

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

a) Current Health Insurance Rate Review Capacity and Process

General health insurance rate regulation information

In the Commonwealth of Massachusetts, insurance companies are licensed and regulated by the Division of Insurance under M.G.L. c. 175. Health maintenance organizations (HMOs) are licensed and regulated under M.G.L. c. 176G and regulation 211 CMR 43.00. Non-profit hospital service corporations (Blue Cross) and medical service corporations (Blue Shield) are organized and regulated under M.G.L. c. 176A and M.G.L. c. 176B respectively. Within each of the noted statutes, there is general rate review authority that applies to all the rates that are offered, issued or renewed to accounts in Massachusetts. In addition to the general authority, there is specific authority relevant to individual and small group rates which are discussed below and certain individual health plans closed to new enrollment by July 1, 2007 continue to be regulated under M.G.L. c. 176M and regulation 211 CMR 41.00.

Merged Market (individual and small group markets combined)

The market for the offer and renewal of Individual and small group (covering employers with between one and fifty eligible employees) plans were combined beginning July 1, 2007 and have been regulated together under M.G.L. c. 176J and 211 CMR 66.00 since that time. The premiums charged to all eligible individuals and small employers are based on adjusted community rating rules and must be established according to the following:

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

The Division promulgated emergency regulations that were effective 2010 whereby the Division required that the Massachusetts HMOs and Blue Cross and Blue Shield of Massachusetts submit proposed small group base rates for all small group products at least 90 days prior to the proposed effective date(s) according to 211 CMR 43.00. During the summer of 2010, certain statutory changes were made by Chapter 288 of the Acts of 2010 to M.G.L. c. 176J that further defined the content and

review standards that were to apply to all small group and individual market rate filings, including required presumptive disapproval standards that would trigger a mandatory rate hearing if submitted rate filings included proposed rates with projected loss ratios greater than 88% (changed to 90% for calendar year 2012), with contribution-to-surplus levels greater than 1.9% or with administrative expense loadings increasing by more than the medical CPI. The Division promulgated final changes to 211 CMR 66.00 to implement these rate review changes as of April 1, 2011 to be applicable for all rates proposed to be effective on or after July 1, 2011.

As of December 31, 2010, there were a total of 759,151 persons enrolled in the combined small group/individual health insurance market.

Large Group Market

The emergency regulations that were promulgated in 2010 that required HMOs and Blue Cross and Blue Shield of Massachusetts, Inc. to submit proposed proposed base rate changes also applied to large group products. The regulation called for large group products to be submitted at least 30 days prior to the proposed effective date(s) according to 211 CMR 43.00. The emergency regulations were made final and continue to require the submission of the same materials required in 2010.

Closed Guaranteed Issue Nongroup Health Insurance Plans

Individual (nongroup) guaranteed issue health insurance plans issued after December 1, 1997 yet prior to the merging of the individual and small group market on July 1, 2007 continue to be regulated under M.G.L. c. 176M and 211 CMR 41.00. These plans may establish premiums considering the following:

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

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

As of December 31, 2010, there were a total 759 persons enrolled in closed individual plans that were issued as guaranteed issue nongroup plans that had been initially effective between December 1, 1997 and June 30, 2007. Changes made by Chapter 288 of the Acts of 2010 amended certain sections in M.G.L. c. 176M to permit carriers to close certain of these plans and it is likely that many fewer individuals will be covered under these plans in the future.

Closed Individual Plans

Individually underwritten health insurance plans issued prior to December 1, 1997 are subject to the general rate review standards established under M.G.L. c. 175, M.G.L. c. 176A/B and M.G.L. c. 176G. In

addition, the rates charged for individual plans written by health insurance companies are reviewed according to the provisions of 211 CMR 42.00 (“The Form and Substance of Individual Accident and Sickness Insurance”) and must meet the content and review standards established in that regulation.

As of December 31, 2010, there were a total 1166 persons enrolled in closed individual plans that were issued prior to December 1, 1997. Changes made by Chapter 288 of the Acts of 2010 amended certain sections in M.G.L. c. 176M to permit carriers to close certain of these plans and it is likely that many fewer individuals will be covered under these plans in the future.

Information Technology (IT) and systems capacity

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

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

Consumer Protections

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

As a result of changes enacted under Chapter 288 of the Acts of 2010 and subsequently under Chapter 359 of the Acts of 2010, modifications were made to the law relevant to small group health insurance rates filings so that “[a]ny rates of reimbursement included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4.” As such, certain parts of small group rate increase filings are not to be part of the public record.

The Division is also taking steps as communicated to Centers for Consumer Information & Insurance Oversight on June 29, 2010 to comply with the following:

1. §154.301(b): A State with an Effective Rate Review Program must provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews. A State may satisfy this requirement by posting on its Web site parts I and II of the Preliminary Justification, or by linking to CMS’ Web site.
2. §154.301(b): A State with an Effective Rate Review Program must have a mechanism for receiving public comments on those proposed rate increases.

We are coordinating with our IT and external affairs staff to ensure that this is operational in the near future.

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

In the event that a health insurance carrier submits a rate filing that triggers the required Preliminary Justification that is required under 45 C.F.R. 154.01, then the summary of rate changes offered will be required to be explained in the plan language for consumers that have been designed by federal regulations and guidelines.

In the event that the rate filing is submitted with rate increases that do not trigger the required Preliminary Justification, M.G.L. c. 176J requires that the Division complete its review of rate filings within 45 days of receiving completed rate filing materials. This allows time for carriers, intermediaries, the Connector and contracting producers to communicate renewal rate premiums to consumers and enables eligible individuals and eligible small employers to shop among the other products that are available in the Massachusetts guaranteed issue market.

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

In the event that a health insurance carrier submits a rate filing that triggers the required Preliminary Justification that is required under 45 C.F.R. 154.01, notification will be made as required under federal regulations and consumers will be provided time to submit comments according to the timelines that are required under federal regulations.

Existing Rate Hearing Processes

Under Massachusetts law, the Division has the authority to disapprove the insured health plan rates offered in Massachusetts by Blue Cross and Blue Shield of Massachusetts, Inc. (M.G.L. c. 176B, § 4) and licensed Health Maintenance Organizations (M.G.L. c. 176G, § 16) if the rates are unfairly discriminatory, excessive, inadequate or unreasonable to the benefits provided. While these standards continue to apply, for rates in the merged individual/small group market, proposed rates are also presumptively disapproved and subject to formal rate hearings if filings are submitted with a projected medical loss ratio is less than 88% (it increases to 90% for rates effective in 2012), with a contribution-to-surplus greater than 1.9% or with administrative expenses increasing by more than the medical CPI. If rates are disapproved or presumptively disapproved, they are subject to a rate hearing as described within the provisions of 211 CMR 66.00. If a rate filing is disapproved, a carrier may not apply any rate changes and must wait until the conclusion of the rate proceeding.

Consumer Inquiries and Complaints

The Consumer Services Section (CSS) of the Massachusetts Division of Insurance handles all manner of consumer inquiries and complaints through a phone hotline and through a formal complaint process.

During 2008 and 2009 combined, approximately 52,000 calls came in to the CSS phone hotline. Nearly 15,000 of these calls involved some sort of question or inquiry regarding a health insurance product or health insurer. Another 2,600 calls are actual complaints about health insurance. Among those 2,600

complaint calls, the most common reasons were: Denial of Claim; Coordination of Benefits; Delays; Coverage; and, Further Consumer Education. Complaints regarding the rates or premiums for group or individual coverage were infrequent during this two year period.

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

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

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

Resources and Capacity for Reviewing Health Insurance Rates - Budget and Staffing

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

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

Qualifications for Rate Review Staff

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

The Deputy Commissioner is a 17 year DOI supervisor of health coverage with Masters degrees in Public Health and Public Policy.

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

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

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

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

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

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

In the rate filings conducted between April 2010 and July 2011, the Division has conducted quarterly comprehensive small group/individual market rate filing reviews for the 10 major health carriers offering coverage in this market. Internal and external actuaries coordinate the review of all the rate filing materials for all the plans for a few assigned health carriers. On average, the actuaries spend 25-35 hours reviewing the materials, corresponding with the companies to question assumptions, conferring with Division staff to ensure consistency of review and developing final reports that summarize the review conducted.

For large group rate increase filings, as well as closed block guaranteed issue nongroup and closed block individually underwritten plans, the Division has received approximately 40 filings within the past year. Although the review of such filings will vary based on the complexity of the filings, the average review can take an average of 5 hours per filing.

b) Proposed rate review enhancements for health insurance

Expanding the scope of current review and approval activities

As noted in the Division's initial application, during March 2010, the Division shifted internal resources to review the April 1, 2010 small group filings and disapproved 235 out of 274 small group base rates. Following this disapproval, members of Division staff have been actively involved in administrative rate hearings to review the disapproval decisions. These reviews created substantial shifts in the use of Division resources away from the regulation of other items and in 2010 expanded the number of staff directly involved in health insurance rate hearings.

The changes brought about by Chapter 288 of the Acts of 2010 were expected to increase by fourfold the effort devoted to the review of rates in the small group/individual rate review process and this is consistent with what the Division did see in these reviews.

During 2010, the Division devoted unexpectedly high legal resources to work on rate disapprovals and conduct rate hearings on disapproved rates. Although the Division has not held any rate hearings during 2011, it is increasingly possible that these hearings will happen in the future as companies need to be held accountable to more stringent presumptive disapproval standards in 2012. It is estimated that this will require approximately \$150,000 of additional legal support to work on the new regulatory tools and participate in the hearings that are associated with any disapprovals.

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

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

Improving Rate Filing Requirements

As noted in its initial application, the Division has only able to do a quick analysis of the claim cost trends, administrative expenses and contribution-of-surplus needs of those companies filing small group health insurance rates. Based on our first review, we are aware that we in the Health Care Access Bureau need to expand the array of materials that we collect from filing companies that explore the detailed actuarial basis for the requested rate increases. During the initial year of the grant, the Division worked closely with external actuaries to examine the materials that will zero in on individual company rate factors and develop tools to question the assumptions that companies are using to develop rates. The reports submitted by the actuaries were essential to spell out in the Division's regulations the details that health insurance carriers should submit in order to identify all relevant claims, administrative expense and contribution-to-surplus factors.

The noted reports are enabling the Division to develop new tools that require companies to separate claims trends and administrative costs into standardized buckets so that we can track spending in

certain areas and we do intend to devote additional research to evaluate company positions on contributions to surplus and investment income. We also expect to develop internal models that will assist actuaries to evaluate utilization forecasts.

As the Division has collected its information, it recognizes the need to collect more in-depth information to zero in on the underlying reasons for claims cost increases, including targeted analyses that understand changes in utilization and also the rates of reimbursement for specific providers. Recognizing the impact of certain of these cost pressures will enable the Division to thoroughly evaluate the reasonableness of rate filings by understanding the reasonableness of the underlying claims cost assumptions.

In addition to the above-stated changes made to the Division's rate review process, Chapter 288 of the Acts of 2010 made additional changes to the types of products that will be available in Massachusetts in 2011 and 2012. Among the changes, M.G.L. c. 176J was amended to require that carriers develop and offer smaller network/tiered network products that cost 12% less than their large network products and carriers will be required to offer products through newly approved group purchasing cooperatives that offer wellness programs to contracting small employers. Both of these products will challenge the Division to evaluate the relevant actuarial assumptions and how the introduction of these types of products impact the availability and cost of health coverage in Massachusetts.

It is estimated that research projects devoted to this expanded review will require approximately 2500,000 of contracted actuarial support to conduct the analysis and develop the new tools for the Division to collect and review the rate filings in a more in-depth manner.

Enhancing Rate Review Process – Staffing

In order to conduct its reviews in March 2010, the Division contracted with 2 external actuarial firms to assist in the review of the rates at a cost of over \$50,000. Following that time, the Division expended an additional \$150,000 to assist with such reviews and added a third actuarial firm to assist with reviews.

Based on the additional complexity of review and new products that are being submitted to the market, it is estimated that the new reviews will require approximately \$250,000 of additional contracted actuarial support to conduct the reviews necessary for the next fiscal year, especially if we expand the scope of each review and look at more than small group rate filings.

In addition to the external actuarial firms, the Division is seeking to expand its own staff to add a Health Rating Director, 1-2 additional research staff, 1-2 actuarial staff and 2-3 interns to permit time and resources to expand the types of review conducted by the Division.

Enhancing Rate Review Process-IT Capacity

It is estimated that it will require approximately \$50,000 to expand existing consultant work to pay for enhanced and standardized methods to collect rate review information so that it can be aggregated and effectively reviewed by actuarial staff. This will improve the reliability of information collected from

filing companies and standardize the materials that are reviewed by the internal and external actuaries reviewing submitted rate filings.

Enhancing Consumer Protection Standards

It is estimated that this will require approximately \$50,000 in consultant work to improve consumer information that advises consumer about their options for health with an explanation about health care cost increases, as well as to improve the transparency of information on the Division's website associated with the rates of all the products that are available in the market.

c) Reporting to the Secretary on Rate Increase Patterns

Working with the Division's and the NAIC's IT staff, we intend to improve our ability to capture and report on the noted data elements identified by OCCIO, and also to allow for more robust internal analysis of the rate filings received from the companies. We will also need to work with the NAIC and our own IT staff to create a process to collect and report on the aggregate data for rate filings in each market segment in an efficient manner. It is estimated that this will require approximately \$50,000 of additional IT support and system development to provide data on the health insurance rate trends.