Massachusetts House and Senate Approve Insurance Bill

On Friday July 30, 2010, the Massachusetts House and Senate approved compromise legislation S. 2585, entitled "An Act To Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Businesses." The bill became law on August 10, 2010.

Like earlier iterations of the bill, S. 2585 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. The Legislature failed to include administrative proposals to provide direct governmental oversight of provider rates of reimbursement. However, passage of the legislation also impacts providers, as the bill would increase pressure on providers to accept lower reimbursement rates as insurers face increased pressure on premium rates. To provide oversight of and research support for these efforts, S. 2585 establishes numerous councils and commissions dedicated to studying cost and quality issues.

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 a filing proposing rate increases if: (i) the administrative expense loading component (excluding taxes and assessments) increases by more than medical inflation; (ii) the carrier's reported contribution to surplus exceeds 1.9%; or (iii) the aggregate medical loss ratio (MLR)[1] for the carrier's merged market plans is less than 88%.

However, if an insurance carrier's rate filing is presumptively disapproved for failure to meet only the aggregate MLR threshold of 88%, such rate would nevertheless not be presumptively disapproved if the carrier's aggregate MLR is not less than 1% greater than the carrier's equivalent MLR 12-months prior to the present filing. Further, however, if a carrier's annual aggregate MLR is less than 88%, or less than the MLR that was not presumptively disapproved for being in excess of 1% of the carrier's prior year base rate, for the applicable 12-month period, the carrier would be required to issue refunds to eligible members. The Commissioner could waive the refund requirement only if it determined that such refund requirement would result in financial impairment for the carrier.

Note also: Under the federal Patient Protection and Affordable Care Act, effective 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.

[1] The bill requires that a uniform methodology for calculating and reporting MLRs be established by October 1, 2010.

Of Providers:

In order to allow consumers to compare providers based on cost and quality, insurance carriers would make available to enrollees and prospective enrollees comparative information for network providers, including: total medical expenses, relative price of medical services, and standardized quality measures. The bill mandates that insurance carriers in the merged market maintain a list of in-network providers on the carrier's internet website, including information on providers' (i) quality performance based on standard quality metrics and (ii) cost performance based on health status adjusted total medical expenses[2] and provider price relativity.[3] Carriers would be required to prominently promote providers based on providers' quality and cost performance.

Increased Affordability of and Access to Insurance Products

Selective or Tiered Networks:

To date, there are only a limited number of tiered network providers available. In order to foster competition and choice, insurance carriers in the merged market would be required to offer in at least one geographic area at least one selective or tiered network product with a base premium rate at least 12% 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.

Small Business Group Purchase Cooperatives:

The bill authorizes the certification by the Commissioner of up to six small business group purchasing cooperatives to, among other activities, purchase health plans for the benefit of qualified association members that include all state-mandated benefits, provide access to wellness programs, and do not deny coverage on the basis of health condition, age, race or sex. Such group purchasing cooperatives would be limited to 85,000 covered lives in a given year. Member-employers shall not have more than 50 eligible employees. The Commissioner would be required to report on the resulting cost savings and impact of the group purchasing cooperatives on the risk pool and premium costs in the merged market.

Expanded Research and Oversight

The bill establishes a number of study commissions that appear to be collecting information that would serve or be a basis for future legislation aimed more directly at provider rate regulation and administrative efficiency.

Health Care Quality and Cost Council

The bill establishes an independent health care quality and cost council to promote the transparency of health quality and cost data among consumers, providers, and insurers, including the dissemination of such information online. The council would also develop annual cost containment goals and compile data on state agencies' and other organizations' quality improvement programs.

[2] The bill defines "health status adjusted total medical expenses" as the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all nonclaims related payments to providers, adjusted by health status, and expressed on a per member per month basis.

[3] Mass. Gen. Law 188G § 6 provides that comparisons among provider profiles shall adjust for patient case-mix and other relevant risk factors and control for provider peer groups.

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Special Commission on Provider Price Reform

The bill establishes a special commission on provider price reform to investigate the rising cost of health insurance and the impact of varying reimbursement rates to providers. Among other things, the commission would study the correlation between the price paid to providers and (i) quality of care, (ii) patient acuity, (iii) payor mix, (iv) unique services provided (e.g., specialty teaching and community services), and (v) operational costs.

Special Commission on Reducing the Number of Health Plans Offered

The bill establishes a special commission to investigate the impact of reducing the number of health plans that insurance carriers may maintain and offer, including a study of the following factors: (i) administrative costs of claims processing; (ii) consumer and employer choice; (iii) competition for products; and (iv) market disruption.

Special Commission on Capital Needs of Community Hospitals

The bill establishes a special commission to investigate (i) the ability of the community hospital sector to meet capital needs for technology and facilities and (ii) potential sources for required capital. To assist with access to such capital needs, the bill also allows for the creation of a Community Hospital and Community Health Center Capital Reserves Funds.

Commission on Uniform Claims Administration System

The bill requires the DOI, prior to promulgating regulations to promote administrative simplification in claims processing, to consult with a statewide advisory commission that investigates the value of a single claims administrative system for all payers, other than Medicare. The commission would conduct a feasibility study to analyze factors such as the benefits and limitations, potential models, and potential cost savings of a uniform system.

Research on Bundled Payment Arrangements

The bill requires the division of health care finance and policy to promote the adoption of bundled payment (rather than fee-for-service) arrangements. The division would, among other activities, research models for bundled payment arrangements, provide technical support to providers participating in such arrangements, and aim to implement pilot bundled payment programs for certain acute conditions.

Commission on Falls Prevention

The bill establishes a commission on falls prevention within the department of public health to investigate the effects of falls on older adults and the potential for reducing such falls. The commission would use its findings to, among other things, recommend intervention approaches and promote collaboration between medical community members to reduce the number of falls by their patients.

Other Provisions

Financial Review and Risk-Based Capital Ratio:

The bill mandates that insurance carriers[4] in the merged market submit a comprehensive financial statement, including the risk-based capital ratio, on an annual basis to the division of health care finance and policy. If the reported risk-based capital ratio exceeds 700%, the division would hold a public hearing within 60 days to review how such surplus could be redirected by the carrier towards new efforts to (i) reduce the cost of health plans or (ii) improve health quality, patient safety, or health cost containment.

[4] Carrier is defined to include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

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Special Needs of Children

The bill authorizes state agencies to consider the special needs of children and pediatrics in implementing the bill, such as in the development of data standards, quality measurement systems, wellness initiatives, or price comparisons.

Assessments on Acute Care Hospitals

The bill contains language that permits providers to contract with insurance carriers to provide one-time supplemental funding (so called "shared sacrifice" payments) for the purposes of alleviating rising premium costs on small businesses and individuals. While such assessments were mandatory under prior iterations of the bill, they are now voluntary.

If you have questions regarding this bill, please contact the Ropes & Gray attorney with whom you regularly work.

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