EPSTEIN BECKER GREEN | HEALTH CARE & LIFE SCIENCES CLIENT ALERT

Thought Leaders in Health Law®

Massachusetts Division of Insurance Rate Disapprovals Show Mixed Results; Implications for National Health Reform

by Jesse M. Caplan, George B. Breen, and Robert E. Wanerman

October 2010

As we await federal medical loss ratio ("MLR") standards and federal rulemaking by the Secretary of the US Department of Health and Human Services ("HHS") related to new federal reporting obligations by health insurance issuers of "unreasonable premium increases," it is helpful to consider recent health insurance premium rating activities and challenges in Massachusetts. In summary, on April 1, 2010, the Massachusetts Division of Insurance ("Division") disapproved all premium rate increases filed by health insurance carriers for small business and individual customers that exceeded 7.7 percent – which was 150 percent of the New England Medical CPI for 2009. The affected health insurance carriers filed administrative appeals of the Division's disapprovals of their premium rates. All of these administrative appeals have now been resolved, with mixed results. This client alert summarizes the Massachusetts rate disapproval proceedings and resolutions, the new Massachusetts rate filing legislation, and the implications of the Massachusetts experience for national health reform.[1]

Background

In 2006, Massachusetts enacted a state law precursor to national health reform that mandated that virtually all Massachusetts individuals obtain health insurance or face tax penalties.[2] The law also combined the individual and small group insurance markets, creating a "merged market" that would make individual insurance more affordable by spreading those risks across a broader risk pool. In 2009, many Massachusetts insurance carriers suffered significant merged market losses.[3] In order to cover the anticipated merged market claims costs, the health insurance carriers began notifying small business

[1] EpsteinBeckerGreen and the authors served as co-counsel, along with local counsel, Bowditch & Dewey, in representing Fallon Community Health Plan, Inc. ("FCHP"), one of the Massachusetts health insurance carriers in the administrative proceedings before the Division. FCHP was successful in having its rate disapprovals reversed.
[2] Chapter 58 of the Acts of 2006.
[3] See "Health Insurers Sue to Raise Rates," *Boston Globe* (April 6, 2010).

and individual subscribers in January 2010 of health insurance premium increases for the new merged market to be effective April 2010.

In response to complaints from small businesses, on February 10, 2010, Massachusetts Governor Deval L. Patrick directed the Commissioner of Insurance to issue emergency regulations requiring that new merged market rates, and additional documentation and data supporting those rates, be filed by the insurance carriers with the Division 30 days in advance of their effective date.[4] The regulations did not alter the statutory requirement that HMO rates can be disapproved if "the benefits provided … are unreasonable in relation to the rate charged, [or] if the rates are excessive, inadequate or unfairly discriminatory."[5] Nor did the regulations alter the regulatory requirement that every rate filing be accompanied by an actuarial opinion certifying that the rates conform to accepted actuarial practices.[6] On or about March 1, 2010, each of the insurance carriers filed for approval by the Division new merged market rates for business effective April 1, 2010. Most of the rates filed reflected increases greater than 150 percent of the Medical CPI – or greater than 7.7 percent.

On March 25, 2010, the Division notified carriers that any rate increase greater than 7.7 percent would likely be disapproved, and that carriers could immediately re-file April rates at increases of 7.7 percent or less. Three national carriers re-filed at 7.7 percent; the local carriers chose not to re-file.

The Division's Disapprovals

On April 1, 2010, the Division disapproved the filed rates for 235 (of 274) health insurance products that reflected increases over 7.7 percent.[7] In disapproving the health insurance carriers' rates, the Division focused on four principal areas:

Provider Contracting – The Division took the position that paying providers differing reimbursement rates was justified *only* by differences in the providers' quality of care, mix of patients, geographical location, or intensity of services, and that the carriers had failed to demonstrate that provider rate differences fell into those categories. Further, the Division found that the carriers had not demonstrated that they had taken adequate steps to renegotiate rates of reimbursement to providers.

Contribution to Surplus – The Division deemed that any rate developed with a contribution-to-surplus (or profit margin) greater than 1.9 percent was unreasonable and excessive. Five of the six carriers had used higher figures, ranging from 2.0 percent to 4.5 percent.

Medical CPI – The Division deemed that rates developed using an assumed trend greater than 150 percent of the 2009 Consumer Price Index for medical care services for the New

[4] 211 CMR 43.08. Governor Patrick further stated that "[a]ny increases significantly higher than the current level of medical cost inflation, which today is 3.2 percent, will be challenged." Governor Deval L. Patrick, Small Business Jobs Bill Remarks, Greater Boston Chamber of Commerce, Feb. 10, 2010. Governor Patrick also filed legislation (which was never enacted) that would have required the Division to presumptively disapprove any rate increases above 150 percent of the Medical CPI.
[5] M.G.L. c. 176G, §16.
[6] 211 CMR 66.09.
[7] See April 1, 2010, Notices of Disapproval, issued by the Massachusetts Division of Insurance to Blue Cross and Blue Shield of Massachusetts; FCHP; Harvard Pilgrim Health Care, Inc.; Health New England; Neighborhood Health Plan, Inc.; and Tufts Associated Health Maintenance Organization, Inc.

England Region – which came to 7.7 percent – were unreasonable and excessive. Each of the carriers had filed rates with assumed trends above 7.7 percent, ranging from 8.6 percent to 12.3 percent.

Utilization – The Division found that the proposed rates were unreasonable and excessive because each of the carriers had failed to demonstrate that they were adequately controlling utilization, or adjusting their utilization control practices, in a manner sufficient to maintain claims costs at reasonable levels (*e.g.,* resulting in an assumed trend at or below 7.7 percent).

The Administrative Hearings

Each of the carriers filed for an administrative hearing before the Division seeking reversal of the Division's rate disapprovals.[8] The Massachusetts Attorney General's Office intervened in the administrative hearings on behalf of consumers' interests. The carriers presented documentation and testimony justifying their rates from their actuaries, provider contracting executives, and, in some cases, other witnesses. Neither the Division nor the Massachusetts Attorney General's Office presented any testimony.

On June 24, 2010, the presiding officers of the administrative hearings[9] issued their first Final Agency Decision, reversing the Division's disapproval of Harvard Pilgrim Health Care's proposed rates.[10] On August 6, 2010, the presiding officers reversed the Division's disapproval of Fallon Community Health Plan's rates.[11] Between June 4 and August 16, 2010, the Division entered into settlements with the remaining four carriers (Neighborhood Health Plan, Tufts Health Plan, Blue Cross Blue Shield of Massachusetts, and Health New England).[12]

---

[8] The Division's amended rate approval scheme and guidance required carriers to continue to offer and charge merged market customers at the previous year's premium rates, unless and until the rate disapprovals were reversed, or until the carriers filed, and the Division approved, new lower rates. Massachusetts Division of Insurance Revised Filing Guidance Notice 2010-A [Revision Date – March 5, 2010]. The carriers argued that this new requirement – that they continue to use year-old rates during the pendency of any administrative review of the rate disapprovals – would result in collective losses that could exceed $100 million. As a result, the carriers filed a civil suit seeking court intervention to allow them to use rates most recently approved by the Division, rather than rates from the previous year, during the pendency of the administrative proceedings. The court declined to grant the carriers their requested relief. See *Massachusetts Association of Health Plans, et al. v. Joseph G. Murphy, Commissioner of Insurance*, Civ. Action No. 10-1377-BLS2 (Memorandum and Order dated April 12, 2010; Memorandum and Order dated April 21, 2010).

[9] The Commissioner of Insurance appointed three hearing officers who presided over each of the administrative hearings. The Commissioner delegated final authority for the Division's decisions to a single presiding hearing officer.

[10] *Harvard Pilgrim Health Care, Inc. v. Division of Insurance*, Docket No, R2010-02, Final Agency Decision dated June 24, 2010 ("June 24th Final Agency Decision"). On July 2, 2010, the Division and Harvard Pilgrim Health Care entered into a settlement addressing rates for the remainder of 2010.

[11] *Fallon Community Health Plan, Inc. v. Division of Insurance*, Docket No. R2010-07, Final Agency Decision dated August 6, 2010 ("August 6th Final Agency Decision").

[12] In each of the settlements, the Division and carrier agreed on rates through 2010 that represented a compromise between what the carrier had filed initially for approval and the Division's goal of holding increases to 7.7 percent or less. In several settlements, the Division "pre-approved," with conditions, first quarter of 2011 rate increases up to 9.9 percent. The carriers also agreed not to retroactively bill customers the differences between the settlement rates and the previous year's rates for the period between the April disapprovals and the settlement dates. As a result, impacted policyholders were not charged their new higher rates until either August or September 2010.

The Final Agency Decisions

In the two Final Agency Decisions, the presiding hearing officers rejected each of the reasons the Division cited in disapproving the carriers' proposed rates.

Provider Contracting – The panel of hearing officers found that there was no basis for limiting the review of payments to providers to just the four criteria stated by the Division. In fact, the panel found that the carriers had "no realistic option in the merged market but to reimburse providers of similar services at different rates based on reasons beyond the four articulated Regulatory bases."[13] With respect to renegotiating provider contracts, the panel found that there are legal and practical barriers to reopening existing provider contracts and that the carriers adequately had described their efforts to do so in the short period of time provided under the Division's emergency regulations and rate review process.[14]

Contribution to Surplus – The panel of hearing officers held that a "rate is not adequate, from an actuarial and regulatory perspective, if it does not cover the sum of the projected costs of covering claims, administrative costs, *and some contribution to reserves/surplus*" (emphasis added), and rejected the Division's finding that any contribution to surplus above 1.9 percent is unreasonable. The panel acknowledged that there were inherent risks in the merged market and that an appropriate contribution to surplus for a particular carrier depended on that carrier's specific circumstances.[15]

Medical CPI – The panel of hearing officers concluded that the Division's reliance on the New England Medical CPI as the sole criterion for review of an assumed trend "is improper from both an actuarial and regulatory perspective," in part due to the fact that the Medical CPI is "backward-looking (*i.e.,* it looks at past costs) whereas rates are set prospectively," and because it did not reflect accurately a specific carrier's claims and administrative costs.[16]

Utilization – The panel of hearing officers rejected the Division's finding that the carriers' utilization control efforts were inadequate, crediting the carriers' cost containment programs and pay-for-performance/risk-sharing arrangements with providers. The panel acknowledged that the carriers had accounted for savings from these programs in developing their proposed rates when those savings could be reliably measured and projected.[17]

Rate Increases v. Actual Rates – The panel of hearing officers also made clear that "[l]ooking at a percentage increase, as opposed to the actual rate, is a flawed methodology, from an actuarial perspective, for determining whether a rate is excessive or unreasonable and leads to flawed results." Indeed, by looking only at the percentage increase, the Division had approved rates for certain carriers' insurance plans that were actually higher than those rates disapproved for other carriers' equivalent plans.[18]

---

[13] August 6th Final Agency Decision at ¶¶1-56 and fn 6; June 24th Final Agency Decision at ¶¶1-24.
[14] August 6th Final Agency Decision at ¶85; June 24th Final Agency Decision at ¶59.
[15] August 6th Final Agency Decision at ¶140 (finding a contribution to surplus of 2.5 percent reasonable under the circumstances).
[16] August 6th Final Agency Decision at ¶¶141-197; June 24th Final Agency Decision at ¶¶60-93.
[17] August 6th Final Agency Decision at ¶¶198-237; June 24th Final Agency Decision at ¶¶94-103.
[18] August 6th Final Agency Decision at ¶¶179-181, 196.

The New Massachusetts Merged Market Rate Filing Law

During the administrative appeals of the Division's disapproved rates, the Massachusetts legislature considered, and then enacted, new legislation that, at least temporarily, requires merged market rates to meet certain MLR, administrative cost, and contribution-to-surplus parameters or be presumptively disapproved by the Division. Chapter 288 of the Acts of 2010 provides that, beginning in 2011, proposed rates for products sold in the merged market will be presumptively disapproved (with certain exceptions) if: (i) the rates include an administrative expense loading component increase greater than the New England Medical CPI, (ii) the carrier's reported contribution to surplus exceeds 1.9 percent, or (iii) the aggregate MLR is less than 88 percent. Beginning in October 2011, the minimum MLR increases to 90 percent.[19] Significantly, while the new law may share the Division's goal as reflected in its rate disapproval actions – putting downward pressure on merged market premium rate increases – it relies on a very different approach to achieve that result.

Implications for National Health Reform

The Patient Protection and Affordable Care Act ("PPACA") added Section 2794 of the Public Health Service Act to require the Secretary of HHS to establish an annual review of unreasonable premium rate increases, to monitor premium increases, and to award grants to states to carry out their rate review process. On April 14, 2010, HHS published in the Federal Register a Request for Information to aid HHS in the development of regulations implementing the federal premium rate review process for unreasonable premium increases.[20] HHS has received comments from, among others, the National Association of Insurance Commissioners ("NAIC") and America's Health Insurance Plans. On August 16, 2010, the Secretary announced the award of $1 million Health Insurance Premium Review Grants to 45 states and the District of Columbia to help them develop or enhance their state's health insurance premium review processes.[21] On September 9, 2010, the Secretary announced that regulations governing review of unreasonable premium rate increases would be issued later in the Fall.[22]

At this time, we can only anticipate what those regulations will provide. It is unclear how the Secretary will interpret her new authority in light of existing rate review authority at the state level. Also unknown is whether the new regulations will set specific standards that will take into account accepted actuarial principles. Nevertheless, health insurance carriers should expect that proposed premium rate increases will be subject to greater scrutiny, and greater emphasis will be placed on the data and methods used to develop actuarial opinions.

---

[19] Massachusetts Acts of 2010, Chapter 288, section 29. Available at: http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter288.

[20] Federal Register, Vol. 75, No. 71, pp. 19335-19338 (April 14, 2010).

[21] "$46 Million in Grants to Help States Crack Down on Unreasonable Health Insurance Premium Hikes," US Department of Health and Human Services, Aug. 16, 2010. Available at: http://www.hhs.gov/news/press/2010pres/08/20100816a.html.

[22] "Sebelius Calls on Health Insurers to Stop Misinformation and Unjustified Rate Increases," US Department of Health and Human Services, Sept. 9, 2010. Available at: http://www.hhs.gov/news/press/2010pres/09/20100909a.html.

In the NAIC-filed comments on this subject, the NAIC identified a range of options that regulators could use to define "potentially unreasonable" rate increases.[23] One of those options – comparing rate increases to the Medical CPI plus a certain percentage – was relied on by the Massachusetts Commissioner of Insurance, but was then rejected by the Division's hearing officers panel as actuarially unsound. Other options – including minimum MLR requirements and rejection of excessive administrative expenses or profits – more closely track the new Massachusetts legislation. PPACA provides that, beginning in 2011, health insurance carriers will be required to provide an annual pro rata rebate to each enrollee if its MLR is less than 80 percent for plans in the small group or individual markets, and less than 85 percent in the large group market. Uniform federal MLR definitions and standards are currently under development through the NAIC.[24] Arguably, the minimum MLR approach could preclude the need for more-restrictive regulatory rate-setting schemes.

Comments

The Massachusetts premium rate disapproval experience in 2010 for the merged market may prove to be a test case for anticipated premium rate review regulations and disapproval efforts across the country. If so, it would appear that rate reviews and rejections by regulators that seek to limit rate increases based on certain one-size-fit-all indexes – like the Medical CPI – could be vulnerable to legal attack by the carriers based on sound actuarial principles. As a result of its new rate filing legislation, Massachusetts also could prove to be the laboratory for evaluating the effectiveness of using minimum MLR and maximum administrative cost and profit thresholds to attempt to achieve efficiencies and to attempt to keep premium rate increases in check.

* * *

This Client Alert was authored by Jesse M. Caplan, George B. Breen, and Robert E. Wanerman. For additional information about the issues discussed in this Client Alert, please contact one of the authors or the EpsteinBeckerGreen attorney who regularly handles your legal matters.

[23] NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act, May 12, 2010, at 2. Available at: http://www.naic.org/documents/committees_e_hrsi_hhs_response_rr_adopted.pdf.
[24] See NAIC Draft Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012, and 2013 Per Section 2718(b) of the Public Health Service Act (Sept. 23, 2010).

The EpsteinBeckerGreen Client Alert is published by EBG's Health Care and Life Sciences practice to inform health care organizations of all types about significant new legal developments.

Lynn Shapiro Snyder, Esq.
EDITOR

If you would like to be added to our mailing list or need to update your contact information, please contact, Kristi Swanson, at Kswanson@ebglaw.com or 202-861-4186.