Massachusetts Senate to Debate Insurance Bill Today

On Friday May 14, 2010, the Massachusetts Senate Ways and Means Committee released S. 2437, entitled "An Act To Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses." Scheduled for debate by the full Senate today, S.2437 contains a number of provisions primarily intended to increase the authority of the Division of Insurance (DOI) over insurance companies offering products in the Massachusetts small group and individual health insurance markets. Secondarily, the bill would increase pressure on providers to accept lower reimbursement rates as insurers face increased pressure on premium rates.

Broadly speaking, the bill seeks to (1) increase regulation of insurers by requiring greater transparency of cost and quality data from insurance companies and health care providers; (2) control year over year volatility in insurance premium costs; (3) reduce instability and subscriber loss in the small group and individual insurance markets; and (4) increase the affordability of insurance products in The Commonwealth.

1. Increased Regulation by the DOI

Of Insurers:

Insurance companies offering products in the small business and/or individual insurance markets (the "merged market") would be subject to broad DOI authority, which would allow the DOI to limit rate increases by insurance companies. In particular, carriers would be required to file all changes to plan base rates, rating factors, and administrative costs with the DOI and the Attorney General at least 90 days before implementing such rate increases. The DOI would review all proposed changes to evaluate reasonableness of proposed administrative costs, to prevent cost-shifting to consumers, and to examine whether medical service spending levels are appropriate. The Commissioner of the DOI (the Commissioner) would presumptively disapprove any filings proposing rate increases exceeding 150% of medical inflation.

Insurance carriers could also file rates under an efficiency guarantee subject to specified medical loss ratios and profit margins preventing presumptive disapproval by the Commissioner. The bill would define medical loss ratio (MLR) as the ratio of direct claims incurred to direct premiums calculated using data required to be reported to the Commissioner.

To qualify for the efficiency guarantee, merged market rates would have to meet the following criteria:

A. Not less than an 88% MLR, and not more than a 1% profit/surplus margin for year one of the efficiency guarantee.

B. Not less than a 90% MLR, and not more than a 1% profit/surplus margin for year two of the efficiency guarantee.

C. If, at the end of the year, the insurer does not meet the applicable MLR standard, the insurer would be required to issue rebates to all members. The DOI would waive the rebate requirement only if an insurer demonstrates that it would be placed at risk of fiscal insolvency.

Note also: Under the federal Patient Protection and Affordable Care Act, as of January 1, 2011, all commercial and federally regulated health plans must report their MLR to the Secretary of HHS. Large group plans must maintain an MLR of at least 85%, and all small group and individual plans must maintain an MLR of at least 80%. If any plan's ratio is less than the required percentages, the plan would be required to provide an annual rebate to each enrollee on a pro rata basis.

Of Providers:

In order to allow consumers to compare providers based on cost and quality, health care providers would be compared on the basis of the following criteria based on information collected from insurance companies: total medical expenses, relative price of medical services, and standardized quality measures.

2. Controlling Year Over Year Rate Volatility

The Senate bill would mandate annual measurement of age for rating purposes to make rate increases for aging enrollees more gradual. Currently, insurers use five-year age factor brackets, which measure the age of enrollees in five-year increments, leading sometimes to significant cost increases for an employee entering a new age bracket. The bill would also establish "rate shock bumpers" authorizing the Commissioner to set limits on the effect of particular rating factors on premium rate increases. In order to reduce the risk that carriers may attempt to shift costs from rating factors to the trend factor in response to the imposition of "rate shock bumpers," the bill also would limit any cost-shifting that resulted in an aggregate increase to the base premium rate exceeding 1%.

3. Reduce Instability and Subscriber Loss in the Merged Market

The DOI will phase in a staged open enrollment process for individuals beginning in July 2010. Individuals could enroll outside open enrollment through a waiver program in the case of certain qualifying events, such as job loss, reduced work hours, divorce, and relocation.

The bill would prohibit insurance market practices that seek to direct sicker employees away from employer sponsored group coverage. In addition, individuals eligible for quality, affordable health insurance through their employers would not be eligible for individual coverage.

The bill would establish a high-risk reinsurance pool to reduce adverse selection among insurance plans and reduce premiums by protecting insurers against high-risk claims. Insurance companies would pool funds to support the high-risk pool, and no state funds would be provided. The DOI would explore availability of federal funds to support the high-risk reinsurance pool.

4. Increased Affordability of Insurance Products

Insurance carriers in the merged market would be required to offer at least one selective or tiered network product with a base premium rate at least 10% lower than their most actuarially similar non-selective network product. The insurance carriers would have to report their methodologies for creation of tiered or selective networks. Further, carriers would be required to report on utilization trends by groups and individuals in these plans. The Commissioner would determine the adequacy of the limited network provided in the low-cost plan based on the carrier's overall tiered network.

Selective and tiered network products would place additional pressure on providers within those networks as insurers would likely seek reimbursement concessions from participating providers. While the bill currently targets insurance carriers in the merged market, it is important to consider whether the selective and/or tiered network requirements will be extended to the broader health insurance markets in Massachusetts.

5. Other Provisions

A. Mandated Payments by Acute Care Hospitals

Hospitals would contract with insurance carriers to provide supplemental funding (so called "shared sacrifice" payments) for alleviation of rising premium costs on small businesses and individuals. Tier 1 hospitals, defined as acute care hospitals with an operating margin greater than 2.5% that also receive more than 50% of annual net patient service revenue from private carriers, will make a one-time payment of 1.25% of net patient service revenue. Tier 2 hospitals, defined as acute care hospitals with an operating margin greater than 2.5% that also receive more than 35% and less than 50% of annual net patient service revenue from private carriers, will make a one-time payment of 0.75% of net patient service revenue. By targeting hospitals with large private pay patient populations, the mandated payments are likely intended to recalibrate hospital payment rates in Massachusetts and protect hospitals with high government payor populations (Disproportionate Share Hospitals).

The statewide amount collected through mandated payments cannot exceed $100 million. The Massachusetts Division of Health Care Finance and Policy would establish a waiver process to exempt providers with less than 25 days of cash on hand or providers that make contract concessions with insurance carriers worth an amount equal to or more than the contribution amount.

B. Prohibition on Setting Reimbursement Rates Based on Rates Paid to Others

The bill would amend the Massachusetts "Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance" statute by prohibiting carriers from entering into contracts that establish reimbursement rates to providers or health care facilities based on prices, or average prices, paid to any other provider or health care facility.

C. Wellness Programs

The bill would establish a pilot program offering a state subsidy of 5% of eligible health insurance costs from 2011 to 2014 in addition to federal tax credits for small businesses that purchase health insurance through the Connector and participate in qualified wellness programs.

D. Administrative Standards

The bill also seeks to reduce administrative costs of health care providers by establishing processes for standardized credentialing, eligibility verification, claims processing, and authorizations for care.

E. Benefits Review

The bill would establish a mandated benefit expert review including a comprehensive review of the cost, public health impact, and clinical efficacy of all existing mandated benefits every four years. If benefits are found to be out of line with standards of care, the Division of Health Care Finance and Policy would recommend legislation to remove or amend the mandated benefit statute.

For further information, please contact your regular Ropes & Gray attorney.