SENATE DOCKET, NO. 333 FILED ON: 1/28/2021

SENATE . . . . . No. 787

The Commonwealth of Massachusetts

PRESENTED BY:

Jason M. Lewis

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 establishing a public health option.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Jason M. Lewis	*Fifth Middlesex*

SENATE DOCKET, NO. 333 FILED ON: 1/28/2021

SENATE . . . . . No. 787

By Mr. Lewis, a petition (accompanied by bill, Senate, No. 787) of Jason M. Lewis for legislation to establish a public health option. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *697* OF 2019-2020.]

The Commonwealth of Massachusetts

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

An Act establishing a public health option.

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. The General Laws are hereby amended by inserting after chapter 176Q the following new chapter:-

CHAPTER 176S. PUBLIC HEALTH INSURANCE OPTION

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:—

"Commonwealth Connector Board", the board of the commonwealth health insurance connector, established by subsection (b) of section 2 of chapter 176Q.

"Commonwealth Connector", the commonwealth health insurance connector authority, established by subsection

(a) of section 2 of chapter 176Q.

"Connector seal of approval", the approval given by the board of the connector to indicate that a health benefit plan meets certain standards regarding quality and value, as established by section 10 of Chapter 176Q.

"Carrier", an insurer licensed or otherwise authorized to transact accident and 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.

"Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; a coverage for young adults health insurance plan under section 10 of chapter 176J. The words "health benefit plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that

is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self-insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A. The commissioner of insurance may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

"Eligible individuals", an individual who is a resident of the commonwealth; provided however, that the individual is not offered subsidized health insurance by an employer with more than 50 employees.

"Eligible small groups", groups, any sole proprietorship, labor union, educational, professional, civic, trade, church, not-for-profit or social organization or firms, corporations, partnerships or associations actively engaged in business that on at least 50 per cent of its working days during the preceding year employed at least one but not more than 50 employees.

"Eligible large groups", groups, any labor union, educational, professional, civic, trade, church, not-for-profit or social organization or firms, corporations, partnerships or associations

actively engaged in business that on at least 50 per cent of its working days during the preceding year employed at least 51 employees.

"Public Option", the public health benefits plan offered through the Commonwealth Connector, established by section 2.

"Trust Fund", the Public Health Insurance Trust Fund, established by section 7.

Section 2. The Commonwealth Connector Authority shall provide for the offering a public health benefits plan - the public health insurance option - to eligible individuals and groups, to ensure choice, competition, and stability of affordable, high quality coverage throughout Massachusetts. The public option shall:-

(a) be made available exclusively through the Commonwealth Connector, alongside health benefit plans receiving the Connector seal of approval;

(b) meet all the requirements established for health benefit plans to receive the Commonwealth Connector seal of approval;

(c) meet the Connector's standards for minimum creditable coverage; and

(d) comply with subsections (b), (c), and (d) of section 5 of chapter 176Q.

Section 3. The public option shall be made available to eligible individuals and eligible small groups through the Connector no later than January 1, 2021. In addition the public option shall be made available to eligible large groups no later than July 1, 2021.

Section 4. The executive director of the commonwealth connector may contract with managed care organizations or other such health benefits administrators to administer aspects of

plans offered under the public health insurance option. Notwithstanding any general or special law to the contrary, the executive director shall collaborate with the secretary of health and human services and the commissioner of insurance to ensure that only Medicaid managed care organizations, that have contracted with the commonwealth as of January 1, 2016, to deliver such managed care services, are so contracted with to administer aspects of the public option. The executive director may accept applications from non-Medicaid managed care organizations for the provision of such services after January 1, 2023.

Section 5. A report on the activities, receipts, expenditures, and enrollments of the public option shall be included in the Commonwealth Connector's annual reports and shall be subject to the prescription and oversight of the Commonwealth Connector Board and state auditor as per section 14 and section 15 of chapter 176Q.

Section 6. The Commonwealth Connector shall establish premium rates for the public health insurance option at a level sufficient to fully finance the costs of:-

(a) health benefits provided by the public option; and

(b) administrative costs related to operating the public option.

Section 7. The Connector Board shall establish payment rates for the Public Health Insurance Option for services and providers based on parts A and B of Medicare. The Commonwealth Connector Board may determine the extent to which adjustments to base Medicare payment rates shall be made in order to fairly reimburse providers and medical goods and device makers, as well as to maintain a a strong provider network.

Section 8. Health care providers (including physicians and hospitals) participating in Medicare are participating providers in the public option unless they opt out through a process to be established by the Commonwealth Connector. This opt-out process must ensure that:

(a) no provider shall be subject to a penalty for not participating in the public health insurance option;

(b) the connector shall include information on how providers participating in Medicare who chose to opt out of participating in the public health insurance option may opt back in; and

(c) there shall be an annual enrollment period in which providers may decide whether to participate in the public health insurance option.

Section 9. The Commonwealth Connector may adopt regulations to implement this chapter.

SECTION 2. Chapter 26 of the General Laws is hereby amended by inserting after section 8J the following new section:-

Section 8K. (a) The commissioner of insurance is hereby authorized to make an assessment against all health plans, health insurers, and health maintenance organizations in the Commonwealth, as well as the public health insurance option established by section 2 of chapter 176R of the General Laws (which shall be referred to herein as "risk-adjusted health plans") , if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all risk-adjusted health plans for such year. Self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974), shall be exempted from such risk adjustment.

(b) Using the criteria and methods developed under subsection (c), the commissioner of insurance shall provide a payment to risk-adjusted health plans (with respect to health insurance coverage) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all risk-adjusted health plans for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(c) The commissioner shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. In calculating the actuarial risk of risk-adjusted health plans, the commissioner may utilize data including but not limited to enrollee demographics, inpatient and outpatient diagnoses (in similar fashion as such data are used under parts C and D of title XVIII of the Social Security Act), and such other information as the commissioner determines may be necessary such as the actual medical costs of enrollees during the previous year. Upon request, such risk-adjusted health plans shall make information available to the division of insurance for the purposes of risk adjustment under this section. Such information shall be limited to the minimum amount of personal information necessary, shall be confidential, and shall not constitute a public record.

(d) Section 123 of chapter 58 of the Session Laws of 2006 is hereby amended by striking out the last two sentences of the section, beginning with “The director shall collaborate with the secretary…”

SECTION 3. Chapter 29 of the General Laws is hereby amended by inserting after section 2XXX the following new section:-

Section 2FFFF. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Public Health Insurance Option Trust Fund, in this section called the trust fund. Amounts credited to the trust fund shall be expended without further appropriation for operation of the public health insurance option. Not later than January 1, the comptroller shall report an update of revenues for the current fiscal year. The comptroller shall file this report with the secretary of administration and finance, the office of Medicaid, the joint committee on health care financing, and the house and senate committees on ways and means.

SECTION 4. Subsection (a) of section 5 of Chapter 176Q of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting, after the words "underwritten by a carrier," the following words:- , as well as the public health insurance option,

SECTION 5. Section 1 of Chapter 176Q of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting, after the definition of "Eligible Small Groups", the following definition:-

"Eligible large groups", groups, any labor union, educational, professional, civic, trade, church, not-for-profit or social organization or firms, corporations, partnerships or associations actively engaged in business that on at least 50 per cent of its working days during the preceding year employed at least 51 employees.'

SECTION 6. Section 4(a) of Chapter 176Q of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting prior to the words "groups as defined," the following words:- eligible small and large

SECTION 7. Section 4(b) of Chapter 176Q of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out the phrase “or small group” and inserting in its place the following words:- , small group, or large group

SECTION 8. Effective no later than July 1, 2022, the board of the Commonwealth Connector shall, consistent with the Board’s powers and duties as enumerated in section 3 of chapter 176J, extend its seal of approval to large group plans and offer such plans, alongside a public health insurance option for large groups, through the Connector.