

A HISTORY OF PROMOTING HEALTH COVERAGE IN MASSACHUSETTS

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Bob Carey
RLCarey Consulting

TABLE OF CONTENTS

INTRODUCTION	1
MASSACHUSETTS HEALTH COVERAGE REFORM TIMELINE	2
PROVIDING COMPREHENSIVE COVERAGE	4
ENSURING FAIR COMPETITION AMONG INSURANCE CARRIERS	8
PROVIDING ACCESS TO COVERAGE	13
PROVIDING CONSUMER PROTECTIONS	16
CONCLUSION	18

INTRODUCTION

This issue brief provides an overview of the steps that the State of Massachusetts has taken to establish a functioning market that provides consumers with meaningful access to health coverage. The brief reviews statutory and regulatory provisions in place today, and provides context for key health reform initiatives that have occurred over the past 30+ years. While the primary focus of this brief is the private insurance market, we do note the critical role of MassHealth, the state's Medicaid program, in providing coverage to nearly two million Massachusetts residents.

The brief is structured around four key components of a functioning market for health coverage:

1. Encouraging or requiring coverage of a comprehensive set of benefits and services;
2. Ensuring fair competition among insurance carriers;
3. Providing access to coverage, particularly for low- and middle-income residents; and
4. Instituting mechanisms to protect consumers.

Within each section, we discuss the ways the state has sought to address market inefficiencies, protect consumers, promote competition, and extend coverage to uninsured and underinsured residents.

The categories used are not mutually exclusive. That is, certain statutory and regulatory provisions do not fall neatly into one category or another. For example, the adoption of a minimum set of health benefits associated with the state's requirement for most adults to have health coverage is discussed under the "Providing Comprehensive Coverage" section of the brief; but the state's Minimum Creditable Coverage (MCC) standards could also fit under the "Providing Consumer Protections" section.

The key point is not how the policies are categorized here, as this approach is used only as an organizing framework, but rather how they impact Massachusetts residents and how the package of provisions provides residents, insurance carriers, and employers with a competitive market for health coverage that ensures consumers are treated fairly and coverage is robust.

Together, these provisions have been instrumental in enabling the Commonwealth to have the highest rate of health insurance coverage in the country. Nonetheless, while more than 96 percent of residents now have health insurance coverage, maintaining the gain requires lowering the rate of growth in health care costs without sacrificing comprehensiveness of coverage.¹ In 2016, \$59 billion was spent on health care in the Commonwealth, equal to \$8,663 per person,² among the highest amounts in the country.³ The affordability of health coverage for all residents remains a significant challenge.⁴

Today, the Massachusetts market for health coverage looks quite different from the way it did in the 1980s, 1990s, or early 2000s. It will likely look different five or 10 years hence. This review found a market that has evolved over the years and continues to evolve. There are common themes around the desire to extend coverage to all residents, promote competition among insurance carriers, and protect consumers. As federal policymakers consider a range of initiatives that may affect the market for health coverage, this brief serves to describe the policies in place today in Massachusetts and provide some context as to the rationale for introducing and maintaining these provisions.

¹ Center for Health Information and Analysis, December 2017, "Findings from the 2017 Massachusetts Health Information Survey." Boston, MA. Available at www.chiamass.gov/assets/docs/r/survey/mhis-2017/2017-MHIS-Report.pdf.

² Center for Health Information and Analysis, September 2017, "Performance of the Massachusetts Health Care System: Annual Report." Boston, MA.

³ In 2014, National Health Expenditure Data compiled by the Centers for Medicare and Medicaid Services reported that Massachusetts' spending per resident was third highest among U.S. states and the District of Columbia, 31 percent higher than the national average.

⁴ Blue Cross Blue Shield of Massachusetts Foundation, March 2016, "Summary of Health Insurance Coverage and Health Care Access and Affordability in Massachusetts: 2015 Update." Available at www.bluecrossmafoundation.org/sites/default/files/download/publication/MHRS_2015_Summary_FINAL_v02.pdf.

MASSACHUSETTS HEALTH COVERAGE REFORM TIMELINE



1 Ch. 574 of Acts of 1985, "An Act Relative to the Establishment of Hospital Rates of Payment and Charges."

2 See *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1985); www.supreme.justia.com/cases/federal/us/471/724 and "Court: State Can Require Mental Health Coverage," Boston Globe, June 4, 1985.

3 Although the statute became law on April 7, 1986, its official name is the Consolidated Omnibus Budget Reconciliation Act of 1985. The law included a wide range of provisions but is best known for the continuation of insured health coverage provision.

4 All reforms noted in 1988 were part of Chapter 23 of the Acts of 1988, "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing."

5 The state's Medicaid program was renamed MassHealth in 1997 with the establishment of an 1115 Medicaid demonstration waiver from the U.S. Department of Health and Human Services.

6 All reforms noted in 1991 were part of Chapter 495 of Acts of 1991, "An Act Improving Health Care Access and Financing."

7 All reforms noted in 1996 were part of Chapter 297 of the Acts of 1996, "An Act Increasing the Affordability and Accessibility of Health Insurance in the Commonwealth."

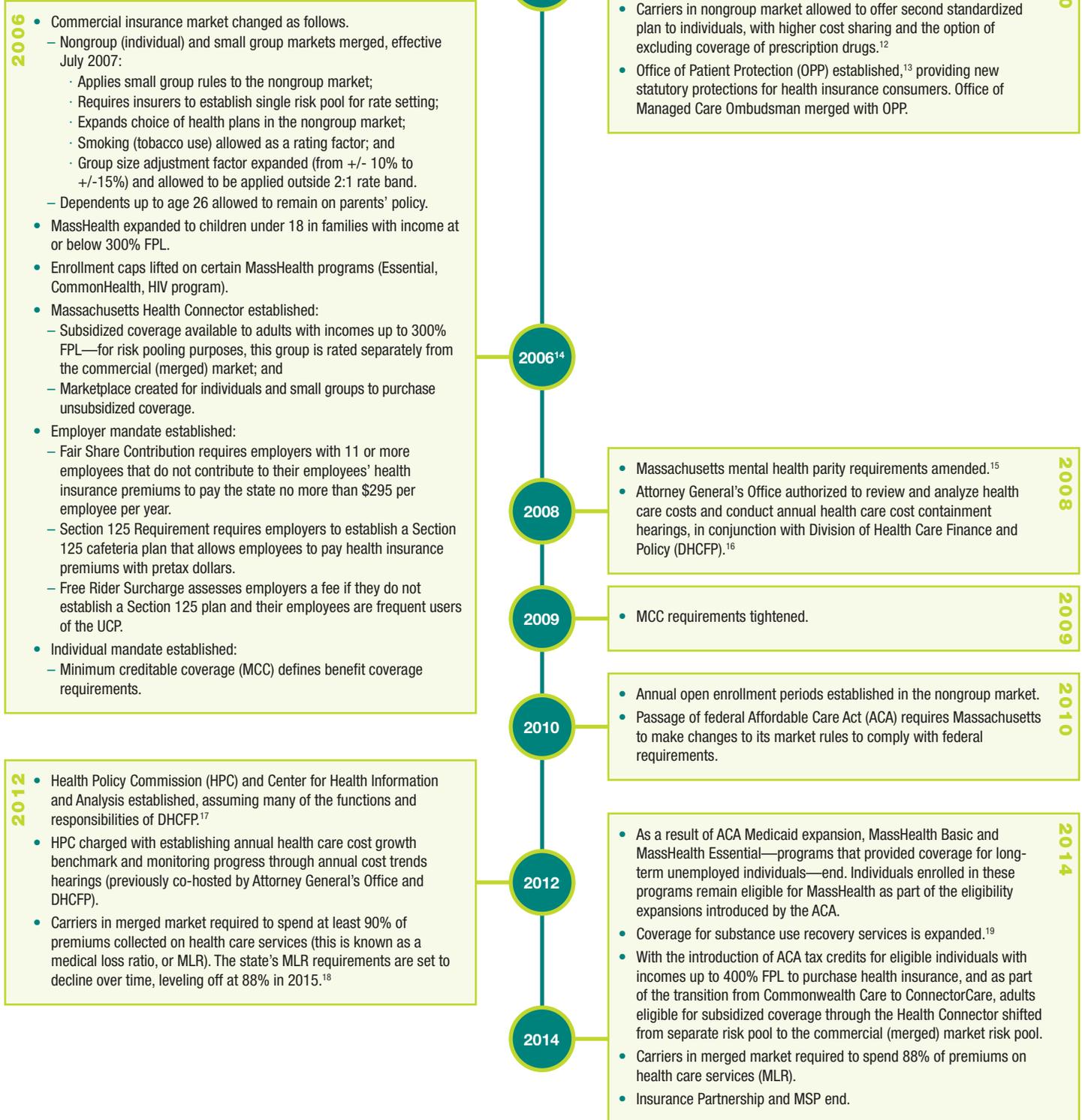
8 Seifert, R., June 2017, "The Importance of CHIP Reauthorization for Massachusetts," Boston, MA: Massachusetts Medicaid Policy Institute. Available at www.bluecrossmafoundation.org/sites/default/files/download/publication/CHIP_MassHealth_Final.pdf.

9 Ch. 27 of Acts of 1997, "An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth."

10 Massachusetts Executive Order #405. Available at www.mass.gov/courts/docs/lawlib/eo400-499/eo405.txt.

MASSACHUSETTS HEALTH COVERAGE REFORM TIMELINE

continued



11 Ch. 80 of Acts of 2000, "An Act Relative to Mental Health Benefits."

12 Ch. 143 of Acts of 2000, "An Act Relative to Nongroup Health Insurance Products."

13 Ch. 141 of Acts of 2000, "An Act Relative to Managed Care Practices in the Insurance Industry."

14 Ch. 58 of Acts of 2006, "An Act Providing Access to Affordable, Quality, Accountable Health Care."

15 Ch. 256 of Acts of 2008, "An Act Relative to Mental Health Parity."

16 Ch. 305 of Acts of 2008, "An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care."

17 Ch. 224 of Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation."

18 Center for Health Information and Analysis, 2015, "Massachusetts Medical Loss Ratios." Boston, MA. Available at www.chiamass.gov/assets/docs/r/pubs/15/MLR-Brief-2015.pdf.

19 Ch. 258 of Acts of 2014, "An Act to Increase Opportunities for Long-Term Substance Abuse Recovery."

PROVIDING COMPREHENSIVE COVERAGE

Massachusetts has passed a number of laws and regulations to help ensure that residents of the Commonwealth have health coverage that includes a comprehensive set of benefits. The most significant of these statutes was the 2006 health reform law—Chapter 58 of the Acts of 2006 (Chapter 58)⁵—considered one of the models for the federal Affordable Care Act (ACA) enacted four years later.

While the 2006 law was the most comprehensive in its approach to health coverage requirements, the state has a long history of proactively addressing gaps in coverage through benefits mandates and the adoption of a managed care (Health Maintenance Organization [HMO]) law,⁶ along with subsequent regulations that required HMO plans to cover a broad range of benefits and placed limits on cost sharing, medical underwriting in setting rates, and the use of pre-existing condition exclusions.

MANDATED BENEFITS

Prior to the 2006 health reform law, the state generally addressed health insurance benefit requirements on a piecemeal basis.⁷ For example, in 1985, the Massachusetts Division of Insurance (MA DOI) promulgated a regulation to require that all insured health plans include benefits for pregnancy and pregnancy-related conditions. It was noted at the time that while most insurance provided coverage for maternity benefits, “some Bay State women find they must purchase more expensive family insurance coverage instead of an individual plan to obtain maternity benefits.”⁸ This regulatory requirement was subsequently enacted into state law.⁹

Massachusetts was one of the first states to require coverage of mental health services. Enacted in 1973, the law required insurance carriers to provide at least \$500 per year in mental health coverage. The state’s mental health mandate became the subject of a legal challenge that ultimately wound its way to the U.S. Supreme Court and resulted in a landmark ruling.

The Massachusetts case, brought against two insurance companies that did not comply with the mental health mandate, was unanimously decided in favor of the state.¹⁰ Not only did the decision uphold mental health coverage mandates in Massachusetts and 12 other states, but more broadly the decision established the authority of states to adopt an array of insured health coverage mandates.¹¹

Today, state and federal mental health parity laws require coverage on a non-discriminatory basis for biologically based and non biologically based mental health disorders, including substance use disorders.¹² While the initial mental health mandate required insurance carriers to cover at least \$500 of mental health services, the Commonwealth’s mental health parity requirements in effect today do not allow insurance carriers to limit the amount of medically necessary mental health and substance use disorder services.

5 Chapter 58 of the Acts of 2006: www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58.

6 Chapter 454 of the Acts of 1976, “An Act Further Regulating the Organization and Operation of Health Maintenance Organizations,” which established MGL Chapter 176G.

7 A list of Massachusetts General Laws pertaining to health benefits mandates can be found here: www.mass.gov/ocabr/docs/doi/consumer/healthlists/mndatben.pdf.

8 “Pregnancy Benefits Extended to All Plans,” Boston Globe, March 12, 1985.

9 MGL Chapter 175, section 47F: www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47F.

10 *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1985) www.supreme.justia.com/cases/federal/us/471/724.

11 “Court: State Can Require Mental Health Coverage,” Boston Globe, June 4, 1985.

12 See, for example, MGL Chapter 175, section 47B: www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47B.

One other state mandate worth noting is the requirement that insurance policies issued in the Commonwealth cover preventive care and screenings, as well as primary care, for children from birth to age six.¹³ The law also requires coverage for medically necessary early intervention services for children from birth until their third birthday and coverage of a newborn hearing-screening test.

In total, Massachusetts has 39 health insurance mandates in effect.¹⁴ State benefits mandates apply to fully insured coverage but not to coverage that is self-insured by an employer or group.¹⁵

TARGETED COVERAGE EXPANSIONS

The state also has a long history of proactively ensuring access to insured health coverage for certain groups. In 1989, Massachusetts became the first state to require college students to maintain health coverage, and it required institutions of higher education to offer health plans to students.¹⁶ As part of the 2006 health reform law, the Commonwealth extended the dependent coverage requirement through the earlier of the dependent's 26th birthday or two years following the loss of dependent status according to federal tax rules.¹⁷ The state also required insurance carriers to extend coverage to children of policyholders, including newborns, children of dependents (i.e., the grandchildren of the policyholder), adopted children,¹⁸ and adult children with disabilities.¹⁹

The Difference Between Self-Insured and Fully Insured

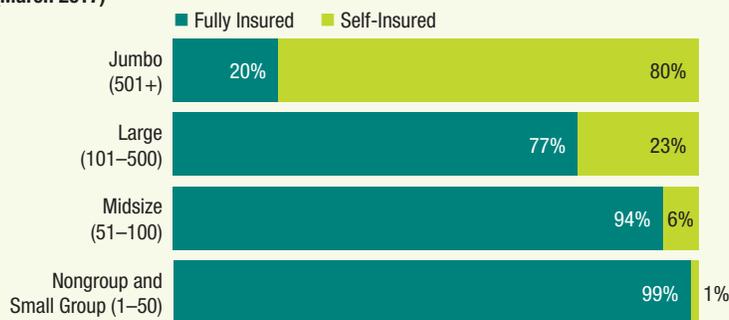
Fully insured coverage is sold by an insurance carrier to an individual, employer, or other plan sponsor such as a union or group of employers (e.g., a purchasing cooperative). Monthly premiums are charged to the individual or group, and the insurance carrier pays for covered medically necessary services that a member uses (excluding any applicable member cost sharing).

In a self-insured arrangement, an employer or union (i.e., plan sponsor) is responsible for paying the cost of claims, excluding member cost sharing. In many cases, the plan sponsor contracts with an insurance carrier or third party administrator under an administrative services only (ASO) arrangement to administer the benefits, adjudicate claims, contract with a provider network, and provide member services.

In Massachusetts, according to enrollment data compiled by the Center for Health Information and Analysis (CHIA)^{*}, approximately 56 percent of residents with private health insurance (or roughly 2.3 million individuals) are covered under employment-based self-insured benefit plans. The distribution of fully insured vis-à-vis self-insured coverage varies greatly depending on the size of the group.

Residents who purchase coverage as individuals (nongroup) and over 99 percent of residents who receive coverage through small employers (i.e., with 50 or fewer eligible employees) are enrolled in fully insured health plans. Virtually all residents (98 percent) whose employers have 100 or fewer employees also are covered through insurance coverage issued by an insurance carrier (i.e., fully insured); and more than 75 percent of residents covered by employment-based health plans with 101–500 employees are part of the fully insured market. On the other hand, approximately 80 percent of residents receiving coverage through a jumbo employer (i.e., with more than 500 employees) are in self-insured plans.^{**}

MA Residents Private Insurance Enrollment by Group Size and Funding Type (March 2017)



^{*}Center for Health Information and Analysis, February 2018, "Enrollment Trends—February 2018 Edition." Boston, MA. Available at www.chiamass.gov/enrollment-in-health-insurance.

^{**}The CHIA report measures the number of Massachusetts residents with health insurance.

Residents whose coverage is through an employer plan located in another state may not receive all Massachusetts mandated benefits.

13 See, for example, MGL Chapter 175, section 47C: www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47C.

14 Compass Health Analytics, December 2016, "State Mandated Health Insurance Benefits and Health Insurance Costs in MA." Boston, MA: Center for Health Information and Analysis. Available at www.chiamass.gov/assets/docs/r/pubs/16/2016-Combined-Comprehensive-12-2016.pdf.

15 State health insurance laws are generally pre-empted by the federal Employee Retirement Income Security Act of 1974 (ERISA), which sets minimum standards for most voluntarily established pension and health plans in private industry: www.dol.gov/general/topic/retirement/erisa.

16 Chapter 23 of the Acts of 1988.

17 Chapter 58 of the Acts of 2006, as amended. See also MA DOI Bulletin 207-01, Amendments Created by Chapters 58 of the Acts of 2006, as amended, Related to Eligibility as a Dependent in an Insured Health Plan: www.mass.gov/ocabr/docs/doi/bulletins/bulletins-07-01.pdf.

18 See MGL Chapter 175, section 47C (commercial insurer); MGL Chapter 176A, section 8B, and Chapter 176B, section 4C (Blue Cross and Blue Shield); and MGL Chapter 176G, section 4 (HMO); as well as MA DOI Bulletin 2008-01.

19 See MGL Chapter 175, section 108.2(a)(3) (commercial insurer); and MGL Chapter 176A, section 8(d), and Chapter 176B, section 6(c) (Blue Cross and Blue Shield).

However, as noted above, although state mandates apply to fully insured coverage,²⁰ they do not apply to self-insured plans.²¹ To address instances in which self-insured health plans might have provided dependent coverage but did not cover certain care for dependents of policyholders (e.g., maternity and newborn care), the state's MCC regulations include the following provision: "A health benefit plan, or the aggregate of multiple health benefit plans, that provide(s) coverage for dependents must provide coverage for all core services and all of the benefits included in the broad range of medical benefits."²² These regulations define the benefits and cost-sharing provisions that an individual's health plan must have to satisfy the individual mandate and are discussed in more detail below.

While the guaranteed issue and guaranteed renewability requirements (i.e., that coverage must be offered and available for purchase and renewal of coverage to all eligible groups regardless of health status) that are now in place across all market segments eliminated the need to extend protections to specific groups, the state previously established protections for certain vulnerable individuals, including victims of domestic abuse²³ and blind or deaf persons.²⁴

HEALTH MAINTENANCE ORGANIZATION COVERAGE REQUIREMENTS

The Commonwealth's Health Maintenance Organization (HMO) statute,²⁵ which was enacted in 1976 and patterned after the 1973 federally qualified HMO law, required coverage of a broad range of benefits with limits on member cost sharing, as well as restrictions on the use of medical underwriting and pre-existing condition exclusions. The state law required HMOs to provide or arrange for the "provision of health services to voluntarily enrolled members in exchange primarily for a pre-paid per capita or aggregate fixed sum."²⁶ The term "health services" included physician services, inpatient and outpatient hospital services, and emergency health services. In exchange, HMO members receive (non-emergent) health care services from a closed network of providers.

2006 HEALTH REFORM LAW

The state's 2006 health reform law addressed a range of issues and expanded access to health coverage to hundreds of thousands of uninsured and underinsured individuals by expanding eligibility for MassHealth and subsidizing health plan premiums through the Commonwealth Health Insurance Connector Authority (Health Connector), a quasi-public entity responsible for implementing policies and programs to make affordable health coverage available to more people.²⁷

The **Health Connector** is governed by a board consisting of public and private members, including ex officio members of the administration*, gubernatorial appointees, and appointees of the Attorney General. The Health Connector, among other responsibilities, has organized an "insurance exchange" to facilitate the purchase of subsidized and unsubsidized health insurance plans by individuals and small groups; promulgated rules to allow individuals to purchase coverage with pretax dollars; established affordability and coverage standards associated with the state's individual responsibility/individual mandate requirement (described below); and worked with other state agencies and key stakeholders to promote health coverage across the Commonwealth.

*Ex officio members of the administration include:
Secretary of Health and Human Services;
Commissioner, Massachusetts Division of Insurance;
Secretary of Administration and Finance; and
Executive Director, Group Insurance Commission.

20 Several state mandated benefit statutes apply the mandate to all fully insured health plans, regardless of the state of issuance. For example, the mental health parity law (Chapter 256 of the Acts of 2008) applies the state mandate to a health plan "which is issued or renewed within or without the commonwealth ... to residents of the commonwealth and to all policyholders having a principal place of employment in the commonwealth."

21 As a general policy, the Group Insurance Commission (GIC) requires its self-funded plans to cover state mandated benefits regardless of any direct statutory language that may not apply the mandate to the GIC. Other large employers with self-funded plans often adopt state mandated benefits as part of their health plan offering to employees.

22 956 CMR 5.03: Minimum Creditable Coverage, subsection 2.

23 Chapter 38 of the Acts of 1995, sections 153, 155, 156, and 157, which amended MGL Chapters 175 (commercial insurer), 176A and 176B (Blue Cross and Blue Shield), and 176G (HMOs).

24 MGL Chapter 175, section 108A (commercial insurer); Chapter 176A, section 8C, and Chapter 176B, section 4D (Blue Cross and Blue Shield).

25 Chapter 454 of the Acts of 1976, "An Act Further Regulating the Organization and Operation of Health Maintenance Organizations," which established MGL Chapter 176G.

26 Chapter 176G, section 1.

27 The expansion of MassHealth eligibility and subsidized coverage available through the Health Connector is discussed further in the "Providing Access to Coverage" section of this issue brief.

MINIMUM CREDITABLE COVERAGE

Chapter 58 also established a requirement (i.e., the “individual mandate”) that adult residents maintain “creditable coverage” or face a tax penalty. While the law deemed certain types of coverage as “creditable” for the purpose of satisfying the individual mandate (e.g., student health insurance plans, most Medicaid plans, Medicare), the law directed the Health Connector board to define what constituted MCC for residents covered by other health insurance plans. MCC established a floor of benefits and coverage, below which a health plan would not satisfy the individual mandate’s health coverage requirement, thereby potentially subjecting tax filers covered by that plan to a tax penalty.²⁸

The initial MCC regulations, which were finalized in early 2007 for coverage effective July 1, 2007, provided wide latitude with regard to what constituted MCC in the first 18 months of the individual mandate (July 2007 – December 2008).²⁹ During this time period, any health plan issued by a licensed insurance carrier or any self-insured plan that provided health, accident, and sickness coverage issued in any state met the broad definition of MCC.

For plan years effective January 1, 2009, and beyond, individuals were required to have a plan that provided coverage for a “broad range of medical services,” including:

- Inpatient acute care;
- Physician services;
- Diagnostic tests and procedures;
- Outpatient care; and
- Prescription drugs.

The MCC regulations also prohibited annual or lifetime limits on coverage of core services, which include physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

The MCC standards limited the upfront deductible before a plan begins to pay for coverage and placed a cap on the maximum amount a consumer is required to pay out of pocket (i.e., co-payments, co-insurance, and deductibles). While the MCC regulations have been updated since 2009 to provide clarification, respond to changes in the market, and address ACA requirements, the core set of benefits that must be covered to satisfy the MCC requirements has remained largely unchanged.³⁰

The MCC standards apply to an individual and specify the level of benefits and cost-sharing protections individuals must have in their health insurance plan to satisfy the state’s individual mandate. While MCC standards are not applied to health insurance carriers or employers, this policy approach had the effect of influencing the types of health plans—including the scope of benefits and cost-sharing designs—offered by insurance carriers and employers.

The MCC standards, which in some ways are the precursor to the ACA’s “Minimum Essential Coverage” (MEC) requirements, serve as the de facto benefits benchmark against which all health coverage sold in the Commonwealth is measured. More important, as described above, the MCC standards apply at the individual level and therefore require

28 In addition to directing the Health Connector board to determine MCC standards for private insurance, M.G.L. c. 111M, section 1, identified other health plans deemed to be “creditable coverage.” These include Medicare Part A or Part B, a qualifying student health insurance plan, most Medicaid coverage, Indian Health Service plans, Peace Corps plans, and public health plans as defined by the federal Public Health Service Act.

29 Minimum creditable coverage for the period from July 1, 2007, through December 31, 2008, included: “Any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under MGL c. 175; a group hospital service plan issued by a non-profit hospital service corporation under MGL c. 176A; a group medical service plan issued by a non-profit medical service corporation under MGL c. 176B; a group health maintenance contract issued by a health maintenance organization under MGL c. 176G; coverage for young adults health insurance plan under MGL c. 176J, § 10; any self-funded health plan, including a self-funded health plan which is an ERISA ‘employee welfare benefit plan’ providing medical, surgical or hospital benefits, as that term is defined in 29 U.S.C. § 1002; and any individual, general, blanket or group policy of health, accident and sickness insurance issued in any state within the United States of America other than the Commonwealth of Massachusetts by an insurer that is licensed or otherwise statutorily authorized to transact business in such other state.”

30 The Connector’s MCC regulations determined that other types of coverage were creditable, including Veterans Administration health care programs, health plans available to AmeriCorps and VISTA volunteers, and health coverage provided by religious organizations (e.g., health sharing ministries): www.mahealthconnector.org/wp-content/uploads/rules-and-regulations/956CMR5.00.pdf.

an individual to have coverage meeting these benefit and cost-sharing standards regardless of the particular market segment (i.e., nongroup, small group, large group) or funding arrangement (self-insured or fully insured) through which the individual acquires insurance. That is, since these standards are used to determine if an individual has coverage that satisfies the state's individual mandate, they, in practice, indirectly apply to virtually all health coverage.

It is worth noting that the Commonwealth's health reform law does not prohibit insurance carriers from selling policies that do not meet MCC standards; although the MA DOI requires insurance carriers to notify consumers as to whether their health coverage meets or does not meet MCC standards.³¹ In addition, as discussed further below, the MA DOI reviews and approves health insurance products sold in the nongroup and small group markets.³²

MINIMUM ESSENTIAL COVERAGE

In contrast to the state's MCC requirements, the federal MEC standards incorporate broad types of coverage, including essentially all employer health plans,³³ as compliant for the purpose of satisfying the federal individual mandate.³⁴ While the ACA introduced several benefit and cost-sharing standards, such as essential health benefit (EHB) requirements and limitations on deductibles and out-of-pocket maximums, the majority of these insurance market reforms apply only to the nongroup and small group markets and are not explicitly required to satisfy the MEC requirement for purposes of the (now repealed) federal mandate. One consequence of this policy is that it is possible for an individual to have an employer plan with high upfront deductibles or not particularly robust benefits and still meet the federal MEC requirement.

ENSURING FAIR COMPETITION AMONG INSURANCE CARRIERS

To promote a fair and competitive market for health coverage, Massachusetts has taken a number of steps over the years to stabilize the market and address inequities. These measures have included prohibiting insurance carriers from denying coverage to residents with pre-existing health conditions; initially requiring insurance carriers that offered small group coverage to offer coverage in the nongroup market, and subsequently merging the nongroup and small group markets³⁵; and further expanding the insurance risk pools by including residents with subsidized coverage purchased through the Health Connector within the merged market.

Today, small employers³⁶ and consumers in Massachusetts seeking coverage as individuals (i.e., nongroup) can choose from hundreds of health plans offered by a dozen carriers. Insurance carriers are prohibited from screening or rejecting applicants based on health status, imposing pre-existing condition exclusions, or establishing coverage waiting periods. Rate variation is limited to a 2:1 band (i.e., the premium the insurer charges for older members can be no more than twice the premium it charges for younger members). These market conditions are dramatically different from the conditions that existed in the 1990s.

31 See MA DOI Bulletin 2010-07: www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2010-doi-bulletins/bulletin-2010-07-requirements-for-disclosure.html.

32 The MA DOI has established a health policy form checklist that provides details on the information that must be submitted by insurance carriers that wish to offer coverage in Massachusetts. The checklist can be found here: www.mass.gov/ocabr/docs/doi/companies/checklists/2017-a.pdf.

33 Coverage consisting solely of excepted benefits, such as stand-alone dental and vision insurance, accident or disability income insurance, and workers' compensation insurance, does not meet federal MEC standards.

34 See www.irs.gov/affordable-care-act/individuals-and-families/aca-individual-shared-responsibility-provision-minimum-essential-coverage. Note that the federal individual mandate has been repealed, while the state's health coverage requirement for adult residents remains in place.

35 Chapter 58 of the Acts of 2006.

36 The small group market now includes employers with 50 or fewer eligible employees.

ADVERSE SELECTION AND THE USE OF HEALTH STATUS TO DENY COVERAGE

Insurance works best when a broad and diverse group of individuals are covered, in order to spread the cost of members that require extensive care or have costly medical conditions. In 2014, the top one percent of U.S. residents ranked by their health care expenditures accounted for 23 percent of total health care expenditures, and the top five percent accounted for half of all health care expenditures. At the other end of the spectrum, 50 percent of the U.S. population covered by commercial insurance accounted for less than three percent of total health care expenditures.³⁷

While medical underwriting may have allowed insurance carriers to avoid issuing coverage to high-cost individuals and reduce their claims costs, this made it especially challenging for those most in need of health insurance coverage to obtain it. In markets where a subset of insurance carriers were required to cover all applicants while other insurance carriers could screen and reject applicants based on health status, the end result was often an uneven playing field and a dysfunctional market.

In Massachusetts, that scenario played out in textbook fashion during the late 1980s and early 1990s. At that time, Blue Cross and Blue Shield of Massachusetts (BCBSMA)—like BCBS plans in several other states—was the “insurer of last resort,” accepting all applicants.³⁸ Other insurance carriers could choose to whom to offer coverage and were allowed to deny coverage based on the applicant’s or group’s health status or prior health experience.

In the nongroup market, the few insurance carriers that offered health plans screened applicants and denied coverage to people with pre-existing conditions. While BCBSMA was permitted to impose a three-year waiting period before covering pre-existing conditions, BCBSMA was not permitted to deny coverage. Not unexpectedly, the result was a dysfunctional and volatile nongroup market.³⁹

Similar problems existed in the small group market (which was defined at the time as employers with 25 or fewer employees). Prior to enactment of insurance reforms in the early 1990s, small groups could be denied coverage or charged higher premiums based on the underlying health conditions of employees and dependents covered by the employer’s health plan. If the health history of an employer’s employees and their dependents was poor, insurance carriers could deny the group’s application, cancel the coverage, or charge large rate increases when the plan was up for renewal.⁴⁰

SMALL GROUP REFORMS AND PROHIBITING HEALTH STATUS AS A RATING FACTOR

The Massachusetts legislature first addressed the problems in the small group market by enacting reforms in 1991 that (1) required insurance carriers to establish a single risk pool for employer groups with 25 or fewer eligible employees; (2) required insurance carriers to offer coverage to all eligible groups (i.e., guaranteed issue / guaranteed renewal); and (3) instituted rating rules that limited the rating factors used to set premiums, prohibited the use of health status in setting rates for an employer group, and established rate bands.⁴¹ While insurance carriers were still permitted to impose waiting periods for pre-existing conditions, waiting periods could last no more than six months. Prior to this change, waiting periods for pre-existing conditions could extend for several years.⁴²

37 Mitchell, Emily M., November 2016, “Statistical Brief #497: Concentration of Health Expenditures in the U.S. Civilian Noninstitutionalized Population, 2014.” Agency for Healthcare Research and Quality.

38 Kirk, A., 2000, “Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts,” *Journal of Health Politics, Policy, and Law* 25(1), 133–173.

39 “Blue Cross Requests 32.8 percent Increase in Nongroup Premium,” *Boston Globe*, April 2, 1991.

40 “The Insurance Picture: Health Coverage Takes a Big Toll on Small Businesses,” *Boston Globe*, December 13, 1991.

41 Chapter 495 of the Acts of 1991 permitted insurance carriers to use the following rating factors to adjust a small group’s premiums: age, gender, employer’s industry, group size, participation rate, and rate basis type (e.g., individual, family, employee + spouse).

42 “The Insurance Picture: Health Coverage Takes a Big Toll on Small Businesses,” *Boston Globe*, December 13, 1991.

NONGROUP MARKET REFORMS AND MASSHEALTH EXPANSION

The next wave of change occurred five years later with the enactment of major health reform legislation that expanded MassHealth eligibility and made structural changes to the small group and nongroup markets. Among other provisions, the 1996 legislation expanded the small group market to employers with 50 or fewer eligible employees and officially eliminated the use of gender as a rating factor (although few insurers at the time used gender as a rating factor).⁴³

Statutory changes sought to shore up the nongroup market by extending guaranteed issue and guaranteed renewal requirements to this market segment, limiting the rating factors that insurance carriers could use to set premiums (including a 2:1 age band requirement), eliminating health status as a rating factor, requiring insurance carriers to utilize a single risk pool, establishing health plans with standardized benefits and cost sharing, and prohibiting insurance carriers from applying waiting periods or pre-existing condition exclusions if individuals enrolled during an annual open enrollment period.⁴⁴

Further, in an attempt to increase the number of insurance carriers offering coverage in the nongroup market, the law required insurance carriers that covered 5,000 or more small group members to participate in the nongroup market. Insurance carriers meeting this small group membership threshold were required to offer at least one standardized health plan (HMO, Preferred Provider Organization [PPO], or Indemnity plan) in the nongroup market.

The law standardized nongroup health plans, prohibited medical underwriting, limited the rating factors used to set premiums, and sought to increase the number of insurance carriers offering nongroup coverage.⁴⁵ Not all insurance carriers embraced the new law.

“Some insurers are thwarting a new state law that was supposed to make it easier for consumers to buy nongroup health insurance, according to telephone surveys that found insurers giving out inaccurate information or charging extremely high rates for coverage. A survey by the consumer group Health Care for All found that most insurance companies are improperly telling callers that they don’t sell nongroup health insurance or that they haven’t set those rates yet.”⁴⁶

While the intent of the law was to increase competition and expand the number of carriers offering nongroup coverage, most insurance carriers did not actively market their nongroup plans. In 2005, nine years after enactment of Chapter 297 of the Acts of 1996, BCBSMA covered 78 percent of the nongroup market (35,362 residents), Harvard Pilgrim Health Care covered 16 percent (7,073 individuals), and six percent of nongroup members (2,767 people) were spread across the remaining 10 insurance carriers.⁴⁷

ASSOCIATION HEALTH PLANS REQUIRED TO ABIDE BY SMALL GROUP RULES

Chapter 297 of the Acts of 1996 also removed a statutory exemption previously granted to Association Health Plans (AHPs) that offered coverage to small employers. An AHP is commonly characterized as a group of employers that collectively purchase health coverage on behalf of the group’s members.

Prior to the statutory change, AHPs were exempt from the state’s small group market regulations and were largely outside the purview of the MA DOI. The 1996 law required AHPs that sold health plans to small groups (50 or fewer

⁴³ Chapter 297 of the Acts of 1996. See also, MA DOI Bulletin 1996-20, Health Insurance Rating Requirements for Small Groups: www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/1996-doi-bulletins/1996-doi-bulletins-18.html.

⁴⁴ Waiting periods and pre-existing conditions could be imposed for no more than six months if individuals enrolled outside the two-month annual open enrollment period.

⁴⁵ The MA Division of Insurance reported that 19 carriers were expected to offer coverage in 1997. Several commercial insurers pulled out of the market, according to the DOI, including Mutual of Omaha, Golden Rule Insurance Company, Principal Mutual Life Insurance Company, and Monumental Life Insurance Company. “Health Insurers Can’t Reject Policies; State’s Open Enrollment Starts Tomorrow,” Boston Globe, September 30, 1997.

⁴⁶ “Nongroup Insurance Is Scarce, Polls Find,” Boston Globe, October 15, 1997.

⁴⁷ “2005 Nongroup Membership Details,” MA Division of Insurance.

eligible employees) to abide by the state’s small group rating rules and regulations, including guaranteed issue / guaranteed renewability; prohibiting the use of health status and gender as rating factors; and restricting pre-existing condition exclusions to no more than six months. This change resulted in most AHPs ceasing to offer coverage to small groups in Massachusetts.

MERGING THE NONGROUP AND SMALL GROUP MARKETS

Another significant change to the nongroup market came with enactment of the 2006 health reform law. The law changed the composition of the nongroup market by merging the nongroup and small group markets in an effort to spread nongroup risk across a larger population, which lowered premiums for most nongroup members and expanded the number and types of health plans available to nongroup members.

As a result of the market merger, a prospective analysis estimated that nongroup premiums would decline 15 percent, with only a modest increase in small group premiums (estimated to be 1.0 to 1.5 percent).⁴⁸ A retrospective review demonstrated that rates dropped significantly in the nongroup market.

A comparison of rates for plans with comparable cost sharing—a “Standard” nongroup plan offered in 2006 and a “Gold” plan offered in 2008—showed that nongroup premiums fell by as much as 47 percent, before adjusting for inflation.⁴⁹ Rates vary based on the ages of enrollees and the number of people covered under the policy, but when looking at monthly premiums across comparable ages and group sizes for a Standard plan in 2006 and a Gold plan in 2008, in nearly all instances there is a decrease in premiums.

MONTHLY PREMIUMS FOR NONGROUP STANDARD PLANS (2006) AND GOLD AND BRONZE PLANS (2008)

INSURER	2006: STANDARD PLAN	2008: GOLD PLAN	2008: BRONZE PLAN	% CHANGE 2008 GOLD VS. 2006 STANDARD PLAN	% CHANGE: 8% ANNUAL INFLATION ADDED TO 2006 PLAN
25-year-old					
HMO Blue	\$528	\$470	\$255	-11%	-23%
HPHC	\$507	\$441	\$220	-13%	-24%
NHP	\$436	\$343	\$197	-21%	-32%
Tufts	\$710	\$378	\$218	-47%	-54%
Family (2 children, 35-year-old parents)					
HMO Blue	\$1,248	\$1,660	\$902	+33%	+16%
HPHC	\$1,533	\$1,540	\$767	0%	-13%
NHP	\$1,505	\$1,276	\$731	-15%	-26%
Tufts	\$1,683	\$1,330	\$766	-21%	-31%
Couple in 60s					
HMO Blue	\$1,888	\$1,879	\$1,020	0	-14%
HPHC	\$2,011	\$1,853	\$923	-8%	-20%
NHP	\$1,733	\$1,477	\$847	-15%	-26%
Tufts	\$2,397	\$1,587	\$914	-34%	-43%

Source: Nancy Turnbull, Harvard School of Public Health, September 2008.

Note: HMO Blue = Blue Cross Blue Shield of Massachusetts; HPHC = Harvard Pilgrim Health Care; NHP = Neighborhood Health Plan; Tufts = Tufts Health Plan.

48 Gorman Actuarial, December 2006, “Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Market,” prepared for the Massachusetts Division of Insurance and Market Merger Special Commission: www.mass.gov/ocabr/docs/doi/legal-hearings/nongrp-smallgrp/finalreport-12-26.pdf.

49 The Health Connector utilized metal levels (i.e., Gold, Silver, and Bronze), originally defined by actuarial value, to group health insurance plans available to individuals and small groups. The plan design and actuarial value of the 2006 Standard plan are most comparable to those of the 2008 Gold plan.

Prior to these reforms, the nongroup market covered fewer than 50,000 residents, and consumers could choose from two standardized plan designs. That is, several carriers may have offered plans, but there were only two benefit designs. Today, individuals can choose from a wide variety of health plans and provider networks offered by 12 insurance carriers.

Expanding the risk pool and allowing nongroup consumers to choose from a wide range of plan options helped stabilize the nongroup market, which now covers roughly 309,000 residents, including approximately 202,000 who receive premium subsidies through the Health Connector.⁵⁰ Roughly 108,000 residents purchased unsubsidized health coverage in the nongroup market as of June 2017, more than twice the number who purchased unsubsidized nongroup health insurance in 2006.⁵¹

ANNUAL OPEN ENROLLMENT IN THE NONGROUP MARKET

While changes to the small group and nongroup markets increased access to insurance for individuals, the 2006 health reform law initially allowed individuals to purchase insurance at any time during the year. The “rolling open enrollment” had the unintended effect of allowing residents to sign up when they “needed coverage” and drop coverage after receiving care.⁵² The state sought to address this unintended consequence by instituting an annual open enrollment period for nongroup consumers. With some exceptions,⁵³ individuals may now enroll only during the annual open enrollment period.

UNDERWRITING RULES IN THE GROUP MARKET

Enrollment in the small group market is not limited to a predefined period each year, and employers can purchase coverage throughout the year. However, as noted in a 1991 article on the problems in the small group market, “Cheating on eligibility is common. A business owner’s sick brother-in-law may wind up on the payroll just so he can qualify for health insurance.”⁵⁴

To guard against adverse selection in the group market, insurance carriers are permitted to establish application standards and underwriting rules to verify that the employer is actively engaged in business; covered members are actual employees; a majority of employees take up the employer’s offer of insurance (i.e., minimum participation rate); and the employer contributes to the cost (i.e., minimum contribution rate).⁵⁵

⁵⁰ The expansion of the nongroup market was subsequently boosted by the inclusion of individuals purchasing subsidized coverage through the Health Connector. Prior to 2014, subsidy-eligible individuals were pooled separately from the nongroup market.

⁵¹ Center for Health Information and Analysis, “Enrollment Trends Databook, February 2018 Edition.”

⁵² Oliver Wyman, June 2010, “Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Market.”

⁵³ An individual who has a change in status (e.g., loss of employer coverage, the individual moves into the state, the individual is terminated from MassHealth) is allowed to purchase nongroup coverage outside the open enrollment period but must do so within a limited period of time after the event or change in status.

⁵⁴ “The Insurance Picture: Health Coverage Takes Big Toll on Small Businesses,” Boston Globe, December 13, 1991.

⁵⁵ See, for example, Tufts Health Plan’s Massachusetts Small Employer Application: www.tuftshealthplan.com/documents/employers/forms/ma-small-group-application.

PROVIDING ACCESS TO COVERAGE

The rules and regulations discussed above—as well as others—have helped Massachusetts establish a market for health coverage that provides residents with access to comprehensive health coverage from a relatively large number of insurance carriers. The market rules restrict insurance carriers from selling health plans with limited benefits and prohibit insurance carriers from denying coverage or charging higher premiums based on the health status of an individual or small employer group. The enrollment rules noted above help reduce adverse selection and gaming that can occur in an open market.

For the past 30+ years, the Commonwealth has also expanded access to coverage by subsidizing coverage for lower-income residents, and allowing for the continuation of coverage following a divorce, separation, or loss of employment. Recognizing how important it will be to address issues of health care costs and affordability in order to maintain its coverage gains, the state has turned its focus more recently to increasing health care cost transparency and bringing the annual growth in health care spending in line with growth in the state's overall economy.

MASHEALTH

MassHealth plays a crucial role in providing comprehensive health coverage to 1.9 million Massachusetts residents—more than one-quarter of the state's population. While the principal focus of this issue brief is the private market for health coverage, it is important to consider the relationship to and impact of the MassHealth program on the private market for health coverage. For many members, MassHealth coverage is secondary to other insurance, including employer-sponsored insurance (ESI). MassHealth helps make ESI premiums more affordable or helps to defray the costs of co-pays, co-insurance, and/or deductibles for eligible members. In addition, MassHealth benefits make it possible for many people with disabilities to work, providing coverage for these individuals who generally have higher health care costs and would otherwise be part of the employers' and insurance carriers' risk pools.⁵⁶

As detailed in reports issued by the Foundation through its Massachusetts Medicaid Policy Institute (MMPI),⁵⁷ today more than half of the state's population with disabilities, more than 40 percent of children, three-fifths of people in low-income families, and nearly 60 percent of residents of nursing facilities rely on MassHealth to help them pay for health care. MassHealth covers services that private insurance typically covers, plus other benefits such as long-term services and supports (LTSS), transportation, and additional behavioral health care services.⁵⁸ Just as the private market for health coverage has evolved over time, so has MassHealth. The timeline included on page 2 of this report identifies some of the specific eligibility expansions and program changes that have occurred over the last few decades to expand access to care through MassHealth.⁵⁹

UNCOMPENSATED CARE POOL / HEALTH SAFETY NET

In addition to directly supporting health coverage for lower-income residents through MassHealth, the state reimburses hospitals and community health centers for the cost of providing care to uninsured and underinsured low-income individuals through the Health Safety Net (HSN) Trust Fund, which was initially established as the Uncompensated Care Pool (UCP).

56 "MassHealth: The Basics—Facts and Trends," prepared by Center for Health Law and Economics, University of Massachusetts Medical School, for Blue Cross Blue Shield of Massachusetts Foundation, September 2017.

57 For additional information on MassHealth, see www.bluecrossmafoundation.org/areas-focus/medicaid.

58 "MassHealth: The Basics—Facts and Trends," prepared by Center for Health Law and Economics, University of Massachusetts Medical School, for Blue Cross Blue Shield of Massachusetts Foundation, September 2017.

59 A detailed description of each program and/or eligibility change(s) is not included in the timeline. Rather, these are included to demonstrate the longstanding commitment to improving access to coverage and the incremental approach by which the program has expanded. Descriptions of programs identified in the timeline and associated eligibility criteria can be found here: www.bluecrossmafoundation.org/sites/default/files/download/publication/Changes%20in%20Subsidized%20Coverage%20Programs_final.pdf (see pages 6–7, 19–21).

The UCP started in 1985 as a financing mechanism to mitigate the financial disincentives hospitals faced in providing care to low-income people without health insurance; to more equitably spread the cost of providing free care and bad debt;⁶⁰ and to create a system for uninsured and underinsured people to access care that was consistent across institutions. It was originally funded in part through an assessment on hospitals, but the legislature capped hospitals' liability in 1988⁶¹ and revised the pool's financing structure in 1997 by shifting \$100 million in liability from hospitals to payers (i.e., insurance carriers).⁶² The HSN continues to be financed through a hospital assessment, payer/insurer surcharge, and state and federal funds.

CONTINUATION OF COVERAGE

In the mid-1990s, the state extended continuation of coverage requirements to small groups (i.e., employers with two to 19 members) that were exempt from the federal continuation of coverage protections that applied to groups with 20 or more employees. The 1986 federal continuation of coverage law, often referred to as COBRA because it was part of the Consolidated Omnibus Budget Reconciliation Act of 1985,⁶³ provided employees with the ability to maintain insured health coverage through their employer's health plan after leaving employment.

The state law,⁶⁴ passed in 1996, allows employees and dependents of employees to continue coverage in a small employer's health plan for 18–36 months, with the length of coverage dependent on the type of qualifying event. While former employees and their dependents are allowed to continue coverage, the employer is not required to contribute to the health plan's premiums.

Massachusetts also extended continuation of coverage requirements following a divorce or separation.⁶⁵ In cases of divorce or separation, the spouse of the subscriber may be allowed to remain on the health plan, pursuant to a judge's order.

SUBSIDIZED COVERAGE THROUGH THE HEALTH CONNECTOR

While the state's 2006 health reform law and the ACA expanded MassHealth eligibility to more low-income adults, the state and federal governments have also extended subsidies for health insurance to individuals and families with incomes up to 400 percent of the federal poverty level (FPL) who are not otherwise eligible for MassHealth, Medicare, or affordable ESI.⁶⁶ These programs provide eligible lower-income residents with premium subsidies to purchase health coverage from insurance carriers.

The Commonwealth's 2006 health reform law sought to fill gaps in access to affordable health coverage by establishing an insurance subsidy program for lower-income adults who were not eligible for MassHealth, Medicare, student health plans, or ESI, and had income at or below 300 percent FPL.⁶⁷ From 2007 through 2013, adults who were enrolled in Commonwealth Care, as the program was known, were provided subsidized coverage through Medicaid Managed Care Organizations (MCOs). During this period, individuals enrolled in the Commonwealth Care program were pooled separately for rate-setting purposes and were not part of the merged (nongroup and small group) market.

60 Robert W. Seifert, October 2002, "The Uncompensated Care Pool: Saving the Safety Net," The Access Project.

61 Chapter 23 of the Acts of 1988.

62 Chapter 47 of the Acts of 1997.

63 Although the statute became law on April 7, 1986, its official name is the Consolidated Omnibus Budget Reconciliation Act of 1985. The law included a wide range of provisions but is best known for the continuation of insured health coverage provision.

64 Chapter 297 of the Acts of 1996, which amended MGL Chapter 176J (Small Group Health Insurance) by adding section 9, "Continuous Coverage." The law is often referred to as "Mini-COBRA."

65 MGL Chapters 175, section 110I (commercial insurer); 176A, section 8F, and 176B, section 6B (Blue Cross and Blue Shield); and 176G, section 5A (HMOs).

66 These are the main types of coverage that may preclude an individual from receiving health insurance subsidies through the Massachusetts Health Connector. There are other standards and rules that limit subsidy eligibility.

67 Children in families with incomes of 300 percent FPL or less were eligible for coverage through MassHealth. Based on 2018 FPL standards used by MassHealth, 300 percent FPL for a family of four is the equivalent of \$75,300 annually or \$6,275 per month (www.mass.gov/eohhs/docs/masshealth/deskguides/fpl-deskguide.pdf).

With implementation of the ACA's insurance subsidy program in 2014, eligibility for subsidies was extended to individuals and families with income up to 400 percent FPL. And per the requirements of the ACA, enrollees in this program—now known as ConnectorCare—were transitioned into the merged market risk pool. This change has added roughly 200,000 residents to the merged market since December 2013.⁶⁸ The state also continues to provide premium and cost-sharing subsidies—in addition to those provided by the federal government through the ACA—to individuals with income up to 300 percent FPL.

EMPLOYER REQUIREMENTS

Chapter 58 also established three requirements for Massachusetts employers. First, the law required employers with 11 or more workers who did not contribute to their employees' health plan to pay an annual "Fair Share Contribution" of no more than \$295 for each full-time equivalent employee. Second, the law required employers to establish Section 125 cafeteria plans that allowed employees to pay health insurance premiums with pretax dollars. Third, the law established a "Free Rider Surcharge" on employers with 11 or more workers if the employer did not establish a Section 125 plan and if the employer's uninsured employees were frequent users of the UCP.⁶⁹ After passage of the ACA, all three of these requirements were repealed.⁷⁰

PRICE TRANSPARENCY AND HEALTH CARE COST GROWTH

Six years after enactment of the 2006 health reform law, the main goal of which was expanding access to coverage, the state sought to rein in the rising cost of health care. Among other provisions, Chapter 224 of the Acts of 2012⁷¹ increased price transparency for consumers; sought to align the growth in health care costs to growth in the state's overall economy; promoted adoption of alternative payment models; established new commissions and agencies to monitor health care cost growth; and placed new scrutiny on health care providers' market power and payment variation.

68 CHIA's "Enrollment Trends" report, which measures insurance coverage of Massachusetts residents, noted that as of March 15, 2017, there were 295,993 residents covered through individual (nongroup) insurance.

69 John E. McDonough, Brian Rosman, Fawn Phelps and Melissa Shannon, "The Third Wave of Massachusetts Health Care Access Reform." *Health Affairs* 25, no. 6 (2006), published online September 14, 2006. Available at www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.w420.

70 The Fair Share Contribution was repealed effective July 1, 2013, via Chapter 38 of the Acts of 2013. The Section 125 requirement and Free Rider Surcharge were repealed on March 17, 2014, in Chapter 52 of the Acts of 2014.

71 For more information, see Blue Cross Blue Shield of Massachusetts Foundation "Summary of Chapter 224 of the Acts of 2012": www.bluecrossmafoundation.org/publication/summary-chapter-224-acts-2012.

PROVIDING CONSUMER PROTECTIONS

Protecting consumers by enforcing the broad range of health coverage laws and regulations of the Commonwealth is the fourth key component of a functioning market. This takes a variety of forms, including licensing and oversight of insurance carriers; licensing and oversight of insurance producers (also known as brokers or agents); an effective rate review process; and oversight, monitoring, and enforcement of insurance market rules, which are primarily the responsibility of the MA DOI and Attorney General's Office (AGO).

INSURER LICENSURE, FORM FILING, AND RATE REVIEW

In order to market and distribute health coverage in Massachusetts, an insurance carrier must meet state licensing requirements and be authorized to operate as an insurance company under MGL Chapter 175 (commercial insurer), an HMO under MGL Chapter 176G (HMO), or a hospital or medical service corporation under MGL Chapters 176A and 176B (Blue Cross and Blue Shield). These licensing standards include both financial and operational requirements that insurance carriers must meet before they can offer health insurance coverage to Massachusetts residents and employers.

Insurance carriers that offer insured health plans in the merged (individual and small group) market must file detailed information about each benefit plan with the MA DOI and receive approval from the Commissioner of Insurance to sell the plan. Pursuant to statutory requirements laid out in the state's small group health insurance law, MGL Chapter 176J,⁷² and further detailed in regulations,⁷³ bulletins, and filing guidance⁷⁴ issued by the MA DOI, insurance carriers offering coverage in the merged market are required to submit detailed information and receive prior approval before selling a health plan in this market.

Insurance carriers offering managed care plans (i.e., HMOs, as well as other health products offering access to services provided through a network of providers) must complete a 69-page checklist⁷⁵ developed by the MA DOI that lists the requirements insurance carriers must address before they can market a managed care plan. These include specifications such as the benefits covered, member cost sharing, marketing and disclosure standards, readability of the evidence of coverage, member notifications, eligibility rules, provider directory information, and network adequacy standards.

Monthly rates that insurance carriers wish to charge for each health plan sold in the merged market are also subject to prior review and approval by MA DOI. On a quarterly basis, insurance carriers submit proposed rates along with detailed historical and projected cost and utilization information on medical, behavioral health, prescription drugs, and ancillary services provided to members in the merged market. The rate review is conducted by a team of actuaries and MA DOI staff.

Insurance carriers are also required to spend at least 88 percent of merged market premiums on medical services for members, with the remaining 12 percent used to cover administrative costs and provide a profit margin or contribute to the insurer's reserves, if any funds remain. The 88 percent medical loss ratio (MLR) requirement in the Commonwealth is eight percentage points higher than the ACA's standard of 80 percent for the individual and small group markets. In 2016, across the fully insured market, which includes all market segments (i.e., individual, small group, large group),

⁷² MGL Chapter 176J: www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176J.

⁷³ See the MA DOI Small Group Health Insurance regulations, 211 CMR 66.00: www.mass.gov/files/documents/2017/11/08/211-66.pdf.

⁷⁴ See the MA DOI Merged Market Health Coverage Filing Guidance Notice 2017—A: www.mass.gov/ocabr/docs/doi/companies/checklists/2017-a.pdf.

⁷⁵ See the Managed Care Checklist: Review of Health Maintenance Organizations Licensed Under MGL Chapter 176G: www.mass.gov/files/documents/2017/11/06/hmo.pdf.

insurance carriers collected \$11.2 billion in health care premiums and paid \$10.0 billion in health care claims to hospitals, doctors, pharmaceutical companies, and other providers, resulting in an average MLR of 91.9 percent.⁷⁶

DIVISION OF INSURANCE

Enforcement of the rules and insurance carrier standards is principally the responsibility of the Massachusetts Division of Insurance (MA DOI), which regularly performs market conduct examinations of insurance carriers in addition to the health plan form filings and rate review referenced above.

The MA DOI is also responsible for the licensing and oversight of producers, commonly referred to as brokers or agents. The MA DOI issues producer licenses; examines licensing records and documents to ensure compliance with state laws, regulations, and agency guidelines; oversees the appointment of producers by insurance companies; maintains the division's producer licensing database; and takes enforcement actions against noncompliant producers and insurers.⁷⁷ The oversight and monitoring activities of the MA DOI ensure that individuals and firms that sell, solicit, or negotiate coverage in the Commonwealth are appropriately licensed and abide by the state's health coverage rules and standards.⁷⁸

ATTORNEY GENERAL'S OFFICE

The Attorney General's Office (AGO) Health Care Division also has responsibility for enforcing health care laws "to protect the rights of Massachusetts consumers and to halt unfair or deceptive practices that may harm consumers."⁷⁹ Since enactment of the 2006 health reform law, the AGO has brought enforcement actions against insurance carriers that have failed to cover health care services required by the law,⁸⁰ engaged in deceptive marketing practices,⁸¹ or sold health policies that were not approved for sale in the Commonwealth.⁸²

In addition to these targeted actions, the AGO's Health Care Division issues periodic reports on Massachusetts health care cost trends and cost drivers,⁸³ and plays a critical role in overseeing and monitoring the market. The AGO has been particularly active in reviewing proposed hospital and health system mergers and acquisitions under its antitrust law enforcement authority, and also with an eye to the potential impact on health care costs.

HEALTH POLICY COMMISSION

The Health Policy Commission (HPC)⁸⁴ is a quasi-independent state agency whose main responsibilities include establishing an annual health care cost growth benchmark and monitoring progress through annual cost trends hearings.⁸⁵ The cost growth benchmark sets the target growth rate for the Commonwealth's per capita medical

76 Massachusetts Division of Insurance, "Financial Summary of the 2016 Market for Health Insurance." Boston, MA. Available at www.mass.gov/ocabr/docs/doi/consumer/healthlists/2016-financial-health-summary.pdf.

77 See the MA DOI Administrative Actions Against Licensees: www.mass.gov/ocabr/insurance/providers-and-producers/insurance-producers/enforcement/doi-administrative-actions.

78 MGL Chapter 175, section 162I: www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section162I.

79 For additional information on the Attorney General's Office Health Care Division, see www.mass.gov/ago/bureaus/hcfc/the-health-care-division.

80 Attorney General's Office, April 2017, "Insurance Company to Pay \$2.8 Million to Resolve Claims of Unlawful, Deceptive Sales of Health Insurance Sold Across State Lines." Boston, MA. Available at www.mass.gov/ago/news-and-updates/press-releases/2017/2017-04-04-insurance-company-to-pay-2-8-million.html.

81 Attorney General's Office, August 2009, "Attorney General Martha Coakley Reaches \$17 Million Settlement with Health Insurers Regarding Unfair and Deceptive Conduct." Boston, MA. Available at www.mass.gov/ago/news-and-updates/press-releases/2009/ag-reaches-17-million-settlement-with-health.html.

82 Attorney General's Office, April 2011, "Health Insurance Company to Pay \$760,000 for Unlawfully Selling Unauthorized Health Insurance in Massachusetts and Failing to Cover Mandated Benefits." Boston, MA. Available at www.mass.gov/ago/news-and-updates/press-releases/2011/health-insurance-company-to-pay-760000.html.

83 Attorney General's Office, October 2016, "Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17." Boston, MA. Available at www.mass.gov/ago/docs/healthcare/cc-market-101316.pdf.

84 For additional information on the Health Policy Commission, see www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission.

85 The HPC was created in 2012 as part of Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation." www.bluecrossmafoundation.org/sites/default/files/download/publication/Ch224_summary_FINAL.pdf.

expenditures, including all spending from public and private sources. The HPC may require entities that exceed the benchmark to file and implement performance improvement plans that describe specific cost-saving measures the entity will undertake. The HPC is also charged with reviewing proposed mergers and acquisitions, with a particular focus on the impact of the transaction on the competitive market and the state's ability to meet the cost growth benchmark.

OFFICE OF PATIENT PROTECTION

Within the HPC is the Office of Patient Protection (OPP), which oversees insurance carriers' internal grievance procedures, details certain guarantees of continuity of care and specialty care referral and coverage, and establishes a process for obtaining an independent external review when coverage is denied based upon a medical necessity determination. OPP is also charged with administering and granting insurance enrollment waivers to eligible individuals who seek to purchase nongroup insurance outside the annual open enrollment period. Additionally, OPP assists consumers with questions or concerns relating to health coverage, including grievance and appeal rights, and enrollment waiver questions.⁸⁶

CENTER FOR HEALTH INFORMATION AND ANALYSIS

The Center for Health Information and Analysis (CHIA)⁸⁷ is an independent state agency that took over the majority of the responsibilities of the former Division of Health Care Finance and Policy, including compiling the state's annual cost trends reports, managing the All-Payer Claims Database, monitoring the performance of hospitals and health plans, and analyzing total medical expenses in the Commonwealth. CHIA also regularly prepares a comprehensive review of state-mandated health insurance benefits and health insurance costs.

CONCLUSION

For over 50 years, Massachusetts has worked to promote comprehensive health coverage for all residents through a combination of public programs and competitive markets for insurance carriers. Over time, the state has moved from an environment that allowed some insurers to deny coverage, screen applicants, and set rates based on an individual's health status to a market that requires insurance carriers to offer comprehensive health coverage without regard to an individual's underlying medical condition. The state has used a range of statutory and regulatory levers to pursue its overarching goals of extending access to coverage and promoting a level playing field for insurance carriers.

This brief has used a framework to organize several key provisions—ensuring comprehensive coverage, developing a level playing field for insurance carriers, expanding and promoting health coverage, and actively overseeing consumer protections—whose purpose is to effectuate a “healthy” and competitive insurance market that serves insurance carriers and employers fairly and promotes consumer access to coverage.

The policies and provisions described herein—as well as others—have played an important role in the evolution of the Massachusetts market, helping the state achieve near-universal coverage, enabling most Massachusetts employers to offer comprehensive coverage to their employees, establishing a competitive market for health coverage, and protecting consumers. In light of changes taking place at the federal level and the impact some federal proposals may have on insurance markets across the country, it is important to preserve and protect the state-level policies and programs that form the foundation of the Commonwealth's longstanding commitment to providing access to coverage.

⁸⁶ For additional information on the Office of Patient Protection, see www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection.

⁸⁷ For additional information on the Center for Health Information and Analysis, see www.chiamass.gov.



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