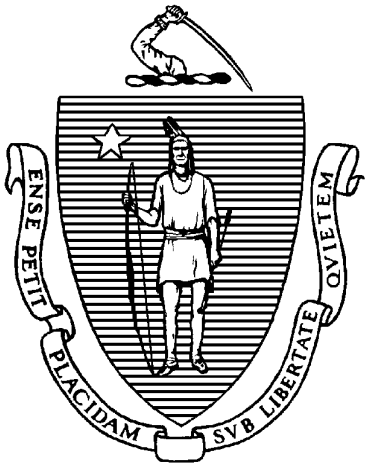
THE IMPACT OF REDUCING THE NUMBER OF HEALTH BENEFIT PLANS THAT A HEALTH CARE PAYER MAY MAINTAIN AND OFFER TO INDIVIDUALS AND EMPLOYERS



REPORT OF THE SPECIAL COMMISSION CREATED BY

SECTION 58 OF CHAPTER 288 OF THE ACTS OF 2010

DECEMBER 31, 2010

Acknowledgements

The enclosed report was prepared by the Special Commission with support from the following staff reporting to Insurance Commissioner Joseph Murphy, Chair of the Special Commission:

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The report is primarily based on materials presented at the Special Commission meetings, with additional information collected from surveys completed by Special Commission members and presentations made at a public comment session. The Special Commission has not audited or otherwise verified the accuracy of survey responses, comments or information presented by the public at the public comment session.

Background information was obtained from statistical and other public reports produced by the Division of Insurance, other state and federal agencies and journals and sources documented within the report.

Any questions regarding the content of this report should be directed to Joseph Murphy, Insurance Commissioner and Chair of the Special Commission, at (617) 521-7301 or his Deputy Commissioner, Kevin Beagan at (617) 521-7323 or kevin.beagan@state.ma.us.

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I. AUTHORITY AND CHARGE

Section 58 of Chapter 288 of the Acts of 2010, *An Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses* (the "Act"), provides for the creation of a "special commission to make an investigation and study relative to the impact of reducing the number of health benefit plans that a health payer may maintain and offer to individuals and employers" (the "Special Commission").

The Special Commission was comprised of the following industry representatives, consumer advocates, and representatives of governmental and quasi-governmental entities:

- Joseph Murphy, Division of Insurance (DOI), Chair of Special Commission
- Glen Shor, Commonwealth Health Insurance Connector Authority (Connector)
- Karen Granoff, Massachusetts Hospital Association (MHA)
- Elaine Kirshenbaum, Massachusetts Medical Society (MMS)
- Eric Linzer, Massachusetts Association of Health Plans (MAHP)
- Alan Rosenberg, Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA)
- Linda Peterson, Massachusetts Health Information Management Association (MaHIMA)
- Ray Campbell, Massachusetts Health Data Consortium (MHDC)
- Carla Bettano, Neighborhood Health Plan (NHP)
- Eileen McAnneny, Associated Industries of Massachusetts (AIM)
- Georgia Maheras, Health Care For All (HCFA)
- Bill Vernon, National Federation of Independent Businesses (NFIB)
- Julie Pinkham, Massachusetts Nurses Association (MNA)

In its examination of "the impact of reducing the number of health benefit plans that a health care payer may maintain and offer to individuals and employers" the Special Commission is specifically instructed by the Act to examine and report on:

> (i) the administrative costs associated with paying claims and submitting claims for multiple health benefit plans on health care payers and providers;
> (ii) the costs associated with reducing the number of health benefit plans on consumer and employer choice;
> (iii) the impact of limiting the number of health benefit plans on competition between and among insurance payers, including but not limited to, tiered products, limited network products and products with a range of cost sharing options; and
> (iv) the potential for disruption to the market resulting from closing a health care payer's existing health benefit plans.

In furtherance of these ends, the Special Commission met a total of six times between the months of September through December, 2010. All of the meetings were conducted pursuant to the Open Meeting Law,[1] with the meeting held on November 22, 2010 including a widely publicized

[1] M.G.L. c. 30A, §§18-25 and 940 CMR 29.00 *et seq*.

public comment session. Approved Minutes of all the sessions are included herein as Appendix A, and all written testimony received from the public is included as Appendix B.

The Members also voted to distribute a modifiable questionnaire ("Survey") which could be responded to by Commission Members and/or forwarded to their constituents for response. A copy of the Survey and all responses received are included herein as Appendix C.

II. BACKGROUND

A. Counting Massachusetts Plans

In assessing the costs, benefits and other impacts of any reduction in the number of plans, it is necessary to determine what counts as a "plan," since there are many different ways to count the number of plans that are being offered to employers and individuals, are administered by third party administrators or health insurance carriers, and pay health care providers' claims.

Although many individuals do buy coverage on their own, the vast majority of Americans obtain health care coverage through their workplace where an employer, union negotiator, or association has worked with carriers and consultants to design the type of health plans that are offered to employees. Health care plan options can differ from workplace to workplace based on the decisions that the employer, union, or trade association makes about the design of the offered plan. Employers usually include in their analysis considerations regarding the balance between providing comprehensive benefits from a quality plan and keeping health costs and premiums to an affordable level.

The main features that distinguish one health plan from another are:

- Whether the health plan is a self-funded employer-sponsored health benefit plan or an insured health plan that is issued/renewed by a licensed health insurance carrier;
- Type of insurance license of the carrier offering the product (*e.g.*, commercial insurer, HMO or hospital/medical service corporation[2]);
- Limitations on coverage to non-network providers or incentives to seek care from certain providers (*e.g.*, closed, tiered, preferred, or open network plans);
- Markets in which the product is offered (*e.g.*, large groups, college students, etc.);
- Services covered, expressly limited or excluded from coverage under the product;
- Cost-sharing scheme (*e.g.*, co-payments, coinsurance and/or deductibles); and
- Utilization review systems (e.g., prior approval systems, referral circles).

In 2010, there were thirty-one accredited health insurance carriers[3] offering insured health plans in Massachusetts. The plans have a multitude of options for employers, unions, and individuals to choose among; there is no uniform method established for counting the many different options in order to compare plans from one carrier to another. Since this is the case, this report does not

[2] Blue Cross and Blue Shield of Massachusetts, Inc. is the only entity in Massachusetts authorized to operate as a hospital corporation and medical service corporation under the provisions of M.G.L. c. 176A and M.G.L. c. 176B.

[3] Accredited health insurance carriers are listed by the Division of Insurance at the following web address: http://www.mass.gov/?pageID=ocaterminal&L=5&L0=Home&L1=Business&L2=Insurance&L3=Insurance+Companies&L4=Group+Products+and+Plans&sid=Eoca&b=terminalcontent&f=doi_Managed_Care_managed_care_carriers&csid=Eoca.

attempt to devise an accurate count of the total number of plans, but identifies a few different approaches by which hundreds of combinations for possible plan design may be counted.

As an example, the DOI received rate filing information from carriers for 274 separate insured health benefit plans, effective in Massachusetts on April 1, 2010, for eligible individuals and small employers.[4] It should be noted, however, that this number differs from the number of plans listed on the DOI's own website[5] which identifies a total of 148 plans. The discrepancies are not reflective of the quality of the data, but of the varying ways that the same plan information has been represented for each presentation. Arguably, this variation underscores that there are many ways to define and count what configuration of benefits constitutes a health plan. It is not easy to identify one health plan as being substantially different from another and, therefore, to definitively count the number of plans is difficult. What is clear is that there are a substantial number of health plan choices available to health benefit plan purchasers.

In the most recent managed care accreditation process coordinated by the DOI, the Bureau of Managed Care requested that each carrier report the benefit features of all the products that it had offered in Massachusetts.[6] The reports make clear that the various permutations of offerings that are or were recently available likely runs into the tens of thousands. This is illustrated by a survey recently conducted by the U.S. Bureau of Labor Statistics.[7] The Survey first breaks down plans into four types of fee-for-service varieties and two types of Health Maintenance Organizations ("HMOs"). Within each of those, some have preferred providers, some allow non-emergency services out-of-network, and some require a primary care physician. Within each of those categories, some plans are high deductible plans, others have annual individual deductibles ranging from $100 to $3,000, with additional variation depending on whether the providers are in or out-of-network. Coinsurance amounts similarly may vary widely, as may annual out-of-pocket maxima, where applicable. Some plans also include drug coverage (with a variety of limits) with separate deductibles or coinsurance, and these amounts may depend on whether the drugs are generics or brand name. Separate limits may also be available for such alternative therapies as acupuncture or Christian Science therapy, and these add-ons may also involve differing co-payment responsibilities. With so many variables, it's easy to see how, if one counts every difference as a new plan, the number of available products can shoot up into the thousands very quickly.

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[4] Small employers are those employers with fewer than 50 eligible employees.

[5] The list maintained on the DOI's website can be referenced at the following web link: http://www.mass.gov/?pageID=ocaterminal&L=5&L0=Home&L1=Consumer&L2=Insurance&L3=Health+Insurance&L4=Health+Care+Access+Bureau&sid=Eoca&b=terminalcontent&f=doi_Consumer_css_health_smlindgroup&csid=Eoca.

[6] These data include plans no longer offered and various modifications that may be available with respect to some but not all offerings. The data were submitted pursuant to a 5/28/2010 Division request in response to a request for additional information for spreadsheets that were to include (among other things) the following information: product name; product type [HMO, preferred provider plan, indemnity, dual certificate, other (specify) offered or renewed]; amendments/riders [clearly noting the evidence of coverage(s) to which each amendment/rider is attached]; and document cost-sharing options [copayment/coinsurance/deductible design options for each product]. The Division's request as well as the spreadsheets submitted by six of the biggest writers (with large group products and blank pages omitted) may be found in Appendix D.

[7] *National Compensation Survey: Health Plan Provisions in Private Industry in the United States, 2008*. **U.S. Department of Labor** (July, 2009).

The submission of one of the largest writers in the state, however, indicates that, by its count, it is currently offering no more than three plans in the small group market.[8] This illustrates the potential confusion in trying to understand the exact nature of the coverage available in the market, or the specific benefits available to any one policyholder.

B. The Health Plans' Cost to Develop and Maintain Their Health Plans

Reports from the Division of Insurance,[9] the Division of Health Care Finance and Policy,[10] and the Attorney General[11] have noted that health care costs have far outpaced the national average. The bulk of the premium dollar – nearly 90 percent – is spent on medical costs, including hospital stays, doctor visits and prescription drugs, with the remaining 10 percent allocated to administrative expenses and surplus.[12] Although these conclusions have been questioned by some in the provider community, the Attorney General's report states both that, "[d]ata from the three largest health plans in Massachusetts show that increases in prices paid for medical services were primarily responsible for the overall increases in medical spending in the past few years;"[13] and that "[p]rice variations are correlated to market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers."[14]

The Division of Insurance held informational hearings between November 2009 and March 2010 on the impact of rising health care costs on small Massachusetts businesses[15] and, among other items, explored the cost to carriers to develop and maintain health plans. What follows are some key findings of the report issued by the Division of Insurance (the "Division") that note the percentage of the administrative portion of the premium dollar devoted to various aspects associated with administering health benefit plans subsequent to those hearings.[16]

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[8] See *Supplemental Volume* of this Report, submission by BCBSMA in Appendix D.

[9] Fritchen, Giesa & Lauters (Oliver Wyman), *Trends in Health Claims for Fully-Insured, Health Maintenance Organizations in Massachusetts, 2002-2006: Report to the Health Care Access Bureau of the Massachusetts Division of Insurance* (Sept., 2008).

[10] *Massachusetts Health Care Cost Trends, 2010 Final Report*, **Division of Health Care Finance and Policy** (April, 2010).

[11] *Examination of Health Care Cost Trends and Cost Drivers, Pursuant to G.L. c. 118G, § 6½(b), Report for Annual Public Hearing*, **Office of the Attorney General** (March, 2010).

[12] A provision that could hold administrative costs to no more than 10% of the total premium dollar is memorialized in Chapter 288 of the Acts of 2010, §§29-30. It is important to note, however, that in absolute dollars, a 10% portion will rise as quickly as total costs do.

[13] *Ibid*, p. 35.

[14] *Ibid*, p. 4.

[15] The complete report of those proceedings, *Small Group Health Premiums in Massachusetts*, may be found on the DOI website, at http://www.mass.gov/Eoca/docs/doi/Companies/small_group_report.pdf. The following companies participated in the hearings: Aetna Health, Inc.; The Assurant Group of Insurance Companies; Blue Cross and Blue Shield of Massachusetts; ConnectiCare of Massachusetts, Inc.; Fallon Community Health Plans, Inc.; Harvard Pilgrim Health Care, Inc.; Health New England, Inc.; Neighborhood Health Plan, Inc.; Tufts Associated Health Plan; and United HealthCare. Unless otherwise noted, the tables and quotations found in the remainder of this section are excerpted from this report.

[16] It is important to remember here that the costs tallied in what follows relate only to those directly incurred by the plans, and do not reflect any additional expenses that may be borne by other stakeholders, such as providers, hospitals and agents.

"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."[17]

Proportion of Total 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.

** These percentages are not of total healthcare costs, but only of the administrative portion of insurer expenditures, which is often estimated to comprise about 10% of total health insurer outlays. For example, a figure of 25% in this chart would amount to 2.5% of total insurer costs. Any additional costs to providers or other parties are also not represented in these data.

Each health insurance carrier participating in the DOI hearings also indicated that it devotes substantial resources to "ensuring that members understand the benefits in the product and the best way to obtain services." These include the costs of producing consumer guides, maintaining internet sites, coordinating help lines, and responding to complaints:

Proportion of Total Administrative Cost	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.

[17] Division of Insurance Docket No. G2009-07: Tr. Vol. II (Tufts), p. 13. One plan estimated the total "costs and resources" associated with implementing a new product to vary between $1 million and $3 million. *Ibid.*

At the hearings, the carriers acknowledged 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." The following table gives an indication of the volume of contacts handled by health plan consumer services staff on an annual average between 2006 and 2008:

	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						

In addition to the above referenced percentages of the administrative portion of the premium dollar devoted to administering health benefit plans, health plans need to devote resources to the costs associated with compliance with regulatory requirements, including a dozen different state and federal regulatory agencies that require detailed reports on similar types of financial, utilization and membership data. For example, the implementation and changes to Minimum Creditable Coverage standards in recent years have increased administrative expenses because each set of changes requires a comprehensive review of products and changes to existing plan design options, as well as education to internal staff, brokers, employers, providers and members. Collateral materials must be reviewed and modified according to specifications set forth by the DOI.

Chapter 288 of the Acts of 2010 established a number of requirements to create additional products in the market, including limited and tiered networks and offerings through small group purchasing cooperatives that will add to the number of products on the market. The Connector's efforts to standardize Commonwealth Choice products across its suite of offerings, changing from its original standard of allowing plans to develop products based on an established actuarial value at each level, has also contributed to increasing the number of products in the market place by introducing new products to the market while working with insurers to close plans that were replaced as membership in these plans decreased over time. Likewise, requirements included under national health reform, such as the grandfathering provisions, also are creating additional variations as employers can opt out of various provisions of the new law. State programs, such

as Medicaid, Commonwealth Care, and the Group Insurance Commission, have unique product designs and ongoing requirements for reporting, managing and development of these programs and offerings. Even if the number of products were reduced in the insured market, health plans would have to continue to employ staff and expend administrative resources to develop and maintain products in response to statutory requirements, state programs, and large employers.

It is the carriers' view that, despite the cost and increased complexity, insurers have been developing new options and plan features simply because the employers have been demanding them. A carrier that does not provide flexible plan options to meet employer demands risks losing business to the competition. Some employers treat health benefits as a recruitment tool and wish to offer benefits with low member cost sharing, while others are primarily concerned with premium expenses and choose products with higher member cost sharing. Employers and individuals balance their desire for supplementary benefits and provider network options that may increase the cost of the core package with the out-of-pocket expenses or cost sharing features that reduce overall premiums. For example, broad and limited networks create options for employers to set a defined contribution and enable employees to purchase the option specific to their needs. It is important to have multiple offerings that provide the employer with a choice that best fits their employees' needs and fits within the employer's budget for benefits.

Further, action to limit the number of health benefit plans would not apply to self-funded employer groups where there tends to be the greatest level of customization. Many employers offer multiple products and expect help developing custom communications solutions to their employees in print and online. Product type also depends upon the target market segment. For example, larger employers require coverage for their out-of-area employees and need PPO-type products. Limiting product choice could result in more employers and institutions moving to self-funded options so that they would have the flexibility to design products and offerings specific to their organizations. While such competition does encourage new innovations for cost containment, some argue it also increases administrative costs in a way that may add to costs overall.

Although there are no data illustrating the specific impact of new plan options on providers' costs, there are ample data showing that there are downstream costs to providers from the additional complexity resulting from differences among numerous health plan options. Providers may need to accommodate new plan options through changes in their own information technology systems and administrative procedures. These changes lead to increased costs for providers; in fact, one hospital estimated that 10% of the money received from payors is used to pay for the cost of responding to new health plan options.

C. External Studies Regarding the Impact of the Number of Health Benefit Plans

Various stakeholders and independent researchers have studied the costs and benefits associated with having a large number of health insurance plans available in the health insurance market and have predicted the expected effects of reducing the number, either through regulation or voluntary activity of market participants.

The research we have reviewed, most of it not specific to Massachusetts, generally points to the following as the costs associated with having numerous plans available in the market:

1. Administrative costs associated with implementing and keeping accurate records reflecting the billing, collecting, and eligibility idiosyncrasies of numerous plans;
2. Administrative costs associated with devising, marketing, explaining, supporting, and perhaps eventually closing a large number of plans;
3. Financial or other costs associated with difficulties faced by consumers in understanding and/or choosing suitable plans;
4. Financial or other costs associated with difficulties faced by regulators, public officials, producers, and advocates in understanding and explaining a large variety of plans to constituents.

Based on this research, the following benefits are commonly attributed to having a large number of plans available in the marketplace, and may be loosely categorized as follows:

1. Financial benefits to sellers and purchasers associated with tailoring products to the precise needs of consumers;
2. Financial benefits associated with the cost containment incentives associated with the existence of a wide variety of cost-sharing designs;
3. Financial and other benefits resulting from the creation of innovative products associated with the operation of unfettered market competition;
4. Financial and other benefits associated with elimination of the costs/inefficiencies resulting from regulatory constraints.

Unanswered questions:

1. How is a health plan defined? Based on this definition, how many plans are actually available to consumers? What are the differences among the plans?
2. What is the role of product choice in employer and consumer decision making? Does this differ by market segment? Does the number of products foster or mitigate adverse selection?
3. How is membership concentrated among the different products? Can products be combined or eliminated?
4. How can technology help to streamline and simplify the administrative complexity of multiple products, and how can all stakeholders use these new technologies more effectively?
5. Do more insurance products foster competition or do they just add to consumer and provider confusion?
6. Do more products result in lower costs for purchasers?

7. Are employers and individuals offered the full array of products in a health plan's portfolio?

8. How much does it cost to maintain and offer hundreds of products, particularly those with low membership?

9. What level of market disruption would result from reducing the number of benefit plans on the market?

The Number of Health Plans and the Individual Purchaser

One would expect consumers of health insurance products, like consumers in most other markets, to prefer to have a wide variety of options from which to choose, and for the majority to purchase the best plan for their needs.[18] However, this may not be the case.

The literature suggests that "competition increases [health care] quality and improves consumer welfare"—at least where prices are regulated."[19] Some suggest that just as product innovation has flourished in the pharmaceutical and medical device markets as a result of market competition, we can expect innovations in the areas of efficient/low cost delivery of quality health care where the market is allowed to experiment.[20] Indeed, the Maryland Health Care Commission, an independent state agency, has counseled that "states may want to keep their markets flexible enough to allow the introduction of new plan types that better meet consumers' needs."[21] This is especially true as Massachusetts moves towards payment reform. Changes from reforming the payment system and how providers are paid may necessitate changes in product design that could add to the number of products in the marketplace. Implementing a "one size fits all" approach by limiting the number of products in the marketplace could restrict the implementation of measures to reform the payment system. Placing limits or restrictions on the number of products that health plans could offer would likely increase employer administrative costs in the short-term as they would need to expend resources to manage the transition and change in products. This would also result in some level of dissatisfaction among employers and consumers from having fewer options available to them.

[18] See, for example, Kerssens & Groenewegen, "Preferences in Social Health Insurance," *The European Journal of Health Economics* (Mar., 2005). This study of consumer preferences in Holland showed that 90% of the time "the health plan with the most attractive characteristics was preferred, indicating a predominantly rational kind of choice." See also *Improving Health Care: A Dose of* Competition, **Federal Trade Commission** & **Department of Justice** (July, 2004); and Friedman & Friedman, *Free to Choose*, Houghton Mifflin Harcourt (1980).

[19] See Gaynor, "What Do We Know About Competition and Quality in Health Care Markets?" *National Bureau of Economic Research Working Papers* (July, 2006) and papers referenced therein, particularly Sage, Hyman, & Greenberg, "Why Competition Law Matters to Health Care Quality," *Health Affairs* (2003).

[20] *Improving Health Care: A Dose of Competition, op cit.* For a discussion of trade-offs between consumer choice, investment in quality, and market management, see Lyon, "Quality Competition, Insurance, and Consumer Choice in Health Care Markets," *Journal of Economics & Management Strategy* (Winter, 1999).

[21] *State Case Studies: Product Standardization in Small Group and Individual Insurance Markets*, **The Nelson A. Rockefeller Institute of Government** (Nov., 2009). See also *Options Available to Reform the Comprehensive Standard Health Benefit Plan as Required under HB 579*, **Maryland Health Care Commission** (Dec. 2007).

Since a health care purchaser's preference for low premiums or deductibles, access to certain hospitals, or coverage for alternative treatments like acupuncture vary,[22] consumers are generally more likely to be satisfied when there is a sufficient range of products to meet the diverging levels of needs.[23] Furthermore, in Massachusetts, where consumers are required to obtain Minimum Creditable Coverage,[24] cost-conscious buyers may choose to buy the minimum level of coverage unless there are a variety of plans from which to choose.

The assertion that covered individuals—rather than their employers—benefit from the number of plans has, however, been widely criticized. A recent study by The Commonwealth Fund summarizes the abundant research in this area by concluding that "[t]here is considerable evidence that consumers neither want nor need unlimited choice in health insurance offerings. Consumers can be overwhelmed by too much choice, particularly when making complex, high-stakes decisions like buying health insurance."[25] Another Commonwealth Fund study attributes to plan proliferation and complexity the adverse result that "[t]he third worst plan for beneficiaries in poor health, which cost its sickest enrollees almost $2,000 more than a high-premium Medigap A plan, had nearly one quarter of the Medicare A enrollees in the local market."[26] One observer worries that, even if consumers benefit from numerous health insurance options, such options present "yet another thing to worry about [since a]…bad decision…can bring complete financial ruin."[27] Indeed, even in a jurisdiction such as Switzerland where (i) public information about plans is plentiful; (ii) the main feature distinguishing one plan from another is price; and (iii) the cost of moving from plan to plan is quite low, a large number of choices often seems to result in consumer paralysis.[28] This "status quo bias" is considered to be present when "enrollees prefer their current plans to lower cost alternatives of comparable quality, even when tangible transition costs are low."[29] Others argue

[22] Kerssens & Groenewegen, *op cit.*

[23] "[W]hat consumers value . . . can vary by race, gender, education and other demographic variables." Rein, "Consumer Choice in the Health Insurance and Provider Markets: A Look at the Evidence Thus Far," *AcademyHealth Issue Brief* (Oct., 2007). See also *Improving Health Care: A Dose of Competition*, *op cit.*

[24] *See* 956 C.M.R. 5.00 *et seq.*

[25] Jost, "Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues," *The Commonwealth Fund Report* (Sept., 2010). See also Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries," *The Commonwealth Fund Report* (May, 2008), in which it was found that "a significant majority of [Medicare beneficiaries] reported that the benefit was too complicated" and that this complexity may have contributed to the failure of four million eligible individuals to enroll in any plan.

[26] Precht, "Role Models and Cautionary Tales: Three Health Insurance Programs Demonstrate How Standardized Health Benefits Protect Consumers," *The Commonwealth Fund Report* (July, 2009).

[27] Schwartz, *The Paradox of Choice: Why More is Less*, HarperCollins (2004).

[28] Frank & Lamiraud, "Choice Price Competition and Complexity in Markets for Health Insurance," *NBER Working Paper No. 13817* (Feb., 2008). Indeed, one canny observer has suggested that "choice" and "competition" are in some ways antithetical, coining the word "confusopoly" to describe a situation in which there can be no real competition precisely because of excessive product diversity: Adams, "Dilbert," (Nov. 21, 2010). See, however, *Employer Health Benefits: Annual Survey*, **Kaiser Family Foundation** (2010), which indicates that 60% of employers offering health insurance to their employees reported shopping for a new health plan or insurance carrier in the past year, with 27% changing their carrier and 33% changing the type of plan purchased.

[29] *Ibid*.

that "insurers have strong incentives to compete on price, service levels, and quality . . . only if individuals assessing the options can easily and meaningfully compare the various offerings."[30]

In addition, the claim that health care quality generally increases with consumer choice is not necessarily supported. One five-year longitudinal study found "no evidence of a strong and consistent relationship" between HMO competition (measured either by the HHI or the number of HMOs) and plan scores on standard performance measure tests.[31] It is important to note, however, that while Massachusetts has a very competitive health insurance marketplace and no limitations on the number of health benefit plans that carriers may offer, the state's locally-based health plans continue to be ranked among the highest in the nation in terms of quality and exhibit the lowest administrative expense ratios compared to plans in other states.

Furthermore, at least one state has found that employers as well as employees may be stymied by a large number of complicated choices. It is estimated that in New Jersey there are now about 30,000 riders across all plans and carriers, and, as the use of these riders spreads, "small businesses [find] it more difficult to distinguish between plan options."[32] The state responded by enacting several measures to assist these businesses, including requiring that plans disaggregate the cost of riders and reduce the number of standardized plans that carriers must offer from five to three.[33]

Discussion

In addition to the potential confusion resulting from the number of plans, critics have also pointed to the costs associated with so many offerings. A study by McKinsey & Company concluded that the total health care costs in the United States are about 14% above what would be expected to be expended on health care administration and insurance compared to a country with the same relative wealth.[34] Adjusted for wealth differences, the United States spends $91

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[30] Wicks, "Implementing a Health Plan Purchasing Pool," *Roadmap to Coverage* (2005), available at http://bluecrossfoundation.org/~/media/Files/Policy/Roadmap%20to%20Coverage/051007RTCpbPurchasingPoolWicks.pdf. The author points out that "people do value some degree of choice, and some variation in benefits may be desirable" and suggests that one might achieve the objectives of both standardization and choice by having "every insurer offer the standard set(s) of benefits, but then allow them to offer add-ons." As will be seen below, just such a scheme resulted in massive complexity in New Jersey. See Burke & Belloff, "Gold, Silver, and Bronze: The Important Role of Product Standardization in Health Insurance Reform," *The Nelson A. Rockefeller Institute of Government* (Nov., 2009).

[31] Scanlon, Swaminathan, Lee, & Chernew, "Does Competition Improve Health Care Quality?" *Health Services Research* (Dec., 2008). The authors suggest the possibility that "the fragmentation associated with competition hinders quality competition."

[32] Burke and Belloff, *op cit*.

[33] *Ibid*. In any case, it has been argued that "[n]ot only do insured individuals and group purchasers have disparate degrees of sophistication; they have different objectives. The former seeks to maximize personal benefit from health insurance, based often on idiosyncratic concerns and ex post perceptions, while the latter strives to minimize aggregate cost and residual risk." Sage, "Regulating Through Information: Disclosure Laws and American Health Care," *Columbia Law Review* (Nov., 1999). The author suggests that this fact supports two separate rationales for disclosure-based regulations: healthy competition (which benefits group purchasers) and the protection of individual employees through standardization and education.

[34] *Accounting for the cost of US Health Care: A New Look at Why Americans Spend More*, **McKinsey Global Institute, McKinsey & Company** (Nov., 2008) (see 1. The facts about the US health system).

billion more than expected on this category, with over one-third of that amount attributable to sales and marketing.[35]

A 2007 Commonwealth Fund study puts the issue this way:

> "Compared with other countries, the U.S. is an outlier with respect to insurance administrative expenses. In 2004, if the U.S. had been able to lower the share of health care spending devoted to insurance overhead to the same level found in the three countries with the lowest rates, it would have saved $97 billion a year. If the U.S. had spent what countries with mixed public–private insurance systems, such as Germany and Switzerland, spend on their insurance systems' administrative costs, it could have saved $32 to $46 billion a year."[36]

Such calculations include estimates of costs other than those associated with number of plans, but a reduction in the number products alone would be expected to produce some savings, if only because it would lower product design and marketing costs for carriers. One observer has warned that "without [plan restrictions] reduction in administrative costs would be difficult, if not impossible."[37] In contrast, a Society of Actuaries publication suggests that although "simplification of plan designs may . . . result in reduced administrative costs," the responsibility for most of the costs of this complexity stem from "a multitude of state and federal requirements" such as setting minimum benefit thresholds.[38]

Costs to carriers do not exhaust the administrative expenses claimed by some to result from the number of health plans. Additional research attempts to quantify the administrative costs to providers from the costs of, *e.g.*, verifying insurance information, answering calls from pharmacies, verifying credentials, negotiating a plethora of slightly differing insurance contracts, handling varying billing and payment processes, etc. In a 2005 study, the Medical Group Management Association ("MGMA") estimated the costs of "wasteful administrative tasks" for a 10-physician medical group at about $250,000 per year, and claimed that "simplifying our health care system's administration could reduce annual health care costs by almost $300 billion."[39] The MHA has estimated that administrative costs for billing and insurance in Massachusetts exceed $5 billion per year and that streamlining reporting, credentialing, quality standards, coding price negotiations, eligibility, prior authorization, and billing-related costs might save 20 percent of that total.[40]

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[35] *Ibid*. A recent report, "Healthcare Policy in an Obama Administration: Delivering on the Promise of Universal Coverage," *Pricewaterhouse Coopers' Health Research Institute* (Nov., 2008) also claims that the "proliferation of health plans add administrative costs for providers and can be confusing to members."

[36] Davis, Schoen, Guterman, Shih, Schoenbaum, & Weinbaum, "Slowing the Growth of U.S. Health Care Expenditures: What are the Options?" *The Commonwealth Fund Report* (Jan., 2007).

[37] Starr, *The Logic of Health-Care Reform*, Grand Rounds Press (1992).

[38] McCarthy & Niehus, "Responsible Health Care Reform: Part 2—Access to Care," *The Actuary* (Apr./May, 2010). Note, however, that a 2008 Congressional Budget Office ("CBO") study has estimated the increase in premiums resulting from government mandates at approximately 2% to 3%. *Key Issues in Analyzing Major Health Insurance Proposals*, **CBO** (Dec., 2008).

[39] *Administrative Simplification for Medical Group Practices*, **MGMA Position Paper** (June, 2005).

[40] "Administrative Simplification: an Underestimated and Overlooked Opportunity for Significant Savings", *Controlling Health Care Costs, A Report Series form MHA*, **MHA** (Feb., 2009).

Other studies have made similar claims. According to one study based on analysis of a large Massachusetts physician organization, physicians use about 12 percent of their net patient service revenue to cover the costs of "excessive administrative complexity."[41] The authors estimate that the apparently simple reforms of "a single transparent set of payment rules for multiple payers, a single claim form, and standard rules of submission" would reduce costs to physicians and clinical services by $7 billion annually: this savings would reportedly result from about four hours saved each week per physician and another five hours each week for each supporting staff member.[42]

While some carriers have closed non-group plans with a small number of members and no longer market these plans, they are required to re-enroll existing members that wish to remain in these plans. For example, some plans have closed non-group plans created prior to the merger of the non-group/small group market and a number of "frozen" plans through the Connector that are no longer offered in the market. Allowing carriers to close these plans and transition these individuals into comparable, alternative options is one area that could reduce the number of products without limiting choice in the existing market.

As might be inferred from some of the reforms suggested above, not all prescriptions for administrative simplification necessarily require mandatory (or even voluntary) reductions in the number of plans.[43] Indeed, even among those who may grant that a large increase in the number of plans suggests some sort of market failure because of the increases in complexity and administrative costs resulting from such growth, regulatory intervention can remain a controversial solution. Doubters of the advisability of a regulatory solution may subscribe to the view espoused in at least one contemporary textbook on this subject: "[M]arket failure is a necessary but not a sufficient condition for government intervention. Although markets may fail and impose costs on society, the costs of government intervention may be much greater."[44]

Certainly, private stakeholders have not ignored other sorts of remedies. It has not been lost on carriers, policyholders, providers, or academics that some of the problems stemming from the number of plans—and, presumably, some of their solutions—are technological in nature. For example, early in 2010, the BlueCross BlueShield Association announced what they called a "Landmark Initiative to Reduce Time, Expense for Physician Office Practice Paperwork" in New Jersey. Attempting to produce a system "comparable to what ATMs did for banks and consumers," America's Health Insurance Plans and the BlueCross BlueShield Association with the collaboration of various New Jersey provider groups hope to produce "a system in which one-stop electronic transactions replace the current, cumbersome system."[45] A Wharton School

[41] Blanchfield, Heffernan, & Osgood, "Saving Billions of Dollars—And Physicians' Time—By Streamlining Billing Practices," *Health Affairs* (Apr., 2010).

[42] *Ibid.*

[43] It has even been noted that a multiplicity of types should have appeal to some of the providers looking for relief from the current administrative morass, if only because it has been the very multiplicity of plans that has produced for physicians a "variety of practice options—from fee-for-service to staff model HMOs." Schwartz, *op cit.*

[44] Santerre & Neun, *Health Economics: Theories, Insights, and Industry Studies,* Harcourt Brace (2000). For a similar perspective, see also MAHU's comments to the commission in Appendix B.

[45] *Health Plans Collaborate on Landmark Initiative to Reduce Time, Expense for Physician office Practice "Paperwork,"* **The Blue Cross and Blue Shield Association**, available at http://www.bcbs.com/news/bcbsa/health-plans-collaborate-on.html.

study estimates that even "if the long run savings from moving to web-based claims processing is only 10% of current administrative expense, this would still be almost 2% of total health expenditures . . . or $20 billion per year."[46] Again, a report of the Healthcare Administrative Simplification Coalition ("HASC") suggests that numerous simplification opportunities in the areas of credentialing, eligibility, machine-readable health ID cards, and prior authorization, could eliminate or simplify clerical work without reducing plan options, in some cases solely by increased "leveraging of information technology."[47] This group estimates that "even a modest 10 percent optimization of administrative processes and technologies would save the U.S. heath care system approximately $500 billion over ten years."[48]

D. Expected Effects of Recently Enacted Legislation and Projected Future Reforms

Some recent changes to state and federal laws might impact the number of health benefit plans or the analysis of how many plans may be sufficient to meet market needs. The provisions that may have such affects include the following:

Chapter 288 of the Acts of 2010

- Sections 20, 26, 27 and 55 change the eligibility requirements for individual coverage to discourage individuals from buying health coverage only when they need expensive health care services;

- Sections 21to 24 and section 34 provide for the creation of up to six small group purchasing cooperatives for the purchase of health coverage;

- Sections 28, 35 and 36 remove some legislative restrictions on cancellation and discontinuation of certain closed health benefits plans, including closed guaranteed issue plans;

- Section 29 changes the standards of review for small employer health plan rates;

- Sections 32 to 32A require that certain carriers offering plans in the merged market offer at least one network product that is a select or tiered network;

The group estimates that, if reproduced on a national scale, such an initiative would produce savings in the "hundreds of billions of dollars."

[46] Danzon & Furukawa, *e-Health: Effects of the Internet on Competition and Productivity in Health Care*, available at http://brie.berkeley.edu/econ/conferences/9-2000/EC-conference2000_papers/danzon.pdf. See, however, those two authors' chapter "Health Care: Competition and Productivity," in *The Economic Payoff from the Internet Revolution*, Brookings Institution Press (2001), in which they warn that "[e]stimates of savings or effects on competition and productivity attributable to the Internet are highly speculative because the ultimate technologies and the rate of uptake are still uncertain" before reiterating that "[n]evertheless . . . the ultimate potential savings are probably equal to at least one or two percentage points of total health spending."

[47] *Bringing Better Value: Recommendations to Address the Costs and Causes of Administrative Complexity in the Nation's Healthcare System*, **HASC Summit on Administrative Simplification Final Report** (July, 2009).

[48] *Ibid.*

- Section 57 mandates that the DOI promulgate regulations to promote administrative simplification in health plan claims processing and establishes a Single Claims Administration System Working Group;

- Section 56 establishes an Administrative Simplification Working Group;

- Section 64 charges the Division of Health Care Policy and Finance to research bundled provider payments and implement pilot payment programs in 2011.

Patient Protection and Affordable Care Act

The act includes provision for:

- Access to insurance for uninsured Americans with pre-existing conditions through a new Pre-Existing Condition Insurance Plan;

- Establishment of an Independent Payment Advisory Board to focus on ways to reduce costs and expand access to high-quality care;

- Encouragement of the development of accountable care organizations (ACOs) to better coordinate patient care and improve quality;

- Introduction of electronic health records regulations;

- Creation of new options for long-term care insurance;

- Formation of a pilot program to study payment bundling;

- Elimination of annual limits on insurance coverage; and

- Requirement of coverage for individuals participating in clinical trials;

- Definition of "Essential Benefits" that may differ from Massachusetts standards for Minimum Creditable Coverage;

- Establishment of Health Exchanges.

Payment Reform

In addition to the above listed changes, there have been studies that have concluded that the implementation of some or all of a variety of possible future changes in the structure of provider payments in the health insurance market, often classified together under the umbrella of "Payment Reform" could lead to major changes in the cost of health care.[49] AIM has noted that

[49] See, for example, Whelan & Feder, *Payment Reform to Improve Health Care: Ways to Move Forward*, **Center for American Progress** (June, 2009) and Guterman, Davis, Schoen, & Stremikis, "Reforming Provider Payment: Essential Building Block for Health Reform," **The Commonwealth Fund Report** (March, 2009).

payment reform should lead to reductions in the number of benefit plans or at least reducing the administrative expenses associated with those plans that are available—regardless of their number. "Payment Reform" refers to a change in the manner or amounts of payments to health care providers or to basic structural changes (such as moving from fee-per-service to fee-per-patient) to the remuneration provided for health services. Such reforms may involve:

- Increases in remuneration for primary care;
- Increased Coordination of Care by the financial encouragement of such entities as "medical homes";
- Bundling payments by medical "episode" or "condition" rather than paying for specific services;
- Bundling payments based on hospital admissions (and perhaps post-hospital care) rather than paying for specific services;
- Global capitation of payments for each patient.

Consideration of the pros and cons of these reforms goes beyond the charge made to this Commission and elaboration of them goes beyond the scope of this Report, but it is worth considering whether any such changes might have an effect either on the number of available plans or on the costs of plan design, marketing and/or administration. The answer to these questions will depend partly on the specific nature of the "reforms" and whether they are undertaken voluntarily.

As indicated in the previous section, the two main classes of reasons that have been proffered for reducing the number of health benefits plans have been associated with consumer confusion on the one hand and administrative costs on the other. A case can certainly be made that, whatever the effect of Payment Reform on plan complexity, administrative costs—at least those imposed on health care providers—are likely to be reduced by any system of remuneration that either reduces the number of items that must be paid for or simplifies the determination of payment on any such item is actually due. For example, it is likely easier to count patients or hospital admissions than it is to count individual procedures. If a plan calls for a set amount to be paid for a particular patient condition, regardless of whether any particular services are provided in that case, one objective may be to streamline billing processes including eligibility.

Not only will any existing financial incentives to provide high-cost services have been eliminated, complexities revolving around whether (and the extent to which) a specific plan compensates for those services will also disappear. Advocates maintain that the general quality of patient care would improve in such an environment in spite of falling costs. It is not unreasonable to infer, then, that implementation of significant Payment Reform could have beneficial effects on one set of problems alleged to ensue from the number of health benefit plans.

In addition, several groups, including BCBSMA, the MAHP, the MHA, and the MMS, have, under the Employers Action Coalition on Healthcare ("EACH") working group of the Administrative Simplification Collaborative, worked collaboratively on major healthcare

administrative simplification initiatives to reduce unnecessary expenses for providers and health insurance organizations. Areas of focus have included eligibility, credentialing, referrals and authorizations, and provider appeals. Further, Chapter 305 of the Acts of 2008 included provisions requiring uniform coding and billing for processing health care claims and Chapter 288 of the Acts of 2010 specifies special studies to explore further opportunities for administrative simplification and claims process.

To the extent Payment Reform is successful in reducing the rate of increase in health care costs year over year to a more modest level, the demand from individuals and employers for additional "buy-down" product options is also very likely to decrease, and the impetus for carriers to introduce more options may also diminish. This could lead to a natural reduction in the number of health plans in the market without the potential adverse impacts that a reduction in the plans being offered today could bring.

III. SUMMARY OF SURVEY RESPONSES

Each Special Commission member brings a unique perspective to the study of the reduction of health benefits plans. In order to share and understand those perspectives, members agreed to provide responses on the issue based on their viewpoints and those of their constituents in the form of a member survey. The guidelines adopted by the Special Commission suggested seven areas for Special Commission members to consider in investigating the costs and benefits of reducing the number of health benefits plans. These guidelines, derived directly from the Commission's authorizing statute, can be summarized as follows: (1) how benefit plan types are counted and what degree of difference is needed before an offered plan is counted as a new plan; (2) the main costs associated with having a large number of health benefit plans; (3) the extent to which a reduction in health benefit plans would reduce the associated costs; (4) the main benefits associated with having a large number of health benefit plans; (5) the extent to which these benefits would be lost if fewer health benefit plans were offered; (6) costs that might be incurred from the process of reducing health plans; (7) any other observations regarding the impact of reduction in the number of health benefits plans.

Nine of the thirteen Special Commission members provided written responses to the survey guidelines. The most robust responses represent viewpoints from physicians, hospitals, small business, health plans, an independent state agency and a consumer advocacy organization. While the survey responses are included in this report as Appendix C, it may be useful to summarize a few main points.

Counting Benefit Plans

Most respondents agree that benefit plans can be counted by plan type (*e.g.*, HMO, PPO, select) and within type, by cost-sharing structure (*e.g.*, co-payments, coinsurance, deductibles). BCBSMA noted that once a plan type and cost-sharing regime has been chosen, employers can customize BCBSMA plans in several additional ways, but most respondents did not count plans at that level of detail. There was no consensus, or even conjecture in the surveys as to the overall number of plans in the Massachusetts market.

Cost of Having a Large Number of Benefit Plans

Employers and health carriers indicate that they do not incur a significant amount of administrative costs to support the large number of available plans. Based on figures provided by the MAHP, the cost to design, market, contract, administer, develop rates and manage regulatory affairs may constitute 1.3 percent to 4.8 percent of total premium costs, depending on the carrier. BCBSMA represented that efforts to manage plans electronically has offered large cost efficiencies. The real financial and other costs seem to fall mainly on providers and certain consumers. As MHA and MMS discovered by surveying their constituents, the complexity caused by having a large number of plans can pose a significant administrative burden to many hospitals and physicians. It can be difficult and time consuming to identify the extent to which the insured is covered by a health benefits plan. Several practices indicated that 20 percent to 40 percent of staff time is taken up by these processes. Consumers, too, may face an inability to choose between health plans and to understand the benefits that they have or which are offered to them. HCFA suggests that this possibility is most severe for individual purchasers of health

insurance; the Connector suggests that it would be worthwhile to research the level of confusion caused by the number of health benefits plans by market segment in order to tailor the right number of plans to different types of purchasers.

Whether a Reduction in the Number of Health Plans Would Reduce Associated Costs

Most respondents agreed that an arbitrary reduction in the number of health benefits plans would likely not alleviate the costs associated with having a large number of plans in the market. Employers expressed that it would be unlikely to reduce premiums and furthermore, there could be short-term cost increases from managing a transition to a new plan. Employers also indicated that businesses might have to pay more for insurance benefits that they would not have chosen if other plans were still available to them. There was broad support, however, for elimination of closed plans and frozen plans and an easing of the processes for doing so. Providers did not necessarily expect to recognize substantial gains from arbitrarily reducing the number of plans unless the remaining plans were standardized so that it would be easier to determine patient benefits and eligibility.

Benefits of Having a Large Number of Health Benefits Plans

The main benefits of having a large number of plans as highlighted by the surveys are choice, flexibility, and innovation. Health plans and businesses advocate for maximum choice in the marketplace because employers have different goals in choosing a health plan including competing against other employers, or reducing costs. The NFIB in particular emphasized the importance of free market principles to small businesses. Along with other survey respondents, they agreed that in order to compete with large and self-insured employers, small businesses especially need the flexibility to find the most suitable plan at the least cost. Employers and carriers also have reservations about the introduction of regulatory restrictions which might stifle plan innovation that may be necessary to keep up with ongoing health reform and the demands of the market.

The Connector and HCFA, while recognizing the benefits of choice, indentified a couple of caveats regarding having a large number of plans. First, the large number of non-standardized plans makes it difficult for many purchasers to choose a plan unless assisted by an expert. Second, the majority of plan enrollment is concentrated in only a few plans indicating that the choice available in the marketplace adds complexity, but not necessarily meaningful choice for individuals and small businesses.

Providers found that administratively, there was no advantage to having a large number of plans, yet they remain concerned that purchasers have the flexibility and choice necessary to have affordable access to health care.

Loss of Benefits that Might Occur by Reducing the Number of Health Benefits Plans

Some Commission members are anxious that if the number of plans is reduced, small employers would lose the flexibility to compete with ERISA-exempt employers who can innovate and design their own plans. Small businesses worry that they would lose the benefits of free market principles if government interference in the market was responsible for plan reduction. HCFA, the Connector, and providers, while recognizing that purchasers need to have access to

affordable health care, could not point to any benefits which would necessarily be lost by reducing the number of health benefits plans, especially if the remaining available plans were thoughtfully tailored to different market needs and standardized so as to be easily comparable.

Costs That Could Be Incurred by the Process of Reducing the Number of Health Benefits Plans

In the opinion of carriers and businesses, the process of reducing the number of health benefits plans could cause market disruption if employers are forced to switch to new plans. This transition, they caution, could increase short-term costs for employers as they implement programs to educate employees on the benefits transition. But, if the plans that are eliminated are those which are currently closed or frozen, the costs incurred by the process of reducing plans would be minimal. The Connector emphasizes that there are already systems and processes in place to transition purchasers from one plan to another, so that the costs of reducing the number of non-closed plans would be limited.

Other Observations Made by Respondents

- HCFA suggests that if the number of health benefits plans is reduced, low membership plans should be eliminated first via a transition process so insureds can adjust gradually. Plans should not be frozen in time but should be reevaluated periodically so that the number and variety of plans is suitable for market participants.

- The MAHP suggests that it should be easier to take products off the market when carriers, upon review, find that a particular offering is no longer necessary.

- BCBSMA is working with carriers to find all-payer solutions for common processes to reduce the administrative burden on providers. Towards this goal, they have adopted electronic systems and are active in the Massachusetts Healthcare Simplification Collaborative.

- AIM suggests that there are other ways of addressing administrative simplification, but reducing the number of health plans is a solution in search of a problem.

IV. RECOMMENDATIONS OF THE MAJORITY OF COMMISSION MEMBERS

The majority of the Commission Members makes the following recommendations:

1. This Special Commission should continue in its present form in order to work with all stakeholders to undertake the additional research necessary to fully answer the questions posed by the General Court regarding the costs and benefits that would be associated with a significant decrease in the number of available health benefit plans in the Commonwealth.

2. Continued focus should be on efforts specified in Chapter 288 of the Acts of 2010 as well as other on-going collaborative efforts to simplify the administrative processes, including those processes involving information exchange with carriers regarding eligibility, benefits, deductible status and claims information for members.

3. The Division of Insurance and the Commonwealth Connector should continue to work with carriers to facilitate the discontinuation of plans that have been closed and/or frozen in the market for some time.

4. The Commonwealth Connector and carriers should continue to ensure that consumers and small groups are aware of their buying options through the Connector and directly from carriers.

5. The impact of the implementation of Chapter 288, as well as the implementation of National Health Reform, on the number of health plans should be considered in any continuing study regarding the number of health plans.

In addition to these conclusions and recommendations, the individual organizations indicated below have requested inclusion of the following statements:

V. MINORITY REPORT[50]

The Special Commission was charged with examining the "impact of reducing the number of health benefit plans that a health care payer may maintain and offer to individuals and employers". The Special Commission has met, discussed, surveyed Commission members and their constituencies, taken public testimony, reviewed other information available through regulatory filings in MA and considered general research papers on the topic. This varied input has demonstrated wide and diverse views on the subject with no clear-cut or definitive findings.

In particular, there is a lack of evidence that there would be measurable cost savings realizable from reducing the number of health benefit plans in MA and in fact, the same could actually result in increased cost to individuals and employers and slower introduction of innovative lower cost solutions for purchasers. While there are administrative costs at the carriers associated with offering health plans and for providers to work with carriers to administer those plans, it is not demonstrated that the number of plans available in MA is a key driver of these costs or causes confusion on the part of individuals or employers in the purchasing of coverage in MA. Further, given that any action to limit the number of health benefit plans would not apply to large self-funded employer groups (where there tends to be the greatest levels of customization), nor to government payers, the potential for recoverable administrative cost savings for carriers or providers is further minimized. In addition, it is worth noting that the Connector was created to facilitate purchasing coverage by individuals and small groups and already offers a buying experience that includes a small subset of the plans offered by carriers, for those buyers who prefer less choice.

Moreover, simplifying administrative processes has been a mutually shared goal among many of the constituencies represented on the Special Commission. Already ongoing and collaborative efforts include among other items, the Massachusetts Healthcare Simplification Collaborative, Health Care Administrative Services, the Massachusetts Health Data Consortium, the All Payer Claims Database and more. These multi-organization efforts all share the goal of identifying and executing on opportunities for shared and consistent administrative processes to simplify and eliminate duplication of efforts. These efforts also share the goal of advancing the use of technology to simplify administration and reduce costs. We should allow these collaborative processes to bear their expected fruit.

In addition to establishing this Special Commission, chapter 288 of the Acts of 2010 included a number of specific provisions in support of administrative savings that are worth noting. The new law includes provisions to make it easier for carriers to discontinue offering plans that had been closed or frozen to new membership, thereby eliminating those plans from the market; it called for an administrative simplification working group under HHS to streamline state administrative requirements and to maximize the use of a singular all payer claims database; it requires the DOI to promulgate regulations to promote administrative simplification in claims processing and eligibility determination and for appeals of denied claims; and it will enable DOI to require carriers to use uniform standards and methodologies for credentialing to simplify the

[50] This Statement was submitted to the Commission on December 20, 2010 by MAHP, BCBSMA, NHP, AIM, and NFIB.

process for providers. In addition, it is worth noting, the law requires the carriers to develop and offer tiered and select network plans, in addition to their full network plans, as a means to create lower cost plans in the market for individuals and small groups. State regulatory processes are well underway to accomplish these purposes. Again, these processes should be allowed to proceed to their fruition.

The Special Commission has not considered why there has been a growth in the number of plans in the market over the last number of years in Massachusetts and around the country. It is important to note, that while Massachusetts has a very competitive health insurance marketplace and no limitations on the number of health benefit plans that carriers may offer, the state's locally-based health plans exhibit the lowest administrative expense ratios. It should be noted that this growth in plan choices is largely a result of sustained year over year health care cost trends that have far exceeded inflation and what employers can absorb, especially in recent years and during a down economy. These factors have led to the demand for an increasing array of lower cost options to enable employers and individuals to find coverage each year that they can afford. These cost trends are driven in Massachusetts by the ninety percent (90%) of the health care dollar that is paid out in benefits, and far less by administrative costs. Much more work remains to be done to address this 90%.

The Payment Reform Commission has made recommendations for transitioning how providers are reimbursed and the Governor is expected to submit proposed legislation relative to the same soon. Changes from reforming the payment system and how providers are paid may necessitate changes in product design. However, implementing a "one size fits all" approach by limiting the number of products in the marketplace could restrict the implementation of measures to reform the payment system. Placing limits or restrictions on the number of products that health plans could offer would likely increase employer administrative costs in the short-term as they would need to expend resources to manage the transition and change in products. This would also result in some level of dissatisfaction among employers and consumers with having fewer options available to them.

In addition, the growth in number of plans also reflects government mandates at both the state and federal levels, as differences in requirements for products as well as their applicability to different segments of buyers, create the need for plan variations across segments. The grandfathering provision under national health reform has also created additional variations as employers can opt out of various provisions of the new law, further necessitating customized health plan solutions.

Recommendations**:**

Accordingly, Associated Industries of Massachusetts, Blue Cross Blue Shield of Massachusetts, the Massachusetts Association of Health Plans, the National Federation of Independent Business, and Neighborhood Health Plan as representative for the MAHP Medicaid Managed Care Organizations (MMCOs), believe that there would be no realizable administrative savings from reducing the number of health plans at this time. Further, that there may in fact, be increases in costs for businesses and individuals unable to find plans that meet their coverage and budget needs if there is a reduction in the number of health plans. In addition, the requirements of new laws, such as Federal Mental Health Parity, the Patient Protection and Affordable Care Act fact

and chapter 288 will necessitate the creation of new health plans by carriers. Therefore, we do not support the Special Commission recommendation to continue to research the impact of reducing the number of health plans. We do support the following Special Commission recommendations:

(1) Continued focus should be on efforts specified in Chapter 288 as well as other on-going collaborative efforts to simplify the administrative processes, including those processes involving information exchange with carriers regarding eligibility, benefits, deductible status and claims information for members;

(2) Division of Insurance and the Commonwealth Connector should continue to work with carriers to facilitate the discontinuation of plans that have been closed and/or frozen in the market for some time;

(3) The Connector and carriers should continue to ensure that consumers and small groups are aware of their buying options through the Connector and directly from carriers; and

(4) The impact of the implementation of Chapter 288, as well as the implementation of National Health Reform, on the number of health plans should be monitored by the Division of Insurance.

This minority report was submitted by MAHP, BCBSMA, AIM, NHP, and NFIB.

VI. STATEMENTS OF INDIVIDUAL COMMISSION MEMBERS

Statement of the Massachusetts Hospital Association (MHA) and the Massachusetts Medical Society (MMS)

As small employers, MHA and MMS strongly believe that it is necessary to have some choice in determining which health plan is the best fit, both financially and coverage-wise, to offer to its employees. MHA and MMS also recognize and support the need for employers to have access to cost-effective health insurance options with varying benefit designs and networks. Yet we believe that both these goals can be achieved without the costly proliferation of health benefit plans and variations that currently exist in the market and add to the administrative complexity providers and patients face.

Although there are still many unanswered questions, the Commission's report provides evidence both locally and nationally that too many choices can be counter-productive for employers and patients and increase administrative costs for payers and providers, indeed for all stakeholders. Insurers believe that they have no choice but to offer a wide range of products to remain competitive because that is what purchasers and their brokers are requesting. Yet it is not clear that employers have ever been sufficiently educated regarding the increased administrative costs that arise from an unlimited number of product offerings with differing co-payments, benefits, networks, referral, authorization and billing requirements. Hospitals and physicians must deal with literally tens of thousands of variations when treating patients who are covered under commercially available health insurance. This constantly changing complexity among health insurance plans requires high cost modifications to billing systems, or high cost manual intervention in billing and payment systems. It requires costly research into changes and one-on-one time with patients explaining coverage and liability determinations. Thus, one of our recommendations is to increase employer engagement in administrative simplification efforts through enhanced education so that they fully understand the implications of having thousands of products on the market.

The Commission's report also emphasizes the potential for both state and federal payment reform efforts to result in a reduction of administrative complexity and therefore eliminate the need for addressing the number of health plan options on the market. MHA and MMS agree that a key objective of payment reform is administrative simplification. However, there are still too many unknowns inherent in the Commonwealth's payment reform plans to say with any certainty that the resulting administrative simplification efforts will be sufficient. Even with payment reform, eligibility and benefit coverage will still have to be verified, patient liability will have to be determined and collected, authorizations and referrals are likely to continue, and some kind of claim adjudication will still have to occur. For these reasons, MHA and MMS believe that it is important for the work of the Special Commission to continue until enough data can be gathered to make an informed decision on the effects that health plan proliferation and lack of standardization has on administrative complexity, consumer confusion, and cost.

VII. APPENDICES

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A. APPROVED MINUTES OF COMMISSION MEETINGS

Special Commission to Study Health Benefit Plan Reductions

September 30, 2010

The Special Commission to Study Health Benefit Plan Reductions met at the Division of Insurance at 11 A.M. on September 30, 2010. Joseph Murphy, Commissioner of the Division of Insurance (DOI) chaired the meeting, with assistance from Walter Horn and Joan Bennett both from DOI. The following Commission members were present:

Glen Shor of the Commonwealth Health Insurance Connector Authority (Connector);
Karen Granoff representing the Massachusetts Hospital Association (MHA);
Elaine Kirshenbaum representing the Massachusetts Medical Society (MMS);
Eric Linzer representing the Massachusetts Association of Health Plans (MAHP);
Alan Rosenberg representing Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA);
Linda Peterson representing the Massachusetts Health Information Management Association (MaHIMA);
Ray Campbell representing the Massachusetts Health Data Consortium (MHDC);
Eileen McAnneny representing the Associated Industries of Massachusetts (AIM);
Bill Vernon representing the National Federation of Independent Businesses (NFIB);
Carla Bettano representing Neighborhood Health Plan (NHP);
Julie Pinkham representing the Massachusetts Nurses Association (MNA); and
Georgia Maheras representing Health Care For All (HCFA).

1. Documents and Exhibits Used at the Meeting
    a. *Proposed Agenda for the First Meeting;*
    b. *Proposed Schedule*.

2. Chairman's Welcome

Commissioner Murphy of the Division of Insurance (DOI) welcomed the inaugural meeting of the Special Commission, which was formed pursuant to section 58 of chapter 288 of the Acts of 2010, and which provides for the creation of a "special commission to make an investigation and study relative to the impact of reducing the number of health benefit plans that a health payer may maintain and offer to individuals and employers." He summarized the requirement to conduct commission meetings in accordance with the Open Meeting Law and previewed the meeting's agenda. Members of the commission were invited to introduce themselves and make an initial statement about the costs and benefits.

Georgia Maheras (HCA) emphasized that simple choices are best for consumers of health care plans. Eileen McAnneny (AIM) noted the importance of weighing the drawbacks/ benefits of plan choice in relation to savings associated with reducing the number of plans. Elaine Kirshenbaum (MMS) cited her members' desire to streamline the number of plans. Alan Rosenberg (BCBSMA) indicated that carriers develop products as customers demand options suited to their business needs.

Eric Linzer (MAHP) suggested the need for flexibility in health plan choice for employers, especially small businesses, to be able to manage costs. Bill Vernon (NFIB) noted that after payroll, health care costs are the largest cost of employers and indicated that flexibility in plan design is important for efforts to lower cost. Julie Pinkham (MNA) expressed her concern as an employer and as a provider in the level of choice impacting costs for all.

3. Discussion of the nature and types of possible costs and benefits that might ensue from reducing the number of health benefit plans offered by health payors and of data that might be usefully collected and research projects that might be conducted that would be helpful in determining the impact to various constituencies of reducing the number of health benefit plans.

Commissioner Murphy discussed the potential to engage a consultant to collect data for the Commission's report and asked Kevin Beagan, Deputy Commissioner in DOI's Health Care Access Bureau to discuss his calls with consultants on the approved consultant list. Mr. Beagan indicated that he had been in touch with the Oliver Wyman consulting firm to develop a proposal to examine information that could be collected and indicated that he would review their proposal at the next Special Commission meeting for the commission members to review and evaluate. Roni Mansur, a Director within the Commonwealth Health Insurance Connector Authority, offered to also contact other consulting firms that his agency may contract with to determine whether any would be interested to perform the Special Commission's work. Mr. Beagan and Mr. Mansur agreed to pursue these proposals and present options at the next committee meeting.

Ms. McAnneny offered that it would be helpful to discuss the scope of the Commission and the problem the Commission was trying to address. She questioned whether the term "payor" is defined as "carrier" for the purposes of the Commission's research. She also inquired whether the Commission was concerned only with the offerings of insurers, or also the offerings of self-insured groups. Commissioner Murphy and Mr. Shor confirmed that the Commission will consider fully insured employers, but not the self-insured.

Mr. Linzer indicated that there should be some sort of acknowledgment of challenges to the reduction in benefit plans presented by self-insured entities, such as large employers offering multiple products and networks, indicating that that, in his view, the Commission won't get to the full extent of the problem it is addressing without looking at self-funded groups. The GIC, he observed, is not represented on the Commission but influences what is offered in the market.

Ms. Maheras asked how many plans are currently offered. Commissioner Murphy and Mr. Beagan responded that they are aware of an aggregate of at least 274 HMO and BCBSMA products in the small group market alone. Ms. Granoff suggested that the Connector share its experience with the Commission. Mr. Shor stated that the Connector had initially twenty-four adult plans, but reduced that to seven adult plans. They offer a limited subset of plans, he said, standardized so that consumers could compare the competition apples to apples.

Mr. Rosenberg elaborated that BCBSMA continually reviews its plans but tries to reach a market which is broad in terms of price point, geographic area, and needs of employers. They offer, he continued, plans to 40,000 employers and individuals as well as coverage beyond Massachusetts. Mr. Linzer observed that employers have very different needs.

Ms. Kirshenbaum said that if technology was better, and the administrative burden less, there may not be a reason to reduce plans. Mr. Campbell discussed his vision for reengineering choice by looking at health care administration systemically to develop and implement improved systems and technology to reduce administrative costs. Mr. Campbell said that he supports a systemic approach to reviewing and reforming health care administrative structure.

Mr. Linzer claimed that any cost-savings that may be produced by a reduction in the number of health plans is limited, since all administrative costs combined comprise only 10% of total costs, on the rest being made up of medical costs. Ms. Kirshenbaum acknowledged that the cost of care is huge, but that administrative reduction adds up and added that the stream of administrative stuff that physicians must deal with because of the large number of plans is quite time consuming, especially chasing down patients to get information from them.

Ms. Granoff stated that the Commission should consider the types of choices employers have when they purchase a benefit plan, with regard to how many different products are offered and the differences among them in benefits, cost sharing and other details. She continued that it would be useful to know how many accounts are enrolled in each product in order to know where the bulk of the business is concentrated.

Ms. McAnneny stated that she was for saving costs where appropriate but asked, if money is saved, whether the savings will result in reduced premiums? She also said that the Commission should be mindful of changing plans because of the new requirements of federal health reform. Specifically, she worried about timing in changing plans because it could affect which plans are grandfathered under the federal law. Separate but related, she continued, how might future payment reform impact benefit design? The Commission should be mindful of that, as well.

Mr. Rosenberg asked for Mr. Campbell's thoughts on technology: Mr. Campbell advocated an administrative simplification project. He suggested that a good starting point was the idea that health claims processing is less efficient than payment in other industries like collections or receivables. Studying these other industries, he concluded, to find efficiencies and then using those approaches in health care billing would be advantageous.

4. Discussion of the Chairman's proposal for a schedule for future meetings and timeline for the drafting of the report required by Chapter 288 of the Acts of 2010.

Commissioner Murphy then proposed the Special Commission's next meetings and there was discussion about meeting at the following times:

Oct. 15 to discuss potential consultant research;
Oct. 29 to hold a public hearing on the Special Commission's work;

Dec. 3 to discuss any consultant work product;
Dec. 14 to discuss the draft report.

Chairman Murphy subsequently adjourned the meeting.

Special Commission to Study Health Benefit Plan Reductions

October 15, 2010

The Special Commission to Study Health Benefit Plan Reductions met at the Division of Insurance at 10:30 A.M. on October 15, 2010.

1. Documents and Exhibits Used at the Meeting
    a. *Oliver Wyman's Proposal to support the Special Commission investigating the impact of reducing the number of health benefits products in the market.*
    b. *Oliver Wyman Presentation of the Proposal to support the Special Commission investigating the impact of reducing the number of health benefits products in the market.*
    c. *Draft Notice of Hearing.*
    d. *Draft Minutes of the first Special Commission meeting.*
    e. *Collection of Cost-Sharing Designs – Offered/Renewed, dated 7/28/2010.*
    f. *Supplemental Report of the 2009 Health Insurance Market in New Hampshire*
    g. *Email from Brenda Wilson, Associate Commissioner, Life and Health Section, Maryland Insurance Administration to Walter Horn regarding NAIC Survey question regarding the number of health plans in a jurisdiction.*
    h. *Email from Leslie Ludtke, Health Policy Analyst, New Hampshire Insurance Division to Walter Horn regarding NAIC Survey question regarding the number of health plans in a jurisdiction.*
    i. *Excerpt from Supplemental Report of the 2009 Health Insurance Market in New Hampshire, dated Sept. 20, 2010.*
    j. *Notice of Meeting of Public Body including proposed agenda for the Special Commission's second meeting.*

2. Introduction and Attendance

In Commissioner Joseph Murphy's absence, Kevin Beagan, Deputy Commissioner of the Division of Insurance (DOI) chaired the meeting, with assistance from Walter Horn and Joan Bennett both from DOI. The following Commission members were present:

Karen Granoff representing the Massachusetts Hospital Association (MHA);
Elaine Kirshenbaum representing the Massachusetts Medical Society (MMS);
Eric Linzer representing the Massachusetts Association of Health Plans (MAHP);
Alan Rosenberg representing Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA);
Linda Peterson representing the Massachusetts Health Information Management Association (MaHIMA);
Eileen McAnneny representing the Associated Industries of Massachusetts (AIM);
Bill Vernon representing the National Federation of Independent Businesses (NFIB);
Carla Bettano representing Neighborhood Health Plan (NHP);
Georgia Maheras representing Health Care For All (HCFA).

Kevin Beagan served as Commissioner Murphy's designee in his absence.

Roni Mansur, Director of Commonwealth Choice, served as Mr. Shor of the Connector's designee in his absence.

3. Presentation of Proposed Research by Oliver Wyman

Terri Stone and Howard Lapsley, partners from the Boston office of the Health and Life Sciences Division of Oliver Wyman, were in attendance to present their research proposal. Their presentation consisted of a high level overview of the proposal and proposed work plan. They emphasized that the proposal is part of a conversation, a draft, of what the Commission might eventually engage Oliver Wyman to do. Ms. Stone indicated that Oliver Wyman would try to balance three competing concerns in their analysis: (1) choice for payors and consumers, (2) reduction of confusion in choosing a plan, (3) reduction of financial and systemic inefficiencies in the health care system.

Ms. Kirshenbaum raised concerns that the proposed research should not neglect the impact of plan proliferation on employers, physicians and hospitals not only in financial terms, but in terms of benefits to health care delivery generally. Mr. Rosenberg noted that the market for health insurance products has many disparate segments and raised concerns that the research account for the lack of homogeneity between payor groups. Mr. Lapsley confirmed that while there are commonalities regarding the rational methods used by purchasers of health insurance products in choosing a product, the proposed research would reflect characteristics of various market segments.

Ms. Stone discussed the structure of possible definitions of a health insurance "product:" (1) network access and payment structure; (2) coinsurance and copayments ("page one" benefits); and, coverage details ("page two" benefits). Changes to the configuration of page two benefits, she said, can be used to fine tune plans on an actuarial level, but policyholders may be confused by the rules governing such benefits after purchasing a plan.

Ms. McAnneny encouraged the Commission to adopt a definition of "product" which includes the page two benefits, because it is not necessarily administrative costs, but the risk of not knowing whether a procedure is covered which stresses the provider community.

Mr. Beagan provided Oliver Wyman with an example of product data submitted by a small carrier to the DOI indicating that the carrier offers fourteen page one benefit options for products available in the small group market. Mr. Lapsley continued by offering instances where Oliver Wyman helped companies successfully reduce products offered while increasing profits. For example, he elaborated, they assisted a long-term care insurer in marketing fewer plans which were targeted to consumers' key values, thereby simplifying choice and increasing market share.

The representatives from Oliver Wyman offered two levels of data in their proposal: A report based on in house data and substantial interviews, at $475,000, and a report based on in house data and a modicum of interviews at $375,000. They will provide the Commission with the average rate of the professionals who would create the report.

4. Discussion of Proposed Research

Mr. Beagan recommended that the Commissioners consider the timeframe and cost of accepting the Oliver Wyman proposal or of pursuing an alternative plan. He suggested as alternatives either a report by a consultant mentioned by Ms. Kirshenbaum, or developing resources for the report independently without an outside consultant.

Mr. Beagan offered that DOI is able to contribute some resources to retain a consultant, but not the amount identified in the Oliver Wyman proposal, and asked the Commissioners to consider what their organizations could contribute if the Special Commission would seek to engage Oliver Wyman or another consultant. He stated that Commissioner Murphy or his staff would be in touch with each member of the Special Commission to determine whether they may be able to contribute to the cost of a consultant's report.

Mr. Beagan also suggested that the Commission members focus on what could be reported to the Legislature on December 31 and consider issuing a preliminary report as required by December 31, but also asking to extend the Special Commission beyond December 31 to provide sufficient time for the members to consider the complex issues before it. There was brief discussion of the possibility of a Commission member other than the DOI contracting with whatever consultant is chosen if that contractor was not already on DOI's approved vendor list.

5. Proposed Agenda for October 29, 2010 Meeting

The Commissioners unanimously approved a motion to postpone any session explicitly set aside for public comments to a later date. The October 29 meeting will be convened instead to discuss the resources available to support consultant research, any other proposals that might be submitted to the Special Commission, and decide the next step in preparing the report. The Special Commission may at that time reconsider the issue of holding a public comment session or providing an alternative avenue for public comment regarding the reduction of health benefit plans.

Mr. Beagan adjourned the meeting at 12:14 pm.

Special Commission to Study Health Benefit Plan Reductions

October 29, 2010

The Special Commission to Study Health Benefit Plan Reductions met at the Division of Insurance at 10:30 A.M. on October 29, 2010 and the meeting began at 10:45 A.M.

1. Documents and Exhibits Used at the Meeting
    a. *Draft Minutes of the second Special Commission meeting.*
    b. *Notice of Meeting of Public Body including proposed agenda for the Special Commission's second meeting.*
    c. *Draft Notice of Public Comment Meeting.*
    d. *Draft Survey of Special Commission Members Regarding Reduction in the Number of Plans*

2. Introduction and Attendance

In Division of Insurance (DOI) Commissioner Murphy's absence, Kevin Beagan, Deputy Commissioner at DOI chaired the meeting, with assistance from Walter Horn and Joan Bennett both from the DOI. The following Commission members were present:

Karen Granoff representing the Massachusetts Hospital Association (MHA);
Eric Linzer representing the Massachusetts Association of Health Plans (MAHP);
Alan Rosenberg representing Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA);
Linda Peterson representing the Massachusetts Health Information Management Association (MaHIMA);
Eileen McAnneny representing the Associated Industries of Massachusetts (AIM);
Carla Bettano representing Neighborhood Health Plan (NHP);
Georgia Maheras representing Health Care For All (HCFA).
Julie Pinkham representing the Massachusetts Nurses Association (MNA).

Roni Mansur, Director of Commonwealth Choice, served as Mr. Shor of the Connector's designee in his absence.
Tracy Ledin served as Elaine Kirshenbaum of the Massachusetts Medical Society (MMS)'s designee in her absence.

3. Adoption of the Minutes

The minutes of the 2nd meeting of the Special Commission were unanimously approved by the Commissioners.

4. Discussion of Whether to Engage Consultant; Member Survey

Mr. Beagan disclosed that the pool of resources for hiring Oliver Wyman was less than one fifth of their proposed charge.

Ms. Granoff introduced the idea that there may be grant money available for research regarding the number of benefit plans because of the national interest in health care costs. Perhaps the Special Commission, she continued, could issue a preliminary report requesting that the legislature provide a mechanism for the Special Commission to apply for grant funding.

Mr. Beagan suggested that the Special Commission proceed by either conducting surveys or relying on a description of the available research because he was no longer optimistic that any consultant could contribute meaningfully to the project by December 31.

Ms. Maheras was supportive of asking the legislature if they would tolerate a later report to enable the Commission to solicit grant funds and also suggested that each member might give a quarter-person to the effort. Ms. McAnneny supported an interim report and suggested that going-forward, the Special Commission fine-tune the consultant proposal.
Mr. Beagan suggested it might be useful for the Special Commission members to fill out a survey to collect each member's views on such issues as the number of health benefit plans. The Special Commissioners discussed the value of collecting anecdotal information on health benefit plans from each member. Ms. Pinkham made a motion to send out a survey and Ms. McAnneny seconded it. Ms. Pinkham supported the survey because, she said, the costs and benefits of reducing the number of health benefit plans is a value judgment. Ms. Maheras supported a survey, but perhaps not the draft survey prepared by the DOI. Ms. McAnneny pointed out that a survey would instill discipline in the Commissioners to consider the question before them and to make sure all points of view were represented in the report. Mr. Beagan offered that the survey could be a guideline for each organization and that it could be left up to each member whether to survey their constituents or to complete the survey within their organization. Mr. Linzer suggested and several Commissioners concurred that they would like to modify the draft survey to provide different or additional information. The motion to send out a survey was approved by the Commissioners with the request that the survey be returned by Thanksgiving.

The Commissioners then debated whether the draft offered by Mr. Beagan – see attachment – should be adopted. Ms. Pinkham moved that the draft survey be adopted as a guideline; the motion was seconded by Ms. McAnneny and adopted unanimously by the Special Commission.

5. Proposal for Public Comment Meeting

Mr. Beagan recommended that the Special Commission hold a public comment meeting to hear any and all parties, especially those not represented on the Special Commission. Following a review of Special Commission calendars, a motion was made to hold the meeting on Monday the twenty-second of November. The motion was seconded and adopted. Ms. Maheras suggested that the meeting be held on the 21st floor of 1 Ashburton Place if available on that date. There was also general agreement to have the next Special Commission meeting following the open comment session to discuss the next steps of the Special Commission to meet the statutory December 31, 2010 timeline.

Mr. Beagan adjourned the meeting at 11:34 am.

Attachment

Survey of Special Commission Members Regarding Reduction in the Number of Plans

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

[*Here are some examples of possible ways of dividing (more than one may be selected):*

(i) by various cost sharing arrangements (co-pays, deductibles, etc.); (ii) by various benefits offered in addition to Minimum Creditable Coverage; (iii) by groups of providers eligible for payments under the plan; or (iv) the manners in which medical necessity is determined or other features of utilization review.]

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.

[*Here are examples of three possible responses:*

A. (i) determining eligibility for benefits (40%); (i) collecting co-pays (30%); (iii) determining allocation of obligations between patient and carrier (20%); and (iv) other (10%).

B (i) determining whether/what proportion of some medical procedure will be covered by one's plan 40%; estimating which plan will be most costly by the end of the policy term (25%); (iii) estimating which plan will provide the richest benefits for the money (25%); and (iii) figuring out how to shop for various alternatives that may be available (10%).

C (i) designing new products (20%); (ii) marketing new products (20%); (iii) continuing to service old products that are no longer being marketed (20%); (iv) explaining product features to existing consumers (20%); closing old products (25%).]

Please explain your estimates.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

I'm not sure how people will respond to the percentage estimates given that we have no agreement as to how many plans there actually are.

4. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item.

[*Here is an example of two possible responses:*

A (i) allows for as close as possible matching between ability to pay and available programs (35%); (ii) prevents a "race to the bottom" for provision of benefits to lower income individuals (35%); (iii) contributes to product innovation in the area of cost-containment (30%).

B (i) produces the lowest possible total health care costs consistent with policyholder wishes (30%); (ii) allows businesses to compete more efficiently in the area of employee benefits (30%); (iii) reduces the flight to the unregulated market that can be expected to result from excessive standardization (30%); (iv) other (10%).]

Please explain your estimates.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from <u>*the process*</u> of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: explaining changes to stakeholders, closing existing programs, loss of buyer choice/individualized packages, reduction in seller cost-containment innovation, loss of business to self-insurance, etc.*

Please explain your estimates.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

Special Commission to Study Health benefit Plan Reductions
Minutes of the November 22, 2010

The Special Commission met at the Division of Insurance at 10:00 A.M. on November 22, 2010.

1. Documents and Exhibits Used at the Meeting
   a. Draft Minutes of the Third Special Commission Meeting.
   b. Proposed agenda for the Special Commission's Fourth Meeting

2. Introduction and Attendance

In Division of Insurance (DOI) Commissioner Murphy's absence, Kevin Beagan, Deputy Commissioner of the DOI chaired the meeting, with assistance from Walter Horn and Joan Bennett both from the DOI. The following Commission members were present:

Karen Granoff for Massachusetts Hospital Association (MHA);
Eric Linzer for Massachusetts Association of Health Plans (MAHP);
Linda Peterson for Massachusetts Health Information Management Association (MaHIMA);
Eileen McAnneny for Associated Industries of Massachusetts (AIM);
Carla Bettano for Neighborhood Health Plan (NHP);
Bill Vernon for National Federation of Independent Business (NFIB).

Roni Mansur for the Commonwealth Health Insurance Connector Authority in Glen Shor's absence;
Tracy Ledin for Massachusetts Medical Society (MMS) in Elaine Kirshenbaum's absence; and
Michael Katzman for Blue Cross Blue Shield of Massachusetts in Alan Rosenberg's absence.

3. Public Comment Session

A public comment session began at 10:05 A.M. and was followed, after a short break, by a meeting of the Commission at 11:35 A.M.

4. Minutes

A motion to approve the draft minutes of the Commission's third meeting of October 29, 2010 was unanimously adopted.

5. Discussion of content and structure of the Report to the Legislature

Mr. Beagan summarized the information in front of the Commission which might be incorporated in a report, reminding members the report is due December. 31, 2010 including the

- rejected consultant proposal and comments thereto;
- research completed by any commission members;
- surveys of commission members;

- suggestions to extend the Commission to conduct research or the authority to pursue grants for research related to the issue;

The current draft of the report, Mr. Beagan continued, contains background information, the survey responses, and the comments received at the public comment session or from Commissioners. He inquired if there were any suggestions of what might be added to the report. No suggestions were put forth.

Mr. Mansur suggested that the Commissioners try to draw conclusions from the surveys. Ms. Granoff resisted the idea that conclusions could be drawn based on anecdotal survey data.

A discussion of whether to include a request for an extension of the meeting along with a grant of funds for research was tabled until the next meeting.

The Commissioners agreed on the following schedule going forward:

- Survey responses should be submitted to Walter Horn at the Division by Thanksgiving.
- Draft report, survey responses, comments, and meeting minutes will be circulated to Commissioners on December 1st.
- Meeting to discuss the draft report, survey responses and comments will be held Dec. 10.
- Final report draft circulated to members on December 15th.
- Meeting on December 20th to vote on whether to adopt the final report draft as the Commission's report to the Legislature.

A motion to adjourn was unanimously adopted and the meeting was adjourned at 12:05 P.M.

Notes on the Special Commission Special Comment Session

A summary of the public comment session appears below. Written comments submitted to the Commission have been appended to these minutes. Mr. Beagan clarified that the public comment session was not a hearing of the Division of insurance, and had no associated docket and no requirement to pre-file an intent to testify before opening the floor.

Lou Malzone

Mr. Malzone introduced himself as the representative of the Attorney General's office to the Connector. He stated that he supports the Connectors' focus on access to health insurance, but expressed concern that the issue of health care cost and quality needs more attention. In his view, the number of plans causes confusion in the marketplace and adds to premium costs. Although he supports choice, he has reservations about what he termed "too much choice," and advocated a need to explore and find compromise between choice, unlimited choice, and restricted choice of health insurance plans. He stated that with the correct balance, greater cost efficiencies could be achieved which would allow hospitals and providers to put money back into the health care system.

Ms. McAnneny asked if Mr. Malzone would agree that purchase of health care insurance by employers is different than the purchase by individual consumers. Mr. Malzone replied that in his experience, there is a need to compromise and to resist the impulse to allow every employer or individual to tweak plans, and to have carriers offer only four to five designs.

Mr. Beagan added that every product available to small employers must be offered to individuals under the law. He asked whether Mr. Malzone was saying that smaller employers and individuals should have fewer plans available. Mr. Malzone agreed that small employer plans should be reduced in number, and that such employers offer employees standard plans. He stated that providers find that the number of plans in the marketplace is not very cost efficient.

Mr. Linzer followed up by pointing out that although the Commission could make recommendations in its report, but such recommendations, if implemented, would impact only fully insured employers, who continue to desire increased flexibility. He asked Mr. Malzone where there would be a cost impact from a reduction in plans. Mr. Malzone disclosed that he runs three self-insured plans, all of which base their benefits on what is in the marketplace, even if not required of self-insured plans. Other large employers, he continued, would welcome a change that would lead to greater simplification and cost containment. His comments, however, were focused on the small business community to show how costs can be reduced. He also expressed that another related issue is unrestricted guaranteed renewal, because plans cannot be changed to be more affordable. He encourages development of a method of transitioning members on guarantied issue plans to new plans without losing economic benefits.

Kate Bardsley, Exec Dir, Massachusetts Association of Health Underwriters (MAHU)

Ms. Bardsley expressed the need for free market choice and competition. In her opinion, limiting choice is counter to these goals and to economic theory, and restricts innovation spurred by competition. Clients want choice and competition make better plans for small business.

She recommended the following:

- All health care contracts should be transparent to the consumer
- Variation in provider rates of reimbursement should be reduced and community hospitals offer better value than expensive clinics affiliated with teaching hospitals.
- Flexibility be provided to employers in what is purchased for their employees; MCC should be reexamined to allow increased flexibility.

Mr. Beagan inquired of Ms. Bardsley whether the large number of available plans increases administrative expenses, including brokers' expenses. Ms. Bardsley replied that brokers already understand a large number of plans and that an increase in plans would not impact their costs.

Jeff Rich, of the Massachusetts Business Association (MBA)

Mr. Rich explained that the Massachusetts Business Association manages plans for many small businesses, and must, along with those businesses, make decisions to manage premium costs. No business, he stated, has asked him for less choice. In his view, they want more choice to manage costs because plan benefit designs are the only tools available for them to do that. Limiting plans, he emphasized, puts small employers at an additional disadvantage to large self-insured employers.

Ms. Granoff inquired about how many choices an employer needs. Mr. Rich responded that employers are enrolling in more than 300 plans through the MBA. Small employers, he stated again, should not be hampered in the options available to them.

Mr. Linzer asked what options employers have to manage rate increases. Mr. Rich elaborated that employers are not concerned only with price, but also with the fact that employees are interested in keeping their doctors, and may be impacted by high deductibles. Brokers help with this analysis and know the marketplace, the carriers, plans, and groups. Mr. Linzer followed up by asking if this system minimized confusion. Mr. Rich said that although there are a lot of options, there is not much confusion because of brokers and intermediaries, like MBA, and their efforts at educating employers about plans. He compared it to shopping for a mortgage, where, in his view, one also needs a broker.

Mr. Mansur asked if the estimated three hundred plans constitute sufficient choice for MBA's members. Mr. Rich replied that the choice available will be what the market will bear. There are a lot of plans that are not being purchased, and this reflects trends in what employers are looking for over time.

Mr. Beagan asked how many groups or members are covered by MBA. According to Mr. Rich, MBA covers 30,000 groups. How many plans offered, followed Mr. Beagan? There are 180 to 200 plans, said Mr. Rich.

Mr. Mansur inquired how many plans have significant enrollment. Qualifying that MBA does not offer BCBSMA plans, Mr. Rich stated that popular plans vary from year to year, and that about 50% are enrolled in on a regular basis.

Gerald Belastock, owner of CGR Insurance

Mr. Belastock spoke about the complexity in the market which stems from the number of insurance plans. This complexity, he stated, has a great impact on members of small business plans. As an example, Mr. Belastock spoke about colonoscopies to illustrate one such complexity:

A mandate from the federal government specifies that colonoscopies should be paid in full even for members of high deductible plans, with no cost-sharing. If, however, the physician snips a polyp, some insurers find that that act transforms the services provided beyond the federal mandate, and apply a deductible equal to the cost of the entire procedure. There is no way that

the patient could know beforehand whether or not they will need to pay a deductible: the eventual out-of-pocket cost could range from $0-$2500.

Mr. Belastock emphasized that situations like the one above are too complex, and are often caused by mandates. When the government puts itself between employer and insurers, he said, there are bound to be problems. The government should regulate insurance, he continued, but in a less invasive manner. He felt that fewer people should be designing the pie of available plans.

In Mr. Belastock's experience as a broker, keeping track of the variations between plans is monumental. Brokers must also know about old plans no longer sold, and educate themselves about changes in applicable laws and regulations. The brokers' job today, he noted, is almost unmanageable as it becomes more and more complex to make recommendations to employers.

Mr. Beagan followed up in two parts: First, he stated that this issue with the Federal colonoscopy payment mandate is a somewhat separate issue from the number of plans, and that the Division is aware of that issue and working towards resolution with the Federal government. Second, he asked whether Mr. Belastock was an advocate of having fewer health benefits plans. Mr. Belastock proposed a system where health plans offered by carriers must fall within a limited range of actuarially determined value. For example, the most popular plans could be given a score of 1. Less popular plans would then be allowed to deviate from those popular plans in small increments up to a predetermined range, perhaps between. .65 and 2.5. Insurers should be allowed to decide what to issue, and at what actuarial level to offer plans, and decide the cost sharing.

Mr. Horn inquired whether the same pricing practices could occur if there were no federal mandate for colonoscopies. Mr. Belastock indicated that government intervention in the market should take the form of guidance more often, rather than outright regulation.

Mr. Linzer wondered how the actuarial value approach differs from the system operated by the Connector. Mr. Belastock expressed approval of the Connector's products, but indicated that his comments are directed at non-Connector plans.

<u>Eileen McAnneny, Associated Industries of Massachusetts</u>

Ms. McAnneny acknowledged that although she is a member of the Commission, she wanted to be certain that AIM is on the record as being opposed to limiting plans for the following reasons:

1. The Commission appears to be a solution in search of a problem. Administrative simplification would solve the problems posed by having to deal with a large number of plans. Other Commissions are already addressing administrative simplification.
2. Cost. Proliferation of plans is a response to the need to control costs. The reduction of the number of plans will not necessarily translate to savings for employers.
3. ERISA. The Division has jurisdiction over fully insured plans, but not the self-insured plans which make up a large portion of the market.

4. Limiting choice. The idea before the Commission is in opposition to the rest of chapter 288 of the Acts of 2010, including provisions for limited and tiered network plans, co-ops, Connector plans, wellness components and the closing of old plans. Inasmuch as choice impacts individual consumers, the Connector has the authority to resolve such issues.
5. Timing. Assuming it is appropriate to limit choice, the timing would be wrong because of payment reform and federal reform. Benefit reform should be in the context of payment reforms and other regulatory changes.

Eric Linzer, Massachusetts Association of Health Plans

Mr. Linzer briefly that a reduction in health care benefits plans is not the answer to address costs or relieve small business. Reduction in the number of health benefits plans, he said, impacts the 10% of health insurance premium expenses that are spent on administrative expenses, not the 90% spent on health care services. Mr. Linzer also echoed the sentiment that in the context of ERISA, small employers are at a disadvantage relative to large plans, and that limiting the selection of health benefits plans available would disadvantage them further. A better course of action, he continued, would be to take plans out of the marketplace that aren't much used.

Michael Katzman, Public, Government and Regulatory Affairs, BCBSMA

Blue Cross Blue Shield, Mr. Katzman said, believes that affordability is the most pressing issue in health insurance. Their administrative costs are less than ten cents on the dollar. They look to streamline plans and recently reduced the number of plans offered. They will end closed plans as allowed under recent changes to the law. But, the cost of having a lot of plans is very small. Choice is the most important value to participants in the health insurance market and BCBSMA need to offer a lot of choice in order to fit coverage to each unique employer.

Mr. Beagan suggested that each Commission Member's written comments be appended to the report, whether or not they chose to comment at the public comment session.

The Open Comment Session of the Special Commission ended at 11:25 A.M.

Special Commission to Study Health Benefit Plan Reductions
December 10, 2010

The Special Commission to Study Health Benefit Plan Reductions met at the Division of Insurance at 10:30 A.M. on December 10, 2010.

1. Documents Used at the Meeting
    a. *Notice of Meeting of Public Body including proposed agenda for the Special Commission's fifth meeting.*
    b. *Draft Report of the Special Commission to the Legislature*
    c. *Additional Comments from the Massachusetts Medical Society (MMS)*
    d. *Possible Framework for Conclusion and Recommendations of the Special Commission authored by Blue Cross and Blue Shield of Massachusetts*

2. Introduction and Attendance

In Division of Insurance (DOI) Commissioner Murphy's absence, Kevin Beagan, Deputy Commissioner at DOI chaired the meeting, with assistance from Walter Horn, Meg Parker and Joan Bennett, all from the DOI. The following Commission members were present:

Karen Granoff representing the Massachusetts Hospital Association (MHA);
Eileen McAnneny representing the Associated Industries of Massachusetts (AIM);
Ray Campbell representing the Massachusetts Health Data Consortium (MHDC);
Alan Rosenberg representing Blue Cross and Blue Shield of Massachusetts, Inc. (BCBSMA)
Linda Peterson representing the Massachusetts Health Information management Association (MaHIMA);
Carla Bettano representing Neighborhood Health Plan (NHP);
Eric Linzer representing the Massachusetts Association of Health Plans (MAHP);
Elaine Kirshenbaum representing the Massachusetts Medical Society (MMS).

Roni Mansur, Director of Commonwealth Choice, served as Mr. Shor of the Connector's designee in his absence;
Jekkie Kim, Legal/Policy Analyst, served as Ms. Maheras of Health Care for All (HCFA)'s designee in her absence.

Not present were:

Bill Vernon, representing the National Federation of Independent Businesses (NFIB);
Julie Pinkham, representing the Massachusetts Nurses Association (MNA).

3. Adoption of the Minutes

The draft minutes of the fourth meeting of the Special Commission, which took place on November 22, 2010, were amended slightly by Roni Mansur. The amended minutes were adopted unanimously by the Commissioners.

4. Discussion of the Format and Structure of the Draft Report to the Legislature

Ms. McAnneny suggested that the report should be amended to include an inventory of recent legislative changes that make it easier to close plans and require implementation of certain standard quality measures. New legislation, she said, also addresses administrative simplification. It would be worthwhile, she concluded, to see the impact of those changes before acting to reduce the number of health benefits plans. Mr. Rosenberg agreed with Ms. McAnneny, adding that claim simplification and administrative collaboration should be allowed to play out because it will impact this issue.

Mr. Linzer commented that the report should be adjusted to make it clear that, since the actual percentage of total costs due to administration is only about ten percent, the percentage of administrative costs allocated to one or another category must be multiplied by 10% to get the individual administrative cost's percentage of total insurer expenditures. He also commented on Ms. McAnneny's suggestion regarding new legislation, stating that the recently enacted chapter 288 of the acts of 2010 also mandates additional health plans, and that federal reform introduces a scheme of grandfathering plans. These changes, he said, will exacerbate the issues regarding the number of health benefits plans.

Ms. McAnneny said that although there was a lot of good information in the report, much of the data was not specific to Massachusetts and might not be applicable. Information specific to Massachusetts, but collected before the implementation of state health reform, she continued, may not be applicable to the Special Commission's work.

Mr. Beagan summarized that members would like to incorporate into the report: (1) information on changes stemming from chapter 288 and other recent legislation; (2) clarify that cost associated with the number of plans is part of administrative costs; (3) acknowledge that much of the background data is national, not Massachusetts-specific information.

Mr. Rosenberg expressed doubt that the number of plans is really the problem regarding provider issues with authorization and other related issues. Ms. Kirshenbaum agreed that if administrative process were better, the number of actual plans would not matter. Mr. Rosenberg continued that perhaps the number of plans would be ok after the changes to chapter 288.

Mr. Beagan asked Commission members to forward suggested amendments to the report to the DOI by Dec. 15, 2010, so that they can be incorporated into the report and voted on during the next session on Dec. 20. All changes should be written down and submitted to the DOI, he said, so that they can be voted on at the next session.

Ms. McAnneny then suggested that the report mention payment reform and whether that reform would eliminate issues associated with the number of health benefit plans. Ms. Kirshenbaum thought perhaps global payment would eliminate related issues, but that it is not clear that prior authorization would be eliminated by payment reform. Mr. Rosenberg countered that it is double-digit trend which drives the number of plans. Mr. Campbell offered that payment reform is a coming sea change and it's not clear what it would mean for the purposes of the Special Commission's report.

Mr. Beagan reminded the Commission members that several documents would be appended to the report – the minutes, comments, and survey responses. None of the Commission members offered additional suggestions for appendices.

Mr. Horn pointed out that he did not attempt to summarize or characterize survey responses in the report. Ms. Granoff said that it is difficult to read the survey responses and that a summary would be helpful. Ms. Kirshenbaum agreed that a summary would be helpful.

5. Discussion of Whether to Extend the Special Commission and the Scope of Future Research, if Any.

Mr. Beagan noted that a few things were tabled at the last meeting until the December 10th meeting: whether to recommend an extension of the Special Commission; whether to recommend appropriations for future work; and whether to include in the report information about the scope of future research which could be conducted in this area.

The Commission members held a lively discussion regarding whether and how the Special Commission might continue its work after filing the required report with the Legislature by December 31, 2010.

Ms. Kirshenbaum and Ms. Granoff agreed that there are not enough data for the Special Commission to make many recommendations in its forthcoming report and that it would be worthwhile for the Special Commission to pursue additional research. Mr. Campbell suggested that the Special Commission might consider the issue of the number of health plans in the context of upcoming payment reforms, but added that the issue might be one better addressed by other forums dealing with administrative issues in health care generally. Mr. Rosenberg and Ms. McAnneny agreed that whether or not the Special Commission continues meeting, substantive recommendations should be reserved until payment reform, national reform, and administrative simplification plays out in the market.

Ms. Kirshenbaum made a motion to extend the Special Commission to conduct further research. Ms. Granoff seconded her motion.

Ms. Peterson moved to amend the motion to seek funding for future research. Ms. Bennett interrupted that the Special Commission should keep in mind that to handle funds it would need to request additional authority from the Legislature. Ms. Peterson withdrew her amendment.

Mr. Rosenberg moved to amend the motion to advocate that the Special Commission continue to monitor the issue in light of forthcoming reforms rather than pursue future research. After a discussion, Mr. Rosenberg's amendment to Ms. Kirshenbaum's motion was considered unfriendly and was withdrawn.

Ms. Kirshenbaum's motion was voted on and passed.

6. Discussion of Blue Cross' Recommendations

BCBSMA submitted a written document to the Commission members entitled *Possible Framework for the Conclusion and Recommendations of the Special Commission.* The Commission members discussed the recommendations on page three of that document. The language preceding the enumerated recommendations was rejected by several members.

Mr. Rosenberg was asked to make a motion to include the recommendations in the report, which he did. Mr. Linzer seconded the motion. Several modifications were suggested for the enumerated recommendations and accepted by Mr. Rosenberg. The four modified recommendations were unanimously adopted:

(1) Continued focus should be on efforts specified in Chapter 288 as well as other ongoing collaborative efforts to simplify the administrative processes, including those processes involving information exchange with carriers regarding eligibility, benefits, deductible status and claims information for members;

(2) DOI and the Connector should continue to work with carriers to facilitate the discontinuation of close and/or frozen plans that have been closed in the market for some time;

(3) The Connector and carriers should continue to ensure that consumers and small groups are aware of their buying options through the Connector and directly from carriers; and

(4) The impact of the implementation of Chapter 288, as well as the implementation of National Health Reform, on the number of health plans should be considered as part of the Special Commission's study.

7. Future Actions

Mr. Beagan announced that copies of the report would be available to members prior to the Special Commission's next meeting on December 20th. The agenda at the next meeting will be to vote on any changes to the draft and adopt a version as the final report.

Having no other business, Mr. Beagan adjourned the meeting of the Special Commission at 11:55 A.M.

APPENDIX B. WRITTEN TESTIMONY FROM THE PUBLIC RECEIVED BY THE COMMISSION

Leadership is our business
Associated Industries of Massachusetts
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November 23, 2010

STATEMENT OF ASSOCIATED INDUSTRIES OF MASSACHUSETTS (AIM) BEFORE THE SPECIAL COMMISSION TO STUDY THE IMPACT OF REDUCING THE NUMBER OF HEALTH BENEFIT PLANS THAT A HEALTH PAYER MAY MAINTAIN AND OFFER TO INDIVIDUALS AND EMPLOYERS.

Good morning. For the record, I am Eileen McAnneny, Senior Vice President for Government Affairs and Associate General Counsel at Associated Industries of Massachusetts (AIM), the state's largest nonprofit, nonpartisan association of Massachusetts' employers. AIM's mission is to promote the well-being of its thousands of members and their employees and the prosperity of the Commonwealth of Massachusetts by improving the economic climate, proactively advocating fair and equitable public policy, and providing relevant, reliable information and excellent services.

AIM is opposed to limiting the number of health benefit plans available at this time for several reasons, including the following:

1. **We are offering a solution in search of a problem.** At the outset, and continuing throughout the discussions of the Commission, it is unclear what exactly the purpose of the Commission is and the problem we are trying to solve. Two potential issues have emerged – making it easier for hospitals to get paid for the services they provide and making it easier for consumers to purchase health care. Both of these issues would be better addressed by actions other than reducing the number of health benefit plans that insurers can offer in the marketplace. While the issue raised by providers that they are often unable to collect payment for services rendered at the point of service is a legitimate one, the solution is not to reduce the number of health benefit plans available. Whether there are 5 or 1005 health benefit plans, a provider will still not know whether or not a particular benefit plan covers the service at issue nor will the provider know whether the patient has co-insurance or a deductible that has been satisfied. The solution for addressing this issue is use of health information technology that will be able to ensure payment is collected at the point of service in an accurate and timely way.

Others have indicated that the purpose of limiting health benefit plans is to simplify administratively. Chapter 288 has established a separate commission to address that issue specifically. In addition, the Employer Action Coalition on Health Care (EACH) has a pilot program to address administrative simplification. This Commission should allow sufficient time for both entities to complete their work and report on their progress before moving ahead on a distinct course of action.

2. **Cost.** For employers, the overwhelming concern is the cost of health insurance. AIM surveys its members prior to the start of each legislative session and the cost of health insurance tops the list of issues of concern by a wide margin. Indeed, finding ways to reduce health care costs will be the overarching focus of AIM efforts for the foreseeable future. The proliferation of products is in large part in response to the need for employers to cover their employees in the most cost effective way possible. The problem with reducing the number of health benefit plans offered, like many other issues in health care, is that the goal is always about reducing cost, but somehow that reduction never finds its way into the premium.
   To reduce choice for employers, therefore, without any corresponding reduction in costs, is simply not something that AIM can support. We cannot solve the health care cost crisis on the backs of small employers.

3. **ERISA.** As you know, the Division of Insurance ("DOI") has jurisdiction over fully insured products sold in Massachusetts. The authority of the DOI does not extend to self-funded plans, as they are subject to the provisions of ERISA. In light of t he fact that almost half of the commercial insurance market is self-insured; attempts to reduce the number of health benefit plans offered would be insufficient at best to solve the problem and could limit market choice for small businesses at a time when they are struggling.

4. **Limiting choice runs counter to the other provisions of Chapter 288 and may stifle much needed innovation in the marketplace.** Chapter 288 of the Acts of 2010 contained several provisions that would, in fact, require expansion of product offerings in the small group marketplace. There is a requirement effective January 1, 2011 that all carriers offer a limited network or tiered network product that would cost 12% less than their full network. In addition, the new law allows for the establishment of 6 small business health care purchasing cooperatives that will require the creation of a new product offering by the carriers. The Connector is also required to offer products with a wellness component that will provide small business that purchase it with a 5% discount. While over time these new products may become sufficiently popular to eliminate the

need for some of the existing products that have become outdated, it will not happen overnight. Chapter 288 also made it easier for carriers to stop offering products that have limited enrollment. AIM suggests we give the provisions of Chapter 288 time to play out before requiring additional product changes in the marketplace

5. **Connector has authority currently to resolve consumer choice issue.** An additional issue that has surfaced over the course of the Special Commission's deliberations is the concern of consumer representatives who indicate that too many choices for consumers makes the process of purchasing health insurance overly complicated. That may in fact be true, but employers and consumers purchase insurance in fundamentally different ways. Individuals purchase insurance with their own particular health, financial and risk needs in mind whereas employers are purchasing for a group of individuals and their families with diverse interests. The preferable way to simplify the purchase of insurance for individuals is to have the Connector limit the choices it offers to those individual purchasers. Indeed, the Connector's primarily role as envisioned by the authors of Chapter 58 of the Acts of 2006, i.e. the Massachusetts health care reform law, was to "connect" individuals with high-value health insurance products by giving the Commonwealth's seal of approval to a subset of the products in the market that offered the best value. AIM encourages the Connector to do so if it would facilitate the purchase by individual consumers but does not believe that limiting choice in any way would facilitate the purchase of health insurance by small businesses.

6. **Timing is wrong.** Assuming that reduction in the number of health benefit plans make sense down the road, we should wait until we have a clearer vision for payment reform and the requirements of federal health care reform. Both of these envision significant changes to health plan benefit design, and to our healthcare delivery system. For example, one of the promises of payment reform is to eliminate a lot of the complexity associated with health care administration under a fee for service model. Under a global capitation model, doctors will be incented to provide the best care for the patients in the most cost-efficient and efficacious manner possible making many of the payment nuances obsolete. The Special Commission should wait until those changes go into effect before recommending reduction in health benefit plans because the reduction may not be necessary and because Massachusetts employers should not have to revamp their benefit offerings twice.

MHA

SPECIAL COMMISSION TO STUDY HEALTH BENEFIT PLAN REDUCTIONS

November 30, 2010

These comments are being submitted on behalf of the Massachusetts Hospital Association (MHA) and our member hospitals and health systems. MHA appreciates the opportunity to serve on the Special Commission to Study Health Benefit Plan Reductions. The Commission's role, as specified in Section 58 of Chapter 288 of the Acts of 2010 is "to make an investigation and study relative to the impact of reducing the number of health benefit plans that a health plan may maintain and offer to individuals and employers."

As a small employer, MHA strongly believes that it is necessary to have some choice in determining which health plan is the best fit, both financially and coverage-wise, to offer to its employees. As a trade association, MHA also recognizes and supports the need for employers to have access to cost-effective health insurance options with varying benefit designs and networks. Yet MHA believes that both these goals can be achieved without the costly proliferation of health benefit plans that currently exist in the market.

According to the Commonwealth's Division of Insurance (DOI), there are at least 300 different products offered by health plans in the small group/individual market. The actual number of plans may in fact be significantly higher as there is no standardized definition of "health benefit plan" and no agreement on how those products or plans are actually counted. By some estimates, there are thousands of products, some of which have minute differences that add cost and complexity but no real value. In order to define the impact of reducing the number of plans, it is necessary to know: how many are actually on the market? How many are still being sold? And how many are closed to new members? Additional questions that must be answered include:

- Do more insurance products foster competition or do they just add to consumer and provider confusion?
- Do more products result in lower costs for purchasers?
- How are products differentiated?
- Are employers and individuals offered the full array of products in a health plan's portfolio?
- What effect does product proliferation have on adverse selection?
- How much does it cost to maintain and offer hundreds of products, particularly those with low membership?

- What level of market disruption would result from reducing the number of benefit plans on the market?

Without the answers to these questions, it is difficult to determine what is the "right" number of insurance products on the market. However, there is ample evidence that: 1) too many products increase complexity, raise administrative costs, and result in provider confusion; and 2) the current market in Massachusetts clearly has too many products. Excerpts from several journal articles and the experience of the Massachusetts Health Connector support these points:

MASSACHUSETTS ASSOCIATION OF HEALTH UNDERWRITERS
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POSITION STATEMENT

PRESENTED TO
THE SPECIAL COMMISSION TO MAKE INVESTIGATION AND STUDY RELATIVE TO THE IMPACT OF REDUCING THE NUMBER OF HEALTH BENEFIT PLANS THAT A HEALTH PAYER MAY MAINTAIN AND OFFER TO INDIVIDUALS AND EMPLOYERS

BY THE
MASSACHUSETTS ASSOCIATION OF HEALTH UNDERWRITERS
(MASSAHU)

BASED UPON SECTION 58 OF CHAPTER 288 OF THE ACTOS OF 2010, ***AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE PROVISION OF QUALITY HEALTH INSURANCE FOR INDIVIDUALS AND SMALL BUSINESSES***

PUBLIC COMMENT MEETING
COMMONWEALTH OF MASSACHUSETTS
DIVISION OF INSURANCE
1000 WASHINGTON STREET, ROOM 111
BOSTON MA 02118
NOVEMBER 22, 2010

7.

The Massachusetts Association of Health Underwriters (MassAHU) is a state association and chapter of the National Association of Health Underwriters (NAHU). MassAHU's membership is comprised of independent, licensed insurance professionals who specialize primarily in health insurance and employee benefits for thousands of businesses and hundreds of thousands of families and individuals across the Commonwealth. Our association and members have been and continue to be active participants in healthcare reform both on the state and federal levels. It is our understanding that this Special Commission has been tasked with examining the following:

- Determining the administrative costs associated with paying claims and submitting claims for multiple health benefit plans on health payers and providers;
- Determining the costs associated with reducing the number of health benefit plans on consumer and employer choices;
- Determining the impact of limiting the number of health benefit plans on competition between and among insurance payers, including but not limited to, tiered products, limited network products and products with a range of cost sharing options; and
- Determining the potential for disruption to the market resulting from closing a health care payer's existing health benefit plans.

The law does not require that the commission recommend that the number of health benefit plans be reduced, but to report their findings on the potential impact a reduction of health plans might have.

As the association that represents thousands of employers and consumers in the Commonwealth of Massachusetts – with the primary responsibility for understanding their unique needs, goals, objectives and challenges – we have significant concerns with the thought process behind this provision of Chapter 288. Why? Because we believe in the principles of free markets, choice and competition drive down cost and improve quality – limiting the number of health plan options doesn't support those principles.

According to world-renowned economist Milton Friedman, basic economic theory suggests that free markets, choice and competition spur innovation, improve quality and drives down costs. If you look outside of healthcare – in almost every other area of our lives, this premise holds true – so why is healthcare different?

MassAHU believes the lack of transparency in provider to health plan contracting (unit cost) and responsibility for living a healthy lifestyle and making informed healthcare choices (units of service) is ultimately what contributes to the rising costs of health insurance. Health insurance is expensive because healthcare is expensive. To suggest limiting free markets, choice and competition will drive down the cost of health insurance ignores this basic economic theory.

MassAHU's position on rising healthcare costs can be framed around three fundamental principles:

1. **Transparency of cost and quality**

Notwithstanding important provisions of contract law, information about provider price and performance is essential and a significant driver of rising healthcare costs. Without transparency, it is next to impossible to ask consumers to make informed healthcare choices when they do not have the access to information to help them make those choices. MassAHU recommends making ALL provider contracts with health plans transparent – and while quality measures are also important to those decisions, we do not believe the absence of that information should prohibit the disclosure of those prices. Similar to the thought process of MA Healthcare Reform – provide universal access to health insurance first, then address cost – we believe provider costs need to be transparent to the consumer and then allow the provider community to support their prices with quality information.

2. **Reduce the variation in the rates charged by providers**

While payment reform may result in better integration of care by rewarding quality over quantity, its full benefit will not be realized unless we address the market clout of certain providers. Differences in prices between and among providers should be based on the quality, acuity and complexity of the patients served, not brand or market clout. Expansions by academic medical centers into suburban communities have increased prices by steering patients away from community hospitals despite research that community hospitals offer comparable, if not superior, care in a more cost-effective setting. The January 29, 2010 report from the Attorney General pinpoints this issue as a major driver of rising healthcare costs and MassAHU believes it is a significant driver of rising costs.

3. **Restrict and/or eliminate new costs on small businesses**

Shifting state costs onto health plans and employers through new fees, assessments, or surcharges to fund state programs or mandating new benefits will make it more difficult for employers to find affordable coverage options and will do nothing to address the underlying factors driving health care costs. Providing businesses with a range of coverage options and price points is essential to meeting the unique needs of employers and consumers dealing with the rising cost of healthcare. Reducing the number of health plan product options restricts free markets and limits competition and choice. The state should re-examine its standards for minimum creditable coverage (MCC) to provide more flexibility in benefit plan design and ensure that the standards concerning deductibles and out-of-pocket maximums are indexed with the rising cost of health care. Finally, the state should work to ensure that implementation of Federal Health Care Reform does not impose new costs on employers who are complying with state standards.

The above principles are the basis for a meaningful discussion on reducing healthcare cost increases. To suggest that limiting free markets, competition and choice will reduce costs in a meaningful way is akin to focusing on the symptoms rather than the underlying disease.

MassAHU does not support the supposition that there are too many products in the market and that they are too complex. Basic economic theory and the demand from our clients for choice and competition are the tenets of our thought process. We need to provide small businesses a range of coverage options and price points in order to match their needs with comprehensive, affordable health plan product coverage. Higher quality and lower cost health benefit plans are what our clients want - not restricted choice and limited competition.

Providing Employee Benefits and Administration for over 50,000 Small Businesses, Associations and Chambers of Commerce

Dear members of the Special Commission,

I'm Jeff Rich the managing Principal of MBA
We currently manage small group benefits for over 30k small businesses in Massachusetts
My perspective is from that of the small business person. As you're probably aware employers face a formidable challenge in trying to manage their business in the face of ever increasing health insurance premiums. Every year we have an open enrollment period in April where the businesses have a change in their rates and they must make decisions as to how to manage their premium increase. Over all the years we have gone through the April open enrollment I can't recall any time that an employer has requested fewer choices. As a matter of fact they are always looking for more choice. As carriers have gotten more innovative in plan design it has afforded employers the opportunity to better manage their premium cost increases.
We regularly enroll employers in virtually every plan available from HSA's, PPO's, High deductible health plans, HMO's, limited network plans and tiered plans. The bottom line and practical reality of health plan enrollment right now is that employers want and need choice. Choice in health plan design right now is the only tool available to employers to manage their health plan costs.
One of the key things to realize is that small employers would be put at a disadvantage over large employers as large employers in the self insured market place would not be subject to the same limited choice provision.
MBA works with small employers every day and understands better than most the pressure that these companies are under to provide cost effective health insurance and we feel that limiting the choice in plan design and subjecting them to an additional hurdle that large employers don't face will be detrimental.

Sincerely,

Jeff Rich
Managing Principal
Massachusetts Business Association
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(781) 228-2164

Louis F. Malzone
26 West Street, 3rd Floor
Boston, MA 02111
(781)-929-6484

November 30, 2010

Special Commission to Study Health Benefit Plan Reductions
c/o Walter Horn
1000 Washington Street, Suite 810
Boston, MA 02118

Re: November 22, 2010 Public Comment Meeting

Dear Members of the Special Commission:

On November 22, 2010, I appeared before the Special Commission to provide testimony regarding the impact of reducing the number of health benefit plans offered by insurers and the resulting effect on consumer and employer choice.

Since my appointment to the Board of the Commonwealth Connector Authority (CCA) in June 2006 I have voiced my opinion that the health care system is overly complex and inefficient. Specifically, I feel that there are too many choices of health plan designs. This vast array of choices is difficult to administer and generates confusion at the consumer, provider and insurance payer levels. Although there was support on the CCA Board for this position and recognition of the practicality of streamlining the CCA's own product designs, this had to be weighed against the potentially greater goal of access to health care coverage.

During the many months of work performed by the CCA the debate continued concerning the choice of plan designs and just how much choice was necessary to satisfy consumer desire and not add to the already excessive number of products in the market, and confusion and complexity for consumers.

Since most of us agree that, for the moment, a one payer system and presumably one plan design is not a viable option, I suggest that, as provided in Section 58 of Chapter 288, we should look at alternatives to reduce the number of plans available to consumers and employers who purchase insured products since this is an area over which we have some control. Reducing the number of plans by standardizing the plan designs will reduce the extremely costly administrative expenses, imbedded in the premiums we pay, that currently plague the health care system. As an added bonus, standardization of plan designs will allow consumers to better compare premiums among the various participating insurers.

A statistic that I have heard many times is that we spend $300 billion in the United States to administer the current health care system which is, on average, $6 billion per state. Assuming Massachusetts would be higher than average, or roughly $10 billion spent on administration, we could conclude that there is a potential to save $1 billion for every 10% of savings in administrative costs.

During the past 5+ years on the CCA, I have heard many people advocate for consumer choice. That choice spirits competition and is inherent in the free market system. But there should be limits to choice. Choice must be defined. Too much choice can be confusing. Does choice mean an unlimited number of plan designs? When choice adds considerable additional cost to the product, consumers will

resist. As consumers we must learn to recognize the key elements of good product design. Then, each of us can make an informed purchasing decision based upon our own risk tolerance. In this respect, health care products may begin to behave as other economic commodities.

One could sight as an analogous situation the purchasing of auto insurance. Auto insurance has compulsory insurance with minimum liability coverage; health insurance has MCC. Auto insurance has optional insurance coverages; health insurance could have standardized optional coverage (rider packages) that could be purchased with varying deductibles to allow consumers to assume various levels of risk commensurate with their individual financial situation and tolerances.

One could also look to the auto industry to see what happens when markets don't act on consumer preferences. Had GM, Chrysler and Ford recognized that a focus on a limited number of car models, as Toyota and Honda did, it would have allowed them to divert dollars and energy to improved quality and lower costs. As an example, I was informed by a member of the Special Commission who had worked in the auto industry that Cadillac once offered 72 different configurations of the Escalade. Too much choice? I think so!

Most people, when asked if they want choice will say yes, but without knowing the scope of choice and the associated cost implications of unlimited choice, it would be an uninformed response.

Although many of the individuals who commented on November 22, 2010 advocated to continue to allow choice and not to have government involved with limiting the number of insured products, none of them could define or was willing to set parameters on choice. When questioned by Special Commission members there was hesitancy on all of their parts to say unlimited choice was the proper approach.

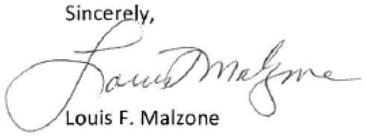
As a member of the broker community put it, "the number of plans available in the market is overwhelming!" and even he can't keep up with all of them.

Some suggested in their oral testimony that administrative costs represent only 10% of the cost of health care and reducing this isn't worth the effort. I would take exception and say that effecting a reduction in costs of administration could be done quickly and show immediate returns. The more complex issues there are surrounding medical cost and quality the tougher they will be to solve.

I am convinced from listening to consumers, brokers, providers, and yes, even insurers, that the imbedded administrative costs resulting from too much choice is an overwhelming expense which requires providers, especially, to spend large amounts of time and money tending to the administrative issues rather than focusing on providing "care" to their patients!

So together, let us bridge the gap and find a legitimate solution to reducing the number of plans and plan designs that will satisfy the advocates for consumer choice but allow the system to function efficiently and cost effectively.

Sincerely,



Louis F. Malzone
Board Member- Commonwealth Health Connector Authority
Executive Director- SEIU Local 615 Affiliated Benefit Funds
Executive Director- IUOE Local 877 Health and Welfare Fund
President- Massachusetts Coalition of Taft Hartley Funds

Small Business Service Bureau, Inc.

National Operations
Service Center
554 Main Street
P.O. Box 15014
Worcester, MA 01615-0014
Member Services
Toll Free 1-800-472-7199
www.sbsbhealth.com

November 22, 2010

Mr. Walter Horn
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02218

Subject: Special Commission

Dear Mr. Horn,

I am submitting comments to the Special Commission charged with investigating and studying the impact of reducing the number of health benefit plans that a health payer may maintain and offer to individuals and employers.

The number of health benefit plans administered in the small and non-group market far exceeds the number sold for new enrollments, due in part to the restrictions on elimination/reduction of benefit plans that may contain active enrollments. These products are maintained for renewal business, and are often referred to as grandfathered, scheduled for future sunset, etc.

Servicing clients in "old" products adds to health insurance administrative cost; infrastructure is needed to maintain rating, billing, and claims payment systems, while enrollments decrease over time due to natural attrition. A streamlined, organized "shut-down" process for obsolete product offerings could reduce the overhead related to the current regulatory process.

On behalf of the small employer members of Small Business Service Bureau, Inc. (SBSB), I request the commission re-examine the method by which irrelevant and outdated products are removed from the market. Specifically, could revised regulations allow for transfer of impacted members to a replacement benefit option?

I appreciate your consideration of these comments. Please feel free to contact me at 508-770-0195 if you have any questions.

Sincerely,

Lisa M. Carroll
President

TOWN OF WELLESLEY

MARC V. WALDMAN
Treasurer & Collector

Tel (781) 431-1019 Ext. 2266
Fax (781) 237-5037

OFFICE OF THE TREASURER/COLLECTOR
525 Washington Street
Wellesley, MA 02482

November 17, 2010

The Special Commission
Attn: Walter Horn
1000 Washington Street, Suite 810
Boston, MA 02118

Dear Commission Members:

I am writing to express my objection to any effort by the Commonwealth of Massachusetts to restrict the number of health plan offerings that health care companies could provide to employers. I believe it is presumptuous for any government agency to believe that its judgment can supplant an employer's judgment regarding the type of health plan offerings that are in the best interest of that employer and its employees and retirees. Decisions regarding health plan offerings vary tremendously depending on an employer's location, size, workforce demographics, workforce education level and collective bargaining obligations.

The Town of Wellesley (and many other municipalities) is a member of a municipal joint purchasing group consisting of 16 municipal members, known as the West Suburban Health Group (WSHG), . This consortium has over 10,000 subscribers (actives and retirees), providing coverage to more than 20,000 people. WSHG currently offers 11 active plans through 4 carriers and 8 retiree Medicare supplement plans, also through the same 4 carriers.

The WSHG is one of a small number of purchasers in the state that currently offers several tiered network products. WSHG may also consider offering restricted network products in the future. In some circles, these two product designs are touted as the future of health plans. However, due to collective bargaining limitations, not all WSHG members can move to these plan designs at

the same pace. Therefore, as a transitional tool, the consortium must maintain a larger number of plan offerings. This situation will continue as health plans evolve and any artificial restrictions on the type and number of health plans available to employers could blunt future efforts at cost containment and quality improvement.

I believe that the WSHG's circumstances are similar to other large employers that might have multiple sites or a combination of unionized and non-unionized workforces. This will also be true for the small business group purchasing cooperatives that are envisioned in Section 34 of C.288 of the Acts of 2010. The type of limitations that this Special Commission is evaluating, could end up reducing the effectiveness of these cooperatives before they ever get started.

Thank you for considering my position.

Sincerely,

Marc V. Waldman

Treasurer

Comments from Gerry Belastock, Owner, CGR Insurance

1. Complexity results from government mandates and regulation as well as insurers' attempts at differentiation. Employers--almost none of whom are specialists in teasing out the differences among group health policies--are *FIRST* concerned with cost of premiums and *SECOND* with the out-of-pocket expenses their employees will have to pay. When a plan has multiple tiers of providers, each with a deductible and some then calling for copays, it is extremely difficult to evaluate and compare with competing plans. A simple reduction in the number of plans will not directly reduce complexity.

2. If the Commission's goal, "...to Study Health Benefit Plan Reductions", is to serve a purpose, I suggest that it be to help employers to compare the relative benefits their employees will receive from each of a large number of different plans. Actuaries at each of the insurers are capable of providing relative values of the benefits in every one of their plans. At the same time I make this claim, I realize the issue of "trade secrets" comes into play. To address this, insurers could be instructed to append to the names they give their plans a term such as "Relative Value: 0.95 to 1.00". Employers--and brokers too(!)--would then be in a far better position to discuss plans with similar levels of benefits. This would have the additional advantage of not infringing on insurers' desires to seek market differentiators in the form of rearranged deductibles and copays or $400/family health club reimbursements compared to $150 for the employee only. Rather, an insurer offering two plans in the 0.95 to 1.00 range where one has a $500 deductible followed by $100 emergency room copay and the other has a $100 copay followed by $500 deductible, would decide to eliminate one plan. It seems to me that, given a requirement to prominently post the "Relative Values" of each of their plans, insurers would be reluctant to offer more than one or two plans in a particular range and they might automatically respond by eliminating those plans with few buyers.

3. One area that would clearly ***increase*** the number of plans, but which needs to be addressed very soon is the loosening of MCC requirements. At the very least MA residents must be allowed to purchase plans with higher deductibles and out-of-pockets. The other "floor" under MCC requirements should be the rules--as they are evolving--coming to us from HHS under PPACA. I realize this is not part of the Commission's charge, but it represents one area where additional health plans ought to actually be mandated!

4. The Special Commission's name should be changed "...to Study and Make the Best Use of Health Insurance Complexity".

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APPENDIX C. QUESTIONNAIRES (AS DISTRIBUTED) AND RECEIVED RESULTS

Guidelines For Special Commission Stakeholder Questionnaire

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

[*Here are some examples of possible ways of dividing (more than one may be selected):*

(i) by various cost sharing arrangements (co-pays, deductibles, etc.); (ii) by various benefits offered in addition to Minimum Creditable Coverage; (iii) by groups of providers eligible for payments under the plan; or (iv) the manners in which medical necessity is determined or other features of utilization review.]

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.

[*Here are examples of three possible responses:*

A. (i) determining eligibility for benefits (40%); (i) collecting co-pays (30%); (iii) determining allocation of obligations between patient and carrier (20%); and (iv) other (10%).

B (i) determining whether/what proportion of some medical procedure will be covered by one's plan 40%; estimating which plan will be most costly by the end of the policy term (25%); (iii) estimating which plan will provide the richest benefits for the money (25%); and (iii) figuring out how to shop for various alternatives that may be available (10%).

C (i) designing new products (20%); (ii) marketing new products (20%); (iii) continuing to service old products that are no longer being marketed (20%); (iv) explaining product features to existing consumers (20%); closing old products (25%).]

Please explain your estimates.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

4. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item.

[*Here is an example of two possible responses:*

A (i) allows for as close as possible matching between ability to pay and available programs (35%); (ii) prevents a "race to the bottom" for provision of benefits to lower income individuals (35%); (iii) contributes to product innovation in the area of cost-containment (30%).

B (i) produces the lowest possible total health care costs consistent with policyholder wishes (30%); (ii) allows businesses to compete more efficiently in the area of employee benefits (30%); (iii) reduces the flight to the unregulated market that can be expected to result from excessive standardization (30%); (iv) other (10%).]

Please explain your estimates.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from <u>*the process*</u> of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: (i) explaining changes to stakeholders, (ii) closing existing programs,(iii) loss of buyer choice/individualized packages, (iv) reduction in seller cost-containment innovation,(v) loss of business to self-insurance, etc.*

Please explain your estimates.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

Response From Health Care For All

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

[*Here are some examples of possible ways of dividing (more than one may be selected):*

(i) by various cost sharing arrangements (co-pays, deductibles, etc.); (ii) by various benefits offered in addition to Minimum Creditable Coverage; (iii) by groups of providers eligible for payments under the plan; or (iv) the manners in which medical necessity is determined or other features of utilization review.]

Consumers count health benefit plan types by the cost sharing arrangements. This includes the benefit variations of HMOs, PPOs and POS plan types. Additionally, consumers consider whether the plan (as defined by benefit design) is offered by each carrier. For example, if BCBS has one plan with a specific cost-sharing arrangement and HPHC has the same cost-sharing arrangement, this would be the same plan offered by two different carriers.

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.

Consumers in the individual market can expend significant financial and personal resources in dealing with multiple variations of plan offerings. For this reason, we were very supportive of the Connector's decision to standardize plans.

Prior to deciding on a plan to purchase, a consumer must do extensive research to determine if the plan is the right one for them. This can take 5 minutes or tens of hours depending on the individual. Further, consumers expend significant resources in determining how much their contribution will be for a given course of treatment. This is exacerbated by benefit structures that include a combination of co-insurance, co-payments and deductibles.

For those receiving employer-sponsored insurance, individuals are frequently in a position where the benefit structure and carrier changes each year. The burden of learning a new system and new structure on an annual basis causes countless hours of lost time.

According to a report done by Consumers Union and the Medicare Rights Center (see attached), wide variation in benefit design does not provide consumers with sufficient protections: "insurers are well versed in shifting costs onto the sickest plan enrollees through hard-to-decipher benefit designs. For example, the absence of standardized benefit designs means many people with Medicare can, and do, select a Medicare Advantage plan that will charge them more for high-cost treatment, including chemotherapy or rehabilitation in a skilled nursing facility after a stroke, than they would pay under Original Medicare or under a different Medicare Advantage plan." Consumers are placed in an unnecessarily vulnerable position as a result of the lack of standardization in product offerings.

[*Here are examples of three possible responses:*

A. (i) determining eligibility for benefits (40%); (i) collecting co-pays (30%); (iii) determining allocation of obligations between patient and carrier (20%); and (iv) other (10%).

B (i) determining whether/what proportion of some medical procedure will be covered by one's plan 40%; estimating which plan will be most costly by the end of the policy term (25%); (iii) estimating which plan will provide the richest benefits for the money (25%); and (iii) figuring out how to shop for various alternatives that may be available (10%).

C (i) designing new products (20%); (ii) marketing new products (20%); (iii) continuing to service old products that are no longer being marketed (20%); (iv) explaining product features to existing consumers (20%); closing old products (25%).]

Please explain your estimates.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

Consumers would expend fewer resources evaluating, purchasing and using their health plans if there were fewer plans and these plans were standardized. Requiring caps on all out-of-pocket costs and ensuring that all cost-sharing (co-pays, coinsurance, deductibles) count towards this cap will afford consumers with financial protections. Additionally, standardizing benefit designs will drive competition on the basis of premiums among products that are easy to compare. Consumers will be able to choose based on provider network and quality of care delivered by those providers. More standardization should allow for clearer, more easily understandable plan information for consumers.

4. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item.

While consumers value choice, the number of plans available is overwhelming. Consumers are not able to make meaningful decisions other than on price. Oliver Wyman indicated that people are able to make more informed decisions when the options are clear and limited in number. The limited benefits of consumer choice should be weighed against the ability of those choices to be informed.

[*Here is an example of two possible responses:*

A (i) allows for as close as possible matching between ability to pay and available programs (35%); (ii) prevents a "race to the bottom" for provision of benefits to lower income individuals (35%); (iii) contributes to product innovation in the area of cost-containment (30%).

B (i) produces the lowest possible total health care costs consistent with policyholder wishes (30%); (ii) allows businesses to compete more efficiently in the area of employee benefits (30%); (iii) reduces the flight to the unregulated market that can be expected to result from excessive standardization (30%); (iv) other (10%).]

Please explain your estimates.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

Not Applicable

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from *the process* of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: (i) explaining changes to stakeholders, (ii) closing existing programs,(iii) loss of buyer choice/individualized packages, (iv) reduction in seller cost-containment innovation,(v) loss of business to self-insurance, etc.*

Please explain your estimates.

If we were to significantly reduce the number of health plans, there would inevitably be individuals who would lose their current health plan. There are some individuals who are in 'legacy' plans that result from guaranteed issue in Massachusetts. These individuals will have to change from these policies to different plans and this may be a challenging adjustment for them. An example would be if the indemnity plans were closed and someone then had to shift to an HMO model with higher cost-sharing.

Product innovation is important, but it is unclear how much innovation is occurring in the fully-insured market. Individuals who purchase plans are looking at a few key components: cost-sharing, premiums and benefit design. Recent plan design changes have tended to focus on increasing cost-sharing, modifying prescription drug tiers and altering benefits in an attempt to keep premium rates low.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

The Oliver Wyman proposal indicated that for the majority of plans (by their definition) membership was very low. There were some plans that had significant membership. It appears that the low membership products should be those that are eliminated first if we were to reduce

plan offerings. We should develop a transition process to reduce the current number of offerings so that all participants can adjust.

Additionally, limiting plan offerings does not mean that new plans cannot be introduced. Rather, the intent is that we reduce to current number of plans and evaluate new plans. We should develop a process by which plans are reviewed every 4-5 years so that we ensure the number and variety of plans is good for all participants in the market.

We have included a copy of an article entitled, Role Models and Cautionary Tales: Three Health Insurance Programs Demonstrate How Standardized Health Benefits Protect Consumers, done by the Medicare Rights Center and Consumers Union with our response. This article looked at consumers and included focus groups who evaluated the complexity of health plan offerings and their affect on consumers.

MHA Survey: Reducing the number of Health Plan Benefit Options

What do you think is the biggest advantage of reducing the number of health plan benefit options?

- Less variability leads to consistent policies and easier training
- Less time expended determining the differences
- Time for Admitting and Patient Accounting to handle other things; reduction in denials resulting from difficulty keeping track of numerous policies and procedures
- Simplification on the front end
- Ease the administrative burden in operational areas
- Administrative simplification due to simpler insurance masters, plan code dictionaries, contract models, registration errors
- Less confusion for facilities and patients
- Less confusion relative to benefits and coverage
- Fewer authorization errors and claim denials
- Improved patient registration, collection of co-pays and deductibles, easier to model expected payments
- Reduced confusion from patients and hospital staff
- Insure collection of proper patient responsibility, reduction in bad debt expense

What do you think is the biggest disadvantage?

Less flexibility in benefit design for employers (5)

Less choice for consumers (8 respondents)

Seven hospital respondents saw no disadvantage to reducing the number of available options.

MHA
(cont.)

Health Benefit Plans

1. What is the primary way that you measure/distinguish among the number of health plan products that are offered (in other words, how do you count the number of different benefit plans that your hospital accepts)?

	Response Percent	Response Count
Cost sharing arrangements (e.g.) different co-pays or deductibles so that an HPHC plan with a $15 co-pay is considered a different product that a plan with a $20 copay even if the benefits are identical	9.5%	2
Different benefit package	0.0%	0
Type of plan (Blue Cross HMO, Blue Cross PPO, Blue Cross select network product)	**85.7%**	**18**
Other (please specify)	4.8%	1
Other (please specify)		2
answered question		**21**
skipped question		**0**

2. What are the main costs/challenges (financial or otherwise) associated with a large variety of health benefit plans? Please indicate which of these processes are the most difficult (level 1) to the least difficult (level 3) to manage when you have multiple health plan products.

	1 Most difficult	2 Moderate	3 Least difficult	Rating Average	Response Count
Determining eligibilty	19.0% (4)	33.3% (7)	**47.6% (10)**	2.29	21
Collecting the correct co-payments from patients	**71.4% (15)**	19.0% (4)	9.5% (2)	1.38	21
Determining coverage for medical procedures	**52.4% (11)**	42.9% (9)	4.8% (1)	1.52	21
Determining authorization requirements	**75.0% (15)**	25.0% (5)	0.0% (0)	1.25	20
Determining which providers are in the network	20.0% (4)	**50.0% (10)**	30.0% (6)	2.10	20
Submitting the claims	5.3% (1)	**47.4% (9)**	**47.4% (9)**	2.42	19
Reconciling the payments	30.0% (6)	**50.0% (10)**	20.0% (4)	1.90	20
			answered question		**21**
			skipped question		**0**

3. If the number of different health plan options offered in the market were reduced by 50%, approximately how much would you be able to reduce your hospital's administrative costs?

	Response Percent	Response Count
10%	15.8%	3
20%	5.3%	1
30%	10.5%	2
40%	0.0%	0
50% or more	0.0%	0
Unlikely to see any significant reductions unless the remaining products were standardized	68.4%	13
answered question		19
skipped question		2

4. What do you think is the biggest advantage of reducing the number of health plan benefit options?

	Response Count
	21
answered question	21
skipped question	0

5. What do you think is the biggest disadvantage to reducing the number of health plan benefit options?

	Response Count
	21
answered question	21
skipped question	0

6. Please complete the demographic information. Individual hospital responses will NOT be shared. Aggregate information will be shared with the DOI.

	Response Percent	Response Count
Name:	100.0%	21
Hospital:	100.0%	21
Email Address:	100.0%	21
answered question		21
skipped question		0

Commonwealth Connector Response to Questionnaire

Background / Overview

The Massachusetts Health Insurance Connector Authority (Health Connector) was established as part of the landmark Massachusetts healthcare reform legislation (Chapter 58) that was signed into law on April 12, 2006. The Health Connector collaborates with health insurance carriers to administer two programs:

- Commonwealth Care is a subsidized program for adults who are not offered employer-sponsored insurance, do not qualify for Medicare, Medicaid or certain other special insurance programs, and who earn up to 300% of the Federal Poverty Level (FPL)

- Commonwealth Choice is a program for individuals and families who make more than 300% FPL and small businesses with 50 or fewer workers in the state to purchase unsubsidized health insurance.

  Seven private health insurance carriers (carriers) participate in the Commonwealth Choice Program:

  ✓ Blue Cross Blue Shield of Massachusetts
  ✓ CeltiCare Health Plan of Massachusetts
  ✓ Fallon Community Health Plan
  ✓ Harvard Pilgrim Health Care
  ✓ Health New England
  ✓ Neighborhood Health Plan
  ✓ Tufts Health Plan

  These carriers have received the Connector's "Seal of Approval" to offer a range of health benefit plans. These health benefit plans are grouped by level of benefits and cost-sharing into the following "benefit tiers":

  ✓ Gold
  ✓ Silver (High, Medium, Low)
  ✓ Bronze (High, Medium, Low)
  ✓ Young Adult Plans

  Each of the plans offered through the Health Connector by the seven carriers may also be purchased directly from the individual carriers.

  From the perspective of the Health Connector, this survey is most relevant to our Commonwealth Choice program.

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

[*Here are some examples of possible ways of dividing (more than one may be selected):*

(i) by various cost sharing arrangements (co-pays, deductibles, etc.); (ii) by various benefits offered in addition to Minimum Creditable Coverage; (iii) by groups of providers eligible for payments under the plan; or (iv) the manners in which medical necessity is determined or other features of utilization review.

As outlined in the "Background / Overview" section, carriers provide a plan for each of the following benefit tiers:

- ✓ Gold
- ✓ Silver (High, Medium, Low)
- ✓ Bronze (High, Medium, Low)
- ✓ Young Adult Plans

Several core benefit categories and cost sharing features are standardized for a given benefit tier. For example, plans offered by carriers in the Gold tier must have a PCP co-pay of $20 and no annual deductible.

We believe that standardizing core benefit categories and cost sharing features allows consumers purchasing insurance through Commonwealth Choice to have the ability to compare plans on an "apples-to-apples" basis.

In other words, they can compare Gold plans across seven carriers with the knowledge that core benefit categories and cost sharing features are the same for all plans. This allows them to make their decision to buy insurance based on premium, network, or other criteria relevant to their needs.

There also needs to be consideration for how the Patient Protection and Affordable Care Act (PPACA) enacted in March 2010 envisions five benefit tiers (Platinum, Gold, Silver, Bronze and Catastrophic) being sold through exchanges starting 2014.

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.

[*Here are examples of three possible responses:*

A. (i) determining eligibility for benefits (40%); (i) collecting co-pays (30%); (iii) determining allocation of obligations between patient and carrier (20%); and (iv) other (10%).

B (i) determining whether/what proportion of some medical procedure will be covered by one's plan 40%; estimating which plan will be most costly by the end of the policy term (25%);

(iii) estimating which plan will provide the richest benefits for the money (25%); and (iii) figuring out how to shop for various alternatives that may be available (10%).

C (i) designing new products (20%); (ii) marketing new products (20%); (iii) continuing to service old products that are no longer being marketed (20%); (iv) explaining product features to existing consumers (20%); closing old products (25%).]

Please explain your estimates.

There are varying consumer perspectives regarding how many health benefit plans are required for "sufficient choice" and at what point there starts to be "too much choice". This will also vary based on the market segment that the consumer represents.

In other words, individuals may be able to choose an appropriate health benefit plan from fewer choices than large employers who may be seeking more variation and customization in plan design and funding. This is a key distinction that needs to be better understood.

To that end, research should be conducted to understand consumer perspectives on this issue with particular attention to any differences by the various market segments:

- Individual / Non-Group
- Mini-Groups
- Small Groups
- Mid Sized Groups (Fully Insured)
- Mid Sized Groups (ASO)
- Large Groups (Fully Insured)
- Large Groups (ASO)

For those consumers who are looking for less complexity in terms of product choices and benefit designs, the Connector provides a streamlined online shopping experience that allows consumers to compare standardized plans across carriers. This allows consumers to compare "apples to apples" when buying health insurance.

In addition, there is a significant cost associated with maintaining "frozen plans". Frozen plans are health benefit plans that are no longer available for purchase by new members through Commonwealth Choice, but are maintained for renewing members.

Each additional frozen plan that may not be closed or "sunsetted" represents additional administrative complexity. Plan design changes, carrier file exchanges, and internal reporting and financial analysis are made more complicated with each frozen plan that must be maintained. In addition, performing customer service is more complex with a large number of frozen plans and requires additional training of call center and administrative staff to continue to service these products to renewing customers.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a

reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

Administrative costs and customer service challenges associated with maintaining a large number of frozen plans could be significantly ameliorated if the process to close or sunset plans were streamlined.

A reduction in the number of frozen plans, especially those plans with low enrollment, would significantly reduce administrative costs associated with internal plan maintenance, carrier file exchanges and customer service.

4. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item.

[*Here is an example of two possible responses:*

A (i) allows for as close as possible matching between ability to pay and available programs (35%); (ii) prevents a "race to the bottom" for provision of benefits to lower income individuals (35%); (iii) contributes to product innovation in the area of cost-containment (30%).

B (i) produces the lowest possible total health care costs consistent with policyholder wishes (30%); (ii) allows businesses to compete more efficiently in the area of employee benefits (30%); (iii) reduces the flight to the unregulated market that can be expected to result from excessive standardization (30%); (iv) other (10%).]

Please explain your estimates.

The existence of a large variety of health benefit plans provides consumers with more choice, which needs to be balanced against the administrative and other downstream costs associated with providing this choice. There are varying consumer perspectives regarding how many health benefit plans are required for "sufficient choice" and at what point there starts to be "too much choice", which likely varies based on market segment. This distinction needs to be better understood through research as outlined in the response to Question 2.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

The impact on consumer choice of reducing the number of active health benefit plans that can be sold depends on the market segment. As mentioned in the response to Question 4, additional research should be conducted to understand this impact.

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from *the process* of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: (i) explaining changes to stakeholders, (ii) closing existing programs,(iii) loss of buyer choice/individualized packages, (iv) reduction in seller cost-containment innovation,(v) loss of business to self-insurance, etc.*

Please explain your estimates.

The process of significantly reducing the number of health benefit plans would not have a significant impact on costs or operations. Most of these processes already exist and are scalable.

The changes include updating existing communications to existing and prospective members, conducting trainings for call center and administrative staff and some website changes.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

AIM Response to the Special Commission on Health Benefit Plan Reduction

Stakeholder Questionnaire

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

Employers generally divide up or count health benefit plan types according to the various cost sharing arrangements and the various benefits offered. HDHP, HMO, PPO, POS, HSA qualified and limited networks are all plan "types," within each plan "type" are various options which can raise the total count of such products in the marketplace to over 200.

For many small businesses, due to insurance underwriting and participation requirements, they would offer one benefit plan to their employees. For larger employers, they typically would offer an HMO product and a PPO product, which have both different cost sharing and different benefits.

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.

[*Here are examples of three possible responses:*

A. (i) determining eligibility for benefits (40%); (i) collecting co-pays (30%); (iii) determining allocation of obligations between patient and carrier (20%); and (iv) other (10%).

B (i) determining whether/what proportion of some medical procedure will be covered by one's plan 40%; estimating which plan will be most costly by the end of the policy term (25%); (iii) estimating which plan will provide the richest benefits for the money (25%); and (iii) figuring out how to shop for various alternatives that may be available (10%).

C (i) designing new products (20%); (ii) marketing new products (20%); (iii) continuing to service old products that are no longer being marketed (20%); (iv) explaining product features to existing consumers (20%); closing old products (25%).]

Please explain your estimates.

For employers, there is no direct cost to having a large variety of health benefit plans in the Commonwealth. For larger employers who are self-insured, they typically customize their benefit plan to meet their financial needs and the health and financial needs of their employees making the number of plans offered largely irrelevant. For smaller employers, the large array of products allows them to choose the product that best suits their financial, competitive and health and wellness needs. This decision is typically made with the assistance of a broker who uses his expertise to winnow down the choices to 5-6 choices within the employer's price range.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

AIM 's membership does not perceive any costs/disadvantage to a wide array of products that might be mitigated through a reduction in the number of health plans. As a representative of AIM members, and as a result of conversations with stakeholders on this Commission and elsewhere, I can see that there is value in reducing the complexity associated with many different plan designs that complicates payment at the point of service, however, unless the cost savings associated with simplification are returned to the employers and other purchasers of health insurance, it would seem that reduction of health benefit design would be received negatively by small businesses and the fully insured and would not have a significant impact on the self insured.

4. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item.

The benefits of having a wide array of health benefit plans are numerous and vary considerably among members of the employer community. Different industries have different competitive pressures and different profit margins. For low-margin, small businesses like a restaurant or retailer; they may offer insurance to avoid government penalties for not doing so and managing the cost of health care may be their primary concern. For them, finding the product that allows them to provide health insurance at a reasonable price may be the goal. For other industries that compete for a highly skilled workforce, like professional services or biotechnology, the primary concern for an employer may be attracting and retaining talent. For those industries, offering an innovative and competitive benefit package that focuses on overall health of their particular employees and their particular health needs determined through claims data may be the primary concern. For other companies, the corporate philosophy may place an emphasis on personal responsibility and the notion that people need to be accountable for their lifestyle choices. For those companies, there is an intentional emphasis on rewards and incentives for making healthy choices and penalties for personal choices, such as smoking, that adds to the cost of health. For all of these employers, their purpose for offering insurance differs and the product they purchase to meet their needs varies.

The Division of Insurance offered several suggestions for what the main benefits of offering a variety of choices could be. They include: (i) allowing for as close as possible matching between ability to pay and available programs; (ii) preventing a "race to the bottom" for provision of benefits to lower income individuals; (iii) contributing to product innovation in the area of cost-containment; (iv) allowing businesses to compete more efficiently in the area of employee benefits. Other reasons include: (v) getting the most value from your health care dollar by tailoring your benefit plan to the specific needs of your employee population using claims data, health risk assessments, biometric and other tools with the goal of keeping your employees healthy, more productive and present at the workplace. All of the aforementioned are important in varying degrees and order of priority for the employer community.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

While AIM is not able to provide estimates because of the variation among our membership, it is clear that an array of benefit plans and product designs is a positive thing for the employer community. Again, for the self-insured who are not subject to the authority of the Division of Insurance because of ERISA preemption, and who comprise almost half of the insured market, their ability to innovate and design a health benefit plan that meets their needs is far greater than those employers who are fully insured and would not be subject to any limitations imposed on the insured market. For those employers in the fully insured market, there could potentially be some benefit to reducing the number of health benefit plans offered if, and only if, the reduction in product offering translated into lower premiums. For all businesses, the cost of health insurance is a primary concern and they may be willing to entertain trade-offs to lower the cost.

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from *the process* of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: (i) explaining changes to stakeholders, (ii) closing existing programs,(iii) loss of buyer choice/individualized packages, (iv) reduction in seller cost-containment innovation,(v) loss of business to self-insurance, etc.*

For employers, there are several costs to changing health benefit plans. Among them are the administrative costs of researching different plans, including any regulatory, legal and system changes necessary to doing so. There is the cost of educating employers on the changes and producing educational materials. Often, changes are perceived negatively as a reduction in benefits so there are significant resources that must be devoted to making the case for why the changes are necessary and why they may be a good thing. The most obvious cost could be the additional cost of purchasing a different product if the lower cost product offering of an employer is no longer available.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

BCBSMA Response to Special Commission Stakeholder Questionnaire

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

Blue Cross Blue Shield of Massachusetts (BCBSMA) defines its standard health benefit plans principally based on differences in benefits, cost sharing, geographic coverage and provider network. These standard health benefit plans are offered on a consistent basis to all individual and small group customers. For large groups, in the past we sought to offer largely the same standard benefit plans, but now find it necessary to offer variations in standard plans due to accommodations needed for government mandates, such as meeting the requirements of Federal Mental Health Parity and grandfathering under National Health Reform that apply to large employer groups. In addition, we allow customization of benefits and cost sharing through riders to standard plans, by our various business segments, with the range of customization permitted directly related to the size and financial arrangement of the customer. We do not allow customers to modify our provider networks.

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item. Please explain your estimates.

As the largest carrier in Massachusetts, BCBSMA believes the affordability of high quality health care coverage for our customers is the most pressing challenge facing all constituents in our industry. To this end, our administrative costs make up less than 10% of every premium dollar collected. More importantly, we continue to take steps to manage these costs, while maintaining outstanding service levels and striving to find new ways to make it easier and more efficient for our customers and providers to do business with us.

BCBSMA continuously assesses the plans we offer and the needs to our customers. On a regular basis, BCBSMA will close a plan to new sales, if there is no longer a need for it. In addition, we will discontinue plans entirely, as permitted by law and regulation. For example, effective January 2011, BCBSMA reduced the number of standard plans being offered directly to individuals and small businesses from 33 to 20, a reduction of 39% (not including the 11 plans required to be offered through the Connector). In addition, we are entirely discontinuing 13 plans beginning January 1, 2011, with dwindling membership that were previously closed. With the passage of Ch. 288, we believe there is an expanded opportunity to discontinue more plans that have been closed for some time with dwindling membership.

BCBSMA very carefully manages its product development and marketing costs related to its product portfolio. The average percentage of our annual administrative expenses for development of new products is .33% and for marketing support for our product portfolio is 4%, which in total accounts for less than .45% of total premium. As a carrier, we have invested in

deploying technology that enables individuals and employers to select a plan, enroll and renew all electronically, without the use of paper forms. These efficiencies keep the management of our product portfolio at as low a level as possible, significantly less than the administrative fee, for example, charged to BCBSMA by the Connector for similar administrative services for plans offered through the Connector.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%. Please explain your estimates.

BCBSMA does not believe that arbitrarily reducing the number of standard plans or allowable customization would generate meaningful savings in health plan administrative costs, given the small portion of administrative costs devoted to maintaining the portfolio and the efficiencies already in our systems for exchanging information with customers and providers, as noted above. Moreover, approximately one half of our 3 million members are covered through plans established by self-funded employer groups that would not be covered by any mandated limits on plan designs, which would further serve to mitigate any possible savings and likely lead to more employers choosing self-funding in order to retain the flexibility they need.

As stated previously, BCBSMA already has streamlined and restructured its standard plan offerings, particularly for individuals and small groups, reducing our number of standard plans by 39%. We continue to discuss with the Connector ways that it can support our efforts to reduce the number of plans in the merged market by allowing carriers more flexibility in the plan designs the Connector requires, possibly using actuarial values as provided for under National Health Reform, rather than specifying unique plan designs for their seal of approval .

4. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item. Please explain your estimates.

BCBSMA believes that choice from a range of plans is important for its customers to be able to meet their coverage as well as financial needs. Further, a range of benefit designs at different price points enables businesses to work with BCBSMA to plan multi-year health benefit strategies in order to manage health care costs for the business and their employees. BCBSMA provides coverage to almost 50,000 non-group individuals, as well as over 2.8 million members covered by almost 40,000 employer groups including solo proprietorships and other small businesses with up to 50 employees and larger customers that range from 51 employees to many thousands of employees locally and throughout the United States. This variation in customers demands a broad range of product solutions and flexibility.

Although individuals who buy directly represent a small segment of our total membership, BCBSMA has been able to effectively explain our product options in an easy to understand way and to meet a range of consumer needs. We have been able to do this online through our streamlined Web shopping site offering our more popular plans for individual purchasers as well as additional options and information available through our consumer telesales team. At the same time, the Connector offers a smaller subset of our plans to consumers through its Web shopping tool. It is worth noting that of our almost 50,000 non-group members, over 80% have purchased directly from BCBSMA compared with the balance purchasing through the Connector, which offers a much smaller selection of our plans. We feel this affirms our belief that choice of plans does not deter or confuse most consumers, but rather enables us to satisfy the needs of a broader range of individual purchasers. That being said, for those individuals who prefer the more limited choice of plans offered through the Connector shopping site, we advise consumers that this option is available to them through the Connector.

In terms of employer groups, both small and large, we are firmly convinced that a range of options enables groups to buy the right amount of coverage to fit their budget and employee needs. Restricting choice is likely to result in a misfit of coverage for some employers, thereby potentially increasing costs to them and their employees. In fact, most employer group customers also utilize brokers or benefit consultants to support them in choosing the best plan or plans to meet their needs. As such, the range of choices we have in our product portfolio enables these advisors to work with their clients, to find the best plan for the employer. Ultimately, the employer will consider a limited number of choices which ultimately is narrowed down further to one, two or three options offered to the employees.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

We believe that arbitrarily reducing the number of plans that carriers are able to offer will not only adversely impact the choice available to our customers, but it is likely to increase their costs, as employers and consumers with fewer choices of plans may end up with more coverage than they want or a lower priced plan with more out-of-pocket costs than necessary. We are also concerned that restrictions in the number of plans will inhibit the development and deployment of innovative plan design options, which in the current environment of rising costs, is an important tool for carriers and their customers to manage costs. As noted above, BCBSMA has significantly reduced the number of standard plans offered to individuals and small groups beginning January 1, 2011 by 39 % and in addition will be discontinuing entirely 13 previously closed plans with dwindling membership. We believe that doing this in response to the changing needs of our customers, rather than to meet an arbitrary guideline is in the interest of employers, members and the community.

Also, given the extensive level of automation in our sales and administrative processes and the very small portion of our administrative costs associated with these activities, we do not

believe there would be significant savings from the potential reductions above. Furthermore, as noted previously, we have been continuously streamlining our portfolio, long ago closing any plans with low membership, which would mean further closings would affect plans with significant membership, which would necessitate continuing to renew those plans for existing members for some time to come, thereby further offsetting any possible savings.

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from *the process* of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: (i) explaining changes to stakeholders, (ii) closing existing programs,(iii) loss of buyer choice/individualized packages, (iv) reduction in seller cost-containment innovation,(v) loss of business to self-insurance, etc.* Please explain your estimates.

We believe there would be considerable potential for disruption and confusion among individual and employer group customers from the process of arbitrarily trying to reduce the number of health plans. The process of closing plans to new sales and the more significant steps needed to discontinue plans requires thoughtful planning and the flexibility to have viable alternatives available for customers. We would be extremely concerned that a "one size fits all" mandate regarding a reduction in the number of plans to be offered by a carrier would inadvertently raise costs for coverage and adversely impact individuals, employers and our members who may not be able to find the best fit for their needs. We also believe that the possible curtailing of innovative and new plan designs in the market would further slow the introduction of lower cost product solutions. Moreover, approximately one half of our 3 million members are covered through plans established by self-funded employer groups that would not be covered by any mandated limits on plan designs, which would further serve to mitigate any possible savings and likely lead to more employers choosing self-funding in order to retain the flexibility they need.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

BCBSMA is acutely aware that the number and complexity of products we offer affect the many health care providers with whom we partner. BCBSMA has been a leader in working with all constituencies to look for ways to simplify what we require of those providers who contract with us and more importantly, working with other carriers to find all payer solutions for common processes that can reduce work efforts for all constituencies through collaboration.

We have led the market in introducing the electronic exchange of eligibility and referral information with providers, electronic claim submission and payment with more than 93% of claims submitted electronically and an over 82% first pass approval rate, as well as funding

support for electronic prescriptions and electronic health records. We actively participate with other carriers in the collaborative for uniform credentialing of providers to reduce duplication of efforts. In addition, we play a leadership role in the Massachusetts Healthcare Simplification Collaborative focused on finding ways across all payers to reduce the administrative burden on providers. The collaborative is currently working on streamlining the hospital credentialing process, standardizing processes across payers, and reducing re-work for both providers and payers. Ch. 288 also specifies special studies to further explore opportunities for administrative simplification and claims processing and we look forward to working with all parties in these efforts.

BCBSMA is fully committed to making quality health care affordable for our members, employer groups and the broader community. We believe the best opportunity to derive administrative savings for all constituencies, carriers and providers, is from these collaborative efforts to develop new and deploy available technology that can facilitate service to our members and make it easier for our network providers to work with us. We believe these efforts are much more likely to produce meaningful opportunities for savings than would be achieved by mandating an arbitrary reduction in the number of health plans offered by thoughtful carriers meeting their customers' needs.

The Medicaid Managed Care Organizations (MMCO's) Response to the Guidelines for the Special Commission Stakeholder Questionnaire

This response represents the four Massachusetts Medicaid Managed Care Plans (MMCOs) that currently provide health care coverage to members enrolled in MassHealth as well as Commonwealth Care through the Connector. These MMCO's include BMC HealthNet Plan, Fallon Community Health Plan, Neighborhood Health Plan and Network Health.

For Medicaid MCO's, coverage for members under MassHealth is determined by income and health status and benefits are determined based on rating categories and federal requirements. There is very little variation in coverage and little or no cost sharing. Members are not allowed to choose benefits, they are provided to them based on their income and health status. The plans are not allowed to develop products that deviate from the benefits included within the individual rating categories.

For Commonwealth Care, the Connector determines the members plan type and benefit coverage is based on income. Cost sharing is adjusted on an annual basis. There is currently discussion underway under the 2011 procurement process that MMCO's will be asked to offer limited network products. Depending on the approach, this could add more products to the Commonwealth Care portfolio but as a general rule, the plans do not develop individual products.

Due to the nature of the programs that our constituency offers, MassHealth and Commonwealth Care, the Medicaid MCO's have little or no ability to create new products or vary plan designs. We are limited already by regulation in what we can offer. Therefore responses to the following questions are not applicable to our constituency and have not been completed. We support the special commission's efforts to study health plan benefit reductions, thank the commission for allowing us the opportunity to comment and look forward to receiving the final report due on December 31, 2010.

Two of the four plans, Neighborhood Health Plan and Fallon Community Health Plan also provide commercial insurance to groups and individuals. The response to the questionnaire relative to these two plans commercial line of business will be provided through the Massachusetts Association of Health Plans (MAHP) written response.

mahp MASSACHUSETTS ASSOCIATION of HEALTH PLANS

November 24, 2010

Joseph Murphy, Commissioner
Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston MA 02118-6200

Re: Comments on the Special Commission to Make an Investigation and Study Relative to the Impact of Reducing the Number of Health Benefit Plans that a Health Payer May Maintain and Offer to Individuals and Employers (the "Special Commission")

Dear Commissioner Murphy:

I am writing on behalf of the Massachusetts Association of Health Plans (MAHP), which represents 13 health plans that provide coverage to over 2.2 million Massachusetts residents, to offer our comments in response to the survey issued by the Special Commission to Make an Investigation and Study Relative to the Impact of Reducing the Number of Health Benefit Plans that a Health Payer may Maintain and Offer to Individuals and Employers (the "Special Commission").

MAHP and its member health plans recognize the challenge employers and consumers face with the rising cost of health care. Health insurance premiums and medical costs are inextricably linked and the major contributing factor to the increases in premiums has been the rising cost of medical services charged by providers. Limiting or reducing the number of products in the market is not the answer to make health care more affordable and will stifle innovative product designs.

Reports from the Division of Insurance, the Division of Health Care Finance and Policy, and the Attorney General have noted that health care costs have far outpaced the national average and the bulk of the premium dollar – nearly 90 percent – is spent on medical costs, including hospital stays, doctor visits and prescription drugs, with the remaining 10 percent allocated to administrative expenses and surplus. As the Attorney General's report stated, provider prices and the market clout of certain providers are responsible for almost all of the increases in health care costs over the last several years.

In the absence of measures to address underlying health care costs, ensuring that employers and the individuals they employ have a wide array of health benefit plans from which to choose is essential in deciding the coverage that best meets their needs and fits within their financial means and tolerance for risk.

Our specific responses to the survey questions are outlined below.

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

Health plans may offer different product designs around a core package of benefits and core provider network. The designs may differ in a number of ways:

- By supplementary benefits. Some products may include additional benefits chosen by the employer, such as chiropractic care, while others may include it on a limited basis and others may exclude it.
- By provider network options. Offerings include access to out-of-network or out-of-state providers, tiered or limited network products.

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- By member cost-sharing (copayments, deductibles or coinsurance). Employers have increased demands to reduce benefit costs while maintaining the same level of health benefits through an array of cost-sharing options.

Some employers treat health benefits as a recruitment tool and wish to offer benefits with low member cost sharing, while others are primarily concerned with premium expenses and choose products with higher member cost sharing. Employers and individuals balance their desire for supplementary benefits and provider network options that may increase the cost of the core package, with the out-of-pocket expenses or cost sharing features that reduce overall premiums. It is important to have multiple offerings that provide the employer with a choice that best fits their employees' needs and fits within the employer's budget for benefits.

2. **From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of their magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.**

Total plan design and management: For our locally-based, commercial member health plans, the costs associated with product development and marketing, sales, and account management ranges between roughly 10 percent to nearly 37 percent of the administrative portion of the premium dollar. This is due in part to several reasons. Marketing to large employers typically involves more customization of material and online communications. Many employers offer multiple products and expect help developing custom communications solutions in print and online to their employees. Product type also depends upon the target market segment. For example, larger employers require coverage for their out-of-area employees and need PPO-type products. Smaller employers are typically under greater cost pressures and may choose to offer products with greater cost-sharing designs.

Total network administration and contracting: For our commercial member health plans, the costs associated with network administration and contracting range between roughly 2.5 percent to 5.3 percent of the administrative portion of the premium dollar. Health plans need to contract with sufficient numbers and types of providers to be able to market an adequate network and need to develop provider contracts, negotiate provider rates of reimbursement, credential providers, and maintain systems to respond to provider questions and complaints. Further, the market is transforming how health plans pay providers for the care they deliver. As this system changes to drive better outcomes and more accountability, plans will need to develop new products to work in concert with these principles.

Total rate development: For our commercial member health plans, the costs associated with rate development range between one and two percent of the administrative portion of the premium dollar. When making projections, health plans will review detailed historical claims data, internal and external factors, and the risk of each market segment to develop premiums for each product design to ensure the rates are actuarially sound.

Total regulatory affairs: For our commercial member health plans, the costs associated with compliance with regulatory requirements range between 0.4 percent and 4.1 percent of the administrative portion of the premium dollar. Health plans need to devote resources to a dozen different state and federal regulatory agencies that require detailed reports on similar types of financial, utilization and membership data. The implementation and changes to Minimum Creditable Coverage standards in recent years have increased administrative expenses. Each set of changes requires a comprehensive review of products and changes to existing plan design options, as well as education to

internal staff, brokers, employers, providers and members. Collateral materials must be reviewed and modified according to specifications set forth by the Division of Insurance.

3. **Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%. Please explain your estimates.**

It is difficult to project the actual cost impact of reducing the number of health benefit plans. As the Division's July 2010 Report on Small Group Health Premiums in Massachusetts noted "health plans spend between 10 percent and 15 percent of each premium dollar on costs to administer the health plan." Reducing the number the number of products by 20 percent – 80 percent would do little to mitigate premium increases as the costs of administering products is not the driving factor behind premium increases and restricting/reducing the number of products that could be offered would not apply to large, self-insured plans. As the Division of Health Care Finance and Policy's May 2010 *Key Indicators Report* noted, roughly half of the commercial market is covered by self-insured plans, and these companies and institutions continue to move in the direction of greater customization to meet their own needs. If product choice were limited, we would expect more employers to consider self-funding so that they would have the flexibility to design products and offerings specific to their organizations.

Additionally, there were a number of requirements established under Chapter 288 of the Acts of 2010 to create additional products in the market, including limited and tiered networks and offerings through small group purchasing cooperatives that will add to the number of products on the market. Further, state programs, such as Medicaid, Commonwealth Care, and the Group Insurance Commission have unique product designs and ongoing requirements for reporting, managing and development of these programs and offerings. Even if the number of products were reduced in the insured market, health plans would have to continue to employ staff and expend administrative resources to develop and maintain products in response to statutory requirements, state programs, and large employers.

4. **From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of their magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.**

While it is difficult to quantify the advantages of multiple products, most employers want to offer choice of products to meet the benefit and economic needs of their employees. For example, large employers with employees in multiple states typically want to offer a PPO product to satisfy the needs of those employees, but also want to offer an HMO product alongside the PPO for in-state staff so that they can enjoy the lower premiums from that design. Likewise, small employers want to have a range of options so that they can compete with large employers for talent, including utilizing benefit offerings as a means for attracting and retaining staff. Employers are looking for choice as their employees' characteristics and preferences can vary tremendously by industry type. Employers also have different perspectives about consumer engagement and tax-advantaged products, such as HRAs and HSAs, and are looking for a choice of designs.

5. **Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.**

   It is difficult to project the cost of reducing the number of health benefit plans and, in response to changes in the health care system, it is likely that benefit options will continue to change. If plans were required to reduce the product types they can offer, there would be a significant reduction in product innovation and affordability and the ability to offer high quality and effective products would be limited. Further, it is important that the health plans have flexibility to respond to trends in utilization and technology. As an example, when people started to over utilize the ER plans needed to respond with ways to steer them away and back to the primary care setting. With the rise of MRIs and advance machine testing, plans need to implement pre-certification protocols. As technology changes health plans need to have the ability to develop products that address those changes.

6. **Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from *the process* of significantly reducing the number of health benefit plans.**

   It would depend on the type of product. For example, some plans have closed non-group plans with a small number of members. While carriers no longer market these plans, they are required to re-enroll existing members that wish to remain in these plans. Allowing plans to close these plans and transition these individuals into comparable, alternative options is one area that could reduce the number of products without limiting choice in the existing market. Conversely, placing limits or restrictions on the number of products that health plans could offer would likely increase employer administrative costs in the short-term as they would need to expend resources to manage the transition and change in products. This would also result in some level of dissatisfaction among employers and consumers with having fewer options available to them.

7. **Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.**

   Our members have indicated to us that some of the regulatory requirements placed on health plans makes it extremely difficult to take products off the market, even in instances where there are only a small number of members in a plan. Today, in some instances where a plan has been off the market or comes off the market, those products still need to be available to members in them. Before imposing or limiting what plans can offer, one approach the Commission should consider is what statutory and regulatory changes can be made so that products that are no longer being offered can be closed completely and members can be transitioned to comparable products.

Sincerely,

Eric Linzer
Senior Vice President, Public Affairs & Operations

MMS Response to Survey

The Massachusetts Medical Society (MMS) is pleased to offer the following comments to the Division of Insurance in its efforts of the Special Commission to study health benefit plan reduction. The following background information and survey results are being submitted on behalf of The Massachusetts Medical Society (MMS) and our physician membership.

The MMS believes that, in the interest of patient and employer choice, the availability of a variety of health benefit plan options is important. However, choice must be balanced against the potential negative ramifications an excess of options may have on administrative requirements for physicians and their practices. MMS' experience and preliminary research supports the theory that physicians and their patients are negatively impacted by the resultant excessive and inconsistent administrative requirements.

For the patient, a plethora of health benefit plan options may actually lead to choice overload. Research conducted in Sweden found that as people face an increasingly large number of similar health plan choices, their tendency to switch plans to reduce their premiums is unlikely to increase and may actually decline in the phenomenon of "inertia due to numbers". (Health Insurance Exchanges-Making the Markets Work, *New England Journal of Medicine*, July 22, 2009.

For the physicians, more choice may mean higher costs as the availability of increasing numbers of benefit plan products can lead to increased complexity for physician' billing practices. The cost associated with this increasing complexity has been quantified by researchers throughout the country. For example, the McKinsey Global Institute estimated that excess spending on "health administration and insurance" accounted for as much as 21 percent of the estimated total excess spending. In 2008, 21 percent of excess spending on administration would amount to about $150 billion. The financial impact of the administrative burdens on physicians has been quantified in a study by L. P. Casalino, S. Nicholson, D. N. Gans et al., entitled "What Does It Cost Physician Practices to Interact with Health Insurance Plans?" (*Health Affairs Web Exclusive*, May 14, 2009). Key findings include:

- Physicians, on average, spent 142.3 hours per year interacting with health plans, or 3.0 hours per week and 2.7 physician work weeks per year.
- Nursing staff spent an additional 23 weeks per year per physician interacting with health plans; clerical staff spent 44 weeks and senior administrators spent 2.6 weeks doing so.
- Compared with other interactions, physicians, on average, spent more time dealing with formularies and the least on submitting or reviewing health plan quality data.

Casalino et al. found that converted into dollars, practices spent an average of $68,274 per physician per year interacting with health plans. Primary care practices spent $64,859 annually per physician, nearly one-third of the income, plus benefits, of the typical primary care physician.

Local researchers from the Massachusetts General Hospital Physicians Organization in Boston found the third party billing system and its administrative requirements to be similarly daunting. Specifically, 12% of net patient service revenues from physician practices were spent on administrative complexity (Blanchfield et al, *Health Affairs*, June 2010).

The Massachusetts Medical Society conducted a survey of physician practices regarding the costs and benefits of reducing the number of health benefit plans in the marketplace. This survey included ten interviews and a brief online survey of physicians across varying specialties and structures including small, medium, and large physician practices. There was general agreement that fewer health benefit plans will reduce the administrative overhead and complexity of running a physicians' office.

Interviews

There was agreement from the physician interviews regarding the necessity to reduce the number of health benefit plans, which would in turn reduce the administrative burden on physicians and their offices. Specifically this would help with the complex process of checking patient eligibility for the large number of benefit plans. In addition, the reduction in health benefit plans would simplify the choice for patients and allow a better understanding of their benefit structures; especially with deductible plans. Physicians however, want to ensure that affordable health benefit plan options are still available for patients.

Online Survey Results

Physicians indicated that eligibility is mostly checked on-line, while some are checked through patient's insurance cards, phone calls to the payers or asking the patients themselves. The majority of physicians indicated that the degree of burden incurred during the eligibility process was quite burdensome. The following administrative activities were ranked most frequently as having significant cost for physician practices:

- Determining authorization requirements
- Determining whether/what proportion of some medical procedure will be covered by one's plan
- Determining eligibility for benefits
- Determining allocation of obligations between patient and carrier
- Estimating which plan will be most costly by the end of the policy term

Most physicians estimated the percentage of their overhead that is associated with a large variety of health benefit plans to be 20%-30%, while the other respondents said 10% or less.

When asked their opinion of the benefits and disadvantages associated with the existence of a large variety of health plans in the Commonwealth, respondents reported the following as benefits associated with the existence of a large variety of health plans:

- "Offers patients and companies choices"
- "Affordability is impacted by having plans with more limited benefits so that at least some insurance is available to everyone regardless of ability to pay."

Respondents reported the following as disadvantages associated with the existence of a large variety of health plans:

- Confusing
- "It is dealing with this extreme variability that adds significantly to the administrative burden and cost of practice."
- "Impossible to keep up with all the plans and their rules, and patients are not always very helpful in determining what they are eligible for"

NFIB Response to Special Commission Stakeholder Questionnaire

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

Small businesses "count" health care plans interchangeably by cost and by the providers eligible for payment. If there is an owner, worker or family member with a particular medical condition, then benefits offered becomes an issue. Employers want their workers to be able to access their own physicians. They are also concerned about cost – the employer's cost paying the majority of premium, as well as the cost sharing arrangements affecting themselves and the employees.

(i) by various cost sharing arrangements (co-pays, deductibles, etc.); (ii) by various benefits offered in addition to Minimum Creditable Coverage; (iii) by groups of providers eligible for payments under the plan; or (iv) the manners in which medical necessity is determined or other features of utilization review.]

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.

The principal cost is financial – the off the top payment of health insurance premiums necessary to attract and keep qualified workers. With that kind of investment, small business owners obviously want the best deal for the money. But small business owners typically are less concerned with how to shop for alternatives as their expertise is not health insurance and they generally employ a broker to "shop" the alternatives. Again the businesses are small so they are often aware of workers' medical situations and will respond, if financially able, to coverage for a particular medical procedure if that is relevant to a particular employee.

[*Here are examples of three possible responses:*

A. (i) determining eligibility for benefits (40%); (i) collecting co-pays (30%); (iii) determining allocation of obligations between patient and carrier (20%); and (iv) other (10%).

B (i) determining whether/what proportion of some medical procedure will be covered by one's plan 40%; estimating which plan will be most costly by the end of the policy term (25%); (iii) estimating which plan will provide the richest benefits for the money (25%); and (iii) figuring out how to shop for various alternatives that may be available (10%).

C (i) designing new products (20%); (ii) marketing new products (20%); (iii) continuing to service old products that are no longer being marketed (20%); (iv) explaining product features to existing consumers (20%); closing old products (25%).]

Please explain your estimates.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

The faith of our small business owner members' in the free market cannot be underestimated. Reducing the number of health plans will not in their view reduce costs in the long term. Government regulations that force the continuation of underutilized plans should be modified or eliminated. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item.

First, the large number of plans allow small employers to match their ability to pay with the insurance coverage desired; it increases flexibility and choice (60%). Second, small business owners believe that in the long run, more plans will produce lower health care costs in a less regulated market (30%). Third, innovation is encouraged which is part of flexibility and choice cited above (10%).

A (i) allows for as close as possible matching between ability to pay and available programs (35%); (ii) prevents a "race to the bottom" for provision of benefits to lower income individuals (35%); (iii) contributes to product innovation in the area of cost-containment (30%).

B (i) produces the lowest possible total health care costs consistent with policyholder wishes (30%); (ii) allows businesses to compete more efficiently in the area of employee benefits (30%); (iii) reduces the flight to the unregulated market that can be expected to result from excessive standardization (30%); (iv) other (10%).]

Please explain your estimates.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

The goal of reducing costs by reducing the number of health plans is in many respects incomprehensible to a small business owner who is involved in a competitive market every day. The health care "market" makes little sense to most small business owners. Any short term cost savings will soon be lost. In addition, both providers and insurers offering lower costs lacks credibility in the small business community.

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or

disadvantages that you/your constituency would expect to result from *the process* of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: (i) explaining changes to stakeholders, (ii) closing existing programs,(iii) loss of buyer choice/individualized packages, (iv) reduction in seller cost-containment innovation,(v) loss of business to self-insurance, etc.*

Please explain your estimates.

The conversations between employers and employees about health insurance are difficult now. There is seldom a human resource officer or person with HR expertise in a small business. Explaining a further reduction in choice and flexibility to the business owner would be difficult. Business owners would not understand regulations that restricted choice that resulted in closing their existing program or the loss of their current package. As difficult as that conversation would be, the loss of choice would be an even more difficult conversation between business owners and workers. A reduction in the number of plans without significant and immediate out of pocket savings on premiums could disrupt the market.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

Guidelines For Special Commission Stakeholder Questionnaire

(Responses from the Massachusetts Nurses Association)

1. How do you and/or your constituencies generally divide up or count health benefit plan types?

[*Here are some examples of possible ways of dividing (more than one may be selected):*

(i) by various cost sharing arrangements (co-pays, deductibles, etc.); (ii) by various benefits offered in addition to Minimum Creditable Coverage; (iii) by groups of providers eligible for payments under the plan; or (iv) the manners in which medical necessity is determined or other features of utilization review.]

Primarily by cost share arrangement and choice arrangement. For example, out of pocket/deductible arrangement and in network /out of network arrangement – as well as generally descriptor of HMO, PPO, and EPO.

2. From you/your constituency's perspective, what are the main costs (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these costs to your membership. If possible, please estimate the percentage of total costs represented by each item.

[*Here are examples of three possible responses:*

A. (i) determining eligibility for benefits (40%); (i) collecting co-pays (30%); (iii) determining allocation of obligations between patient and carrier (20%); and (iv) other (10%).

B (i) determining whether/what proportion of some medical procedure will be covered by one's plan 40%; estimating which plan will be most costly by the end of the policy term (25%); (iii) estimating which plan will provide the richest benefits for the money (25%); and (iii) figuring out how to shop for various alternatives that may be available (10%).

C (i) designing new products (20%); (ii) marketing new products (20%); (iii) continuing to service old products that are no longer being marketed (20%); (iv) explaining product features to existing consumers (20%); closing old products (25%).]

Please explain your estimates.

Diminishing the risk pool, thereby driving up the costs to smaller subgroups who may need more comprehensive and therefore more costly coverage. 50% plan coverage (facility and provider choice) and 50% cost both premium and deductible issues.

3. Please provide any estimates you can regarding the extent (if any) you/your constituency believe(s) the costs/disadvantages identified in answer to #2 might be mitigated through a reduction in the number of health plans in the market, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

Carving up the pool by high deductible low choice plans pushes the healthy and young to those plans while leaving those in need of more comprehensive coverage due to health issues (most not of their making i.e. cancer). Those in the higher end are pushed and genuinely coerced into moving out of such plans with the carrot of employer reduced cost share arrangement if all employees go into the low coverage high deductible plan. In essence, a race to the bottom pitting the healthy against those less fortunate.

4. From you/your constituency's perspective, what are the main benefits (financial or otherwise) associated with the existence of a large variety of health benefit plans in the Commonwealth? Please present these items in order of the magnitude of these benefits to your membership. If possible, please estimate the percentage of total utility represented by each item.

[*Here is an example of two possible responses:*

A (i) allows for as close as possible matching between ability to pay and available programs (35%); (ii) prevents a "race to the bottom" for provision of benefits to lower income individuals (35%); (iii) contributes to product innovation in the area of cost-containment (30%).

B (i) produces the lowest possible total health care costs consistent with policyholder wishes (30%); (ii) allows businesses to compete more efficiently in the area of employee benefits (30%); (iii) reduces the flight to the unregulated market that can be expected to result from excessive standardization (30%); (iv) other (10%).]

Please explain your estimates.

We see a great difference between the numbers of insurers in the market for choice versus the number of varied plans. Having many different insurers is desirable having an overwhelming number of varied choices within each insurer creates a labyrinth often viewed as a means of reducing the likelihood of accessing care versus providing care. The choices tend to be driven by cost savings to the employer versus best health options for those covered.

5. Please provide any estimates you can regarding the extent you/your constituency believe(s) the advantages identified in answer to #4 might be lost through a reduction in the number of health plans you either offer, are offered, or must service, supposing such reductions were to be in the vicinity of 20%, 40%, 60% and 80%.Please explain your estimates.

It is extremely difficult to estimate savings because there has been little or no appetite to do this. Moreover, plan and design changes seemingly now take place on an annual basis and as a result comparison for savings is elusive with both insurer and product changes occurring on a 12 month basis.

6. Whether or not you have indicated that the result in the number of health plans would be a net improvement or detriment to your constituency, please provide estimates for the costs or disadvantages that you/your constituency would expect to result from <u>*the process*</u> of significantly reducing the number of health benefit plans. If possible, please again allocate any expected additional costs or disadvantages to reductions to such areas as*: (i) explaining changes to stakeholders, (ii) closing existing programs,(iii) loss of buyer choice/individualized packages, (iv) reduction in seller cost-containment innovation,(v) loss of business to self-insurance, etc.*

Please explain your estimates.

Capping high deductible plans with some standardization/regulation of benefits would level the playing field for those who do not actually get to choose the plan. Employers choose and design the plans. Employees, consumers/patients, have choices that are limited in terms of clinicians/physicians and facilities by both the plan itself in terms of contracted relationships as well as the co-pay deductible arrangement. While some may offer an expanded choice it may be elusive due to the out of pocket cost.

7. Please provide any other thoughts you would like to have considered regarding the potential for improvements in and/or disruptions to the market (if any) that would be expected by you/your constituency to result from the closure of existing health benefit plans or a significant reduction in the total number of plans available.

The three major stakeholders who dictate the majority of all decision making in health care, namely: employers, providers and insurers react to cost containment through a variety of mechanisms that seek to limit their exposure to lost revenue. The clinicians beyond some limited leverage of MD's due to the ability to control patient admission and therefore revenue, most have little say in the delivery arrangement and reimbursement of health care – the collateral damage is the patient or consumer ("patient in waiting") who every year experiences increased cost with greater restrictions on choice of clinical provider or location of, or whether services will be rendered. Without some regulation limiting the numbers of variations in products and coverage, the patient/consumer will continue to see a downward trend in choice of health services and clinicians while undoubtedly paying more. Even for the most experienced of clinicians within the system, registered nurses, the acquisition of insurance and navigating coverage is a challenge. Understandably the general population feels an even greater degree of frustration.