SENATE DOCKET, NO. FILED ON: 1/14/2009

SENATE . . . . . No.

The Commonwealth of Massachusetts

PRESENTED BY:

Mark C. Montigny

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 passage of the accompanying bill:

An Act Relative to Health Care Affordability .

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Mark C. Montigny	Second Bristol and Plymouth

The Commonwealth of Massachusetts

In the Year Two Thousand and Nine

AN ACT RELATIVE TO HEALTH CARE AFFORDABILITY .

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 third sentence of the first paragraph of subsection (d) of section 38C of chapter 3 of the General Laws is hereby amended by striking out the words “the division of insurance” and inserting in place thereof the following words:– the division of health insurance.

SECTION 2. The second paragraph of section 16 of chapter 6A of the General Laws is hereby amended by striking out the words “and (7) the health facilities appeals board” and inserting in place thereof the following words:– (7) the health facilities appeals board; and (8) the division of health insurance under the direction of the commissioner of health insurance.

SECTION 3. The second sentence of subsection (a) of section 16D of chapter 6A of the General Laws is hereby amended by striking out the words “the commissioner of insurance” and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 4. The first sentence of subsection (b) of section 16K of chapter 6A of the General Laws is hereby amended by striking out the words “the commissioner of insurance” and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 5. Sections 7A and 7B of chapter 26 of the General Laws are hereby repealed.

SECTION 6. The first paragraph of section 8H of chapter 26 of the General Laws is hereby amended by adding the following sentence:– Assessments received under this paragraph from domestic health insurance companies, including nonprofit hospital, medical and dental service corporations as defined in section 1 of chapter 176A, section 1 of chapter 176B, and section 1 of chapter 176E shall be paid to the division of health insurance.

SECTION 7. Section 8H of chapter 26 of the General Laws is hereby amended by striking out the third and forth paragraphs.

SECTION 8. The first sentence of section 3 of chapter 32A of the of the General Laws is hereby amended by striking out the words "the commissioner of insurance" and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 9. Subsection (a) of section 2 of chapter 111M of the General Laws is hereby amended by inserting after the words "established by chapter 176Q" the following:- by regulation, in accordance with the requirements of subsection (d).

SECTION 10. The first sentence of subsection (b) of said section 2 of said chapter 111M of the General Laws is hereby amended by striking out clauses (ii) and (iii) and inserting in place thereof the following clauses:- (ii) claims an exemption under section 3, (iii) had a certificate issued under section 3 of chapter 176Q, or (iv) had adjusted gross income as shown on the individual's state tax return such that the amount required to purchase the lowest cost insurance on the market for which an individual would be eligible for creditable coverage, taking into consideration the out of pocket costs, as shown in the schedule created pursuant to subsection (p) of section 3 of chapter 176Q, exceeds the amount which an individual could be expected to contribute towards the purchase of insurance in the report published pursuant to subsection (q) of section 3 of chapter 176Q.

SECTION 11. Said section 2 of chapter 111M of the General Laws, as so appearing, is hereby further amended by inserting after subsection (c) the following subsections:-

(d) The affordability schedule set by the board of the connector pursuant to subsection (a) shall be subject to the following requirements:

(1) in determining whether creditable coverage is affordable, the board of the connector shall consider expected enrollee expenditures as the 90^{th} percentile of out of pocket costs plus premiums for those enrolled in creditable coverage;

(2) For the purposes of this section, "out-of-pocket costs" shall mean the amount paid by an enrollee to satisfy the applicable annual deductible, co–payments and co-insurance, not including monthly premiums.

SECTION 12. The General Laws are hereby amended by inserting after chapter 111M the following chapter:–

Chapter 111N.

Division of Health Insurance.

Section 1. There is hereby established a division of health insurance under the supervision and control of the commissioner of health insurance. The secretary of health and human services shall appoint the commissioner, with the approval of the governor, who shall serve at the pleasure of the secretary and may be removed by the secretary at any time, subject to the approval of the governor. The commissioner shall have such educational qualifications and administrative and other experience as the secretary of health and human services determines to be necessary for the performance of the duties of commissioner. The position of commissioner shall be classified in accordance with section 45 of chapter 30 and the salary shall be determined in accordance with section 46C of said chapter 30.

The commissioner shall appoint and may remove such agents and subordinate officers as the commissioner may deem necessary and may establish bureaus and subdivisions within the division. The division shall adopt and amend rules and regulations, in accordance with chapter 30A, for the administration of its duties and powers and to effectuate the provisions and purposes of this chapter and other duties of the division.

Section 2. There shall be in the division a health care access bureau overseen by a deputy commissioner for health care access, whose duties shall include, subject to the direction of the commissioner of health insurance, administration of the division's statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers about health insurance coverage and access to affordable products. The commissioner shall appoint at least the following employees of the health care access bureau: a deputy commissioner for health access, a health care finance expert, an actuary, and a research analyst. They shall devote their full time to the duties of their office, shall be exempt from chapters 30 and 31, and shall serve at the pleasure of the commissioner. The commissioner may appoint such other employees as the bureau may require.

The commissioner may make and collect an assessment against the carriers licensed under chapters 175, 176A, 176B and 176G to pay for the expenses of the bureau. The assessment shall be at a rate sufficient to produce $600,000 annually. In addition to that amount, the assessment shall include an amount to be credited to the General Fund which shall be equal to

the total amount of funds estimated by the secretary for administration and finance to be expended from the General Fund for indirect and fringe benefit costs attributable to the personnel costs of the bureau. If the commissioner fails to expend for the costs and expenses of the bureau in a fiscal year the total amount of $600,000 for the purposes set forth in this section, any amount unexpended in that fiscal year shall be credited against the assessment to be made in the following fiscal year, and the assessment in the following fiscal year shall be reduced by that unexpended amount. The assessment shall be allocated on a fair and reasonable basis among all carriers licensed under said chapters 175, 176A, 176B and 176G. The funds produced by the assessments shall be expended by the division, in addition to any other funds which may be appropriated, to assist in defraying the general operating expenses of the bureau, and may be used to compensate consultants retained by the bureau. A carrier licensed under said chapters 175, 176A, 176B and 176G shall pay the amount assessed against it within 30 days after the date of the notice of assessment from the commissioner.

Section 3. (a) For the purposes of implementing chapter 111M and section 8B of chapter 62C, the commissioner may consult with the department of revenue and may enter into an interdepartmental service agreement with the department that may include the transfer of information from statements and reports provided under said section 8B.

(b) Upon request, carriers licensed under chapters 175, 176A, 176B and 176G and the office of Medicaid shall make information available to the bureau for the purposes of chapter 111M. Such information shall be limited to the minimum amount of personal information necessary, shall not include information about diagnoses or treatments and, except for the office of Medicaid, shall not include social security numbers. The information acquired under this section shall be confidential and shall not constitute a public record.

(c) The division may consider violations of this section and said section 8B when licensing or authorizing entities to provide health coverage.

Section 4. The division, in consultation with the commonwealth health insurance connector established by chapter 176Q, shall establish and publish minimum standards and guidelines at least annually for each type of health benefit plans, except qualified student health insurance plans as set forth in section 18 of chapter 15A, provided by insurers and health maintenance organizations doing business in the commonwealth.

Section 5. The division shall require all health insurers and health maintenance organizations doing business in the commonwealth to identify persons who are recipients of medical assistance under chapter one hundred and eighteen E or recipients of health care services, including hospital and other services funded through the uncompensated care pool under section 18 of chapter 118G, or who are responsible for supporting such recipients, and who are also beneficiaries under any policy for health insurance or parties to any health maintenance contract in force and effect in the commonwealth. The department of public welfare and the division of health care finance and policy shall provide information to the extent sufficient to allow all insurers to identify such persons. Such information shall be made available by such insurers and health maintenance organizations and by the department and the division of health care finance and policy only for the purposes of and to the extent necessary for identifying such persons. No health insurer or health maintenance organization which complies with this section shall be liable in any civil or criminal action or proceedings brought by such beneficiaries

or members on account of such compliance. The division of health insurance shall further direct all health insurers and health maintenance organizations doing business in the commonwealth to participate with the department and the division of health care finance and policy in any procedures, including but not limited to automated file matches, conducted under the direction of the department and the division of health care finance and policy for the purpose of identifying those persons who are recipients of medical assistance under chapter 118E or recipients of health care services, including hospital and other services funded through the uncompensated care pool, under section 18 of chapter 118G, or who are responsible for supporting such recipients, and who are also beneficiaries under any policy for health insurance or parties to any health maintenance contract in force in the commonwealth. Participation in such a procedure by a health insurer or health maintenance organization doing business in the commonwealth shall include but not be limited to reasonable financial participation in the cost of any such procedure. The commissioner of health insurance is authorized to promulgate regulations necessary to ensure the effectiveness of this section

Section 6. (a) As used in this section the following words shall have the following meanings, unless the context clearly requires otherwise:-

"Adjusted weighted average market premium price", the arithmetic mean of all premium rates for a given prototype plan sold to eligible insureds with similar rate basis type by all carriers selling prototype plans or alternative prototype plans in the commonwealth, weighted pursuant to regulations promulgated by the commissioner.

“Alternative prototype plan”, a health plan which meets the criteria established by the commissioner and which is intended for sale under section 4 of chapter 176Q, to eligible individuals and to eligible small groups, as defined in section 1 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 non-profit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

“Health plan”, any individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175 or the laws of any other jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B or the laws of any other jurisdiction; a health maintenance contract issued by a health maintenance organization under chapter 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I or the laws of any other jurisdiction. “Health plan” shall not include accident only, credit-only, limited scope dental or vision benefits if offered separately, hospital indemnity insurance policies if offered as independent, noncoordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to 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. chapter 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. The commissioner may by regulation define other health coverage as a health plan for the purposes of this chapter.

"Prototype plan", a health plan which meets the criteria established by the commissioner.

“Rate basis type”, each category of individual or family composition for which separate rates are charged for a health benefit plan as determined by the carrier subject to restrictions set forth in regulations promulgated by the commissioner.

(b) After a date established annually by the commissioner pursuant to regulation, every carrier desiring to increase or decrease premiums for any health insurance policy or desiring to set the initial premium for a new health insurance policy under any health plan shall file its rates with the commissioner at least 90 days before the proposed effective date of such new health insurance rates.

(c) Any increase in premium rates shall continue in effect for not less than 12 months, except that an increase in benefits or decrease in rates may be permitted at any time.

(d) A carrier shall annually report to the commissioner and to the health care quality and cost council, established under section 16K of chapter 6A, no later than May 1, the actual loss ratio calculated for each health plan for the previous calendar year.

(e) If a carrier files for an increase in premium of 7 per cent or more than the premium previously charged for any rate classification or coverage, or if a carrier files an initial premium request that is 7 per cent or more than the adjusted weighted average market premium price, or if the attorney general files with the commissioner, within 30 days of the carrier’s filing, a preliminary determination that the benefits provided in any health insurance policy are unreasonable in relation to the premium charged, the commissioner shall initiate a hearing conducted pursuant to chapter 30A on any such filing prior to its effective date on at least 10 days notice. The commissioner may consolidate hearings for more than 1 carrier, and may consolidate hearings for multiple health plans filed by one carrier. The carrier shall provide information on the reasons for the proposed premium increase, and members of the public may testify. All testimony and evidence received shall be public records. The commissioner may promulgate guidelines to safeguard the confidentiality of contracts that establish rates between insurers and institutional providers licensed under section 51 of chapter 111 which shall apply when the commissioner obtains such contracts under his authority in section 8A of chapter 175 for purposes of a hearing under this section.

The attorney general shall have the authority to intervene in any hearing called for under this section.

Such requested premium increase or initial premium request shall be filed at least 90 days before the proposed effective date of such increase, and shall be communicated to the insureds at least 90 days before the proposed effective date of such increase, in the manner directed by the commissioner.

The rate filer shall advertise any public hearing conducted under this section in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell.

Within 30 days of the conclusion of any hearing initiated under this section, the commissioner shall issue a report containing findings of fact from the evidence presented in the carrier's filing and in the hearing. The findings of fact shall include, but shall not be limited to:

1. the carrier's administrative expenses, including but not limited to the carrier's salary structure, advertising and other marketing expenses, and commissions, brokerage fees and other distribution expenses, as compared to other carriers within and without the commonwealth;
2. the carrier's expenses related to health care contract, including but not limited to the costs of services rendered by health care providers, the rates at which it pays for such services and the volume of services provided;
3. the carrier's loss experience under the health plan, including evaluations of the carrier's loss ratio and of utilization by the carrier's insureds, and of identifiable cost drivers for that health plan, as compared to other carriers within and without the commonwealth;
4. cost-sharing assumptions made in the health plan, including, but not limited to, the use of deductibles, co-payments and coinsurance;
5. the carrier's provisions in the rates for reserves and surplus; and
6. the carrier's programs of cost containment, as compared to other carriers within and without the commonwealth.

Nothing in this paragraph shall be construed to prohibit the attorney general from publishing any report concerning a hearing under this section.

This section is not intended to alter any procedures for the approval or disapproval of health plan rates provided elsewhere in the General Laws, except as specifically provided herein.

The commissioner shall promulgate regulations to specify the conduct and scheduling of the hearings required pursuant to this section, provided that any such regulation shall facilitate adequate discovery of information related to the filed rates.

(f) The supreme judicial court shall have jurisdiction in equity upon the petition of the attorney general, on behalf of the commissioner and upon a summary hearing, to enforce all lawful orders of the commissioner.

Any person aggrieved by any final action, order, finding or decision of the commissioner under this section may, within 20 days from the filing of such final action, order, finding or decision in his office, file a petition in the supreme judicial court for the county of Suffolk for a review of such action, order, finding or decision. The final action, order, finding, or decision of the commissioner shall remain in full force and effect, pending the final decision of the court, unless the court or a justice thereof after notice to the commissioner shall by a special order otherwise direct. Review by the court on the merits shall be limited to the record of proceedings before the commissioner. The court shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order, finding or decision and shall uphold the commissioner's action, order, finding, or decision if it is consistent with the standards set forth in paragraph 7 of section 14 of chapter 30A. The court may make any appropriate order or decree and may make such order as to costs as it deems equitable. The court may make such rules or orders as it deems proper governing proceedings under this section to secure prompt and speedy hearings and to expedite final decisions thereon.

(g) The commissioner may promulgate regulations to facilitate the administration and enforcement of this section and to govern hearings and investigations thereunder, and may issue such orders as he finds proper, expedient or necessary to enforce and administer this chapter and to secure compliance with any rules and regulations made thereunder.

SECTION 13. Clause (ii) of the second paragraph of subsection (d) of section 2 of chapter 118G of the General Laws is hereby amended by striking out the words “the division of insurance” and inserting in place thereof the following words:– the division of health insurance.

SECTION 14. Clause (i) of the second sentence of the third paragraph of section 6 of chapter 118G of the General Laws is hereby amended by striking out the words “the division of insurance under section 8H of chapter 26” and inserting in place thereof the following words:– the division of health insurance.

SECTION 15. The second sentence of subsection (b) of section 6½ of chapter 118G of the General Laws is hereby amended by striking out the words “the division of insurance” and inserting in place thereof the following words:– the division of health insurance.

SECTION 16. Section 1 of chapter 175 of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of insurance; provided, that the term “Commissioner” shall mean the commissioner of health insurance established by chapter 111N with respect to all health insurance, including accident and sickness insurance under sections 108 and 110 and any other insurance that provides medical, surgical, dental, or hospital expense benefits.

SECTION 17. Section 2 of chapter 175I of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of insurance or his designee; provided, that the term “Commissioner” shall mean the commissioner of health insurance established by chapter 111N with respect to all health insurance.

SECTION 18. Section 1 of chapter 176A of the General Laws is hereby amended by inserting before the first paragraph the following paragraph:–

Notwithstanding any general or special law to the contrary, the words “commissioner” and “commissioner of insurance” as used in this chapter shall mean the commissioner of health insurance.

SECTION 19. Section 1 of chapter 176B of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of health insurance.

SECTION 20. Section 1 of chapter 176D of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of insurance; provided, that the terms “Commissioner” and “commissioner of the division of insurance” shall mean the commissioner of health insurance established by chapter 111N with respect to all health insurance, including accident and sickness insurance under sections 108 and 110 and any other insurance that provides medical, surgical, dental, or hospital expense benefits.

SECTION 21. Section 1 of chapter 176E of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of health insurance.

SECTION 22. Section 1 of chapter 176G of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of health insurance.

SECTION 23. Section 1 of chapter 176I of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of health insurance.

SECTION 24. Section 1 of chapter 176J of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of health insurance.

SECTION 25. Section 1 of chapter 176K of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 26. Section 1 of chapter 176M of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 27. Section 1 of chapter 176N of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 28. Section 1 of chapter 176O of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 29. Section 1 of chapter 176O of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 30. Said section 1 of said chapter 176O of the General Laws is hereby amended by striking out the definition of "Division" and inserting in place thereof the following definition:–

"Division", the division of health insurance.

SECTION 31. Section 1 of chapter 176Q of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 32. The second sentence of subsection (b) of section 2 of chapter 176Q of the General Laws is hereby amended by striking out the words “the commissioner of insurance” and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 33. Subsection (m) of section 3 of chapter 176Q of the General Laws is hereby amended by striking out the words “the division of insurance” and inserting in place thereof the following words:– the division of health insurance.

SECTION 34. Section 1 of chapter 176R of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of health insurance.

SECTION 35. (a) Notwithstanding any general or special law to the contrary, this section shall facilitate the orderly transfer of the employees, proceedings, rules and regulations, property and legal obligations and functions of state government from the division of insurance, solely to the extent that they relate to health insurance, as transferor agency, to the division of health insurance, as transferee agency.

(b) Subject to appropriation, the employees of the transferor agency, including those who immediately before the effective date of this act held permanent appointment in positions classified under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A of chapter 30 of the General Laws or did not hold such tenure, or held confidential positions, are hereby transferred to the transferee agency, without interruption of service within the meaning of section 9A of chapter 30, without impairment of seniority, retirement or other rights of the employee, and without reduction in compensation or salary grade, notwithstanding any change in title or duties resulting from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without change in union representation or certified collective bargaining unit as certified by the state labor relations commission or in local union representation or affiliation. Any collective bargaining agreement in effect immediately before the transfer date shall continue in effect and the terms and conditions of employment therein shall continue as if the employees had not been so transferred. The reorganization shall not impair the civil service status of any such reassigned employee who immediately before the effective date of this act either held a permanent appointment in a position classified under chapter 31 of the General Laws or had tenure in a position by reason of section 9A of chapter 30 of the General Laws.

(c) Notwithstanding any general or special law to the contrary, all such employees shall continue to retain their right to bargain collectively pursuant to chapter 150E of the General Laws and shall be considered employees for the purposes of chapter 150E.

Nothing in this section shall confer upon any employee any right not held immediately before the date of the transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge or layoff not prohibited before such date; nor shall anything in this section prohibit the abolition of any management position within the divisions of telecommunications or community antenna television after transfer to the department.

(d) All petitions, requests, investigations, filings and other proceedings appropriately and duly brought before the transferor agency, or pending before it before the effective date of this act, shall continue unabated and remain in force, but shall be assumed and completed by the transferee agency.

(e) All orders, advisories, findings, rules and regulations duly made and all approvals duly granted by the transferor agency, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency.

(f) All books, papers, records, documents, equipment, buildings, facilities, cash and other property, both personal and real, including all such property held in trust, which immediately before the effective date of this act are in the custody of the transferor agency, shall be transferred to the transferee agency.

(g) All duly existing contracts, leases and obligations of the transferor agency, shall continue in effect but shall be assumed by the transferee agency. No such existing right or remedy of any character shall be lost, impaired or affected by this act.

(h) Whenever the term “division of insurance” appears in any statute, regulation, contract or other document, it shall be taken to mean the division of health insurance to the extent that it relates to health insurance. Otherwise, it shall be continue to be taken to mean the division of insurance.