

By Mr. Mann of Hanson, petition of Charles W. Mann for legislation to regulate non-group insurance rates for non-profit hospital service corporations. Insurance.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Ninety.

AN ACT RELATIVE TO NONGROUP RATE FILINGS.

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. Section 6 of chapter 176 A of the General Laws
2 is hereby amended by striking out the second paragraph, and
3 inserting in place thereof, the following: —

4 For nongroup contracts other than those providing supple-
5 mental coverage to medicare, the commissioner shall establish by
6 regulation a schedule for the annual filing of rates and for the
7 hearing and decision thereon. Such regulations shall provide that
8 rates shall be filed at least four months prior to their proposed
9 effective date, that such rates shall be approved or disapproved
10 within thirty days following the conclusion of the public hearing,
11 that such rates shall be approved or disapproved no more than
12 four months after their filing, and that there shall be prompt
13 refiling and reconsideration of an amended rate application in the
14 event that rate is disapproved. Any rate so approved, including
15 rates approved after having previously been disapproved shall be
16 effective as of the originally proposed effective date unless the
17 commissioner shall specify an earlier effective date. Any rate
18 approved after the proposed effective date, shall be adjusted for
19 the difference between the approved rate and the prior rate
20 collected, such adjustment to be prorated over the ensuing twelve
21 months, without regard to any subsequent revisions of the annual
22 rates.

23 For nongroup contracts providing supplemental coverage to
24 medicare, the commissioner shall approve or disapprove such

25 contracts or rates within thirty days following the conclusion of
26 the public hearing, to be effective not earlier than thirty days
27 subsequent to such approval. Rates charged to nongroup
28 subscribers with contracts providing supplemental coverage to
29 medicare or other governmental programs shall not be approved
30 by the commissioner if they include a subscriber's contribution
31 to the reserves of the corporation or do not provide a credit for
32 investment income subject to the approval of the commissioner.

33 For the purposes of this section, "rates" shall mean the
34 individual components determined by the nonprofit hospital
35 service corporation making the filing, and the commissioner shall
36 approve or disapprove each component separately. If the commis-
37 sioner disapproves one or more components of a rate, the
38 nonprofit hospital service corporation may implement the rate for
39 the components approved or deemed approved, and continue to
40 charge the previously approved rate for the components
41 disapproved. When revised rates are approved, these shall become
42 effective as specified in this section.

43 Notwithstanding the provisions of this section that contracts
44 and rates shall continue in effect for not less than twelve months
45 after approval, the nonprofit hospital service corporation may
46 apply for an adjustment of rates for nongroup contacts, other than
47 those providing supplemental coverage for medicare, for any
48 modification in deductibles, copayments, coinsurance or benefits
49 mandated or required by statute, regulation, regulatory agency
50 decision or judicial decision. The commissioner shall adjust the
51 rates within thirty days of application by the corporation. Any
52 such rate adjustment shall equal the incremental cost to implement
53 the change in coverage. The change in coverage shall not become
54 effective until the rates are so adjusted.

55 No nongroup contracts or rates shall be approved if the benefits
56 provided herein are unreasonable in relation to the rate charged,
57 nor if the rates are excessive, inadequate or unfairly discrimina-
58 tory. Classifications shall be fair and reasonable. The commis-
59 sioner shall make a finding on the basis of information submitted
60 by a nonprofit hospital service corporation that such corporation
61 employs a utilization review program and other techniques
62 acceptable to him which have had or are expected to have a
63 demonstrated impact on the prevention of reimbursement by such

64 corporations for services which are not medically necessary. The
65 commissioner shall establish by regulation the standards on which
66 such a finding is to be made. Such regulations shall be promul-
67 gated no later than May 1, 1990. For nongroup contracts other
68 than those providing supplemental coverage to medicare, if the
69 commissioner is unable to make such a finding, an amount shall
70 be calculated to be deducted from the rates approved, provided
71 that such amount must be based on actual savings obtained by
72 comparable utilization review programs operating within the
73 commonwealth.

74 The contracts and rates so approved shall be applicable to all
75 such subscribers except as otherwise herein provided whether such
76 subscribers become such before or after the effective date thereof,
77 and shall continue in effect for not less than twelve months after
78 said effective date and thereafter until any changes shall have been
79 approved as provided above, except that an increase in benefits
80 to subscribers may, with the approval of the commissioner, be
81 allowed at any time and provided that such contracts may be
82 cancelled for nonpayment of subscribers' fees, misrepresentation
83 or fraud or as provided in sections eight and ten. No classification
84 of risk may be established on the basis of age.

1 SECTION 2. Section four of chapter 176B of the General Laws
2 is hereby amended by striking out the second and third paragraphs
3 thereof, and inserting in place thereof, the following: —

4 Any agreement between a medical service corporation and a
5 person whereby such corporation undertakes to furnish benefits
6 for medical service to said person and his covered dependents, if
7 any, shall be considered a nongroup medical service agreement.
8 For nongroup contracts other than those providing supplemental
9 coverage to medicare, the commissioner shall establish by regu-
10 lation a schedule for the annual filing of rates and for the hearing
11 and decision thereon. Such regulations shall provide that rates
12 shall be filed at least four months prior to their proposed effective
13 date, that such rates shall be approved or disapproved within
14 thirty days following the conclusion of the public hearing, that
15 such rates shall be approved or disapproved no more than four
16 months after their filing, and that there shall be prompt refiling
17 and reconsideration of an amended rate application in the event

18 that rate is disapproved. Any rate so approved, including rates
19 approved after having previously been disapproved shall be
20 effective as of the originally proposed effective date unless the
21 commissioner shall specify an earlier effective date. Any rate
22 approved after the proposed effective date, shall be adjusted for
23 the difference between the approved rate and the prior rate
24 collected, such adjustment to be prorated over the ensuing twelve
25 months, without regard to any subsequent revisions of the annual
26 rates.

27 For nongroup contracts providing supplemental coverage to
28 medicare, the commissioner shall approve or disapprove such
29 contracts or rate within thirty days following the conclusion of
30 the public hearing to be effective not earlier than thirty days
31 subsequent to such approval. Rates charged to nongroup
32 subscribers with contracts providing supplemental coverage to
33 medicare or other governmental programs shall not be approved
34 by the commissioner if they include a subscriber's contribution
35 to the reserves of the corporation or do not provide a credit for
36 investment income, subject to the approval of the commissioner.

37 For the purposes of this section, "rates" shall mean the
38 individual components determined by the nonprofit medical
39 service corporation making the filing, and the commissioner shall
40 approve or disapprove each component separately. If the commis-
41 sioner disapproves one or more components of a rate, the
42 nonprofit medical service corporation may implement the rate for
43 the components approved, and continue to charge the previously
44 approved rate for the components disapproved. When revised
45 rates are approved, these shall become effective as specified in this
46 section.

47 Notwithstanding the provisions of this section that contracts
48 and rates shall continue in effect for not less than twelve months
49 after approval or when deemed approved, the nonprofit medical
50 service corporation may apply for an adjustment of rates for
51 nongroup contacts, other than those providing supplemental
52 coverage for medicare, for any modification in deductibles,
53 copayments, coinsurance or benefits mandated or required by
54 statute, regulation, regulatory agency decision or judicial decision.
55 The commissioner shall adjust the rates within thirty days of appli-
56 cation by the corporation. Any such rate adjustment shall equal

57 the incremental cost to implement the change in coverage. The
58 change in coverage shall not become effective until the rates are
59 so adjusted.

60 No nongroup agreements shall be approved if he finds that the
61 benefits provided therein are unreasonable in relation to the rate
62 charged, nor if the rates charged are excessive, inadequate or
63 unfairly discriminatory. Classifications shall be fair and
64 reasonable. The commissioner shall make a finding on the basis
65 of information submitted by a medical service corporation that
66 such corporation employs a utilization review program and other
67 techniques acceptable to him which have had or are expected to
68 have a demonstrated impact on the prevention of reimbursement
69 by such corporation for services which are not medically
70 necessary. The commissioner shall establish by regulation the
71 standards on which such a finding is to be made. Such regula-
72 tions shall be promulgated no later than May 1, 1990. For
73 nongroup contracts other than those providing supplemental
74 coverage to medicare, if the commissioner is unable to make such
75 a finding, an amount shall be calculated to be deducted from the
76 rates approved, provided that such amount must be based on
77 actual utilization review savings obtained by comparable
78 utilization programs operating within the commonwealth.

79 The contracts and rates so approved shall be applicable to all
80 such subscribers except as otherwise herein provided whether such
81 subscriber becomes such before or after the effective date thereof,
82 and shall continue in effect for not less than twelve months after
83 said effective date and thereafter until any changes shall have been
84 approved as provided above, except that an increase in benefits
85 to subscribers may, with the approval of the commissioner, be
86 allowed at any time and provided that such contracts may be
87 cancelled for nonpayment of subscribers' fees, misrepresentation
88 or fraud or as provided in sections five and six. No classification
89 of risk may be established on the basis of age.

1 SECTION 3. Said section four of chapter 176B is hereby
2 further amended by striking out paragraph 6 and inserting in place
3 thereof, the following: —

4 Any such group medical agreement, subscription certificates
5 and the rates charged by the corporation to subscribers shall be

6 filed with the commissioner within thirty days after their effective
7 date and shall be subject to subsequent disapproval by the
8 commissioner if he finds that the benefits provided therein are
9 unreasonable in relation to the rate charged or that the rates are
10 excessive, inadequate or unfairly discriminatory; and provided
11 that group plan contracts issued and rates charged by a nonprofit
12 medical service corporation to its subscribers providing
13 supplemental coverage to medicare shall be subject to the provi-
14 sions of this section requiring prior filing and prior approval of
15 the commissioner if the subscribers and not their employer,
16 employers or representatives are billed directly for such contracts.
17 In approving or disapproving any rate under this section, the
18 commissioner shall make a finding on the basis of information
19 submitted by a medical service corporation, that such corporation
20 employs a utilization review program and other techniques
21 acceptable to him which had or are expected to have a
22 demonstrated impact on the prevention of reimbursement by such
23 corporation for services which are not medically necessary. The
24 commissioner may make and, at any time, alter or amend
25 reasonable rules or regulations to facilitate the operation and
26 enforcement of this section and to govern hearings and investi-
27 gations thereunder. He may issue such orders as he finds proper,
28 expedient or necessary to enforce and administer the provisions
29 of this section and secure compliance with any rules and regu-
30 lations made thereunder.

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