SENATE DOCKET, NO. 1060   FILED ON: 1/19/2017

SENATE . . . . No. 520

The Commonwealth of Massachusetts

PRESENTED BY:

Eileen M. Donoghue

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:
Eileen M. Donoghue	*First Middlesex*

SENATE DOCKET, NO. 1060 FILED ON: 1/19/2017

SENATE . . . . No. 520

By Ms. Donoghue, a petition (accompanied by bill, Senate, No. 520) of Eileen M. Donoghue for legislation relative to health insurer reserve requirements. Financial Services.

The Commonwealth of Massachusetts

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

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:

1 SECTION 1. Chapter 176O of the General Laws, as appearing in the 2014 official
2 edition, is hereby amended by striking out section 21 in its entirety and inserting in place thereof
3 the following new section:

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

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

11 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25 and
12 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

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

20 (2) The annual comprehensive financial statement shall include, but shall not be limited
21 to, the following information:

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

24 (ii) medical loss ratio;

25 (iii) number of members;

26 (iv) number of distinct groups covered;

27 (v) number of lives covered;

28 (vii) realized capital gains and losses;

29 (viii) net income;

30 (ix) accumulated surplus;

31 (x) accumulated reserves;

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

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

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

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

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

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

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

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

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

51 (xx) board, bureau or association fees;

52 (xxi) any miscellaneous expenses described in detail by expense, including an expense
53 not included in (i) to

54 (xix), inclusive;

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

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

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

60 (xxv) intercompany transfers with subsidiary organizations;

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

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

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

64 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health
65 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
66 176A; a nonprofit medical service corporation organized under chapter 176B; a health
67 maintenance organization organized under chapter 176G; and an organization entering into a
68 preferred provider arrangement under chapter 176I; or a third party administrator, a pharmacy
69 benefit manager or other similar entity with claims data, eligibility data, provider files and other
70 information relating to health care provided to residents of the commonwealth and health care
71 provided by health care providers in the commonwealth; provided, however, that "carrier" shall

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

76 “Self-insured customer”, a self-insured group for which a carrier provides administrative
77 services.

78 “Self-insured group”, a self-insured or self-funded employer group health plan.

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

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

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

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

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

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

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

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

95 (vii) net income;

96 (viii) accumulated surplus;

97 (ix) accumulated reserves;

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

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

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

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

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

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

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

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

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

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

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