CHAPTER 224: WHAT DOES IT MEAN FOR HEALTH PLANS?

FOUNDATION
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CONTINUED PUBLIC REVIEW OF PREMIUMS AND MEDICAL EXPENSE TRENDS

Health plans will be subject to the annual health care cost growth benchmark under the new law. Any health plan whose cost growth rate exceeds the benchmark (measured in terms of the change in per capita health-status-adjusted total medical expenses) may be required to file a performance improvement plan with the Health Policy Commission (HPC) and will be listed on a public website. Health plans that fail to engage in the reporting or performance improvement process will be subject to fines of up to $500,000.

A CONTINUED PUSH FOR TRANSPARENCY AND ADMINISTRATIVE SIMPLIFICATION

Health plans will be required to provide consumers with real-time, provider-specific estimates of their actual out-of-pocket costs for a proposed service or procedure. Barring unforeseen events, these estimates will be binding, and health plans will be prohibited from requiring consumers to pay more than estimated. Health plans must now also provide consumers with easy access to up-to-date utilization review criteria and clearly state policies about costs for in- and out-of-network care. Health insurers must comply with new Division of Insurance requirements about standardized forms for prior authorization and summary of payment, and about a standardized process for determining a patient's eligibility for services.

A RELAXATION OF STANDARDS FOR MEDICAL EXPENSE RATIOS

Health plans will be permitted to spend a smaller proportion of premiums on medical expenses than they are permitted under current law, with the medical loss ratio for individual and small employer plans falling from 90% to 88% over the next three years.

INTENSIFIED PUBLIC ANALYSIS OF CONTRACTS BETWEEN HEALTH PLANS AND PROVIDERS

Several provisions of the new law focus additional review on the terms of contracts between health plans and providers. They mandate, among other things, more reporting about alternative payment arrangements and price variation, and the formation of a special commission to review variation in prices among providers. The provisions are designed to enable policymakers to better understand the impact of market changes, including provider consolidation and new delivery models like ACOs, on market power and leverage, and particularly on the ability of health care entities to meet the state's cost growth benchmark. This could lead to more intense scrutiny of contracts between plans and providers.

MORE ENCOURAGEMENT OF LIMITED AND TIERED NETWORK PRODUCTS

As means of making health coverage more affordable, health plans will be required to offer a wider range of products with selective or tiered provider networks and offer premiums for them that are at least 14% lower than those of their regular network products. The law encourages the development of so-called "smart tiering" products, in which cost-sharing tiers are developed for individual services rather than for all services offered by providers. The smart tiering approach will need to be reconciled with other provisions of the law that seek to encourage the development of more integrated systems of care.

LESS REGULATORY SCRUTINY OF PREMIUM RATES FOR PLANS OFFERED THROUGH GROUP PURCHASING COOPERATIVES

Group purchasing cooperatives, which were authorized in a limited way in 2010 under Chapter 288, are allowed to offer premium discounts of up to 10% without prior regulatory review or approval by the Division of Insurance. This provision, which permits coops to offer lower rates without demonstrating the basis for the discounts, could give coops a competitive advantage over other products that will be subject to stricter regulatory review and approval.

ADDITIONAL DIVISION OF INSURANCE REVIEW TO LOOK BEYOND THE HEALTH PLAN FOR CERTAIN TYPES OF ALTERNATIVE PAYMENT ARRANGEMENTS

The law imposes some oversight by the Division of Insurance on providers that assume insurance risk from health plans. Providers that enter into alternative payment arrangements under which they bear significant downside financial risk will be required to obtain a certificate from the Division of Insurance that attests to their financial solvency and the adequacy of their reserves.

MORE INCENTIVES THROUGH HEALTH INSURANCE FOR EMPLOYEE WELLNESS PROGRAMS

The continued growth of workplace wellness programs will be encouraged by requirements that insurers give premium rate discounts to individuals and small businesses that use state-approved wellness programs, and by state tax credits for employers that offer such programs.