers who commented at the Division's hearings highlighted their need for increased health plan reimbursements to pay for:

- advances in medical, diagnostic and drug technology;
- replacing and updating outdated buildings and equipment;
- trained medical personnel, including nurses and technical staff; and
- updating information technology to respond to new government mandates.

Some providers also pointed out their need to pay for expanded facilities to respond to competitive pressures, while others noted how their medical malpractice costs impacted their overall need for higher reimbursement.³⁵

Health care providers described government underpayments as a major factor in their need for increased levels of reimbursement. One hospital indicated that they believed that the government underpayments have increased over the past decade and commented that hospitals have needed to demand higher reimbursement from health plans to offset their losses from government payers.

E. Barriers to More Efficient Systems

- Consumer perception that all care, even routine care, must be provided by highest cost, most prestigious providers.
- Health plans have permitted members continued access to high cost, prestigious providers with limited incentives to go to lower cost, less prestigious, but comparably-effective providers.
- Health plans believe networks must include high-cost, prestigious providers in order for the health plan to remain competitive which has increased the market power of those providers. Each health plan indicated that it has felt forced to accept contract terms or levels of reimbursement at the risk of a certain provider withdrawing from their system. There was

commentary that there have been instances where government actors intervened in contract negotiations when there were threats of certain providers being left out of a health plan's network.

- Lower-cost, less prestigious providers want to expand their health care delivery systems in order to compete with the higher-cost, more prestigious providers and state Determination of Need systems have not effectively restrained the expansions in service.
- Lower-cost, less prestigious providers need increased per unit cost levels of revenue in order to account for underutilization of certain expanded services developed to compete with other providers.
- Lower-cost, less prestigious providers have limited market power with the health carriers to demand the development of reduced network products that offer care only through such lower-cost providers.
- Providers claim that they need increasing levels of reimbursement from health plans and other payers to make up for revenue shortfalls from Medicare, Medicaid and other government programs.

V. MANAGING NETWORKS AND PAYING CLAIMS

Health plans expend significant resources to manage the administrative complexity of large provider networks.³⁶ They devote systems to support providers and measure performance through direct provider intervention, regular reporting of performance measures, annual surveys, and education and training designed to improve utilization and claims processing.³⁷ One plan indicated that it handles 10,000 calls a year from providers.³⁸ Health plans also provide various levels of administrative support as part of their reimbursement and billing processes.³⁹ Health plans have developed procedures and interactive websites that facilitate communication and allow for a streamlined posting of fee schedules, policies and procedures, and billing practices.⁴⁰

A. Paying Provider Claims

Claims administration is a necessary administrative function for health plans, as this is the means by which health plans process claims filed for the health services covered in a member's health benefit plan. Providers of health care services submit claims to the health plan for services provided to members according to federal HIPAA standards for uniform coding and billing. The health plans use the submitted claim information to process the claims according to the members' health benefit plans. The health plans also use data aggregated from the claims submissions to develop future rates, create programs and benefit designs, and report to various entities such as employers and regulating bodies.

Health plans encourage or require direct electronic claims filing, rather than an electronic billing clearinghouse or paper for filings.⁴¹ Most health plans have implemented changes in an attempt to lower network management expenses and many of those changes are aimed at reducing inefficiencies in connection with claims processing. One health plan described a coordinated effort with various internal departments to address inefficiencies that resulted in "better service to our providers, expedited claims processing, and a reduction in overall costs associated with re-adjudicating claims."⁴² Administrative simplification and standardization have resulted in reduction of expenses associated with contracting and network management activities.⁴³

B. Claims Administration Metrics

In an effort to understand some of the issues and barriers related to claims administration, the Division requested information on certain claims processing results. The information is shown in the chart below, as reported by the health plans (note: the results reported do not reflect a consistent methodology or timeframe):

CARRIER	BCBSMA	CtCare	Fallon	HNE	Harvard	NHP	Tufts
Claims received electronically	91.0%	85.0%	87.0%	80.0%	85.0%	84.0%	81.0%
Dollars paid electronically	92.0%	85-90%	NR	NR	NR	NR	82.0%
Payments made electronically	64.9%	0	0	NR	NR	0	0

Avg. days to process clean claim	2.8	9.6	11.9 s	NR	NRs	10.7	14
“Not clean” electronic claims	1-2%	NR	NR	NR	14%	7%	<2.0%
Clean claims not approved	7.0%	11.9%	5.0%	NR	27.0%	8.6%	17.0%
Claims denied due to coding	NR	0.5%	7.1%	NR	10.0%		11.8%
Resubmits paid	16.0%	NR	45,733 claims	NR	0.2%	17.7%	13.8%

Additional cost of paper claims	NR	NR	1/3 more	NR	\$2.71 more	NR	30-35% more
---------------------------------	----	----	----------	----	-------------	----	-------------

Health plans have devoted significant resources to developing electronic claims payment systems to reduce the administration and speed of claims payments. According to reports from the health plans, 80% to 90% of claims are received electronically, depending on the health plan. Blue Cross and Blue Shield of MA reported that it is making a significant number of its payments electronically, while the other health plans reported that they are not making significant electronic payments at this time.

The health plans advised that they make an effort to encourage providers to make use of electronic filing, either on their own or through claims administrators, sometimes known as “clearinghouses.”⁴⁴ Fallon noted that 31% of its electronic claims transmissions come from clearinghouses.

Health plans can most efficiently process claims when providers submit “clean” claims, i.e., those without any coding errors or missing information. Even when clean claims are submitted, however, health plans reported that they did not approve all such claims, with denials ranging from 5% to 27%.

One factor increasing the cost of claims payments is the cost of continuing to process paper claims. Most of the health plans assert that it is more expensive to process a paper claim than it is to process an electronic claim, with estimates of around 30% more or \$2.71 per claim. Despite the extra cost, the health plans reported that they do not offer any incentive for the electronic submission of claims other than the speed that claims are paid.

Barriers still exist that will affect the ability to achieve 100% electronic transmission. One significant factor that could be addressed is that smaller providers, and non-contracting providers, may not have the technology to submit claims electronically and cost may be a factor. Another addressable factor relates to the transmission of claims subject to coordination of benefits (COB), as some providers may not understand the proper filing format. Other factors that may not be able to be addressed fully at this time include claims with attachments (there is

no standardized format), member-submitted claims (including out-of-area and out-of-country claims), claims with unlisted codes, and adjustments and appeals.

A relatively small number of claims are actually rejected or denied by the health plans, but health plans and providers reported that they spend a substantial amount of their time over these rejected and denied claims. The health plans indicated that claims are denied for a variety of reasons, including claims that were filed:

- as duplicates;
- for non-authorized services;
- past contractual time period;
- for a service not covered by a member's plan;
- for a non-covered member;
- with a coding error;
- for a service not deemed medically necessary; or
- where another insurance plan is primary.

Providers have expressed continued frustrations with denials which are specifically related to a health plan authorizing services and then subsequently rescinding or altering the authorization. In some cases, members were covered at the time services were provided, but a claim for reimbursement is denied because the member's employer submitted paperwork to terminate the member after the service. Providers also reported continued frustration with health plan-specific rules regarding coding and "modifiers" and non-uniform medical necessity guidelines among health plans, calling for continued efforts to standardize these codes and guidelines.

Health Plan	BCBSMA	CtCare	Fallon	HNE	Harvard	NHP	Tufts
ROI from retrospective audits	50:1	NR	NR	NR	4:1	6:1	6.5:1

Many health plans conduct audits of provider payments to ensure that they are making appropriate payments for services provided. As noted in the above chart, reporting health plans indicated that they are able to recover inappropriate payments that are between four and 50 times the cost of conducting the audits. When health plans find billing inaccuracies, they may adjust a previously made payment. Providers claim that the retrospective audits lack consistency from plan to plan, and complain that the health plan makes a unilateral determination without the provider's input. Finally, the providers indicated that the audits are administratively burdensome and occur long after the date of service. Health plans pointed out that they found these audits to be effective cost containment tools to hold down the cost of care and premiums.

C. Ongoing Efforts Leading to Changes in Utilization

As claims administration is increasingly dependent on both a health plan and a provider's technological capabilities, health plans reported undertaking many technology related efforts. Blue Cross and Blue Shield of MA reported that it upgraded technology used to improve first pass rate for claims processing, thereby decreasing the cost per claim by 13.5% and increasing the number of claims handled per full-time employee (FTE) by 30%. Neighborhood advised that it implemented an online electronic data interchange (EDI) tracking tool to monitor claims submissions, as well as an integrated core administrative transaction platform to improve auto-

adjudication rates. Tufts reported that it implemented on-line adjustment capability, and increased electronic usage, Optical Character Recognition, and online eligibility inquiry. Fallon stated that it contracted to convert paper claims into an electronic format and Health New England commented that that it improved the assignment of remittance remark codes.

As efficient claims administration is dependent on the accuracy of the providers' submissions, health plans engaged in other efforts focused on communications with providers. Tufts increased the transparency of its billing guidelines and payment policies, implemented e-mail communications to providers, and developed cross-functional teams to address claims issues. Neighborhood reported that it launched a pilot that offers the ability to access an Explanation of Payment [EOP] electronically with select providers.

If a health plan subcontracts some administrative services to specialized vendors, the health plan must ensure that the subcontract arrangement is working efficiently, so. some health plans reported focusing efforts on contractual arrangements. Blue Cross and Blue Shield of MA restructured its procurement process and various technology contracts. Harvard Pilgrim developed a strong contract for claims processing and provider relations management.

Some health plan efforts focused on member education to help members better understand the claims process. FCHP developed clearer communication material for high-deductible plans and provided outreach to members regarding bills received from providers FCHP also redesigned its new member welcome kit to explain the way to submit claims. FCHP and Health New England both reported improving the clarity of their Explanation of Benefits [EOB] documents. Neighborhood reported that it revised the member handbook, published a pharmacy handbook for members, created an on-line drug look up for members, and redesigned its member website.

D. Barriers to More Efficient Systems

- Health plans continue to receive approximately 10% of all claims in paper. Since this costs more and may have more errors than electronically submitted forms, this practice adds to the overall cost of administering payments to providers and adds to frustration about claims payments. Many small providers have not converted to electronic filing due to the cost and health plans have not established different rates of payment to account for the additional processing cost.
- Health plans continue to apply plan-specific coding and processing rules which slow down the processing of properly submitted "clean" claims.
- Health plans continue to use differing medical necessity and administrative processes, requiring providers to learn and adjust their submissions with each health plan filing.
- Health plans continue to permit employers to submit termination and enrollment forms late, which delays the processing of eligibility information on health plan systems. Providers rely

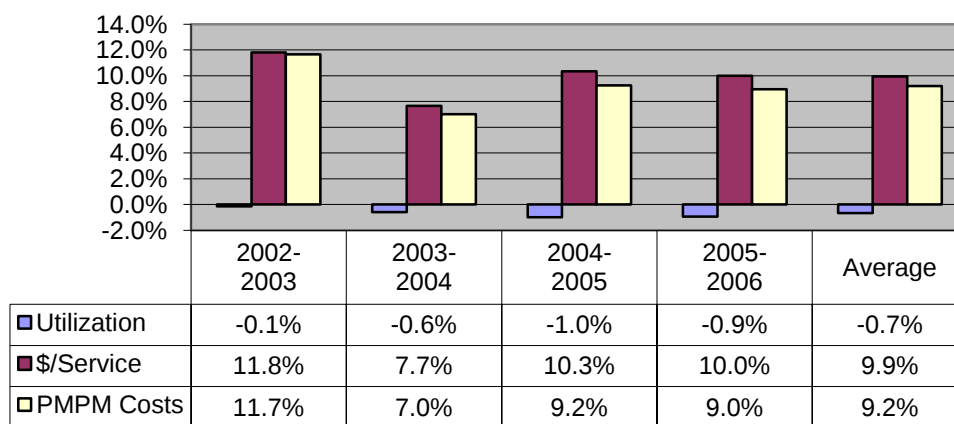
on those systems to learn whether and how a member is covered and if the information is inaccurate because of late paperwork, treatment is provided and claims are denied for a person that the provider believed had appropriate coverage.

VI. UTILIZATION TRENDS AND COST CONTAINMENT

When health plans pay claims, they must not only monitor the way that changes in provider rates of reimbursement (sometimes referred to as the unit cost of services) impact overall cost, but also changes in utilization – the level, type and intensity of services used by plan members.

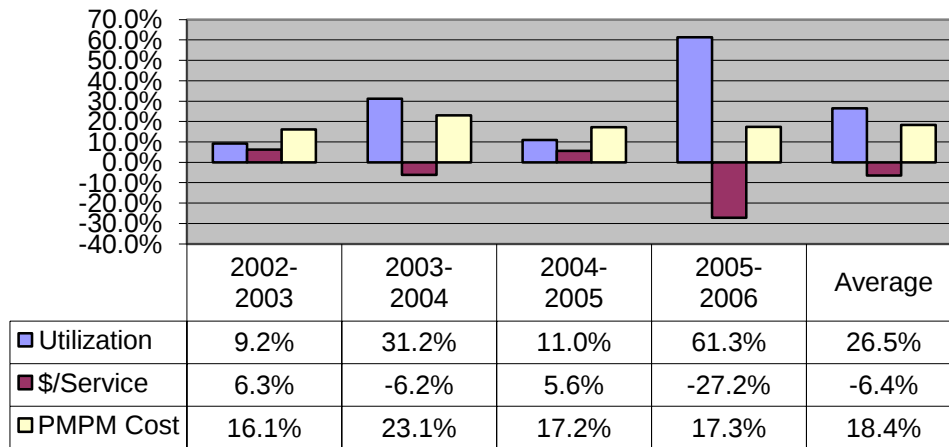
The Division commissioned the Oliver Wyman actuarial firm to study Massachusetts health plans' insured claims trends between 2002 and 2006.⁴⁵ While Oliver Wyman illustrated that claims costs increased for all types of services, the reason for the costs varied. Inpatient hospital utilization decreased by 0.7% over this period, but provider reimbursement (“\$/service”) increased by 9.9% which led to a 9.2% increase in per member per month (“PMPM”) costs.

Trends in Inpatient Hospital Costs per Member Per Month



Outpatient hospital radiology claim costs increased by 18.4% annually, primarily due to a 26.5% annual increase in the number of radiological services provided.

Trends in Outpatient Hospital Radiology Costs per Member per Month



A. Factors Leading to Changes in Utilization

The health plans monitor utilization changes based on volume, type and intensity in order to understand trends that impact future use of services. Some of these changes are due to patterns in members' health while others are due to changes in provider practice patterns. Health plans referred to over-utilization, mis-utilization and under-utilization of many different services as areas of concern.⁴⁶

One health plan described the pressure to use new technology and high-cost treatments that result in increased consumer demand for those services. As noted by this health plan, "[t]he usual model for economic competition is that more competition means lower prices...[but f]or health care services,...the more providers offering a particular medical service, the greater the total expenditure for that service."⁴⁷ As an example, this health plan noted that it recently saw a steep rise in the number of sleep studies ordered by providers, resulting in a large increase in the health plan's outpatient facility costs,⁴⁸ yet these services were not always provided because of minimal evidence of clinical effectiveness.

United stated that "advancing imaging procedures are one of the fastest growing sectors in health care...[with] a 15 to 20 percent overall increase...in imaging services [as national] costs increased from \$7 billion to \$14 billion annually between 2000 and 2006."⁴⁹ In addition, United noted that one service usually leads to increases in other services with "every hospital day...linked to a 6 percent increase in medical complications, negatively impacting both patient health and adding unnecessary cost."⁵⁰

Another health plan noted that more services are being performed at tertiary care or teaching hospitals, instead of at community hospitals or in provider offices. In addition, hospital-based outpatient services (services that can be provided in an outpatient setting, but are instead provided in the hospital) have increased, especially high-tech radiology services and laboratory services.⁵¹ These changes add to the overall use and cost of health care services.

The health plans pointed to changes in utilization from lifestyle to the aging of the population,⁵² both of which contribute to deterioration of health status, as well as an increase in the rate of chronic conditions. Services to treat diabetes, asthma, high blood pressure, high cholesterol, cancer, and heart failure are increasingly needed to respond to the population's growing level of obesity and physical inactivity, and to a lesser degree use of tobacco and other drugs.

Health plans also claimed that consumers are using services at higher cost settings (outpatient hospital facilities), especially high-tech radiology and laboratory services,⁵³ rather than lower-cost settings, such as a doctor's office. Others noted that more services are being performed at tertiary care or teaching hospitals than community hospitals. The new service locations generally cost more than having the same services provided outside of the hospital.

The health plans reported growth in the use of specialty pharmacy medications, which are very expensive and used for specific diseases.⁵⁴ One carrier noted that use of specialty medications is "increasing at a rate of about 25 to 30 percent per year."⁵⁵ These specialty drugs tend to be used by a small percentage of the population, but account for a large percent of total health care expenditures.

Another factor described by the health plans as leading to changes in utilization is the reluctance of health plans to use waiting periods or pre-existing condition limitation periods for individuals. The purpose of using these waiting periods is to reduce adverse selection – *i.e.*, where an individual buys health coverage only when needed– because rates are developed with the expectation that individuals will buy and keep coverage.⁵⁶ When the small employer and individual markets merged in 2007, many health plans stopped applying waiting periods. The Division, using Oliver Wyman for the analysis, studied the individual market and found a marked increase in the number of individuals who buy and drop coverage within the first year, including individuals with high-cost medical treatments.⁵⁷ This increased volume of individuals terminating after short durations of coverage in which they received services results in added costs to all members in the merged market.

B. Cost Containment Systems

Cost containment systems are designed to streamline processes, maintain quality and reduce spending.⁵⁸ Since the Massachusetts market consists of several independent hospital and provider groups, there is no standard way to ensure that care is being delivered in an appropriate and cost-effective manner.

For example, when a new technology emerges, hospitals may want to purchase it due to expected improvements in accuracy, delivery of services with shorter wait time, and cost-effectiveness. In order to implement the new technology, hospitals will purchase equipment, hire specialists and implement procedures to use the technology with patients. Without strong state Determination of Need processes, there are no restrictions, other than business decisions, in the implementation of the technology, which leads to rising costs and increased utilization.⁵⁹ As a result, health plans engage in cost containment processes to evaluate patterns of treatment to attempt to reduce

and control costs or to “bend” the trend where costs are increasing.⁶⁰ Without such cost containment efforts, costs would be rising at a higher rate than they do now.

Each health plan has utilization review and cost containment systems to continually identify best practices for care delivered to its members. The health plans indicated that they are constantly looking for new ways to evaluate utilization and look for ways to contain costs.⁶¹

- ConnectiCare follows a pyramid of “strategic medical management” that concentrates on: 1) promoting preventive health and wellness, 2) implementing chronic care management, and 3) developing case management for catastrophic or complex diseases.⁶²
- FCHP focuses on: 1) unit cost, 2) utilization management, including case management and disease management, 3) fraud and abuse (prevention, identification, recovery), 4) payment policies, and 5) benefit design so that the “right care [is] delivered to the right patient in the right setting, without duplication, errors or gaps in care [which] will result in the most cost-effective care and the best outcome for our members”.⁶³
- HPHC uses a Provider Medical Cost Team that each year defines a set of medical cost savings initiatives to “lower rate of growth in the medical cost trend and a favorable medical PMPM position relative to ... past performance as well as ... competitors” after looking at 1) utilization management, 2) payment policy, 3) reimbursement strategy, 4) medical trends, and 5) product development.⁶⁴
- Tufts focuses on unit cost and fraud/abuse and uses a Medical Cost Containment Committee that looks to focus on: 1) ways to promote efficiency in the delivery system, 2) steps to promote adoption of evidence-based medicine, and 3) ways to incent members to change costly behaviors.⁶⁵

Other health plans discussed their practices, from the largest health plan in the state using a “formal and very comprehensive process”⁶⁶ to a smaller regional plan whose cost containment approach is inherent in all of its daily functions.⁶⁷

C. Ongoing Efforts to Reduce Costs

Utilization Management (UM)

Every health plan described its use of utilization management programs to review the services being performed.

- Blue Cross and Blue Shield of MA employs utilization review processes, including precertification of inpatient admissions and certain inpatient and outpatient procedures, primarily where there is wide variation in practice and expense across networks.⁶⁸
- ConnectiCare characterizes utilization management as a “sledgehammer” and “not optimally effective”, but indicates that it is used to minimize inadvertent claims coverage of benefits that fall outside the benefit plan, or high dollar claims that have multiple

alternatives available. ConnectiCare stated “[u]tilization review is sort of the standard [cost containment program] in the managed care industry.”⁶⁹

- FCHP uses utilization management programs to “evaluate the appropriateness of and the medical need for health care services, procedures, and the use of facilities” and reported savings of \$2.50 for every dollar spent on utilization review.⁷⁰
- HPHC describes its Utilization Management Department as “designed to facilitate the appropriate utilization of health care services” and stated “[we] have a select list of services for which we have prior authorization....We have pared this list down actually over time, because some of what we were authorizing, we rarely said no to.”⁷¹

Health plans discussed addressing cost containment for services such as pharmacy management, to encourage more use of generic drugs and employ pharmacy benefit managers.⁷² In addition, many plans have instituted prior approval of high-tech radiology services (*i.e.*, MRIs and CAT scans)⁷³. These steps have resulted in savings as high as 26% for some health plans.⁷⁴

D. Disease Management

In addition to reviewing requests for services, each health plan has implemented disease and case management programs that identify high risk members, in order to design programs to treat chronic diseases and help manage individuals through acute episodes of care while also lowering overall costs.⁷⁵ They have also worked to identify and reduce avoidable hospital admissions and develop individualized patient discharge plans in order to get members the care needed to manage their condition and improve health outcomes.⁷⁶ The health plans reported the following efforts:

- Blue Cross and Blue Shield of MA and Tufts described programs for members with diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disorders, and asthma.⁷⁷
- ConnectiCare described several case management programs, including transplant, chronic kidney disease, cancer, and behavioral health.⁷⁸
- FCHP reported disease management savings of \$1.50 for every dollar spent.⁷⁹
- HPHC's Medical Management Assessment Team looks at both case and disease management and its return on investment is expected to be 2 to 1.⁸⁰

E. Wellness and Health Management Programs

Health plans are also devoting resources to helping members follow healthy behaviors aimed at reducing chronic diseases. All of the health plans offer health education and smoking cessation programs to members and many offer discounts on health club memberships or weight management programs.

One health plan offers a web-based health risk assessment tool for all members,⁸¹ and offers members in large groups a program to help members determine health risks and learn about actions that may reduce the risk of health care problems.⁸² This health plan piloted its program on its own employees and reduced the number of employees who are overweight.⁸³ Another health plan offers a computerized health risk assessment to encourage members to join its 10,000 Steps Walking Program and take advantage of weight loss and health club memberships.

The health plans noted that they have found it difficult to offer their wellness programs to small employers because of the administrative costs in obtaining results when employers do not have human resources staff to dedicate to such a program. Although health plans offer fitness discounts and treatment programs, they do not currently offer targeted health management programs to these groups.

The offered programs for fitness and weight loss are not as effective as aggressive wellness programs offered by employers who provide financial incentives for participating in a program, such as lower employee contributions to premium. EMC Corporation, a large, self-insured company that presented on its wellness program during the Division's hearings, has saved

millions of dollars by implementing health management and lifestyle coaching programs run by three human resources staff members and a consulting partner at a cost of less than a million dollars per year.⁸⁴ Comprehensive wellness programs that include financial incentives can be very effective at reducing annual cost increases by helping individuals take responsibility for their health, but they are not usually used by small employers and individuals because of the large administrative costs associated with those programs. Since small employers tend to switch carriers frequently over time in search of the most favorable premium, health plans indicated that bringing a wellness program to a small employer with only a few employees is not cost-effective.⁸⁵

F. Provider Payment Incentive Programs

Health plans identified that they are also exploring new payment programs with providers that increase pay-for-performance initiatives. Under pay-for-performance, providers are rewarded for meeting pre-established targets or performance measures for quality and efficiency.⁸⁶

Many health plans stated that they are exploring global payments as an option that move the payment structure away from the traditional fee-for-service reimbursements currently in place.⁸⁷ Under a global payments system, health plans reimburse providers a negotiated cost for an episode of care, permitting the health care provider to use the identified funds to manage the care. Providers become more aware of the cost of procedures and then have an added incentive to take this into account when deciding the appropriate way to treat a patient.

G. Barriers to More Efficient Systems

- The major health plans have networks that include all the major Massachusetts hospitals and large provider systems. Since the health plans claim they would be at a competitive disadvantage if any hospital were not in their system, they have indicated that they have very little leverage to reduce certain providers' demanded rates of reimbursement.
- Health plans have contracts or other agreements with certain providers that limit competition including:
 - Most Favored Nation provisions permitting the health plan or the provider to renegotiate rates of reimbursement based on another party's rates of reimbursement;
 - Product restriction provisions permitting a provider from withdrawing from a health plan's network if it does not like one of the health plan's products, including a plan with a reduced network that does not include the provider; and
 - Tie-in provisions that require a health plan to contract with all the providers with a system or for all the services offered by the system even if it does not want to contract to include the higher costs within their system.
- Providers indicated that they have increased cost-shifting to health plans for underpayments from government payers. Certain Boston-area hospitals have also indicated that they cost shift certain high-cost, but necessary services (e.g., burn centers)

within their hospitals, thereby increasing the average cost of services available at community hospitals.

- Health carriers develop three-year contracts with hospitals and stagger negotiations so that 1/3 of the hospitals are in contract negotiations every year. Although this stabilizes certain contract costs, certain other costs have tended to spike at the end of the three-year term.
- Providers are reluctant to move from a traditional fee-for service system to one based on global payments.
- There are limited standards to restrict the building of unnecessary care sites and no facility licensing rules to prevent inflation of payments to satellite facilities.
- Consumers become aware of new technologies and treatments and increase demand to gain access to these even if there is no evidence that they would be effective for what the patient needs.
- Individual members are more likely to buy and terminate coverage under the merged market, where health plans are not applying waiting periods and pre-existing condition limitation periods because they would be required to do the same for small employers. There is an increase in the number of high-cost cases who have joined the merged market and then dropped coverage after receiving medical care.

VII. DEVELOPING BENEFIT PLANS AND RATES

Employers and individuals make the ultimate decision about the structure of the benefits offered by a health plan. Consumers choose health plans and health products based on their needs, wants and abilities to pay. Health consumers in Massachusetts are described as knowledgeable customers who require broad access to health care services, as well as to doctors and hospitals,⁸⁸ including to the prestigious medical centers available in the Boston area. Health consumers expect to have the ability to get the “best” treatments or supplies provided by the “top” providers, possibly due to aggressive marketing or heightened awareness of reputation.⁸⁹ Employers, including small group employers, expect to have as many provider choices as possible available for their employees as part of a health plan.⁹⁰

A. Marketing to Members

Health plans may offer a hundred different product designs around a core package of benefits and core provider network. The designs may differ by supplementary benefits [*e.g.*, chiropractic care], provider network options [*e.g.*, access to out-of-network or out-of-state providers] or member cost-sharing [*e.g.*, copayments, deductibles or coinsurance]. Employers and individuals must balance the desire for supplementary benefits and provider network options that add cost to the core package, with the out of pocket expense of cost-sharing features that reduce overall premiums by transferring a portion of the cost of treatment to the covered members.

Most employer groups and individuals purchase coverage with rates in effect for a one-year period. Whether at renewal or first purchase, health plan sales representatives work closely with employers and/or non-employee brokers to evaluate health plan designs and premiums based on the characteristics of the group. The health plans generally make premium quotes available 60 days in advance through automatic rate quoting systems and then adjust the premiums after obtaining information on the characteristics of a group. While health plans may collect prior claims experience from employers with over 50 employees, they may only collect limited information regarding the characteristics of a small group or individual to develop premiums. After choosing plans, larger employers allow their employees to choose among the options offered and then forward enrollment information to health plans.

In general, the process is similar for small employers and large employers, but the administrative cost is higher for small employers because certain costs are fixed per group and are thus spread over a smaller number of employees or members.

B. Consumer Services

In general, employers and individuals want to choose the best products that are administratively easy to use and meet their needs. It is true, however, that the more varied the benefit and cost-sharing options and complex the product design, the more difficult it may be for a sick individual to understand the way to use his/her coverage to obtain services when needed. Sales and marketing staff may explain the product clearly at purchase, but covered members often need

health plan assistance to learn how best to use their plans. The following table identifies the average number of contacts handled by health plan consumer services staff between 2006 and 2008.

Member contacts with consumer services staff

	BCBSMA*	Fallon**	HPHC	HNE	NHP	Tufts
Telephone calls (average 2006-2008)	2,131,952	188,640	621,585	144,770	34,107	620,089
% of calls complaints/grievances	0.56%	0.30%	2.86%	0.83%	not avail	0.20%
Letters	31,207	1,200	2,191	not avail	not avail	1,325
E-mail	*	**	9,574	216	not avail	4,056
Letters and e-mail	31,207	1,200	11,766	216	not avail	5,381
% letters complaints/grievances	14.00%	0.30%	not given	not avail	not avail	0.37%
* Blue Cross appears to have combined letters and e-mail into "pieces of correspondence"						
** Fallon combined letters and e-mail, and because data for 2006-2008 was unavailable, reported only 2009						
Note: Counts were for commercial members in this table, but data by small vs large groups were unavailable						

As noted in the table, the Massachusetts health plans respond to millions of telephone calls and tens of thousands of letters and e-mails. Although the majority of contacts are requests for information, the health plans also respond to thousands of complaints or grievances about health plan decisions each year.

The health plans identified that the number of calls and letters have increased in recent years due to new product designs that create different managed care features and higher levels of cost sharing. Some identified that they need to spend more administrative cost to serve individual and small employer members because they do not have in-house human resource staff to answer questions.⁹¹

C. Design of Products

As health plan premiums have increased, many employers and individuals have reduced health coverage by increasing the level of member cost-sharing (*e.g.*, copayments, deductibles and coinsurance). Employers have also challenged health plans to modify existing product designs to develop and offer more affordable products.

Plans with Reduced Benefits

Under Massachusetts law,⁹² as of January 1, 2009, all Massachusetts adult residents who are not exempt due to religious beliefs or income level are required to have health coverage that satisfies Minimum Creditable Coverage (“MCC”) standards or be subject to a tax penalty.⁹³ MCC plans are required to include all mandated benefits and meet the following coverage standards:

1. Coverage includes outpatient prescription drug benefits.
2. Coverage includes at least three routine doctor visits and check-ups for an individual or six routine doctor visits for a family before any deductibles.
3. Deductibles are no more than \$2,000 for an individual or \$4,000 for a family each year.
4. Out-of-pocket deductible or coinsurance spending for non-prescription health services are capped at \$5,000 for an individual or \$10,000 for a family each year.
5. There are not any annual caps on benefits for a sickness or treatment.

All of the health plans developed MCC plans in advance of the 2009 deadline and all but a few stopped offering plans that do not meet these standards.

Although the Division requires health plans to use certain disclosure documents to notify members and employers about whether a plan meets MCC standards, there are no laws or regulations that prevent health plans from offering reduced benefit plans, especially to individuals and employers with employees who are exempt from holding MCC plans due to their income levels. The Division heard testimony from one group that offering a reduced benefit product that does not meet MCC standards could lower premiums by up to 14%.⁹⁴

Consistently, health plans have voiced concern over developing a sub-MCC product because:

1. the financial penalty for such a product falls on the individual member who may not have a choice in which product is available through their group coverage;
2. there is no financial or customer need for such a product; and
3. the reduced benefit products do not serve the best interests of the membership.

In addition to changing cost-sharing, certain employer groups have also called for elimination of mandated benefits which they believe do not need to be in all small group plans.

Plans with Reduced Provider Networks

As noted previously, each of the health plans offers a core provider network that offers access to most hospitals and practitioners within their service area. A few of the health plans – Fallon,

Health New England, Neighborhood and Tufts - have offered reduced or selective provider networks with access to a subset of their core provider network. These products have had mixed results attracting new members.

For these reduced network plans, health plans selected providers that they claim are more efficient and effective in terms of quality and cost^{95,96} than those not in the reduced network. Covered members receive the same level of benefits as available through core plans and health plans claim that members have expressed the same level of satisfaction with access through the reduced network as compared to the core network. Health plans work to ensure that a reduced network plan “will provide sufficient access, cost savings and sustainable benefits to be attractive to the target population.”⁹⁷ The four health plans that offer reduced network plans in Massachusetts indicated that the reduced network plans’ premiums are 8 – 20% lower than comparable coverage through the core full-network plans.

Despite the lower costs of a reduced network plan, some of the largest health plans do not offer reduced network plans and some that do offer them do not aggressively market the plans because they claim that employers will not buy it. One health plan claimed that its groups have “greater affinity to a broader based network.”⁹⁸ Another health plan believed that cost reduction has not proven to be as important as choice of provider in certain larger groups.⁹⁹

Plans with Reduced Benefits for Lower Tier Providers¹⁰⁰

Many plans have explored an alternative to reduced network products in which they place the providers within their core network into different tiers (2, 3 or 4) based on plan-specific quality and efficiency standards. One plan notes that the intent of offering such products is to “provide members with a high-quality, cost-effective alternative to products that include a broader network, and essentially...encourage[e] members to seek care in the most appropriate, cost-effective settings.”¹⁰¹

Members are permitted to obtain coverage through any of the providers within the network but will usually need to pay a higher cost-sharing amount to be treated by a provider in the lower quality/efficiency tiers. These health plans can cost less than traditional health plans because the providers at the lowest cost-sharing tier are the most efficient providers costing in one health plan’s product “10 % less than the average of all other providers and 20 to 25 % less costly than the highest cost tier of providers in the network.”¹⁰² The health plans are using the tiered products as a way to encourage members to use higher quality healthcare providers, and to help shift consumer behavior.

Due to complexity of design, the tier member cost-sharing products have not gained significant appeal among the public or the health plans. These products are offered through the Massachusetts Group Insurance Commission (“GIC”) for state and certain municipal employees, which requires a tiered product, and also through one health plan directly.¹⁰³ Outside the GIC, these plans are difficult to administer across all employer accounts.

The Division has expressed concerns about a health plan changing a member’s copayment to a doctor in the middle of a contract year simply because the doctor has been put into a different tier, because, although health plans may wish to update their tiering on an annual basis, by

switching providers between or among tiers based on changes to their quality or efficiency, employers renew their health coverage on many different months throughout the year. The Division has requested that health plans develop systems allowing members pay the same copayment level until the end of their contract year to reduce member confusion and disruption. Two plans have expressed challenges in developing information systems that would allow an employer group to keep its copayments the same through the end of the year,¹⁰⁴ and as a result, there are not many tiered products in the market.

Health plans have also identified that Division practice has limited their ability to develop more affordable tiered network products, because the Division has discouraged the offer of plans where the difference in copayments between tiers is greater than \$15 for office visits and \$50 for inpatient hospital stays or outpatient procedures, and coinsurance is not more than 5%. The Division has also expected health plans to make providers available throughout their networks at the most preferred provider tiers. Many of the plans offering tiered benefit products suggested that the Division's limits discourage a wider differential between the tiers which "does not provide the necessary incentive to prompt members to change their provider,"¹⁰⁵ especially when considering how committed many members are to their providers.

D. Barriers to Less Costly Products

- Inclusion of benefit mandates in all insured products can increase premiums¹⁰⁶
 - Health plans claim unnecessary mandates for human leukocyte antigen testing¹⁰⁷
 - Health plans claim excessive use of off-label drugs for cancer¹⁰⁸
- Health plans are reluctant to offer reduced benefit plans that do not meet MCC standards
- Health plans are reluctant to offer and market reduced network plans
- Division practices may limit the implementation of tiered network plans
 - Limitations on imposing new copayments in the middle of a contract year
 - Required access to providers at highest tiers throughout plan service areas
 - Limitations on benefit differentials between tiers

VIII. DEVELOPING PREMIUMS

Health plan actuaries strive to balance the need to keep premiums low enough to be competitive while setting premiums sufficient to cover projected claims and administrative expenses, with a contribution to surplus to fund unexpected future costs. Actuaries need to have a thorough understanding of the health plan's operations to use historical experience and knowledge of the existing market to project future costs and revenues. Likewise, actuaries must understand the risks of each market in which the health plan operates in order to develop premiums for each product design, cost-sharing feature, and family type that are actuarially sound.

A. Projecting Claim and Related Health Care Costs

When developing premiums for employers and individuals renewing in a given month, an actuary must project the cost of medical claims and related health expenses for the twelve-month period that premiums will be in effect. Claim costs change every month and the actuary must make projections for each month of the twelve-month period. Since premiums must be set and marketed two to four months prior to a group's renewal date, actuaries are often calculating projections three to five months before a premium's effective date (*e.g.*, in August for January renewals).

When making projections, an actuary usually examines the plan's detailed historical claims data as a starting base to determine future payments.¹⁰⁹ This claims data represents the actual cost of providing services through the plan's network of providers to those persons who were members of the plan during the experience period. Looking back at two or three years of available information on the health plan's past claims payments,¹¹⁰ the actuary develops a base claims cost per member as a starting point to projecting future claims costs.

The actuary then examines all potential internal and external factors that may impact the way that claims costs change over the base level of claims cost. The health plan's operations are reviewed to determine whether there have been changes to types of contracted providers, negotiated rates of reimbursement, cost containment systems or medical necessity systems that are different than were in place during the base premium year. The actuary examines real and potential changes in the health status of potential members, new technology and types of medical services, economic conditions impacting employment and wages and changes in state laws, including mandated benefit laws all of which can impact the costs of health care. All of these factors are considered when evaluating changes in the unit cost of each service and the overall utilization of services, and when projecting the trend in claims payments within the contract year.

Most health care payments are made after a claim is submitted by a provider itemizing the fees for services already delivered to a member (referred to as a "fee-for-service" payment), but some health care providers agree to accept a prepaid periodic fee for certain delineated costs provided to a covered health plan members (sometimes referred to as a "budgeted" payment). The prepaid fees are not included in the base or trended claims payment projections. The actuary needs to examine all existing prepaid fees and project the cost of these arrangements separately for the twelve-month experience period.

The largest health plans projected claims and related health care costs account for between 85% and 88% of each premium dollar.

B. Paying Administrative Expenses

When examining administrative expenses, the health plan actuary can review the prior periods, as well as future budgeted, costs. Many administrative expenses are predetermined and budgeted by health plan management in order to run the health plan properly. Different segments of the health plan project the costs necessary to run their administrative functions and the costs are built into a health plan operating budget.

An actuary needs to evaluate the health plan budget and account for any missing administrative expenses during the twelve-month period that premiums will be in effect. The actuary will need to examine the projected future cost of changing administrative expenses, including capital purchases, cost containment systems, information technology upgrades, regulatory changes or salaries, when making projections about administrative cost changes.

When establishing rates, the actuary will also look at whether the administrative expenses apply to all employers and individuals or specific to certain employers and individuals. While provider payments and overall health expenses do not vary by account, certain marketing and enrollment expenses do vary by market. Small employers and individuals do not have the human resources staff available to large employers. Health plans frequently have higher administrative marketing and enrollment costs for small employers and individuals in order to provide for services that are otherwise provided by large employers and the health plan needs to spread these costs over a smaller pool of employees. The largest health plans' administrative expenses make up approximately 10% of the premium dollar.

C. Protecting Plan Solvency

Health plans are financial companies that take on the risk of employer and individual health claim costs in return for the premiums that they collect. They are expected to continually maintain prudent operations with adequate and liquid finances to pay the costs of the risk they are responsible for under their health plans. Unlike other lines of insurance, health plans do not stockpile premiums to pay for down-the-road medical claims - they use current premium dollars to pay for current medical claims and expenses. In order to stay financially solvent, health plans need to collect an adequate stream of premium revenue sufficient to pay their projected costs and must set aside a certain amount each year to protect the health plan in case of adverse market conditions

D. Regulatory Oversight

The Division's most critical role is to oversee the financial solvency of the risk-bearing companies "in order to promote a healthy, responsive and willing marketplace for customers who purchase insurance products."⁹³ The Division monitors all health plans to ensure they satisfy Massachusetts' statutory minimum capital requirements and additional financial standards established by the National Association of Insurance Commissioners (NAIC).

If a company does not meet appropriate financial standards, the Division has the authority to intervene and seek judicial action to place a health plan into administrative supervision or receivership. If a health plan is deemed unable to return to an appropriate level of administrative or financial management, the Division may ultimately seek to dissolve a health plan which could leave many provider bills unpaid and employers and employees with uncertain coverage. Such a liquidation would be especially disruptive in Massachusetts' health coverage market, because unlike other lines of coverage, Massachusetts does not have a state guaranty fund for health coverage whereby other health plans fund some of the cost of a failed health plan's liabilities.

E. Contribution to Surplus Adjustment

Each health plan is expected to have an appropriate level of available capital – usually referred to as surplus – that is able to fund operations even in adverse market or claims conditions. Although surplus is expected to grow each year as health plan claim costs increase, it can decrease whenever a health plan's actual claims costs and expenses are greater than premium revenues. Surplus also varies depending on the types of risk being covered by a health plan and market conditions that impact the economy or health delivery systems in Massachusetts.

In order to build up the necessary capital, health actuaries are expected to include a “contribution to surplus” adjustment within their premiums. They calculate this adjustment based on conversations with management who are making decisions about a health plan's financial need. If health plans routinely exclude “contribution to surplus” from their premium calculations, premium rates would be inadequate because they would not be adequately funding the appropriate level of capital for the health plan.

The largest health plans usually build in a “contribution to surplus” adjustment that makes up 1%-2% of the premium dollar.

F. Development of Market and Group Level Premiums

After calculating base premium rates, the actuary then calculates premiums for each account.

Large Employer Premiums

In general, health plans initially develop rates for large employers (those with more than 50 eligible employees) based on the claims experience of the pool of large employers. Depending on the size of a large employer, the large group base premium may be adjusted to reflect all or some portion of the actual claims experience of an individual large employer as compared to the average of all large employers.

There is no statute or regulation regarding the rating factors used in establishing an individual large group's premiums, other than restrictions on use of discriminatory characteristics such as race.. Large group premiums are not constrained by the variability in rates that may affect individual large employers from one year to the next. Last, health plans are not required to offer health coverage to every large employer and may deny coverage if they believe that they do not want to cover the risk of any large group, which differs from the requirements under the laws relating to small groups.

Small Group Premiums

Health plans participating in the small group market develop rates based on the overall projected experience of the health plans' pool of small employers (with between 1 and 50 eligible employees) and individuals covered under its small group plans. Health plans are not permitted to factor in the actual or projected medical condition of the members of any individual or small group.

Health plans are permitted to vary the rates of individuals and small businesses within a 2:1 rating band such that the premiums charged to the riskiest account are not more than twice the premiums charged to the least risky account. The rates may vary based on the following factors:

- the average age of the members of the account;
- the account's industry;
- the proportion of members who participate in the group health plan;
- the usage of company wellness programs; and
- the usage of tobacco and tobacco products.

Carriers may also vary premiums outside the 2:1 rating band for the following additional factors:

- the size of the group;
- the geographic location of the account compared to the base region; and
- the richness of the benefit plan, compared to the base plan.

These factors and limitations placed on these factors are described in Appendix A.

In addition to the above-noted factors, each health plan can employ what is called a rate basis adjustment factor to calculate the premiums for the following categories of families: single, two adults, one adult and child(ren), and family.

The following formula is ultimately used by the health plan's actuarial staff to calculate the premiums for an individual or small group:

- the group base premium rate for the single person,
- multiplied by the rate basis type adjustment factor;
- multiplied by the age adjustment factor;
- multiplied by the industry adjustment factor;
- multiplied by the participation rate adjustment factor;
- multiplied by the wellness program adjustment factor;
- multiplied by the tobacco use adjustment factor;
- multiplied by the group size rate adjustment;
- multiplied by the area rate adjustment; and
- multiplied by the benefit level rate adjustment.

Health plans are required to adhere to the specific regulatory requirements of 211 CMR 66.00 when applying these rate adjustments to ensure consistent application to all small groups.

G. Reasons for Small Group Premiums Being Higher Than Larger Group Premiums

Between April 2008 and April 2009, health plan small group rates were higher than those for large employers and small group rates were found to be increasing at a higher rate of growth. Appendix B includes tables illustrating the differences. The following sections explain why small group premiums are in excess of large group premiums.

The health plans indicated that small employers and individuals have higher per person administrative expenses because certain expenses such as billing and account management do not vary with the size of the group and need to be spread over a small number of employees. In addition, health plans may need to expend additional enrollment support than for a large employer who may be able to rely on their own human resources staff.

The health plans also indicated that, on average, individuals and small employees have higher utilization than large employers because of adverse selection.. Individuals and small employers examine their expected health care costs and choose the plan most likely to pay the most costs. Large groups tend to purchase coverage based on other factors with less adverse selection.

H. Small Group Rate Volatility

Individual small employer rates can vary significantly from one year to the next if there are changes in the demographics of the covered employees. If a health plan applies age rating factors and a small employer loses its youngest employee, this change in the group can raise the average age and cause the health plan to apply a larger adjustment factor.

As an example, assume a small employer has a group of three with an average age of 51 and a total monthly premium of \$2,500.00. If one of the three people leaves and the average age

increases to 60, this could increase the age adjustment factor by 14% and this adjustment would be over and above any regular increase to the health plan base rates.

I. Adverse Selection Analysis of Rate Increases

Health plans noted that some individuals are purchasing a health plan, using extensive health benefits and then terminating the plan a few months after issue. For example, several carriers mentioned that individuals who have large group coverage that is self-funded and therefore not required to include mandated benefits have also purchased individual health contract to obtain the state-mandated benefits for fertility treatments. This drives up the cost of insurance to small groups since they are combined with individuals for rate development.

As previously mentioned, in a separate report performed by the Division's actuarial consultant, Oliver Wyman, it was noted that an unintended consequence of the merger of the non-group and small group markets was the reluctance of health plans to use waiting periods for merged market coverage. The report issued by Oliver Wyman found that there were many more "high-cost" individuals purchasing and then terminating coverage within 12 months in 2008 than in 2006.

J. Barriers to Lower Premiums

- Health plans are reluctant to develop and market wellness programs for individuals and employers with fewer than 20 employees AND the small group law requires that if health plans make these programs available to employers with more than 19 employees, they need to make the programs available to all individuals and small employers.
- Small group rating rules compel health plans to apply adjustment factors to all small groups equally which may cause rate shocks when the composition of a group changes and this may dramatically increase the rating adjustment factors applying to a group.
- Small group rating rules compel health plans to charge small groups for the cost of administrative services that they may not even use.
- Small group rating rules do not provide health plans with enough flexibility to develop sufficient discounts if groups implement smoking cessation and wellness programs. One health plan suggested moving the tobacco and wellness discounts outside the 2:1 rating band.
- Small group carriers have developed rating factors that can cause rate shocks when the characteristics of the group suddenly change.
- There are inadequate protections to prevent adverse selection
 - Health plans are not using waiting periods or open enrollment periods
 - The DOR penalty for not maintaining coverage may be inadequate

IX. POLICY OPTIONS

A. Create More Affordable Small Group Products

(1) **Require marketing of all health products through all distribution channels**

PROPOSAL: Carriers in the small group market are required by the Division of Insurance (“DOI”) to make all of their small group products available to any small employer, but only at the request of the small employer. Some carriers do not make small employers aware of all the small group products available and it is up to the employer to ask for a particular option. This option would require that all of a carrier’s products are marketed to small employers through all distribution channels.

PRO: Small employers and individuals would be more aware of all the options available from a carrier, including low-cost options that may be only marketed through one distribution channel.

CON: Carriers, as well as their intermediaries and brokers, would be required to make employers and individuals aware of all the products that the employer and individual may buy and where to buy a product if not available through one type of distribution channel.

(2) **Require carriers to market one product that does not meet Minimum Creditable Coverage (“MCC”)**

PROPOSAL: In order to avoid tax penalties, all Massachusetts residents are required to be covered by a health plan satisfying the MCC benefit standards established by the Commonwealth Health Insurance Connector Authority (“Connector”), unless they meet the religious exemptions or their incomes do not meet the “affordability” threshold established by the Connector. Health plans are not prevented from offering lower-cost plans that do not meet MCC, but DOI requires each Massachusetts insured plan to disclose whether it satisfies MCC benefit standards. Despite the opportunity to offer a lower-cost option, the small group carriers do not offer any plans that do not meet MCC. This option would require legislation to mandate each carrier to offer at least one such plan to all small employers and individuals.

PRO: Small employers and individuals who do not satisfy the Connector’s affordability standards would be able to buy a more affordable product through each carrier.

CON: Despite the disclosure on a non-MCC plan, those who are not exempt from the MCC mandate might buy the non-MCC plan and then be subject to the tax penalties. Some non MCC-plans may not provide the coverage that individuals need or think they have purchased.

(3) **Require offer of at least one reduced network product to small employers and individuals (with premium at least 10% lower than full network product)**

Note: Legislation is pending on this option

PROPOSAL: Each of the largest health carriers’ provider networks includes the vast majority of hospitals and provider groups, whether they are high-cost or low-cost providers. The carriers indicated that the market demands these full network products and they would lose business to their

competitors if they do not offer products with the full network of providers. Since the high-cost providers remain in the network, the health premiums are higher than they may be with a smaller network composed of the lower-cost providers. [One health plan has developed a reduced network product costing 20% less than its full network product, but does not aggressively market this product.] This option would require legislation to mandate each carrier to develop and market at least one product to all small employers and individuals with a reduced network that would be priced at least 10% less than the carrier's full network product.

PRO: Small employers and individuals would be able to buy a lower-cost option.

CON: Certain of the high-cost providers would not be in the reduced network products which could increase complaints when covered persons discover that they cannot see any provider they want. This concern may be addressed by requiring adequate disclosure.

Some small employers and individuals will find that a reduced network does not meet their needs and is therefore not a reasonable option for them.

(4) Permit group purchasing cooperatives with open-access to all eligible groups and individuals

PROPOSAL: Under existing law, all small group carriers must make their products available to all eligible employers and individuals with rates based on the relative cost of the entire market. While other states permit associations of employers to negotiate special products or rates for members, it is generally not permitted in Massachusetts. This legislative option – which was explored in November 2009-January 2010 special sessions at the DOI – would permit the development of group purchasing cooperatives that any group or individual could join as long as they agreed to follow the wellness/health management programs established by the cooperative. This option would also spur the development of wellness programs for small employers and individuals that are only being offered through large employers.

PRO: Small employers and individuals would be able to enroll in otherwise unavailable wellness/health management programs that could lead to lower utilization and lower premiums.

CON: There is substantial concern that only the healthy will join the cooperatives, splitting the existing small group pool among the healthy that join the cooperatives while the less healthy do not join the cooperatives and pay much higher premiums.

(5) Permit health plan products that exclude mandated benefits

PROPOSAL: All insured health plans are required to include those health benefits that are mandated by Massachusetts insurance law. Although many large employers self-insure and are exempt from Massachusetts' mandated benefit laws, most small employers cannot self-insure and must buy small group insurance plans that include all the mandated benefits. The Division of Health Care Finance and Policy ("DHCFP") has estimated that mandates account for approximately 12% of the overall premium. This legislative option would permit carriers to offer plans to small employers that exclude some of the mandated benefits.

PRO: Small employers would have another more affordable option.

CON: Employees in plans without mandated benefits would not have access to those benefits that were otherwise required to be in all insured plans. It is possible costs may increase through various public assistance programs for people losing access to mandated benefits.

This could also fragment the market as healthier individuals select plans without certain benefits, leaving higher utilizers to select plans with those benefits, driving up the cost and utilization for the plans with full benefits.

(6) Permit carriers to offer at least one tiered benefit product where doctors may move from one benefit tier to another during the contract period

PROPOSAL: Over the past five years, each of the health carriers has explored the development of a tiered benefit plan that would provide the highest levels of benefits – and lowest member cost-sharing – when receiving care from Tier 1 providers and lower levels of benefits when going to providers in other tiers of the provider network. The DOI is concerned that consumers understand the tier in which their health care provider is placed when choosing coverage and that the tier that providers are designated in remain the same throughout a contract. The health carriers claim that this is unworkable administratively and without the flexibility of changing the tiers across all the health plans at the same time each year, they will not be able to develop and effectively market a product. This option would permit greater flexibility enabling the health carriers to offer one product where the tiers change in the middle of the contract term, provided that adequate consumer protections are put in place to notify consumers who may think of buying the health plan.

PRO: Carriers may be able to create a tiered benefit plan that would be less expensive than current options because it would provide more appropriate incentives to receive care from the most effective and efficient health care providers.

CON: The health care providers will not support a system where providers may be moved regularly from one tier to another. It will be difficult to develop adequate disclosures so that consumers would be aware that their copayments may change in the middle of a contract year.

(7) Require a plan whose provider rates are capped (the “Affordable Health Plan” legislation)

PROPOSAL: Some participants in the health plan hearings supported a pending bill referred to as the Affordable Health Plan legislation, which, as drafted, would provide immediate solutions for small businesses. As a condition of doing business in the state, carriers that offer health plans to small businesses and eligible individuals would be required to offer to all individuals and small businesses within the Connector a plan where the reimbursement rate to providers would be limited to 110% of what Medicare would pay the providers.

PRO: This option may provide some immediate options for small businesses to be able to obtain a more affordable product in the market.

CON: This is not a long term solution because it only applies to one product and providers have claimed that Medicare rates of reimbursement are inadequate. Additionally, despite the provision requiring that providers refrain from shifting costs, it may not be possible to truly monitor that behavior.

B. Make Adjustments to Small Group Rating Rules

(8) Allow commissioner to adjust rating rules annually to eliminate duplicative or unwarranted costs

Note: Legislation is pending for this option

PROPOSAL: The small group health insurance law requires that health carriers vary the rates from one employer to another within a 2:1 rating band based upon certain specific factors (*e.g.*, age, group size, industry and geographic location of the group). This legislative option would grant the commissioner the authority to review the conditions of the market and promulgate regulations that would modify the rating rules to reduce or eliminate duplicative or unwarranted administrative charges that would not apply to a particular employer or individual.

PRO: This would not bring down overall costs, but could more fairly apportion them. Employers would be made aware of the costs of certain administrative services and could reduce their premium if they decide to forego certain administrative services.

CON: Costs may go up for employers that use certain administrative services that are currently subsidized by employers that do not use those same administrative services.

(9) Eliminate age-rate factors

PROPOSAL: Small group carriers primarily vary rates based on the average age of the group or individual. In general, the older-age groups can be charged twice the cost of the younger-age groups. Although Massachusetts permitted wider variation in the past, this level of variation has been permitted since 1997. This legislative option would eliminate age rate factors.

PRO: This would not bring down overall costs, but would level the premiums for all age groups and reduce rate shocks for groups whose employees' average ages may change with layoffs or other economic activities. Older-age groups would see reductions in average premiums.

CON: Premiums would increase for younger-age groups in order to reduce older-age group premiums.

(10) Cap the application of rating factors to reduce rate shock when group composition changes

Note: Legislation is pending for this option

PROPOSAL: The small group health insurance law requires that health carriers vary the rates from one employer to another only based upon certain factors (*e.g.*, age, group size, industry and geographic location of the group). When a group's composition changes (*e.g.*, younger employees are let go), it may cause the carrier to apply different rate factors that could cause a group to experience a sudden rate shock. This legislative option would allow the commissioner to limit the impact of rating adjustments in the year following a sudden change in the group's characteristics.

PRO: This would reduce the volatility of rates for individuals and groups who would not be charged the allowable charge for the group's composition in the year following a change to the group.

CON: This option could increase overall rates, as carriers look to recover the amount of premium they are not allowed to charge groups that suddenly change characteristics.

(11) Smooth rating factors to reduce rate shock

PROPOSAL: The small group health insurance law requires that health carriers vary the rates from one employer to another only based upon certain factors (*e.g.*, age, group size, industry and geographic location of the group) that can change dramatically with a slight change in a group. For example, the carriers may charge one factor for those when the average age is between 40 and 44 and a higher factor when the average age is between 45 and 50. Although the factor may stay the same between 40 and 44, there is a sudden shift when the average age becomes 45. This option would require a smoothing of the affect so that there is not such a dramatic change just because the average age of the group grows one year older.

PRO: This would not reduce overall rates but would reduce the volatility of rates for individuals and groups based upon minor changes to the group.

CON: This would increase the burden on a carrier to develop factors for all variations of a factor and minimize the volatility of the change from one variation to another.

(12) Allow carriers to offer wellness/tobacco use adjustments outside the permissible 2:1 band

PROPOSAL: Small group carriers are permitted to offer premium adjustments to small employers and individuals who participate in approved wellness programs. At this time, carriers do not offer these discounts because (1) it is administratively difficult to make them available to individuals and the smallest employers, and (2) because their adjustments are constrained because they must be within the 2:1 rating band. This legislative option would modify the small group health insurance law to permit wellness/tobacco use adjustment to be applied outside the 2:1 band.

PRO: If these factors were moved outside of the 2:1 band and employers were able to obtain significant rate adjustments for implementing wellness/tobacco use programs, then they may be more inclined to establish wellness/health management programs to encourage their workers to establish healthy life-styles (*e.g.*, exercise, stop smoking, etc.). If certain employers establish wellness programs and this reduces their employees' utilization, this could reduce those employers' overall premium costs.

CON: If the wellness/health management program only is designed to benefit already healthy employers, it may not impact overall utilization and may lower the rates of the healthy at the expense of the less healthy. Wellness/health management programs also require additional administrative costs; if these costs do not lead to reduced utilization, then it is possible that overall costs could actually increase with the implementation of wellness/health management programs.

(13) Require review of changes in the benefit level rate adjustment factor

PROPOSAL: Small group carriers are required to develop base premiums for their small group business and may develop “benefit level rate adjustment factors” that allow the premiums for specific products to vary based on the actuarial value of the benefits that are in those products compared to those in the base product. This option would require the carriers to file changes in their benefit level rate adjustment factors with the DOI to ensure that carriers are properly basing rate differentials on the value of the benefits and not on the actual level of utilization in any one plan.

PRO: This could reduce rate increase volatility on a product by product basis by requiring companies to submit filings to the DOI to substantiate the reasons for any significant changes in the benefit level rate adjustment factor for any product.

CON: This could increase the number of filings that any carrier submits to the DOI. This could also change the way that certain carriers rate products and reduce their willingness to offer new and innovative products.

C. Control Small Group Market Overutilization

(14) Create open enrollment period for individuals

Note: Legislation is pending for this option

PROPOSAL: In 2007, the guaranteed issue market for individuals was merged into the guaranteed issue market for small employers. An unintended consequence of the merger was that carriers ceased applying 4 month waiting periods or 6 month pre-existing condition limitations for individuals. These waiting periods and pre-existing condition limitations prevented individuals from buying health coverage until they needed it – this is sometimes called “adverse selection.” Absent these waiting periods and pre-existing condition limitations, there has been a spike in the number of individuals who buy coverage, use medical care and then drop the coverage after obtaining the medical services. In order to reduce adverse selection, this legislative option would allow individuals to enroll at any time if they just lost previous coverage – with a gap of no more than 63 days – and create open enrollment periods for other individuals to obtain coverage; this would prevent individuals from delaying enrollment in a health plan until they need health care services.

PRO: This would reduce overall costs by providing appropriate incentives for individuals to buy and keep coverage rather than buying coverage when they need it for services.

CON: This would require individuals who have not had prior coverage to wait until the next open enrollment period before being covered under a health plan.

(15) Require small employers to use wellness/smoking cessation programs

PROPOSAL: Although many large employers offer wellness/health management programs to employees, small employers and individuals do not have the same access to these programs. Health carriers could be required to develop such programs and require that all small employers initially participate in the carriers’ health management program, where the carrier could provide the necessary education, training and follow-up with all the members of the small group. If a small employer or individual did not participate in a carrier’s program, the employer or individual could be transferred from the health management plan to a more expensive plan without the same health management program.

PRO: Employers would be given the option to participate in programs to improve their employees’ health and would benefit from the collective experience of the employers and individuals who participate in the wellness/health management program. This would reward those who participate in programs that may improve their health and not offer the same rewards to those who do not participate in such programs.

CON: There is concern that only the healthy groups and individuals would participate in the wellness/health management programs, splitting the existing small group pool among the healthy who participate and the less healthy who do not and need to pay much higher premiums.

(16) Create a high-risk pool for those individuals with potentially expensive costs

PROPOSAL: Some have claimed that 90% of health care costs are paid on behalf of 10% of the covered members and that one way to lower the health premium costs is to move high-risk persons covered within small group plans from the insured market into a high-risk pool where the costs are either born collectively by the entire market or are subsidized by government or other sources. This option would establish a high-risk pool and permit carriers to deny coverage for high-risk members who would be covered in the pool.

PRO: This would not reduce overall costs but would shift the costs outside the market for small group health insurance and away from the costs of individuals and small employers. Many other states have high-risk pools in order to provide an option for those who carriers may exclude from coverage.

CON: Persons who are transferred to high-risk pools would not have access to the same benefits or rates available to other persons in the small group market, and may not have access to the same provider networks, managed care systems or other options available to others. Although this option may reduce costs for the small employer system, it may increase costs overall, if government needs to administer this system and subsidize the costs of coverage for those in the high-risk pool. This option should be fully explored to ensure that it differs from the state reinsurance pool, which was terminated as part of Ch. 58 of the Acts of 2006.

(17) Require that small group products include higher incentives to use primary care providers

PROPOSAL: Certain medical groups suggested that the system should more substantially promote the use of primary care providers to coordinate more care and reduce reliance on more expensive specialty care for more routine services. Carriers could modify all their plans to apply significantly higher levels of copayment for care provided by specialists than by primary care providers. This legislative option would require plans to modify all existing plans to change the level of copayments.

PRO: If the copayment differentials between care provided by a primary care provider and by a specialist are increased, insureds will have more of an incentive to have more care delivered by primary care providers.

CON: It may be difficult for a covered person to distinguish between care that can be provided by a primary care provider and care that should be provided by a specialist. Such copayments may actually lead to less efficient care if it encourages an individual to see a primary care provider first only to then need to be referred to a specialist, thereby requiring two visits (one with a primary care provider and then with a specialist) when the individual would only have one in the past. Health advocates will likely oppose such mandatory differentials if they tend to delay or reduce a covered person's use of needed specialty care. Availability of primary care providers who are accepting new patients may be an issue here.

(18) Require regular reviews of existing mandates and repeal ineffective ones

PROPOSAL: Several carriers suggested a regular review of existing mandates to remove the ones that may not be the most current or appropriate medical practice.

PRO: This could reduce confusion related to certain medical guidelines and mandates and may reduce some costs associated with them. This legislative option could create an entity to review and advise on the existing mandates.

CON: The individuals who benefit from the mandates – even those mandates that don’t appear to be the most efficacious – would oppose this. The outdated mandates may not be used for current medical treatment, so there may not be much savings in removing them.

(19) Institute a moratorium on mandated benefits

NOTE: Legislation is pending on this option

PROPOSAL: Several carriers suggested a moratorium on mandated benefits because of the costs and the number of individuals affected. This legislative option would prevent any further mandates from being implemented in the fully insured market.

PRO: This could restrict future rate increases to reduce the number of mandated benefits that would increase the need for rate increases.

CON: This could harm the interests of a lot of parties, including some who support pending legislation (*e.g.*, autism services).

(20) Increase penalty on individual mandate and limit pro-rating of penalties

PROPOSAL: Some carriers suggested that the tax penalty and related mechanisms are not sufficient to prevent individuals from avoiding purchasing health coverage (*i.e.*, who would rather pay the penalty than buy the coverage) and then purchasing health coverage only when they know that they need medical services.

PRO: This would help to reduce adverse selection problems in the market and would further create incentives for individuals to obtain and then hold onto the health coverage they have.

CON: This would make the existing mandate much harsher, which could be viewed negatively by the parties who would be most affected.

D. Eliminate Anti-Competitive Forces

(21) Prohibit noncompetitive provisions from being in contracts

PROPOSAL: Some contract provisions or agreements between carriers and providers have reduced the ability of one or the other side to negotiate with other providers/carriers or develop new products. Some have also tied rates of reimbursement with another party to the existing terms of the contract. These terms tend to reduce the competitive position of either party in other contracts and reduce the competitive nature of contract negotiations in Massachusetts. In some cases, these clauses appear to reduce the development of certain reduced network, tiered or other products and may actually lead to automatic increases in rates of reimbursement based on what a carrier or provider is able to negotiate from some other contract. This option would prohibit any carrier from signing any contract with a provider or making any agreement with a provider that would influence or be influenced by any other contract with another party and would require that all contracts be reviewed in order to determine that they do not include prohibited clauses.

PRO: Many carriers or providers with relative market power have required these provisions or agreements as a condition of signing a contract with the other party. This option would prohibit them and prevent the party with relative leverage to force these agreements on the other party.

CON: This may be difficult to enforce if the anti-competitive clauses or agreements are not specifically outlined within the four corners of the contracts. It would require heightened regulatory oversight over actual rates of reimbursement to understand whether rates do not appear to be developed solely based on competitive forces.

(22) Prohibit tie-in deals in provider contract negotiations

PROPOSAL: Many providers will only enter into contracts with health carriers, if the health carrier agrees to also contract for all the services available from the provider or to include all the affiliated providers within the contract. These “all-or-nothing” contracts often force the carriers to pay for expensive services that they may not need or want to include within their provider network. Especially with the increased consolidation of provider systems, such tie-in deals limit any carrier’s ability to reduce the scope of its network or to only contract with hospitals for just their tertiary care services. This legislative option would examine ways to open up provider contracts so that carriers may contract for either some of the providers within a provider system or some of the services that are available within a provider system.

PRO: This would increase the leverage of carriers to obtain the best rates from providers and not be forced to accept all providers even if not needed with its provider network.

CON: Providers would argue that they offer integrated delivery systems to carriers and it is not possible to dismantle such systems and let carriers only contract for parts of those systems without compromising the efficiencies of such systems or the quality of care provided. They argue that this will increase, rather than decrease, overall cost due to the potential harm done to patients.

(23) Limit profits of insurance and pharmacy companies

PROPOSAL: Certain provider and employer groups suggested that the most effective way to reduce overall costs was to limit the level of profit generated by insurance and pharmaceutical companies. This legislative option would establish caps beyond which such companies would not be able to generate profits within the market.

PRO: If there are excess profits, carriers and pharmaceutical companies would be required to limit those profits and decrease the costs passed onto premium payers and patients.

CON: Massachusetts is dominated by not-for-profit health carriers with very thin margins. It is not expected that this option would affect any of the health carriers and would create an expectation that would not materialize.

(24) Change facility licensing rules to prevent inflation of payments to satellite facilities

PROPOSAL: Certain carriers indicated that when large provider groups acquired satellite facilities, there were no restrictions on considering the satellite to be part of the larger entity, thereby causing rates of reimbursement to go up. One suggestion was to change the Department of Public Health licensing requirements to ensure that satellite facilities are registered separately.

PRO: This would increase the leverage of the carriers to obtain appropriate rates for the locations where services are being delivered.

CON: Providers would argue that the satellite facilities are part of the larger integrated delivery system and the increased rates are necessary.

E. Improve Claims Handling Process

(25) Encourage providers filing claims on paper to use of administrators to file electronically

PROPOSAL: During the informational hearings, each of the carriers described their efforts over the past decade to encourage providers to file claims electronically. Approximately 10% of claims continue to be sent in on paper and the administrative cost to process a paper claim is at least 10 times what it costs to process an electronic claim. This could lead to lower administrative costs for both providers and carriers. This option would require all health carriers to use administrators, including for example, NEHEN Net, for smaller providers.

PRO: If providers willingly switched, it would ease the administrative burden and cost of both the provider and also the health carrier processing the claims, while improving the tracking of claims.

CON: Certain providers have been reluctant to change despite past health carrier efforts and this may not be enough to change their claim filing behavior.

(26) Require carriers and providers to use electronic means to process all claims materials and to use Electronic Medical Records (EMRs) to store patient information

PROPOSAL: Recognizing that electronic submissions reduce cost and improve communications between health carriers and providers, carriers could be required to only accept claims materials, and also process the following electronically: (1) appeals, (2) adjustments, (3) attachments, (4) electronic funds transfers, and (5) eligibility inquiries. This legislative option would require carriers to develop solutions for claims with attachments so that all information could be sent in the same way. If a health provider is not able to use the electronic filing system, they would not be permitted to remain in the health carrier.

PRO: If all the providers were required to switch, it would ease the administrative burden and cost of both the provider and also the health carrier processing the claims

CON: Certain small providers without the willingness, funding, or expertise to switch would be excluded from receiving reimbursement from the health care providers.

(27) Require carriers to penalize providers who do not file electronically or file inappropriate claims

PROPOSAL: Each of the health carriers has devoted substantial resources to create electronic filings system that speed the review and payment of claims. Although it costs health carriers significantly more resources to process paper claims, they pay providers the same amount and process claims according to the same prompt payment standards whether a claim is filed electronically or on paper. This option would require carriers to reduce payments to providers and waive the prompt pay requirements for those providers who file on paper to account for the cost of processing the claim. .

PRO: This would allocate the increased cost of processing claims to those providers who are responsible for the increased cost of processing paper claims.

CON: This could negatively impact smaller providers that have not made the switch as well as out-of-state providers that are filing claims for services provided outside the state.

F. Increase Transparency

(28) Increase DOI efforts to make health care costs more transparent

PROPOSAL: DOI can expand the number of hearings it has scheduled and convene working groups to develop new ways to collect data and report on the cost of care across the different providers and health carriers in the market. This information will make health costs more transparent and make consumers more aware of the costs of the care they choose to obtain.

PRO: This option would bring together many groups who are already examining transparency in order to develop an approach that builds upon the wealth of already existing research.

CON: There are many different parties regionally and nationally who are examining ways to improve the transparency of health care costs. If Massachusetts develops its own transparency standards, they may differ from ones that are being agreed to regionally and nationally.

(29) Require reporting of complaint statistics

PROPOSAL: Carriers report limited complaints statistics to the Department of Public Health's Office of Patient Protection and do not publicly report the complete array of complaints that they receive from their own covered persons. In order for public reports to be effective, carriers should report the number and types of complaints that they do receive so that this information may be available for consumers when choosing health plans.

PRO: This option would provide additional information to prospective enrollees and providers considering contracting with a carrier so that they can determine whether or not to sign on with a carrier. It would also provide additional information to the DOI to investigate if a carrier has an abnormally high type of any complaint.

CON: This information would need to be standardized across the health carriers that all currently operate under separate systems. Once finalized, it would mean that carriers would need to expend administrative resources to accommodate the new request.

(30) Require reporting of detailed administrative expenses on supplemental financial statements

PROPOSAL: Carriers only report high-level administrative expenses in financial reports submitted quarterly to the DOI. This option would require health carriers to report additional detail on their administrative expenses on public reporting documents.

PRO: This option would increase the level of information available to the public regarding the costs spent to administer each health plan.

CON: Carriers may claim that this would increase the burden of unnecessary reporting.

(31) Itemize and report all cost containment efforts

PROPOSAL: Carriers do not regularly report their cost containment efforts, including the processes they use, the costs of the efforts and the actual savings; this would require regular reporting.

PRO: This would increase the level of information available to the public regarding the cost containment efforts of each of the health plans.

CON: Carriers may claim that this would increase the burden of unnecessary reporting.

G. Standardize Authorization Processes Across HMOs

(32) Require carriers and providers to follow the same processes to authorize requests for service

PROPOSAL: Each carrier maintains its own authorization processes to determine whether certain requested services will be approved for coverage. Each plan may require different forms, documentation or testing be performed based on the protocols and medical necessity criteria developed by the carrier's management and medical director. This legislative option would require all the health carriers to use the same system to determine whether requested services would be authorized to reduce the differing amounts of paperwork required by each.

PRO: This would reduce providers' need to follow different authorization systems based on the plan in which the patient is covered. Carriers would also have less administrative headaches since providers would all be following the same process.

CON: The carriers all have invested significant funds and resources into developing their own authorizations according to their own standards. If they would need to make any additional changes to further standardize their systems, this could significantly increase their administrative costs.

(33) Require carriers and providers to use the exact same medical necessity criteria

PROPOSAL: Each carrier maintains its own medical necessity criteria to determine whether certain requested services will be approved for a patient based on guidelines developed by the carrier's medical director. This legislative option would require all the health carriers to use the medical necessity criteria as defined by a state agency or an independent board.

PRO: This would standardize medical decision making in one place so that different carriers would not come to different conclusions on similar cases.

CON: It is difficult to develop standard guidelines that will apply in all cases. Even if these guidelines could be developed, the carriers would need to make any additional changes to further standardize their systems, which could significantly increase their administrative costs and increase their need to raise their rates.

H. Standardize Billing and Coding Processes across HMOs

(34) Limit the look-back period for carriers to audit prior payments to providers

PROPOSAL: Providers are contractually required to cooperate with providers who audit past payments to determine whether any were made in error, requiring recoveries from the provider. While providers recognize the need to account for errors, they believe that such audits should be limited to the past year so it minimizes their offices' search for old records and minimizes the financial impact of recoveries that may extend over more than one year of records.

PRO: This would reduce disruption with providers that need to divert their administrative services to respond to carrier retrospective audits of claims from more than a year ago.

CON: This would reduce health carriers' ability to recover inappropriately paid funds when discovering that they were made to providers in error.

(35) Require all product benefits and cost-sharing to be the same

PROPOSAL: Some providers noted that much of their administrative time was caused by shifting among health carrier plans that have different benefits, copayments, deductibles or other types of cost-sharing. They noted that their claims payments and interactions with patients are complicated by differing benefits and patients shifting from one plan to another. This legislative option would require that all plan benefits fall within a narrow spectrum of benefits.

PRO: If all the plans were standardized, consumers and providers would be less confused about the benefits under their plan and there would be less confusion with the processing of claims.

CON: Employers and individuals purchase health benefits based on their budgets and desired options. The reason that so many plans exist is because employers have looked for more affordable options. This would hinder the development of new innovative products.

(36) Require carriers to collect all copayments, deductibles and other cost-sharing

PROPOSAL: Most health plans have copayments or deductibles so that members share some of the cost of services in order to reduce use of unnecessary health services. Certain providers have complained that they incur substantial administrative costs collecting these payments from the members at the point of service. This legislative option would require that health carriers collect all health benefit plan cost-sharing and precluding them from making providers collect the cost-sharing.

PRO: This proposal would reduce providers' administrative services.

CON: This would likely increase costs since it is less efficient for the health carrier to collect the cost-sharing after the service is provided than it is to collect it before the service is provided. These increased costs would be added to overall health carrier premiums.

I. Standardize HMO Administrative Processes

(37) Further standardize credentialing processes across plans

PROPOSAL: Providers must be licensed by their state licensing board to practice. In order to be part of a health carriers' network, they must also be credentialed by the health plan's internal system. Since providers belong to most of the state's health carriers' networks and the health carriers likely have similar credentialing criteria, this option suggests further standardization of the process in order to reduce the time that certain providers need to devote to complete duplicate paperwork and be credentialed in each system.

PRO: This proposal would reduce overall costs for providers and health plans.

CON: It would require additional coordination among health plans, providers and state agencies to ensure that a central credentialing system continued to satisfy all parties' needs.

(38) Prohibit carriers from transferring mental health care to carve-out organizations

PROPOSAL: Some health carriers have contracted with separate health management networks with expertise in behavioral health care to administer mental health services for covered members. The carriers do this both as a cost containment effort and to concentrate the management with those who do have treatment expertise in behavioral health care. Providers believe that such "carve-outs" interfere with the coordination of patient care when a patient needs both medical and mental health treatment. They argue that the carve-outs cost more money due to the added administrative cost in managing overall patient care. This option would prohibit carriers from transferring the management of their behavioral health services to separate "carve-out" companies.

PRO: Some claim this would proposal improve the coordination of patient care, as all medical records and management would be coordinated directly through the health carrier.

CON: This would require health carriers to build expertise in the administration of behavioral health services adding to their overall administrative expenses when the services are more inexpensive when managed by those with the appropriate level of expertise. This could add to health care administrative costs and to higher premiums. This would also prohibit mental health carve-out organizations from operating in the state, which could mean a loss of jobs.

(39) Require all providers to accept global payments at some time in future

PROPOSAL: Almost all health carriers have contracts with providers to reimburse for services delivered on a fee-for-service basis. Since providers get reimbursed more based on the number of services provided, a fee-for-service system rewards utilization, some of which is not necessary. If all provider payments were made on a global payment basis, providers would be paid for treating a patient rather than according to the number of services provided while treating a patient. This switch will reduce the number of claims and the time needed to adjudicate claims and will reduce the cost pressures that are tied to increased utilization of services. This legislative option would require all providers to accept and all health carriers to reimburse providers based on global payments.

PRO: A shift to global payments would dramatically change provider incentives and reduce overutilization of services in treating a patient. This would also tend to reduce overall cost trends for health care and health premiums.

CON: Some providers are hesitant to move to a system where they may be at risk for the level of services they provide to a patient. If the cost of the services is more than the reimbursement that the provider is getting for a patient, the provider will lose money. Certain providers would need to redesign the ways they examine patients and provide care.

(40) Require plans to penalize employers for filing retroactive changes to enrollment

PROPOSAL: Many health carriers permit employers to process paperwork after a plan effective date to add members or terminate members who are no longer covered under a plan. This can create problems for providers who treat persons who they believe and the carrier's system represents as still being a member only to learn that when the retroactive termination is processed that the person did not have an active membership. This legislative option would require that carriers penalize those groups who do file the paperwork after a certain amount of time has passed since the effective date.

PRO: Eliminating this limited timeframe for retroactive member terminations would reduce the providers' administrative burden, as fewer claims are denied for ineligibility reasons.

CON: Employers would be forced to process paperwork on time or penalized for processing paperwork either adding or terminating an enrollee after the actual effective date.

J. Reduce Burdensome Administrative Processes

(41) Make HMO licensing a biennial process

PROPOSAL: By statute, HMOs are required to submit renewal applications annually to the DOI in order to maintain their license to do business in Massachusetts. This option would require that they file materials every other year, rather than every year.

PRO: If the process were switched to a biennial process, it would ease the administrative burden for both carriers and DOI without reducing DOI's oversight over HMOs. Most of the material HMOs file as part of the annual license renewal process duplicates the material filed in the previous year. This option is supported by the HealthyMass Compact.

CON: Some of the public application material would only be updated biennially instead of annually.

(42) Require electronic submission of HMO licensing and accreditation filing materials

PROPOSAL: HMOs currently send all licensing and accreditation materials to the DOI on paper. This option would instead require that all materials be forwarded electronically.

PRO: This would ease the administrative burden for both carriers and DOI.

CON: This would require that those used to looking for licensing and application materials on paper be required to search electronic documents instead.

(43) Eliminate requirement to notify insured that referrals are approved

PROPOSAL: According to existing law, health carriers are required to notify insureds by letter that their request for certain referrals or other services has been approved. This requires health carriers to mail thousands of paper documents that carriers claim are unnecessary. Insureds are more confused than enlightened by a document from a carrier for a procedure that has most likely already been scheduled following verbal approval to the insured's provider. This legislative option would eliminate this requirement when the service is approved by the plan.

PRO: This would reduce a significant administrative expense for health carriers and providers.

CON: Patients would not receive a paper document that confirms the health plan has approved a service.

(44) Eliminate requirement that HMO evidences of coverage be sent in for DOI review

PROPOSAL: Health carriers are required under the managed care law to submit all health products for review by Bureau of Managed Care prior to issuance in Massachusetts. This legislative option would permit health carriers to issue products without their being reviewed by the DOI.

PRO: The carriers claim that this will ease their administrative burden and would allow for the speedier offer of their health plans within the market.

CON: This would eliminate DOI's ability to review health plan material to ensure compliance with statutes and regulations. Almost all reviews are completed within a 30-day period; those reviews

extending beyond that period are usually for products with features that may lead DOI to develop changes to existing guidelines in response to the new product filing.

(45) Eliminate requirement that HMOs put premium on documents to covered employees

PROPOSAL: According to existing law, health carriers are required to notify insureds in a disclosure document about the premium cost for their coverage. This requires health carriers to develop documents that show each insured's premium level. Insureds are more confused than enlightened by this information that shows a number that is almost always different than the amount that they pay their employer for coverage. This legislative option would eliminate this requirement.

PRO: This would reduce a significant administrative expense for health carriers. The information sent to individuals can be confusing.

CON: This would reduce the level of premium information provided to covered persons.

(46) Eliminate requirement that HMOs send annual provider directory to employers

PROPOSAL: According to existing law, health carriers are required to send paper copies of their provider directories annually to covered employers. [Health carriers are also required to send a notice to covered members that explains how to either locate provider directories online or request a paper copy from the employer.] As a result of the law, health carriers mail thousands of paper documents that carriers claim are unnecessary since their provider directories are available on-line and paper directories are obsolete with frequent changes to their networks. This legislative option would eliminate the requirement that paper copies of provider directories are sent annually to employers.

PRO: The carriers claim that this would reduce the cost of printing and mailing large paper documents that are not generally used by the employer or the employees.

CON: This would require consumers to go online or directly contact the carrier for provider directory information instead of visiting their employer's benefit manager for this information.

(47) Reduce rate filing requirements for closed nongroup health plans

PROPOSAL: When the nongroup market was merged into the small group market in 2007, those individuals who had bought nongroup products prior to the merger were permitted to continue in the grandfathered products. Health carriers are required to send in the same annual rate filing materials each May for the grandfathered products. This legislative option would change the rate filing requirements to reduce the carriers' administrative filings.

PRO: The carriers claim that the process is not necessary due to the dwindling number of grandfathered filings and the products should be reviewed in the same manner as all other such filings.

CON: The individuals in the grandfathered filings were granted special rate protections to ensure that all rates would go up on the same day and any one company's premiums would not increase differently than the rates of the general market. Removing this requirement would permit companies to increase rates at any time during the year and not be reviewed in the same manner.

(48) Consolidate data reporting across state agencies to reduce duplicative reporting

PROPOSAL: The carriers pointed out in the informational hearings that they need to submit unnecessarily duplicative membership, utilization, and other regulatory reports to many different state and federal regulators on a regular basis. This legislative option would change the manner in which separate regulators request information so that such requests would go through a central regulatory body responsible to collect information and disseminate it to the requesting regulatory agencies.

PRO: This would substantially ease carriers' administrative burden to produce similar reports to their many regulatory agencies and could theoretically reduce the delay in regulators getting information since they would all come from one source. This option is supported by the HealthyMass Compact.

CON: This would reduce any individual state regulator's ability to request information that may differ from what is centrally reported and will require consistent coordination among agencies to implement.

(49) Enact legislation to ease approval process for termination of closed plans

PROPOSAL: One carrier indicated that the administration of several closed plans (i.e., no new members) is costly both for the plan and the insureds. The requirements for terminating a closed plan, however, have made it difficult to transfer the insureds into new, comparable products.

PRO: This would lead to administrative savings for some carriers in reducing the number of closed plans they have in the market.

CON: The individuals affected may not want to be switched into a new plan, particularly where they may not be a similarly structured plan in the market any longer.

APPENDIX A

Small Group Rates from April 2008 to April 2009

Small Group Rate Per Member Per Month (PMPM)	<u>April 2008</u>	<u>April 2008</u>	<u>Change in \$</u>	<u>Change in %</u>
	\$379.82	\$426.84	\$47.02	12.4 %
<u>Actual Claims through Previous Summer PMPM</u>	<u>April 2008</u> \$267.64	<u>April 2008</u> \$310.86	<u>Change in \$</u> \$43.22	<u>Change in %</u> 16.1 %
x Trend in Costs	116.59%	116.08%	\$5.58	
Projected Claims PMPM	\$312.05	\$360.85	\$48.81	15.6 %
+ Capitated Payments PMPM	\$17.26	\$14.68	(\$2.58)	-14.9 %
	\$329.31	\$375.54	\$46.23	14.0 %
+ Admin Expenses and Contrib to Reserves PMPM	\$50.52	\$51.31	\$0.79	1.6 %
Small Group Rate Per Member Per Month (PMPM)	\$379.82	\$426.84	\$47.01	12.4 %

In each case, companies calculated medical costs paid per member in the most recently available period (in almost all cases, claims paid as of the previous summer). Trend adjustments are then applied to take into account new provider contract rates, utilization patterns and the costs of emerging technology. Additional adjustments are then made to add in the cost of capitated payments to certain providers, administrative expenses and contributions to surplus reserves.

Change in Large Group Rates from April 2008 to April 2009

Large Group Rate Per Member Per Month (PMPM)	<u>April 2008</u>	<u>April 2009</u>	<u>Change in \$</u>	<u>Change in %</u>
	\$347.00	\$381.16	\$34.16	9.8 %
<u>Actual Claims through Previous Summer PMPM</u>	<u>April 2008</u> \$246.98	<u>April 2009</u> \$276.64	<u>Change in \$</u> \$29.66	<u>Change in %</u> 12.0 %
x Trend in Costs	119.47%	118.58%	\$3.32	
Projected Claims PMPM	\$295.06	\$328.04	\$32.98	11.2 %
+ Capitated Payments PMPM	\$11.66	\$10.37	(\$1.29)	-11.1 %
	\$306.72	\$338.41	\$31.69	10.3 %
+ Admin Expenses and Contrib to Reserves PMPM	\$40.29	\$42.75	\$2.46	6.1 %
Large Group Rate Per Member Per Month (PMPM)	\$347.00	\$381.16	\$34.16	9.8 %

ENDNOTES

¹ A report issued in September of 2008 titled “Trends in Health Claims for Fully-Insured, Health Maintenance Organizations in Massachusetts, 2002-2006” completed by Oliver Wyman

² *Ibid.*, p. 2.

³ See Appendix A on p. A-1.

⁴ The companies who participated in the hearings were
Aetna Health, Inc.;
The Assurant Health Insurance Companies;
Blue Cross and Blue Shield of Massachusetts, Inc.;
ConnectiCare of Massachusetts, Inc.;
Fallon Community Health Plan, Inc.;
Harvard Pilgrim Health Care, Inc.;
Health New England, Inc.;
Neighborhood Health Plan, Inc.;
Tufts Associated Health Maintenance Organization, Inc.; and
United HealthCare of New England, Inc.

⁶ The statutory change did not amend a special law that permitted Massachusetts banking associations to continue to be exempt from the guarantee issue and rating rules of the small group health insurance law.

⁷ It appears that the Tufts Associated Health Plan’s submitted figures may include providers that operate in the other jurisdictions.

⁸ The revenue for Health New England excludes the carrier’s Medicare Advantage plan.

⁹ BCBSMA has 242 staff devoted to the administration of health care provider networks.

¹⁰ The Massachusetts portion of ConnectiCare’s administrative expense includes contracting with providers, negotiating rates of reimbursement and managing day-to-day network needs.

¹¹ The Network development and Management (NDM) Department at FCHP is responsible for contracting with providers, negotiating rates of reimbursement and managing day-to-day needs of network providers such as provider appeals and responding to provider calls. 70 staff members support the activity of 21,000 providers.

¹² Several different areas at HNE are responsible for administration of networks and rate negotiation. The principal work is done by the Provider Contracting, Provider Relations and Configuration (IT) Departments.

¹³ HPHC includes contracting with providers, negotiating rate of reimbursement and managing day-to-day needs of providers within the networks as part of the administrative cost of networks. Additionally, HPHC includes the FTEs and costs related to quality assurance education and credentialing in its provider network administration costs.

¹⁴ NHP does not differentiate network –related expenses across lines of business. It has 37 FTEs (full-time equivalents) dedicated to the administration of medical networks.

¹⁵ Relates to 55 staff devoted to network contracting and credentialing and provider information.

¹⁶ Put simply by HNE, “almost all of every health care premium dollar goes towards the cost of health care provided to our members. As the cost of care goes up, the cost of premium has gone up as well. Our challenge, and the challenge facing all of the plans and insurance companies ... is to balance several important objectives: operate efficiently, encourage our providers to provide appropriate evidence-based, well-coordinated health care, and to hold back the pressures pushing medical costs higher every year”. T. 1-5.

¹⁷ BCBSMA indicated that it has “implemented over 50 different cost containment initiatives over the past several years. [The] initiatives have contributed significantly to containing medical cost trends and in aggregate have reduced the rate of increase

in medical costs by approximately 1 percent to 1.2 percent per year, or over the past decade a cumulative 10 percent, roughly". T.1-12.

- ¹⁸ "Rationale for participating in market segments is typically based on the market size and the membership opportunity in that segment, the financial implication of participating, the competitive situation that currently exists, and our judgment of our ability to offer a differentiated and value-added product or service into that segment." At least one plan identified its expenditure of costs and resources associated with implementing new products as varying between \$1 - \$3 million in total cost [T2 - T: p. 11: l. 1-10].
- 19 The process of developing new products is centered on the evaluation of an opportunity. In this evaluation, each carrier continually assesses the need and opportunity for new products that support that carrier's efforts to offer quality and affordability to its existing and future customers. In most cases, this process involves the solicitation of feedback from customers, accounts and members, brokers, and other consultants. [T2 -BCBS p. 9-10].
- 20 The Consumer Services function was described by the health plans as including communication of plan information and assistance to members and potential members via consumer guides and newsletters, web-based applications, telephone, mail and e-mail. This function also includes addressing member complaints and grievances. Consumer services were also cited to include interactions with legislators or regulators, acting on a member's behalf. (T:V III: 4-5)
- ²¹ Underwriting and actuarial systems, though included in the broad definition of financial systems were covered elsewhere in the hearings and addressed separately in this report.
- ²² Of all the goals of managing Financial Systems, maintaining financial solvency is extremely important. An insolvent insurer (in this case, a health plan) would not have sufficient resources to be able to pay provider and member claims. If this happens, the health plan cannot honor its promise to its members to deliver health benefits in exchange for premiums. Responsible health plans must take in enough revenues to cover all of their expenses and liabilities and also must responsibly contribute to surplus in amounts that reflect the risks undertaken, that may vary with growth in membership, and depend often on the types of contracts they have with providers. Adequate surplus is necessary to provide for unknown and unexpected contingencies, such as the additional costs associated with increases in claims due to an unexpected event like the H1N1 flu, an economic downturn which compromises the valuation of the plan's investments decreasing the assets available to pay claims, or additional mandates required by governments. Additionally, it should be noted that unlike other types of insurers, such as life and property and casualty insurers, the health plans in Massachusetts are not covered by a guarantee fund. If a health insurer becomes insolvent, there are effects throughout the healthcare system. Consumers, members of the insolvent health plan, who have paid premiums, may find their coverage discontinued until they can sign up with a new health plan, and providers who have delivered services to the members of the health plan may see their claims go unpaid. The remaining solvent health plans will find themselves strained by the influx of new groups and members.
- ²³ 211 CMR 51.12(8) states that "[c]ontracts between carriers and health care providers shall state that providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance."
- ²⁴ For example, BC/BS = 40,000 (p28); Fallon = 21,000 (p.4); Aetna = 27,000; United 18,000 [add cites]
- ²⁵ Some provisions reflect requirements contained in the Division's regulation 211 CMR 52.12 which enumerates mandatory standards for provider contracts.
- ²⁶ CeltiCare 11:21-24
- ²⁷ M.G.L. c. 176O and 211 CMR 52.00.
- ²⁸ Casto and Laymen, *Principles of Healthcare Reimbursement*, p. ix, AHIMA publication, 2006.
- ²⁹ [T, Aetna V:7:1-6]
- ³⁰ [HP 13:16]
- ³¹ On January 29, 2010, Massachusetts Attorney general Martha Coakley released Preliminary Report "Investigation of Health Care Costs Trends and Cost Drivers." This report identifies "market leverage" of Providers (specifically large health care provider organization) as a significant factor in price variations paid by Health Plans among Providers. The Preliminary Report did not consider insurer leverage.

³² Partners 82:7-11.

³³ HPHC stated “large providers with strong brand reputations have more leverage and can negotiate higher rates for the same services. This is extended to the satellite facilities acquired by these entities because state facility licensing rules allow the entities to operate the satellite facilities under the same license, thereby allowing the entity to charge more at the satellite.” Pp. 7-8. Tufts indicated that “there is tremendous variation in the cost per service which we pay to providers, particularly with respect to hospital-based systems”. P. 6, ll. 13-16. HPHC also stated “[u]ntil we begin to address some of the underlying issues that give certain providers substantial leverage, we will not be able to bring premiums and costs under control”. P. 8. ConnectiCare commented that because it is a small plan with a low volume of patients, it is difficult to contract with some providers and provider groups.

³⁴ P4P

³⁵ The Providers were asked by the Division to consider the impact on their organizations if there were no rate increases in the coming years. The answers were unequivocal that lack of rate increases would disrupt the delivery of health care, including: restrictions to mission critical-only services, reduction of type and amount of services offered, additional pressure on endowment to make up shortfall, freezing wages, layoffs and reducing employee benefits and forcing smaller organizations to join larger health system for economies of scale.

³⁶ Health Plans have thousands of Providers in their networks that submit thousands of claims for payment. A Health Plan may employ more than one type of reimbursement rate depending on the outcome of contract negotiations with a provider. For example, payments methods described by both the Health Plans and Providers include two general categories: fee-for-service reimbursement and episode of care reimbursement.

Under **Fee-For-Service** Reimbursement (FFS), Providers are paid a specific fee or set amount by the insurer for each specific service rendered. The majority of rate reimbursement in Massachusetts is FFS. There is also Discount FFS which are negotiated reduced fees. Versions of **Discount FFS** are UCR (usual, customary and reasonable: usual in the provider’s practice, customary in the community and reasonable for the situation), CPR (customary, prevailing and reasonable). Private health plans use UCR. Medicare used to use CPR until it adopted RBVRS (resource-based relative value scale) in 1992. FFS is considered by the Health Plans to be problematic as it creates great uncertainty. Insurers have no way of knowing what the total charges will be incurred for which they must reimburse providers. Consumers, however, enjoy the greatest choice under FFS since all covered services are reimbursed. A disadvantage to patients is that FFS plans often charge higher co-payments and deductibles.

The other category of reimbursement is known as **Episode of Care** Reimbursement (EOC). This payment method is such that providers receive one lump sum for all the services they provide related to a condition or disease. In EOC, the unit payment is the episode, not each individual health service. One amount is set for all the care associated with an illness. Methods of payment under EOC include **capitated** payment method (plan reimburses provider per capita amount for a period or “per member per month” -- PMPM), **global** payment method (plan pays one combined payment to cover the services of multiple providers who are treating a single EOC or across a continuum of care – there are multiple variations on global payments), **per-diem** payments (fixed rate for each day a covered member is hospitalized), **case-based** payments (fixed, pre-established rate for each case). An example of case-based payment is known as **DRG** (diagnosis related groups). Patients who are homogeneous in terms of clinical profiles and resources are grouped together and “weighted” according to resource needs. Higher weights translate into higher payments. The advantage to Health Plans of EOC methods is that there is no uncertainty. The exact cost of the group’s health care is a known quantity. Providers also receive certainty in that they have a guaranteed consumer base. However, there is uncertainty or risk to Providers because patients’ usage of provider service is unknown. Providers that treat patients efficiently and effectively can make money. But those who exceed average costs tend to lose money. Consumers fear that EOC incentives lead to substitution or elimination of diagnostic and therapeutic procedures.

³⁷ [Neighborhood 8:11, ConnectiCare 17]

³⁸ [ConnectiCare 5;5]

³⁹ [Fallon p.4 “support the needs of providers”]

⁴⁰ [Aetna: V:4:23, 5:6:2-3,17]

⁴¹ See footnote 9.

⁴² [Fallon 4:11 – 8:8]

⁴³ [HP 7:14] [N 9:4-8]

⁴⁴ This would include the use of the New England Healthcare Exchange Network (NEHEN).

⁴⁵ A report issued in September of 2008 titled “Trends in Health Claims for Fully-Insured, Health Maintenance Organizations in Massachusetts, 2002-2006” completed by Oliver Wyman which can be viewed at <http://www.mass.gov/Eoca/docs/doi/Consumer/MAHMOTrendReport.pdf>.

⁴⁶ BCBS commented “[u]nderlying all of our efforts is the belief ... that the best way to reduce the escalating cost of health care is by improving the quality of health care and really trying to address the overuse, misuse and underuse of health care services, and trying to get at what some have identified as up to 30 percent of waste in the system in terms of health care spending.” T.1 - 15.

⁴⁷ HNE transcript 6-11

⁴⁸ HNE transcript 6-23

⁴⁹ T.1 - 7:8-15.

⁵⁰ T.1 – 9:16-21. Fallon also pointed to the rising rate of hospital readmissions. T.1 - 36.

⁵¹ BCBS T.6 - 11and HPHC T.6-21)

⁵² HPHC 12/16 response to question # 14

⁵³ BCBS transcript 6-11and HPHC transcript 6-21

⁵⁴ Fallon transcript 6-12

⁵⁵ HNE transcript 6-25

⁵⁶ Prior to the merger of the markets, all nongroup (individual) plans included six month pre-existing condition exclusions or waiting periods. The existing law as a result of health care reform does allow for the same eligibility and enrollment rules, however carriers have not implemented these eligibility and enrollment rules in the merged market because they feel there would be significant administrative costs to apply these rules to small groups. In addition, the Connector has required that all plans that they offer are not to include any pre-existing condition and waiting period restrictions. Because the carriers are required to offer the same products both inside and outside of the Connector, this further restricts the carriers’ ability to implement these eligibility and enrollment rules for individuals.

⁵⁷ BCBS transcript 6-16

⁵⁸ Put simply by HNE, “almost all of every health care premium dollar goes towards the cost of health care provided to our members. As the cost of care goes up, the cost of premium has gone up as well. Our challenge, and the challenge facing all of the plans and insurance companies ... is to balance several important objectives: operate efficiently, encourage our providers to provide appropriate evidence-based, well-coordinated health care, and to hold back the pressures pushing medical costs higher every year”. T. 1-5.

⁵⁹ HNE noted: “[H]ospitals have been making capital investments to increase and enhance their capabilities related to diagnostic testing”. T. 6-9).

⁶⁰ BCBSMA indicated that it has “implemented over 50 different cost containment initiatives over the past several years. [The] initiatives have contributed significantly to containing medical cost trends and in aggregate have reduced the rate of increase in medical costs by approximately 1 percent to 1.2 percent per year, or over the past decade a cumulative 10 percent, roughly”. T.1-12.

⁶¹ Fallon described its extensive cost containment activities, stating “[y]ou’re going to hear how we monitor, measure, refine, streamline, and all that we do to ensure the most cost-effective use of [Commonwealth residents’] money, and you’ll also hear about the challenges that we face that prevent health plans from being able to pursue even more cost-effective solutions”. T.1-7:5-10.

⁶² See T.1 – 14:9-24.

⁶³ See T.1 -16.

⁶⁴See T.1 - 10-11.

⁶⁵ See T.1-14-15:21-24, 1-5.

⁶⁶ BCBSMA identified a formal and comprehensive process for evaluating cost containment initiatives, utilizing a Trend Management Committee in conjunction with its Project Management Office to conduct ongoing analysis of its own medical cost spending, identifying particular areas as well as trends.

⁶⁷ “At HNE, cost containment is considered in the context of our overall approach to medical policy, quality and process improvement. We have numerous internal teams and committees working on clinical and administrative process improvement, medical policy, initiatives connected with our accreditation. We also have teams focused on specific operational or improvement goals. In some cases this may mean higher costs at least initially. For example, increasing immunization or mammography rates has an immediate claims cost, but any savings are in terms of future costs that might be avoided and those savings might be realized by another health plan or by a government plan like Medicare....In addition, other functions at HNE have a cost containment role that is part of their assignment, but often not the central part. For example, HNE’s Business Development Department, in designing new health benefit plans, must take into account how the benefit design will affect premium costs, because the affordability of the premium is a key issue in its marketability....Utilization review, case management, disease management and health promotion are all performed within our Clinical Services Department”. T.1 - 9-11.

⁶⁸ BCBS, T.1 – 16.

⁶⁹ ConnectiCare, T.1 – 17-18:11-13.

⁷⁰ Fallon T.1 – 22:5-7.

⁷¹ HPHC, T.1-12.

⁷² For example, HPHC stated: “Since 2001, we have reduced pharmacy expense by well over \$50 million. We went to a three-tier pharmacy back in 2000 that helped promote ... generic prescribing ... which has gone from 46 percent ... to 72 percent now.” T.1 - 25. HNE similarly commented “[p]rescription drugs and biologics represent roughly 25 percent of the total amount [HNE] spends for medical care costs, or a total expenditure of \$75 million to \$85 million each year. As a result, [HNE] began to design health benefit plans with different levels of copayments, depending on whether the drug in question was a generic drug, was a brand-name drug in our pharmacy formulary, or was a brand-name drug not in our formulary”. T.1 – 15. HNE switched to a new pharmacy benefit manager and uses its legal department to pursue settlements in class action lawsuits against pharmaceutical companies that engage in unfair and deceptive actions. According to HNE, “[t]aken as a whole...our actions have helped us to bend the curve of cost growth. Our drug costs in total continue to grow at 3 or 4 percent per year, compared with a national trend in the range of 7 to 10 percent per year, as reported by outside agencies.” T.1 – 17. “Consider the issue of the use of generics. Promoting greater use of generic drugs provides a safe and cost-effective way of managing disease states. A 1 percent increase in use of generic drugs yields roughly a 1 percent savings in the total prescription drug budget”. T.1 – 18. HNE’s provider generic prescribing rate is 76 percent. T.1 – 18. Similarly, Fallon’s pharmacy utilization management, which includes quantity limits, prior authorizations, adherence to medical criteria and step therapy, saves \$2.31 for every dollar spent. T.1 - 24. BCBS also described its efforts: “We have a very robust pharmacy management program attempting to provide affordable, quality prescription coverage that meets our members’ needs, while carefully managing the almost \$1 billion in pharmacy spending within our company”. “[The] program encourages the use of safe, effective, proven and affordable generics before treating with more expensive brand alternatives”. One example provided by both BCBS and HNE was “step therapy” (starting with a generic and then moving to a brand name only if necessary). In 2007, there was a 6% increase in use of statins to treat high cholesterol. BCBS’ “step therapy” resulted in members spending \$27 million less than would have otherwise occurred. T.1 – 17.

⁷³ BCBS T.6-19, Tufts T.6-12, and NHP T.6-11.

⁷⁴ NHP T.6-26.

⁷⁵ NHP T.6-15, Tufts T.6-10, HPHC T.6 - 12/16 response to question # 6.

⁷⁶ BCBS transcript 6-15

⁷⁷ Tufts T.1 – 16:15-24, ConnectiCare T.1 - 23, BCBS T.1-16-17. Tufts reported a return on investment (ROI) of 4.5:1. ConnectiCare stated “[w]e staff these programs with registered nurses as a means of identifying patients who are at higher risk of having complications of those diseases, and then focusing on educating them about how to manage their own disease, and encouraging them, using a technique called motivational interviewing, to take on behavior changes necessary to minimize the effects of the disease on their long-term health.” T.1-23. Fallon commented “Disease Management supports the member/practitioner relationship and plan of care. It emphasizes the prevention of exacerbation and complications, using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management.” T.1 – 26:2-7.

-
- ⁷⁸ T.1 - 25-28. ConnectiCare stated “fewer than 50 percent of [identified] patients are willing to engage with us in terms of accessing the services that we offer to them”. T.1-25:14-17. “[P]rimarily [the patients] don’t feel that their disease is such or their illness is such that they need our help”. T.1-25:19-21. “[O]ne of the tenets of the program is to identify gaps in care, patients who, based on their claims information, are receiving care for certain diagnoses, but aren’t receiving the full scope of care that they should be receiving in those situations”. T.1- 26:18-23.
- ⁷⁹ Fallon, T.1 - 27
- ⁸⁰ HPHC, T.1 - 22. HNE stated “a small percentage of the population accounts for a very large portion of medical costs. In some cases, these high-cost individuals are the unfortunate victims of a medical catastrophe or sudden illness.... We developed our own proprietary data-mining techniques to identify individuals at risk and worked with them using our own case managers. Before this initiative, about 11.5 percent of the people in our case management program at any given time would typically be hospitalized during the next month. After our program was in place, this fell to an average rate of 6.7 percent per month, to represent a savings of ... just under \$4 million per year”. T.1 - 24-25.
- ⁹³ www.mass.gov/doi
- ⁹⁴ www.mass.gov/dhcfp - Publications & Analyses
- ⁸¹ ConnectiCare p. 30, ll. 7-9
- ⁸² ConnectiCare p. 30, ll. 6-14
- ⁸³ ConnectiCare p. 30, ll. 15-19
- ⁸⁴ Concluding Public Hearing transcript pages 28, 29, 36
- ⁸⁵ ConnectiCare Pp. 45-46, ll. 23-24, 1-7
- ⁸⁶ HNE transcript 6-41, Tufts transcript 6-16
- ⁸⁷ “We firmly emphasize that broader statewide payment reform is the best way to address affordability. We are encouraged and fully supportive of the recommendations of the most recent Payment Reform Commission, which voted unanimously to recommend from moving away from the current fee-for-service system that rewards overuse of services, does not encourage integration of care or consideration of alternative resources, and is ineffective at slowing growth in cost.” Pp. 22-23 (BCBS)
- ⁸⁸ BC/BS p.6:9, [Fallon p. 19 “diversity of the network”], Emerson Hospital 5:6 “expanded consumer knowledge” from the intranet, advertising.
- ⁸⁹ For example, the captions on an advertisement on the front page of The Boston Globe’s online version convey the message that consumers should demand special services with an active-looking older man holding a golf club: “I have prostate cancer. . . I want Lahey.” (www.boston.com website visited February 5, 2010).
- ⁹⁰ ConnectiCare (p.25)
- ⁹¹ T:V III:7-8
- ⁹² Chapter 58 of the Acts of 2006.
- ⁹³ Minimum Creditable Coverage standards have been established by the Commonwealth Health Insurance Connector Authority under regulation 956 C.M.R. 5.00
- ⁹⁴ T2 – BCBS: p. 13-14: ll. 17-24, 1.
- ⁹⁵ T2 – FCHP: p. 40: ll. 11-14. In discussing Fallon’s Direct Care, i.e. its limited network product, Mr. Hughes indicated that the hospitals and providers within the product “exhibit greater abilities to manage care more [cost] effectively.”
- ⁹⁶ Tufts identified four HMO Select products that have a more limited network than the traditional HMO products. The cost savings of the limited network products has been 20% when compared to the same plan design that would utilize the full network. [T2 – T: p. 14-15: l. 24; 1-6].
- ⁹⁷ [T2 – BCBS: p. 12: l. 6-15].
- ⁹⁸ “There is still not a broad appeal for limited network products.” BCBS. at p. 38, l. 7-8.

-
- ⁹⁹ [T2 – THP: p. 43-44: ll. 1-9]. “We have also found that, while there is certainly a desire for more affordable products, the larger an employer group is, the harder it is to make that decision to restrict the choice of their employees and members. We haven’t got the level of interest in this product, given those restrictions in the network, despite the fact that it is a much more affordable product.”
- ¹⁰⁰ Harvard Pilgrim: “Starting in 2005, we had an administrative expense ratio that was at 12.2 percent. Over the years, to date, we’ve been able to work that down to 10.5 percent. These efficiency gains have come from automation and advancements that we’ve had, our ability to reduce FTEs and staff expenses from 2005 by 14 percent, while maintaining our quality and excellence of the plan. We’ve also reduced our exposure and expenses in the television advertising expenses, and through some strong contract management, we have been able to reduce our claims processing and provider relation expenses.” [T2 - HP: P 7: LL 11-23].
- ¹⁰¹ Tufts Health Plan discusses its Select Network Plan. The plan current provides coverage to 1200 members with a 20% price differential. P.21, ll. 6-24, ll. 1-5.
- ¹⁰² BCBS: p. 13: l. 4-11
- ¹⁰³ BCBS.
- ¹⁰⁴ T2 – HNE: p. 49-51: ll: 10-24, 1-24, 1-11.; T2 – HPHC: p. 12: ll. 6-14.
- ¹⁰⁵ T2 – NHP: p. 20: ll: 5-10.
- ¹⁰⁶ DHCFP Report Comprehensive Review of Mandated Benefits, July 7, 2008, p. 2.
- ¹⁰⁷ Fallon, p. 41-42, ll. 13-24, 1-14
- ¹⁰⁸ Fallon, Pp. 42-44; HNE, p. 28
- ¹⁰⁹ Those plans with small Massachusetts membership have indicated that they find their Massachusetts claims experience to not be actuarially credible for projecting future claims and either use their own claims experience from other states or regions or data from national actuarial firms for baseline information.
- ¹¹⁰ Carriers’ actuarial staff indicated that they often need to make projections for over a two-year period. Due to delays in paying certain medical claims, it is not possible to have reliable claims data until 6 months or more after services have been reported. When using claims data for ratemaking purposes, actuaries often need to use claims data from a period that is 6-18 month ago, trend that data forward (1) until the projected effective date and (2) from the effective date through the end of the 12-month duration of coverage. For example, an actuary developing rates for April 2010, may develop the rates in December 2009 and begin her analysis by examining claims data from the period April 2008 to April 2009. The actuary will trend this data forward two years to project the claim costs covering the period April 2010 to April 2011.