HOUSE . . . . . No. 1353

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:

SECTION 1. Section 6 of chapter 176 A of the General Laws is hereby amended by striking out the second paragraph, and inserting in place thereof, the following: —

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

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

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

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

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

No nongroup contracts or rates shall be approved if the benefits provided herein are unreasonable in relation to the rate charged, nor if the rates are excessive, inadequate or unfairly discriminatory. Classifications shall be fair and reasonable. The commissioner shall make a finding on the basis of information submitted by a nonprofit hospital service corporation that such corporation employs a utilization review program and other techniques acceptable to him which have had or are expected to have a demonstrated impact on the prevention of reimbursement by such

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

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

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

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

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

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

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

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

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

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

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

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

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

filed with the commissioner within thirty days after their effective date and shall be subject to subsequent disapproval by the commissioner if he finds that the benefits provided therein are unreasonable in relation to the rate charged or that the rates are excessive, inadequate or unfairly discriminatory; and provided that group plan contracts issued and rates charged by a nonprofit medical service corporation to its subscribers providing supplemental coverage to medicare shall be subject to the provisions of this section requiring prior filing and prior approval of the commissioner if the subscribers and not their employer, employers or representatives are billed directly for such contracts. In approving or disapproving any rate under this section, the commissioner shall make a finding on the basis of information submitted by a medical service corporation, that such corporation employs a utilization review program and other techniques acceptable to him which had or are expected to have a demonstrated impact on the prevention of reimbursement by such corporation for services which are not medically necessary. The commissioner may make and, at any time, alter or amend reasonable rules or regulations to facilitate the operation and enforcement of this section and to govern hearings and investigations thereunder. He may issue such orders as he finds proper, expedient or necessary to enforce and administer the provisions of this section and secure compliance with any rules and regulations made thereunder.