HOUSE DOCKET, NO. 2708 FILED ON: 2/18/2021

HOUSE . . . . . No. 1247

The Commonwealth of Massachusetts

PRESENTED BY:

Christine P. Barber

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to ensure more affordable care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Christine P. Barber	*34th Middlesex*	*2/18/2021*
Lindsay N. Sabadosa	*1st Hampshire*	*2/24/2021*
John F. Keenan	*Norfolk and Plymouth*	*2/24/2021*
Dylan A. Fernandes	*Barnstable, Dukes and Nantucket*	*2/25/2021*
James J. O'Day	*14th Worcester*	*2/25/2021*
Ruth B. Balser	*12th Middlesex*	*2/25/2021*
Jack Patrick Lewis	*7th Middlesex*	*2/26/2021*
James B. Eldridge	*Middlesex and Worcester*	*2/26/2021*
Carlos González	*10th Hampden*	*2/26/2021*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*3/4/2021*
Patrick M. O'Connor	*Plymouth and Norfolk*	*3/16/2021*
Marcos A. Devers	*16th Essex*	*3/16/2021*
Walter F. Timilty	*Norfolk, Bristol and Plymouth*	*3/18/2021*
David M. Rogers	*24th Middlesex*	*4/1/2021*

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HOUSE . . . . . No. 1247

By Ms. Barber of Somerville, a petition (accompanied by bill, House, No. 1247) of Christine P. Barber and others relative to cost and access of health insurance. Health Care Financing.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

An Act to ensure more affordable care.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after Section 9 the following section:-

Section 9A. (a) For the purposes of this section, market segment shall be defined as the commercial health insurance market, MassHealth and Medicare.

(b) Not later than April 15 of each year, the board shall establish a health care consumer cost growth benchmark for the average aggregate growth in out-of-pocket health care cost growth and premium cost growth in the commonwealth for the next calendar year as determined by the center for health information and analysis under section 18 of chapter 12C. The commission shall establish procedures to prominently publish the annual health care consumer cost growth benchmark on the commission's website along with the commonwealth’s overall health care cost growth benchmark as established under section 9 of chapter 6D.

(c) The commission shall establish the annual health care cost growth benchmark as follows:

(1) For calendar years 2023 through 2024, the health care consumer cost growth benchmark shall be equal to the state overall cost growth benchmark.

(2) For calendar years 2025 and beyond, if the commission determines that an adjustment in the health care consumer cost growth benchmark from the overall health care cost growth benchmark is reasonably warranted, having first considered any testimony at the public hearing under subsection (k) of section 10 of this chapter, the board of the commission may modify the health care consumer cost growth benchmark.

(3) The health care consumer cost growth benchmark shall be calculated and assessed separately for each market segment.

SECTION 2. Subsection (b) of section 10 of chapter 6D of the General Laws, as so appearing, is hereby amended by inserting after the words “exceeding the health care cost growth benchmark” the following words:-

or health care consumer cost growth benchmark as established under section 9A.

SECTION 3. Subsection (d) of section 10 of chapter 6D of the General Laws, as so appearing, is hereby amended by inserting after the words “exceeding the health care cost growth benchmark established under section 9” the following words:-

“or as exceeding the health care consumer cost growth benchmark established under section 9A”

SECTION 4. Subsection (k) of section 10 of said chapter 6D of the General Laws, as so appearing, is hereby amended by inserting after the words “specific elements for approval” the following sentence:-

“If the board determines that the performance improvement plan for an entity that exceeded the health care consumer cost growth benchmark is unacceptable or incomplete, the commission may hold a public hearing to seek additional information from the entity and the public.”

SECTION 5. Chapter 12C of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out section 18 and inserting in place thereof the following section:-

“Section 18. The center shall perform ongoing analysis of data it receives under sections 6, 9 and 10 to identify any payers, providers or provider organizations whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark established by the health policy commission under section 10 of chapter 6D. The center shall further perform analysis of data it receives under sections 6, 9, and 10 to identify any payers that exceed the health care consumer cost growth benchmark in any market segment as established by the health policy commission under section 9A of chapter 6D. The center shall confidentially provide a list of the payers, providers and provider organizations to the health policy commission such that the authority may pursue further action under section 10 of chapter 6D.

SECTION 6. Section 6 of chapter 176J of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking subsection (c) and inserting in place thereof the following subsection:-

(c) The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate, unreasonable or discriminatory in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. In order to determine whether the proposed base rates are reasonable and not excessive, inadequate or unfairly discriminatory, the commissioner shall consider:

(1) reasonableness and soundness of actuarial assumptions, calculations, projections, and factors used by the carrier to arrive at the proposed rate change;

(2) historical and projected medical and hospital expenses, including but not limited to inpatient hospital care, outpatient hospital care by specified service categories, health care providers by specified provider type, and outpatient prescription drugs, which shall further include trends in utilization per 1,000 members, costs per service, and per member per month costs for each of the noted service types;

(3) the financial condition of the carrier for the past 3 years, including but not limited to profitability, surplus, reserves and investment income, and transfers of funds to affiliates and/or parent companies;

(4) whether the proposed rate change and any contribution to surplus or profit margin included in the proposed rate change is reasonable in light of the entire company’s surplus level;

(5) historical and projected loss ratio between the amounts spent on medical services and earned premiums, including reasonableness of historical and projected administrative expenses;

(6) projected changes in the overall risk of the population to be covered;

(7) changes to covered benefits or health benefit plan design;

(8) changes in the carrier's health care cost containment and quality improvement efforts since the carrier's last rate filing for the same category of health benefit plan;

(9) whether the proposed change in the premium rate is necessary to maintain the carrier's solvency or to maintain rate stability and prevent excessive rate increases in the future;

(10) any public comments received under subsection (i).

The commissioner shall further consider whether the health insurance plans subject to the proposed rate change are affordable and whether the carrier has implemented effective strategies to enhance the affordability of its plans. To assess affordability, the commissioner may consider the following factors:

(1) implementation of strategies by the carrier to enhance the affordability of its products, including: (i) whether the carrier offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the carrier itself that promote a focus on primary care, prevention and wellness, active management procedures for the chronically ill population, use of appropriate cost-efficient settings and use of evidence based, quality care; (ii) whether the carrier offers a spectrum of product choices to meet consumer needs; and (iii) whether the carrier employs delivery system reform and payment reform strategies to enhance cost effective utilization of appropriate services;

(2) rate change history over the prior 3 years for the population affected by the proposed rate change;

(3) the hardship on members affected by the proposed rate change and the ability of lower-income individuals to pay for health insurance, including how the proposed rate changes compare to changes in median household income and whether the proposed changes would disproportionately impact people of color based on existing race, ethnicity and language data collected by the carrier;

(4) trends, including: (i) historical rates of trend for existing products; (ii) national medical and health insurance trends; (iii) regional medical and health insurance trends; and (iv) inflation indices, such as the Consumer Price Index;

(5) efforts of the carrier to maintain close control over its administrative costs;

(6) constraints on affordability efforts including: (i) state and federal requirements; (ii) costs of medical services over which plans have limited control; and (iii) health plan solvency requirements; and

(7) any other relevant affordability factor, measurement or analysis as determined by the commissioner.

Nothing in this section shall preclude the commissioner from considering any factor that, in the commissioner's discretion, is relevant to the final determination. The commissioner shall have authority to issue regulations and bulletins to facilitate consideration of the factors in this section. Nothing in this section shall preclude the commissioner from requesting from a carrier information or data to support these factors.

Rates of reimbursement or rating factors included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

SECTION 7. Section 6 of chapter 176J of the General Laws, as so appearing, is hereby amended by inserting after subsection (e) the following subsections:-

(f) Notwithstanding any general or special law to the contrary, carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, shall file small group product base rates and any changes to small group rating factors no more frequently than two times per calendar year. Such filings shall occur according to the following timeframes: (1) any health insurance plans that are to be effective on January 1 of each year shall be filed on or before June 1 of the preceding year; and (2) any health insurance plans that are to be effective on July 1 of each year shall be filed on or before January 1 of the same calendar year.

(g) The commissioner shall issue regulations to establish the specific data and information required to be included in the rate filing to allow the commissioner to consider the factors in subsection (c), any additional factors under federal or state law, and any other information that the commissioner determines should be submitted. The information in the rate filing shall be presented in a standard format to be determined by the commissioner, with information clearly labeled under headings. In conjunction with the rate filing, the carrier shall further submit a rate filing summary on a standard form developed by the commissioner, which shall explain the filing in a manner that allows consumers to understand the proposed rate

change. The information contained in this summary must match the information provided elsewhere in the filing. In developing the standard formats for rate filings and rate filing summaries, the commissioner shall consult with groups representing carriers, providers and consumers.

(h) Upon receipt of a carrier's rate filing requesting a rate change, the commissioner shall, within 3 business days, post the rate filing on the division's website, as well as with the carrier's rate filing summary required under subsection (g). The commissioner shall prominently post links on the division's homepage to a webpage on which rate filings and summaries can be found. Links to rate filings and summaries shall be clearly labeled by name of the carrier, type of policy, and the filing date of the proposed rate change. If the commissioner uses a searchable database to publicly post rate filings, the commissioner shall post search instructions and plain-language explanatory material sufficient to make it easy to find a rate filing in the database.

(i) Beginning on the date that the commissioner posts on the division's website a proposed rate change pursuant to subsection (h), the commissioner shall open a 30 day public comment period on the rate change and rate filing. The commissioner shall allow members of the public to comment by mail and email, and the commissioner may create a website where members of the public can publicly post comments. The commissioner may further convene meetings for the public to comment and ask questions. The commissioner shall prominently post on the division's website information describing the public comment period that applies to proposed rate changes and informing members of the public how to submit a comment. The commissioner shall post all of the comments received to the division's website.

(j) Within 30 days of the close of the 30 day public comment period required under subsection (i), the commissioner shall issue a written decision with findings on the considerations listed in subsection (c), and any other considerations taken into account, to approve or disapprove the proposed rates. Upon issuing the decision, the commissioner shall post the decision on the division's website and provide written notice to the carrier of the decision. The decision shall include: (1) an explanation of the findings and rationale that are the basis for the decision, including any actuarial or other analyses, calculations or evaluations relied upon by the division in its findings or rationale; and (2) in the event of a disapproval, notice of the right of the carrier to request a public hearing under subsection (m).

SECTION 8. Section 6 of chapter 176J of the General Laws, as so appearing, is hereby amended by striking the letter (g) and inserting in place the following letter:- (m)

SECTION 9. Section 6 of chapter 176J of the General Laws, as so appearing, is hereby amended by striking the letter (h) and inserting in place the following letter:- (n)

SECTION 10. Chapter 176J of the General Laws, as so appearing, is hereby amended by inserting after Section 17:-

Section 18 (a) The commissioner, in consultation with the executive director of the connector, shall establish and implement a state reinsurance program to provide reinsurance to carriers that offer health benefit plans in the state's merged individual and small group market. The state reinsurance program shall be consistent with state and federal laws.

(b) The state reinsurance program shall be designed to mitigate the impact of high-risk individuals on rates in the merged health insurance market inside and outside of the connector.

(c) The commissioner, in consultation with the executive director of the connector, shall establish reinsurance payment parameters, in accordance with subsection (d) for calendar year 2023 and each subsequent calendar year that include: (i) an attachment point; (ii) a coinsurance rate; and (iii) a coinsurance cap.

(d) The reinsurance payment parameters shall be established in a manner that ensures all carriers in the merged market benefit substantially from the program.

(e) Beginning January 1, 2023, funding for the reinsurance program shall be made by using: (1) any pass-through funds received from the federal government under a waiver approved under § 1332 of the Patient Protection and Affordable Care Act; (2) any funds designated by the federal government to provide reinsurance to carriers that offer individual health benefit plans in the commonwealth; and (3) any funds generated by subsection (f).

(f) An assessment shall be established for the purpose of funding the reinsurance program that would be assessed on a per-member-per-month bases on all fully-insured and self-insured carriers and third party administrators offering coverage outside of the merged market. The amount of the assessment shall be sufficient to fund a reinsurance program that produces significant reductions in premiums in the merged market.

(g) The executive director of the connector may pursue federal approval of a waiver under §1332 of the Patient Protection and Affordable Care Act, Public Law 111–148 for the purposes of implementing said reinsurance program, and the commissioner of the department of insurance may alter the parameters established in accordance with subsection (c) of this section as necessary to secure federal approval for a waiver submitted under §1332 of said Patient Protection and Affordable Care Act.

(h) On or before January 1, 2023, the commissioner shall adopt regulations implementing the provisions of this section.

SECTION 11. Section 2OOO of chapter 29 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out the second paragraph, and inserting in place thereof the following paragraph:-

There shall be credited to the trust fund:

(a) employer medical assistance contributions under section 189 of chapter 149;

(b) all revenue from surcharges imposed under section 18 of chapter 176Q;

(c) any transfers from the Health Safety Net Trust Fund established in section 66 of chapter 118E;

(d) revenues deposited from penalties collected under chapter 111M; and

(e) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund. Amounts credited to the fund shall be expended without further appropriation for programs administered by the commonwealth health insurance connector authority pursuant to chapter 176Q that are designed to increase health coverage for residents of the commonwealth. A sufficient portion of money from the fund shall be designated to ensure affordable premiums and cost-sharing for enrollees who are eligible for premium assistance payments and point-of-service cost-sharing subsidies pursuant to section 3 of chapter 176Q of the General Laws. Money from the fund may be transferred to the Health Safety Net Trust Fund or any successor fund, as necessary to provide payments to acute hospitals and community health centers for reimbursable health services. Not later than January 1, the

comptroller shall report an update of revenues for the current fiscal year and prepare estimates of revenues to be credited to the fund in the subsequent fiscal year. The comptroller shall file this report with the secretary of administration and finance, the secretary of health and human services, the joint committee on health care financing and the house and senate committees on ways and means. To accommodate timing discrepancies between the receipt of revenue and related expenditures, the comptroller may certify for payment amounts not to exceed the most recent estimate of revenues as certified by the secretary of administration and finance to be deposited under this section. A full accounting of revenue credited to the fund and transfers and expenditures out of the fund shall be reported at least annually to the board of the commonwealth health insurance connector authority established under section 2 of chapter 176Q. Monies remaining in the fund at the end of a fiscal year shall not revert to the General Fund and shall be used solely as designated in this section; provided, however, that the comptroller shall report the amount remaining in the fund at the end of each fiscal year to the house and senate committees on ways and means.

SECTION 12. Section 3 of chapter 176Q of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out the 14th paragraph and inserting in place thereof the following paragraph:-

"(14) develop criteria for plans sold through the connector that are eligible for premium assistance payments or cost sharing subsidies, taking into consideration affordability of premiums and cost-sharing and a reasonable choice of health benefit plans in each area; provided further that an enrollee with household income that does not exceed 100 per cent of the federal poverty level shall have available to them at least two health benefit plans with no premium contribution and copayments shall not exceed the highest copayments required of enrollees in the

MassHealth program with household income that does not exceed 100 per cent of the federal poverty level; provided further that enrollees with income between 100 and 150 per cent of the federal poverty guidelines shall have available to them at least one health benefit plan with no premium contribution. If the health benefit plans submitted through the Seal of Approval process pursuant to section 10 of this chapter do not permit such choice of health benefit plans at a reasonable cost to the Commonwealth, the board may seek additional participation of health benefit plans in conjunction with the Division of Insurance pursuant to section 3(b) of chapter 176J of the General Laws or take other measures to facilitate reasonable access to health benefit plans up to and including establishing contracts under subsection (v) of this section or seeking a waiver under subsection (x) of this section.

SECTION 13. (a) Notwithstanding any general or special law to the contrary, there shall be established a program for cost-sharing eliminations for targeted high-value services, treatments and prescription drugs used to treat certain chronic conditions. In order to implement said program, the secretary of health and human services, in consultation with the commissioner of the department of public health and the center for health information and analysis, shall identify one to three services, treatments and prescription drugs in total used to treat each of the following chronic conditions: diabetes, asthma, chronic obstructive pulmonary disease, hypertension, coronary artery disease, congestive heart failure, opioid use disorder, bipolar disorder, and schizophrenia.

In determining the targeted high-value services, treatments and prescription drugs, the secretary shall consider appropriate services, treatments and prescription drugs that are:

(1) out-patient or ambulatory services, including medications, lab tests, procedures, and office visits, generally offered in the primary care or medical home setting;

(2) of clear benefit, strongly supported by clinical evidence to be cost-effective;

(3) likely to reduce hospitalizations or emergency department visits, or reduce future exacerbations of illness progression, or improve quality of life;

(4) relatively low cost when compared to the cost of an acute illness or incident prevented or delayed by the use of the service, treatment or drug; and

(5) at low risk for overutilization, abuse, addiction, diversion or fraud.

The secretary may further take into consideration other independent resources or models proven effective in reducing financial barriers to high-value care.

(b) Any policy, contract or certificate of health insurance subject to chapters 32A, 118E, 175, 176A, 176B, 176G or 176Q of the General Laws shall provide coverage for the identified services, treatments and prescription drugs. Such coverage shall not be subject to any cost-sharing, including co-payments and co-insurance, and shall not be subject to any deductible, pursuant to guidance from the secretary of health and human services. The commissioner of the division of insurance shall adopt any written policies, procedures or regulations necessary to implement said program.

(c) Every two years, the center for health information and analysis shall evaluate the effect of this section. Said evaluation shall include the impact of this section on treatment adherence, incidence of related acute events, premiums and cost sharing, overall health, long-term health costs, and other issues that the center may determine necessary. The center may

collaborate with an independent research organization to conduct said evaluation. The center shall file a report on its findings, which shall be filed with the clerks of the house of representatives and senate, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means.

(d) The program shall be implemented no later than January 1st, 2024.