

HOUSE No. 489

The Commonwealth of Massachusetts

PRESENTED BY:

Jennifer E. Benson

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 ensuring appropriate allotment of risk.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Jennifer E. Benson</i>	<i>37th Middlesex</i>
<i>Jose F. Tosado</i>	<i>9th Hampden</i>
<i>Kenneth I. Gordon</i>	<i>21st Middlesex</i>
<i>Carolyn C. Dykema</i>	<i>8th Middlesex</i>
<i>Christine P. Barber</i>	<i>34th Middlesex</i>
<i>Brendan P. Crighton</i>	<i>11th Essex</i>

HOUSE No. 489

By Ms. Benson of Lunenburg, a petition (accompanied by bill, House, No. 489) of Jennifer E. Benson and others relative to allotment of risk by certain insurance carriers. Financial Services.

The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court
(2017-2018)**

An Act ensuring appropriate allotment of risk.

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

1 SECTION 1. Subsection (d) of section 6 of chapter 176J of the General Laws, as
2 appearing in the 2014 Official Edition, is hereby amended by striking out, in lines 67 to 70, the
3 words “, there is an exception for a carrier whose Risk Based Capital Ratio falls below 300 per
4 cent for the most recent 4 consecutive quarters. For such carriers the reported contribution to
5 surplus may not exceed 2.5 per cent”, and inserting in place thereof the following words:-

6 for any carrier whose Risk Based Capital Ratio falls below 300 per cent for the most
7 recent 4 consecutive quarters, the reported contribution to surplus may not exceed 2.5 per cent;
8 provided further, that for any carrier whose Risk Based Capital Ratio is greater than 600 per cent
9 for the most recent 4 consecutive quarters, the reported contribution to surplus shall not exceed
10 0.5 per cent; and provided further, that for any carrier whose Risk Based Capital Ratio is greater
11 than 700 per cent for the 4 most recent 4 consecutive quarters, the reported contribution to
12 surplus shall not exceed 0 per cent

13 SECTION 2. Chapter 176O of the General Laws is hereby amended by striking out
14 section 21, as so appearing, and inserting in place thereof the following section:--

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

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

22 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25 and
23 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

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

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

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

- 34 (ii) medical loss ratio;
- 35 (iii) number of members;
- 36 (iv) number of distinct groups covered;
- 37 (v) number of lives covered;
- 38 (vii) realized capital gains and losses;
- 39 (viii) net income;
- 40 (ix) accumulated surplus;
- 41 (x) accumulated reserves;
- 42 (xi) amount of downside risk, as defined in Chapter 176T section 1, transferred to each
43 certified risk bearing provider organization where the carrier has entered into a contractual
44 agreement that utilizes an alternate payment methodology with downside risk;
- 45 (xii) risk-based capital ratio, based on a formula developed by the National Association
46 of Insurance Commissioners;
- 47 (xiii) financial administration expenses, including underwriting, auditing, actuarial,
48 financial analysis, treasury and investment expenses;
- 49 (xiv) marketing and sales expenses, including advertising, member relations, member
50 enrollment expenses;
- 51 (xv) distributions expenses, including commissions, producers, broker and benefit
52 consultant expenses;

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

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

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

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

61 (xx) board, bureau or association fees;

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

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

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

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

69 (xxv) intercompany transfers with subsidiary organizations;

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

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

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

73 "Carrier", an insurer licensed or otherwise authorized to transact accident or health
74 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
75 176A; a nonprofit medical service corporation organized under chapter 176B; a health
76 maintenance organization organized under chapter 176G; and an organization entering into a
77 preferred provider arrangement under chapter 176I; or a third party administrator, a pharmacy
78 benefit manager or other similar entity with claims data, eligibility data, provider files and other
79 information relating to health care provided to residents of the commonwealth and health care
80 provided by health care providers in the commonwealth; provided, however, that "carrier" shall
81 not include any entity to the extent it offers a policy, certificate or contract that does not qualify
82 as creditable coverage as defined in section 1 of chapter 111M; provided, further, that "carrier"
83 shall include an entity that offers a policy, certificate or contract that provides coverage solely for
84 dental care services or visions care services.

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

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

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

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

- 94 (i) the number of the carrier's self-insured customers;
- 95 (ii) the aggregate number of members, as defined in section 1 of chapter 176J, in all of
96 the carrier's self-insured customers;
- 97 (iii) the aggregate number of lives covered in all of the carrier's self-insured customers;
- 98 (iv) the aggregate value of direct premiums earned, as defined in said section 1 of said
99 chapter 176J, for all of the carrier's self-insured customers;
- 100 (v) the aggregate value of direct claims incurred, as defined in said section 1 of said
101 chapter 176J, for all of the carrier's self-insured customers;
- 102 (vi) the aggregate medical loss ratio, as defined in said section of said chapter 176J, for
103 all of the carrier's self-insured customers;
- 104 (vii) net income;
- 105 (viii) accumulated surplus;
- 106 (ix) accumulated reserves;
- 107 (x) the percentage of the carrier's self-insured customers that include each of the benefits
108 mandated for health benefit plans under chapters 175, 176A, 176B and 176G;
- 109 (xi) amount of downside risk, as defined in Chapter 176T section 1, transferred to each
110 certified risk bearing provider organization where the carrier has entered into a contractual
111 agreement that utilizes an alternate payment methodology with downside risk;
- 112 (xii) administrative service fees paid by each of the carrier's self-insured customers; and

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

114 (c) A carrier who fails to file this report on or before April 1 shall be assessed a late
115 penalty not to exceed \$100 per day. The division shall make public all of the information
116 collected under this section. The division shall issue an annual summary report to the joint
117 committee on financial services, the joint committee on health care financing and the house and
118 senate committees on ways and means of the annual comprehensive financial statements by May
119 15. The information shall be exchanged with the center for health information and analysis for
120 use under section 10 of chapter 12C. The division shall, from time to time, require payers to
121 submit the underlying data used in their calculations for audit.

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

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

133 (d) If, in any year, a carrier reports a risk-based capital ratio on a combined entity basis
134 under subsection (a) that exceeds 600 per cent, the division shall hold a public hearing within 60

135 days. The carrier shall submit testimony on its overall financial condition and the continued need
136 for additional surplus. The carrier shall also submit testimony on how the carrier will dedicate
137 additional surplus above the 600 per cent level to increasing the relative price for any acute care
138 hospital below .85 relative price among commercial carriers.. The division shall review such
139 testimony and issue a final report on the results of the hearing. The Division's report shall be
140 made publicly available on the Division's website.

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