HOUSE DOCKET, NO. 3715 FILED ON: 2/19/2021

# HOUSE . . . . . No. 1107

## The Commonwealth of Massachusetts

PRESENTED BY:

***Danielle W. Gregoire***

*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 relative to health insurer reserve requirements.

PETITION OF:

| NAME: | DISTRICT/ADDRESS: | DATE ADDED: |
|---|---|---|
| *Danielle W. Gregoire* | *4th Middlesex* | *2/19/2021* |

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# HOUSE . . . . . No. 1107

By Miss Gregoire of Marlborough, a petition (accompanied by bill, House, No. 1107) of Danielle W. Gregoire relative to health insurer reserve requirements. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *564* OF 2019-2020.]

## The Commonwealth of Massachusetts

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

An Act relative to health insurer reserve requirements.

*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 176O of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out section 21 in its entirety and inserting in place thereof the following new section:-

Section 21. (a) Each carrier shall submit an annual comprehensive financial statement to the division detailing carrier costs from the previous calendar year; provided, however, that for the purposes of this subsection, "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that does not qualify as creditable coverage as defined in section 1 of chapter 111M.

The annual comprehensive financial statement shall include all of the information in this section and shall be itemized, where applicable, by:

(i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25 and 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

(ii) line of business, including individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B; a health maintenance contract issued by a health maintenance organization under chapter 176G; insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I; and group health insurance plans issued by the commission under chapter 32A.

The statement shall include, but shall not be limited to, the following information:

(i) direct premiums earned, as defined in chapter 176J; direct claims incurred, as defined in said chapter 176J;

(ii) medical loss ratio;

(iii) number of members;

(iv) number of distinct groups covered;

(v) number of lives covered;

(vii) realized capital gains and losses;

(viii) net income;

(ix) accumulated surplus;

(x) accumulated reserves;

(xi) amount of downside risk, as defined in Chapter 176T section 1, transferred to each certified risk bearing provider organization where the carrier has entered into a contractual agreement that utilizes an alternate payment methodology with downside risk;

(xii) risk-based capital ratio, based on a formula developed by the National Association of Insurance Commissioners;

(xiii) financial administration expenses, including underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(xiv) marketing and sales expenses, including advertising, member relations, member enrollment expenses;

(xv) distributions expenses, including commissions, producers, broker and benefit consultant expenses;

(xvi) claims operations expenses, including adjudication, appeals, settlements and expenses associated with paying claims;

(xvii) medical administration expenses, including disease management, utilization review and medical management expenses;

(xviii) network operational expenses, including contracting, hospital and physician relations and medical policy procedures;

(xix) charitable expenses, including any contributions to tax-exempt foundations and community benefits;

(xx) board, bureau or association fees;

(xxi) any miscellaneous expenses described in detail by expense, including an expense not included in (i) to (xix), inclusive;

(xxii) payroll expenses and the number of employees on the carrier's payroll;

(xxiii) taxes, if any, paid by the carrier to the federal government or to the commonwealth;

(xxiv) any capital investments or write downs in investments in related or unrelated organizations;

(xxv) intercompany transfers with subsidiary organizations;

(xxvi) any changes in reserves for unpaid claims and any other contingent liabilities; and

(xxvii) any other information deemed necessary by the commissioner.

(b)(1) In this subsection, the following words shall have the following meanings:--

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I; or a third party administrator, a pharmacy benefit manager or other similar entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the commonwealth and health care provided by health care providers in the commonwealth; provided, however, that "carrier" shall

not include any entity to the extent it offers a policy, certificate or contract that does not qualify as creditable coverage as defined in section 1 of chapter 111M; provided, further, that "carrier" shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or visions care services.

"Self-insured customer", a self-insured group for which a carrier provides administrative services.

"Self-insured group", a self-insured or self-funded employer group health plan.

"Third-party administrator", a person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the commonwealth.

(2) Any carrier required to report under this section, which provides administrative services to 1 or more self-insured groups shall include, as an appendix to such report, the following information:

(i) the number of the carrier's self-insured customers;

(ii) the aggregate number of members, as defined in section 1 of chapter 176J, in all of the carrier's self-insured customers;

(iii) the aggregate number of lives covered in all of the carrier's self-insured customers;

(iv) the aggregate value of direct premiums earned, as defined in said section 1 of said chapter 176J, for all of the carrier's self-insured customers;

(v) the aggregate value of direct claims incurred, as defined in said section 1 of said chapter 176J, for all of the carrier's self-insured customers;

(vi) the aggregate medical loss ratio, as defined in said section of said chapter 176J, for all of the carrier's self-insured customers;

(vii) net income;

(viii) accumulated surplus;

(ix) accumulated reserves;

(x) the percentage of the carrier's self-insured customers that include each of the benefits mandated for health benefit plans under chapters 175, 176A, 176B and 176G;

(xi) amount of downside risk, as defined in Chapter 176T section 1, transferred to each certified risk bearing provider organization where the carrier has entered into a contractual agreement that utilizes an alternate payment methodology with downside risk;

(xii) administrative service fees paid by each of the carrier's self-insured customers; and

(xiii) any other information deemed necessary by the commissioner.

(c) A carrier who fails to file this report on or before April 1 shall be assessed a late penalty not to exceed $100 per day. The division shall make public all of the information collected under this section. The division shall issue an annual summary report to the joint committee on financial services, the joint committee on health care financing and the house and senate committees on ways and means of the annual comprehensive financial statements by May 15. The information shall be exchanged with the center for health information and analysis for

use under section 10 of chapter 12C. The division shall, from time to time, require payers to submit the underlying data used in their calculations for audit.

The commissioner shall adopt regulations to carry out this subsection, including standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner, such as third-party administrators, and criteria for the standardized reporting and uniform allocation methodologies among carriers.

The commissioner shall establish a formula to determine the amount of reserves, allocated on an annual basis, to each risk bearing provider organization by each carrier that has entered into an alternative payment methodology with downside risk. The amount to be allocated shall be based on the proportion of risk that the carrier is shifting to the certified risk bearing provider organization. The Division shall promulgate rules to carry out the provision of this subsection, which shall include reporting of such information as part of its requirements for approval of a risk bearing provider organization under Section 3(c) of Chapter 176T.

d) If, in any year, a carrier reports a risk-based capital ratio on a combined entity basis under subsection (a) that exceeds 600 per cent, the division shall hold a public hearing within 60 days. Each carrier that exceeds 600 per cent shall be publicly listed on the Division's website. The carrier shall submit testimony on its overall financial condition and the continued need for additional surplus. The carrier shall also submit testimony on how, and in what proportion to the total surplus accumulated, the carrier will dedicate additional surplus to reducing the cost of health benefit plans. The division shall review such testimony and issue a final report on the results of the hearing. The Division's report shall be made publicly available on the Division's website.

(e) The commissioner may waive specific reporting requirements in this section for classes of carriers for which the commissioner deems such reporting requirements to be inapplicable; provided, however, that the commissioner shall provide written notice, which shall be a public record, of any such waiver to the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 2. The Commissioner of Insurance shall promulgate regulations to enforce the provisions of this Act no later than 90 days after the effective date, which shall be effective for provider contracts which are entered into, renewed, or amended on or after the regulations effective date.