

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:
<i>Christine P. Barber</i>	<i>34th Middlesex</i>	<i>2/18/2021</i>
<i>Lindsay N. Sabadosa</i>	<i>1st Hampshire</i>	<i>2/24/2021</i>
<i>John F. Keenan</i>	<i>Norfolk and Plymouth</i>	<i>2/24/2021</i>
<i>Dylan A. Fernandes</i>	<i>Barnstable, Dukes and Nantucket</i>	<i>2/25/2021</i>
<i>James J. O'Day</i>	<i>14th Worcester</i>	<i>2/25/2021</i>
<i>Ruth B. Balsler</i>	<i>12th Middlesex</i>	<i>2/25/2021</i>
<i>Jack Patrick Lewis</i>	<i>7th Middlesex</i>	<i>2/26/2021</i>
<i>James B. Eldridge</i>	<i>Middlesex and Worcester</i>	<i>2/26/2021</i>
<i>Carlos González</i>	<i>10th Hampden</i>	<i>2/26/2021</i>
<i>Joanne M. Comerford</i>	<i>Hampshire, Franklin and Worcester</i>	<i>3/4/2021</i>
<i>Patrick M. O'Connor</i>	<i>Plymouth and Norfolk</i>	<i>3/16/2021</i>
<i>Marcos A. Devers</i>	<i>16th Essex</i>	<i>3/16/2021</i>
<i>Walter F. Timilty</i>	<i>Norfolk, Bristol and Plymouth</i>	<i>3/18/2021</i>
<i>David M. Rogers</i>	<i>24th Middlesex</i>	<i>4/1/2021</i>
<i>Brian W. Murray</i>	<i>10th Worcester</i>	<i>5/11/2021</i>
<i>Steven Ultrino</i>	<i>33rd Middlesex</i>	<i>5/18/2021</i>
<i>Kay Khan</i>	<i>11th Middlesex</i>	<i>6/3/2021</i>
<i>Danillo A. Sena</i>	<i>37th Middlesex</i>	<i>6/3/2021</i>

<i>Jon Santiago</i>	<i>9th Suffolk</i>	<i>6/3/2021</i>
<i>Sean Garballey</i>	<i>23rd Middlesex</i>	<i>7/1/2021</i>
<i>Natalie M. Higgins</i>	<i>4th Worcester</i>	<i>7/28/2021</i>

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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 “Section 18. The center shall perform ongoing analysis of data it receives under sections
43 6, 9 and 10 to identify any payers, providers or provider organizations whose increase in health
44 status adjusted total medical expense is considered excessive and who threaten the ability of the
45 state to meet the health care cost growth benchmark established by the health policy commission
46 under section 10 of chapter 6D. The center shall further perform analysis of data it receives
47 under sections 6, 9, and 10 to identify any payers that exceed the health care consumer cost
48 growth benchmark in any market segment as established by the health policy commission under
49 section 9A of chapter 6D. The center shall confidentially provide a list of the payers, providers
50 and provider organizations to the health policy commission such that the authority may pursue
51 further action under section 10 of chapter 6D.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

120 (f) Notwithstanding any general or special law to the contrary, carriers offering small
121 group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or
122 176G, shall file small group product base rates and any changes to small group rating factors no
123 more frequently than two times per calendar year. Such filings shall occur according to the
124 following timeframes: (1) any health insurance plans that are to be effective on January 1 of each
125 year shall be filed on or before June 1 of the preceding year; and (2) any health insurance plans
126 that are to be effective on July 1 of each year shall be filed on or before January 1 of the same
127 calendar year.

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

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

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

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

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

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

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

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

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

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

178 (c) The commissioner, in consultation with the executive director of the connector, shall
179 establish reinsurance payment parameters, in accordance with subsection (d) for calendar year
180 2023 and each subsequent calendar year that include: (i) an attachment point; (ii) a coinsurance
181 rate; and (iii) a coinsurance cap.

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

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

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

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

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

202 SECTION 11. Section 2000 of chapter 29 of the General Laws, as appearing in the
203 2018 Official Edition, is hereby amended by striking out the second paragraph, and inserting in
204 place thereof the following paragraph:-

205 There shall be credited to the trust fund:

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

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

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

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

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

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

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

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

244 MassHealth program with household income that does not exceed 100 per cent of the federal
245 poverty level; provided further that enrollees with income between 100 and 150 per cent of the
246 federal poverty guidelines shall have available to them at least one health benefit plan with no
247 premium contribution. If the health benefit plans submitted through the Seal of Approval process
248 pursuant to section 10 of this chapter do not permit such choice of health benefit plans at a
249 reasonable cost to the Commonwealth, the board may seek additional participation of health
250 benefit plans in conjunction with the Division of Insurance pursuant to section 3(b) of chapter
251 176J of the General Laws or take other measures to facilitate reasonable access to health benefit
252 plans up to and including establishing contracts under subsection (v) of this section or seeking a
253 waiver under subsection (x) of this section.

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

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

- 265 (1) out-patient or ambulatory services, including medications, lab tests, procedures, and
266 office visits, generally offered in the primary care or medical home setting;
- 267 (2) of clear benefit, strongly supported by clinical evidence to be cost-effective;
- 268 (3) likely to reduce hospitalizations or emergency department visits, or reduce future
269 exacerbations of illness progression, or improve quality of life;
- 270 (4) relatively low cost when compared to the cost of an acute illness or incident prevented
271 or delayed by the use of the service, treatment or drug; and
- 272 (5) at low risk for overutilization, abuse, addiction, diversion or fraud.

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

275 (b) Any policy, contract or certificate of health insurance subject to chapters 32A, 118E,
276 175, 176A, 176B, 176G or 176Q of the General Laws shall provide coverage for the identified
277 services, treatments and prescription drugs. Such coverage shall not be subject to any cost-
278 sharing, including co-payments and co-insurance, and shall not be subject to any deductible,
279 pursuant to guidance from the secretary of health and human services. The commissioner of the
280 division of insurance shall adopt any written policies, procedures or regulations necessary to
281 implement said program.

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

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

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