

Senate, No. 2585

[Senate, July 30, 2010-- Report of the committee of conference on the disagreeing votes of the two branches, with reference to the House amendments to the Senate Bill to promote cost containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses (Senate, No. 2447) (*amended by the House* by striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4924”)]



The Commonwealth of Massachusetts

IN THE YEAR OF TWO THOUSAND AND TEN

AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE PROVISION OF QUALITY HEALTH INSURANCE FOR INDIVIDUALS AND SMALL BUSINESSES

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to provide forthwith for the containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

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 38C of chapter 3 of the General Laws, as appearing in the 2008 Official
2 Edition, is hereby amended by adding the following subsection:-

3 (e) The division of health care finance and policy shall issue a comprehensive report at least once
4 every 4 years on the cost and public health impact of all existing mandated benefits. In conjunction with
5 this review, the division shall consult with the department of public health and the University of
6 Massachusetts Medical School in a clinical review of all mandated benefits to ensure that all mandated

7 benefits continue to conform to existing standards of care in terms of clinical appropriateness or evidence-
8 based medicine. The division may file legislation that would amend or repeal existing mandated benefits
9 that no longer meet these standards.

10 **SECTION 2.** Section 16K of chapter 6A of the General Laws, as so appearing, is hereby
11 amended by striking out subsections (a) to (c), inclusive, and inserting in place thereof the following 3
12 subsections:-

13 (a) There shall be established a health care quality and cost council, which shall be an
14 independent public entity not subject to the supervision and control of any other executive office,
15 department, commission, board, bureau, agency or political subdivision of the commonwealth. The
16 council shall promote public transparency of the quality and cost of health care in the commonwealth, and
17 shall seek to support the long-term sustainability of health care reform in the commonwealth by
18 developing recommendations for containing health care costs, while facilitating access to information on
19 health care quality improvement efforts. The council shall disseminate health care quality and cost data
20 to consumers, health care providers and insurers through a consumer health information website under
21 subsections (e) and (g); establish cost containment goals under subsection (h); and coordinate ongoing
22 quality improvement initiatives under subsection (i).

23 (b) The council shall consist of 19 members and shall be comprised of: (1) 9 ex-officio members,
24 including the secretary of health and human services, the secretary of administration and finance, the state
25 auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of
26 health care finance and policy, the commissioner of public health and the executive director of the group
27 insurance commission, or their designees; and (2) 10 representatives of nongovernmental organizations to
28 be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement
29 organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a
30 representative of the Institute for Healthcare Improvement recommended by the organization's board of

31 directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of
32 Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association
33 of Health Underwriters, Inc., 1 of whom shall be a representative of the Massachusetts Medicaid Policy
34 Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution,
35 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall
36 be an organization representing the interests of small businesses with fewer than 50 employees, 1 of
37 whom shall be an organization representing the interests of large businesses with 50 or more employees
38 and 1 of whom shall be a clinician licensed to practice in the commonwealth. At least 2 members of the
39 council shall be clinicians licensed to practice in the commonwealth. Members of the council shall vote
40 annually to elect a chair and an executive committee, which shall consist of 4 council members and the
41 chair. The executive committee shall meet as required to fulfill the mission of the council. Members of
42 the council shall be appointed for terms of 3 years and shall serve until the term is completed or until a
43 successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation,
44 but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their
45 duties which may include reimbursement for reasonable travel and living expenses while engaged in
46 council business. All council members shall be subject to chapter 268A; provided, however, that the
47 council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in
48 which any council member is in anyway interested or involved; provided further that such interest or
49 involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings
50 of the council; and provided further, that no council member having such interest or involvement may
51 participate in any decision relating to such organization.

52 (c) All meetings of the council shall comply with chapter 30A. The council may, subject to
53 chapter 30B and subject to appropriation, procure equipment, office space, goods and services.

54 The executive office of health and human services may provide staff and administrative support
55 as requested by the council; provided, however, that all work completed by the executive office of health

56 and human services shall be subject to approval by the council . The council shall appoint an executive
57 director to oversee the operation and maintenance of the website, ensure compliance with the
58 requirements of this section, and coordinate work completed by the executive office of health and human
59 services and may, subject to appropriation, employ such additional staff or consultants as it deems
60 necessary.

61 The council shall promulgate rules and regulations and may adopt by-laws necessary for the
62 administration and enforcement of this section.

63 **SECTION 3.** Said section 16K of said chapter 6A, as so appearing, is hereby further amended
64 by striking out subsections (h) and (i), as so appearing, and inserting in place thereof the following 2
65 subsections:-

66 (h) The council, in consultation with its advisory committee, shall develop annual health care cost
67 containment goals. The goals shall be designed to promote affordable, high-quality, safe, effective,
68 timely, efficient, equitable and patient centered health care. The council shall also establish goals that are
69 intended to reduce health care disparities in racial, ethnic and disabled communities. In establishing cost
70 containment goals, the council shall utilize claims data collected from carriers under this section, and
71 information gathered as part of the division of health care finance and policy's public hearings on health
72 care costs under section 6 ½ of chapter 118G. For each goal, the council shall identify: (i) the parties that
73 will be impacted;(ii) the agencies, departments, boards or councils of the commonwealth responsible for
74 overseeing and implementing the goals; (iii) the steps needed to achieve the goals;(iv) the projected costs
75 associated with implementing the goals; (v) and the potential cost savings, both short and long-term,
76 attributable to the goals. The council may recommend legislation or regulatory changes to achieve these
77 goals. The council shall publish a report on the progress towards achieving the costs containment goals.

78 (i) The council, in consultation with its advisory committee, shall coordinate and compile data on
79 quality improvement programs conducted by state agencies and public and private health care

80 organizations. The council shall consider programs designed to: (i) improve patient safety in all settings
81 of care; (ii) reduce preventable hospital readmissions; (iii) prevent the occurrence of and improve the
82 treatment and coordination of care for chronic diseases; and (iv) reduce variations in care. The council
83 shall make such information available on the council's consumer health information website. The council
84 may recommend legislation or regulatory changes as needed to further implement quality improvement
85 initiatives.

86 **SECTION 4.** Section 2 of chapter 32A of the General Laws, as amended by section 64 of
87 chapter 25 of the acts of 2009 , is hereby amended by adding the following subsection:-

88 (i) "Wellness program", a program designed to measure and improve individual health by
89 identifying risk factors, principally through diagnostic testing and establishing plans to meet specific
90 health goals which include appropriate preventive measures. Risk factors may include but shall not be
91 limited to demographics, family history, behaviors and measured biometrics.

92 **SECTION 5.** Said chapter 32A is hereby further amended by adding the following section:-

93 Section 25. The commission shall, subject to appropriation, negotiate with and purchase, on such
94 terms as it deems to be in the best interest of the commonwealth and its employees, from 1 or more
95 entities that can manage a wellness program covering persons in the service of the commonwealth and
96 their dependents, and shall execute all agreements or contracts pertaining to the program. The
97 commission may negotiate a contract for such term not exceeding 5 years as it may, in its discretion,
98 deem to be the most advantageous to the commonwealth; provided, however that the program shall be
99 able to evaluate individual and aggregate data, give employees access to their individual information
100 confidentially and allow the commission to receive collective reports summarizing baseline and ongoing
101 data regarding the behavior and well being of enrollees. The commission may reduce premiums or co-
102 payments or offer other incentives to encourage enrollees to comply with the wellness program goals.

103 Beginning 1 year after the end of the fiscal year in which the commission has implemented the
104 wellness program, the commission shall submit an annual report to the governor, the secretary of health
105 and human services, the secretary of administration and finance, the chairs of the joint committee on
106 health care financing, chairs of the house and senate committees on ways and means, the speaker of the
107 house of representatives and the senate president. The report shall include the collective results, including,
108 but not limited to, the level of participation among employees, incentives provided for participation, the
109 number and type of screenings and diagnostic tests conducted, the instance of undiagnosed risks defined
110 as out of range diagnostic tests and number of employees seeking and receiving preventative treatment.
111 The commission shall use this information in the negotiating and purchasing, on such terms as it deems in
112 the best interest of the commonwealth and its employees, from 1 or more insurance companies, savings
113 banks or non-profit hospital or medical service corporations, of a policy or policies of group life and
114 accidental death and dismemberment insurance covering persons in the service of the commonwealth and
115 group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance
116 benefits covering persons in the service of the commonwealth and their dependents.

117 Beginning 1 year after the end of the fiscal year in which the commission has implemented the
118 wellness program, the commission shall annually submit a report to the governor, secretary of
119 administration and finance, the chairs of the joint committee on health care financing, the chairs of the
120 house and senate committees on ways and means, the speaker of the house of representatives and the
121 senate president on the savings that have been achieved in procuring such insurance policies since
122 implementing the wellness program.

123 **SECTION 6.** Subsection (b) of section 9of chapter 94C of the General Laws, as appearing in the
124 2008 Official Edition, is hereby by adding the following paragraph:-

125 This section shall not be construed to prohibit a physician or an optometrist from the in-office
126 dispensing and sale of therapeutic contact lenses as long as the medication contained in such lenses is
127 within the profession's designated scope of practice.

128 For the purposes of this section, "therapeutic contact lenses" shall mean contact lenses which
129 contain 1 or more medications and which deliver such medication to the eye.

130 **SECTION 7.** Chapter 111 of the General Laws is hereby amended by inserting after section 25O
131 the following section:-

132 Section 25P Every health care provider, as defined by section 1 or otherwise licensed under
133 chapter 112, shall track and report quality information at least annually under regulations promulgated by
134 the department.

135 **SECTION 8.** Section 217 of said chapter 111, as appearing in the 2008 Official Edition, is
136 hereby amended by inserting after the word "plans", in line 33, the following words:- ; and

137 (7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of section 4 of
138 chapter 176J; provided, however, that the office of patient protection may grant a waiver to an eligible
139 individual who certifies, under penalty of perjury, that such individual did not intentionally forego
140 enrollment into coverage for which the individual is eligible and that is at least actuarially equivalent to
141 minimum creditable coverage; provided further, that the office shall establish by regulation standards and
142 procedures for enrollment waivers.

143 **SECTION 9.** Said chapter 111 is hereby further amended by adding the following section: -

144 Section 222. There shall be a commission on falls preventions within the department. The
145 commission shall consist of the commissioner of public health or the commissioner's designee, who shall
146 chair the commission; the secretary of elder affairs or the secretary's designee; the director of MassHealth

147 or the director's designee; and 8 members to be appointed by the governor, 1 of whom shall be a member
148 of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a member of the AARP, 1 of
149 whom shall be a member of the Massachusetts Senior Care Association, Inc., 1 of whom shall be a
150 member of the Massachusetts Association of Councils on Aging, Inc. 1 of whom shall be a member of the
151 Massachusetts Medical Society Alliance, Inc., 1 of whom shall be a member of the Massachusetts
152 Assisted Living Facilities Association, 1 of whom shall be a member of Mass Home Care and 1 of whom
153 shall be a member of the Massachusetts Pharmacists Association Foundation, Inc.

154 The commission on falls prevention shall make an investigation and comprehensive study of the
155 effects of falls on older adults and the potential for reducing the number of falls by older adults. The
156 commission shall monitor the effects of falls by older adults on health care costs, the potential for
157 reducing the number of falls by older adults and the most effective strategies for reducing falls and health
158 care costs associated with falls. The commission shall:

159 (1) consider strategies to improve data collection and analysis to identify fall risk, health care cost
160 data and protective factors;

161 (2) consider strategies to improve the identification of older adults who have a high risk of
162 falling;

163 (3) consider strategies to maximize the dissemination of proven, effective fall prevention
164 interventions and identify barriers to those interventions;

165 (4) assess the risk and measure the incidence of falls occurring in various settings;

166 (5) identify evidence-based strategies used by long-term care providers to reduce the rate of falls
167 among older adults and reduce the rate of hospitalizations related to such falls;

168 (6) identify evidence-based community programs designed to prevent falls among older adults;

169 (7) review falls prevention initiatives for community-based settings; and

170 (8) examine the components and key elements of the above falls prevention initiatives, consider
171 their applicability in the commonwealth and develop strategies for pilot testing, implementation and
172 evaluation.

173 The commission on falls prevention shall submit to the secretary of health and human services
174 and the joint committee on health care financing, not later than September 22, annually, a report that
175 includes findings from the commission's review along with recommendations and any suggested
176 legislation to implement those recommendations. The report shall include recommendations for:

177 (1) intervention approaches, including physical activity, medication assessment and reduction of
178 medication when possible, vision enhancement and home-modification strategies;

179 (2) strategies that promote collaboration between the medical community, including physicians,
180 long-term care providers and pharmacists to reduce the rate of falls among their patients;

181 (3) programs that are targeted to fall victims who are at a high risk for second falls and that are
182 designed to maximize independence and quality of life for older adults, particularly those older adults
183 with functional limitations;

184 (4) programs that encourage partnerships to prevent falls among older adults and prevent or
185 reduce injuries when falls occur; and

186 (5) programs to encourage long-term care providers to implement falls- prevention strategies
187 which use specific interventions to help all patients avoid the risks for falling in an effort to reduce
188 hospitalizations and prolong a high quality of life.

189 **SECTION 10.** Section 66B of chapter 112 of the General Laws is hereby amended after the third
190 paragraph by inserting the following:-

191 This section shall not be construed to prohibit an optometrist from the in-office dispensing and
192 sale of therapeutic contact lenses as long as the medication contained in such lenses is within the
193 profession’s designated scope of practice.

194 For the purposes of this section, “therapeutic contact lenses” shall mean contact lenses which
195 contain 1 or more medications and which deliver such medication to the eye.

196 **SECTION 11.** Section 1 of chapter 118G of the General Laws, as so appearing, is hereby
197 amended by inserting after the definition of “Health maintenance organization” the following definition:-

198 “Health status adjusted total medical expenses”, the total cost of care for the patient population
199 associated with a provider group based on allowed claims for all categories of medical expenses and all
200 non-claims related payments to providers, adjusted by health status, and expressed on a per member per
201 month basis, as calculated under section 6 and the regulations promulgated by the commissioner.

202 **SECTION 12.** Said section 1 of said chapter 118G, as so appearing, is hereby further amended
203 by inserting after the definition of “Purchaser” the following definition:-

204 “Relative prices”, the contractually negotiated amounts paid to providers by each private and
205 public carrier for health care services, including non-claims related payments and expressed in the
206 aggregate relative to the payer’s network-wide average amount paid to providers, as calculated under
207 section 6 of chapter 118G and regulations promulgated by the commissioner.

208 **SECTION 13.** Section 6 of said chapter 118G of the General Laws is hereby amended by
209 striking out the fourth and fifth paragraphs, as so appearing, and inserting in place thereof the following 3
210 paragraphs: -

211 The division shall require the submission of data and other information from each private health
212 care payer offering small or large group health plans including, but not limited to: (i) average annual
213 individual and family plan premiums for each payer’s most popular plans for a representative range of
214 group sizes, as further determined in regulations and average annual individual and family plan premiums
215 for the lowest cost plan in each group size that meets the minimum standards and guidelines established
216 by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial
217 assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan;
218 (iv) information concerning the medical and administrative expenses, including medical loss ratios for
219 each plan, using a uniform methodology, and collected under section 21 of chapter 176O; (v) information
220 concerning the payer’s current level of reserves and surpluses; (vi) information on provider payment
221 methods and levels; (vii) health status adjusted total medical expenses by provider group and local
222 practice group and zip code calculated according to a uniform methodology; (viii) relative prices paid to
223 every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health
224 facility, rehabilitation facility, skilled nursing facility and home health provider in the payer’s network, by
225 type of provider and calculated according to a uniform methodology; and (ix) hospital inpatient and
226 outpatient costs, including direct and indirect costs, according to a uniform methodology.

227 The division shall require the submission of data and other information from public health care
228 payers including, but not limited to: (i) average premium rates for health insurance plans offered by
229 public payers and information concerning the actuarial assumptions that underlie these premiums; (ii)
230 average annual per-member per-month payments for enrollees in MassHealth primary care clinician and
231 fee for service programs; (iii) summaries of plan designs for each plan or program; (iv) information
232 concerning the medical and administrative expenses, including medical loss ratios for each plan or
233 program; (v) where appropriate, information concerning the payer’s current level of reserves and
234 surpluses; (vi) information on provider payment methods and levels, including information concerning
235 payment levels to each hospital for the 25 most common medical procedures provided to enrollees in

236 these programs, in a form that allows payment comparisons between Medicaid programs and managed
237 care organizations under contract to the office of Medicaid; (vii) health status adjusted total medical
238 expenses by provider group and local practice group and zip code calculated according to a uniform
239 methodology; (viii) relative prices paid to every hospital, physician group, ambulatory surgical center,
240 freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and
241 home health provider in the payer's network, by type of provider and calculated according to a uniform
242 methodology.

243 The division shall require the submission of data and other such information from each acute care
244 hospital on hospital inpatient and outpatient costs, including direct and indirect costs, according to a
245 uniform methodology.

246 The division shall publicly report and place on its website information on health status adjusted
247 total medical expenses, relative prices and hospital inpatient and outpatient costs, including direct and
248 indirect costs under this section on an annual basis; provided, however, that at least 10 days prior to the
249 public posting or reporting of provider specific information the affected provider shall be provided the
250 information for review. The division shall request from the federal Centers for Medicare and Medicaid
251 Services the health status adjusted total medical expenses of provider groups that serve Medicare patients.

252 **SECTION 14.** Section 6C of said chapter 118G is hereby amended by striking out subsection
253 (c), as amended by section 9 of chapter 65 of the acts of 2009, and inserting in place thereof the following
254 subsection:-

255 (c) Information that identifies individual employees by name or health insurance status shall not
256 be a public record, but the information shall be exchanged with the department of revenue, the
257 commonwealth health insurance connector authority, and the health care access bureau in the division of
258 insurance under an interagency services agreement for the purposes of enforcing this section, sections 3,
259 6B and 18B of chapter 118H, and sections 3 to 7A, inclusive, of chapter 176Q. An employer who

260 knowingly falsifies or fails to file with the division any information required by this section or by any
261 regulation promulgated by the division shall be punished by a fine of not less than \$1,000 not more than
262 \$5,000.

263 **SECTION 15.** Section 47H of chapter 175 of the General Laws, as appearing in the 2008
264 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof the
265 following 2 sentences:- For purposes of this section, ‘infertility’ shall mean the condition of an individual
266 who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or
267 younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the
268 criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live
269 birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in
270 the calculation of the 1 year or 6 month period, as applicable.

271 **SECTION 16.** Section 8K of chapter 176A of the General Laws, as so appearing, is hereby
272 amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For
273 purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive
274 or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6
275 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this
276 section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she
277 attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year
278 or 6 month period, as applicable.

279 **SECTION 17.** Section 4J of chapter 176B of the General Laws, as so appearing, is hereby
280 amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For
281 purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive
282 or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6
283 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this

284 section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she
285 attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year
286 or 6 month period, as applicable.

287 **SECTION 18.** Section 3 of chapter 176D of the General Laws, as so appearing, is hereby
288 amended by striking out clause (4) and inserting in place thereof the following clause:-

289 (4) Boycott, coercion and intimidation: (a) entering into an agreement to commit, or by concerted
290 action committing, an act of boycott, coercion or intimidation resulting in or tending to result in
291 unreasonable restraint of, or monopoly in, the business of insurance; (b) an refusal by a nonprofit hospital
292 service corporation, medical service corporation, insurance or health maintenance organization to
293 negotiate, contract or affiliate with a health care facility or provider because of such facility's or
294 provider's contracts, type of provider licensure or affiliations with any other nonprofit hospital service
295 corporation, medical service corporation, insurance company or health maintenance organization; or (c)
296 an nonprofit hospital service corporation, medical service corporation, insurance company or health
297 maintenance organization establishing the price to be paid to any health care facility or provider by
298 reference to the price paid, or the average of prices paid, to such facility or provider under a contract or
299 contracts with any other nonprofit hospital service corporation, medical service corporation, insurance
300 company, health maintenance organization or preferred provider arrangement.

301 **SECTION 19.** Said chapter 176D is hereby further amended by striking out section 3A, as so
302 appearing, and inserting in place thereof the following section:-

303 Section 3A. The following shall be unfair methods of competition and unfair or deceptive acts or
304 practices in the business of insurance by entities organized under chapters 176A, 176B, 176G and 176I or
305 licensed under chapter 175: (i) entering into any agreement to commit or by any concerted action
306 committing any act of, boycott, coercion, intimidation resulting in or tending to result in unreasonable
307 restraint of, or monopoly in, the business of insurance; (ii) refusal to enter into a contract with a health

308 care facility on the basis of the facility's religious affiliation; (iii) seeking to set the price to be paid to any
309 health care facility or provider by reference to the price paid, or the average of prices paid, to that health
310 care facility or provider under a contract or contracts with any other nonprofit hospital service
311 corporation, medical service corporation, insurance company, health maintenance organization or
312 preferred provider arrangement; (iv) refusal to contract or affiliate with a health care facility solely
313 because the facility does not provide a specific service or range of services; (v) selecting or contracting
314 with a health care facility or provider not based primarily on cost, availability and quality of covered
315 services; (vi) refusal to enter into a contract with a health care facility solely on the basis of the facility's
316 governmental affiliation; and (vii) arranging for an individual employee to apply for individual health
317 insurance coverage, as defined in chapter 176J, for the purpose of separating that employee from group
318 health insurance coverage to reduce costs for an employer sponsored health plan provided in connection
319 with the employee's employment.

320 **SECTION 20.** Section 1 of said chapter 176J, as so appearing, is hereby amended by striking out
321 the definition of "Eligible individual" and inserting in place thereof the following definition:-

322 "Eligible individual", an individual who is a resident of the commonwealth and who is not
323 seeking individual coverage to replace an employer-sponsored health plan for which the individual is
324 eligible and which provides coverage that is at least actuarially equivalent to minimum creditable
325 coverage.

326 **SECTION 21.** Said section 1 of chapter 176J, as so appearing, is hereby further amended by
327 inserting after the definition of "Prototype plan" the following definition:-

328 "Qualified association", a Massachusetts nonprofit or not-for-profit corporation or other entity
329 organized and maintained for the purposes of advancing the occupational, professional, trade or industry
330 interests of its association members, other than that of obtaining health insurance, and that has been in
331 active existence for at least 5 years, that comprises at least 100 association members and membership in

332 which is generally available to potential association members of such occupation, profession, trade or
333 industry without regard to the health condition or status of a prospective association member or the
334 employees and dependents of a prospective association member.

335 **SECTION 22.** Said section 1 of said chapter 176J, as so appearing, is hereby further amended by
336 inserting after the definition of “Resident” the following definition:-

337 “Small business group purchasing cooperative”, or “group purchasing cooperative”, a
338 Massachusetts nonprofit or not-for-profit corporation or association, approved as a qualified association
339 by the commissioner under section 13, all the members of which are part of a qualified association which
340 negotiates with 1 or more carriers for the issuance of health benefit plans that cover employees, and the
341 employees’ dependents, of the qualified association’s members.

342 **SECTION 23.** Said section 1 of said chapter 176J, as so appearing, is hereby further amended by
343 adding the following definition:-

344 “Wellness program”, or “health management program”, an organized system designed to improve
345 the overall health of participants through activities that may include, but shall not be limited to, education,
346 health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

347 **SECTION 24.** Subsection (a) of section 3 of said chapter 176J, as so appearing, is hereby
348 amended by striking out clause (2) and inserting in place thereof the following clause:-

349 (2) A carrier may establish an age rate adjustment that applies to both eligible individuals and
350 eligible small groups; provided, however, that the carrier applies the rate adjustment on a year-to-year
351 basis for both eligible individuals and eligible small groups.

352 **SECTION 25.** Said section 3 of said chapter 176J, as so appearing, is hereby further amended by
353 adding the following subsection:-

354 (f) The commissioner may conduct an examination of the rating factors used in the small group
355 health insurance market in order to identify whether any expenses or factors inappropriately increase the
356 cost in relation to the risks of the affected small group. The commissioner may adopt changes to the
357 small group regulation each July 1 for rates effective each subsequent January 1 to modify the derivation
358 of group base premium rates or of any factor used to develop individual group premiums.

359 **SECTION 26.** Subsection (a) of section 4 of said chapter 176J, as so appearing, is hereby
360 amended by striking out paragraphs (2) to (4), inclusive, and inserting in place thereof the following 3
361 paragraphs:-

362 (2) A carrier shall enroll eligible individuals and eligible persons, as defined in section 2741 of
363 the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b), into a
364 health plan if such individuals or persons request coverage within 63 days of termination of any prior
365 creditable coverage. Coverage shall become effective within 30 days of the date of application, subject to
366 reasonable verification of eligibility.

367 (3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph
368 (2) into a health benefit plan during the mandatory biannual open enrollment period for eligible
369 individuals and the eligible dependents of those individuals. Each year, the first open enrollment period
370 shall begin on January 1 and end on February 15. The second open enrollment period shall begin on July
371 1 and end on August 15. All coverage shall become effective on the first day of the month following
372 enrollment. The commissioner shall promulgate regulations for the open enrollment periods. For a Trade
373 Act/HCTC-eligible persons, a carrier may impose a pre-existing condition exclusion or waiting period of
374 no more than 6 months following the individual's effective date of coverage if the Trade Act/HCTC-
375 eligible person has had less than 3 months of continuous health coverage before becoming eligible for the
376 health coverage tax credit; or a break in coverage of over 62 days immediately before the date of
377 application for enrollment into the qualified health plan.

378 (4) No policy may require any waiting period if the eligible individual has not had any creditable
379 coverage for the 18 months prior to the effective date of coverage. Notwithstanding paragraph (3), an
380 eligible individual who does not meet the requirements of paragraph (2) may seek an enrollment waiver to
381 permit enrollment not during a mandatory open enrollment period. Enrollment waivers shall be
382 administered and granted by the office of patient protection established by section 217 of chapter 111.

383 **SECTION 27.** Said subsection (a) of said section 4 of said chapter 176J is hereby further
384 amended by striking out paragraph (3), as appearing in section 26, and inserting in place thereof the
385 following paragraph:-

386 (3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph
387 (2) into a health benefit plan during the mandatory annual open enrollment period for eligible individuals
388 and their dependents. Each year, the open enrollment period shall begin on July 1 and end on August
389 15. A carrier shall only enroll an eligible individual who does not meet the requirements of paragraph (2)
390 into a health benefit plan during the open enrollment period. All coverage shall become effective on the
391 first day of the month following enrollment. The commissioner shall promulgate regulations for the open
392 enrollment period permissible under this section. With respect to Trade Act/Health Coverage Tax Credit
393 Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more
394 than 6 months following the individual's effective date of coverage if the Trade Act/Health Coverage Tax
395 Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible
396 for the health care tax credit; or a break in coverage of over 62 days immediately before the date of
397 application for enrollment into the qualified health plan.

398 **SECTION 28.** Subsection (b) of said section 4 of said chapter 176J, as appearing in the 2008
399 Official Edition, is hereby amended by striking out clause (1) and inserting in place thereof the following
400 clause:

401 (1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual
402 or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that
403 the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible
404 small businesses. A health benefit plan closed to new members may be cancelled and discontinued to all
405 members upon the approval of the commissioner of insurance when such plan has been closed to
406 enrollment for new individuals and small groups and the carrier has complied with the requirements of 42
407 U.S.C. Sec. 300gg-12; provided, however, that cancellation of the plan shall be effective on the individual
408 or small group's next enrollment anniversary after such cancellation is approved by the commissioner of
409 insurance. The commissioner may promulgate regulations prohibiting a carrier from using this paragraph
410 to circumvent the intent of this chapter.

411 **SECTION 29.** Said chapter 176J is hereby further amended by striking out section 6, as so
412 appearing, and inserting in place thereof the following section:-

413 Section 6. (a) Notwithstanding any general or special law to the contrary, the commissioner may
414 approve health insurance policies submitted to the division of insurance for the purpose of being provided
415 to eligible individuals or eligible small businesses. These health insurance policies shall be subject to this
416 chapter and may include networks that differ from those of a health plan's overall network. The
417 commissioner shall adopt regulations regarding eligibility criteria. These eligibility criteria shall require
418 that health insurance policies that exclude mandated benefits shall only be offered to small businesses
419 which did not provide health insurance to its employees as of April 1, 1992. These eligibility criteria shall
420 also provide that small businesses shall not have any health insurance policies that exclude mandated
421 benefits for more than a 5-year period.

422 (b) Notwithstanding any general or special law to the contrary, the commissioner shall require
423 carriers offering health benefit plans to eligible small businesses and eligible individuals to submit
424 information as required by the commissioner, which shall include the current and projected medical loss

425 ratio for plans the components of projected administrative expenses and financial information, including,
426 but not limited to:

427 (i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

428 (ii) marketing and sales expenses, including, but not limited to, advertising, member relations,
429 member enrollment and all expenses associated with producers, brokers and benefit consultants;

430 (iii) claims operations expenses, including, but not limited to, adjudication, appeals, settlements
431 and expenses associated with paying claims;

432 (iv) medical administration expenses, including, but not limited to, disease management,
433 utilization review and medical management;

434 (v) network operations expenses, including, but not limited to, contracting, hospital and physician
435 relations and medical policy procedures;

436 (vi) charitable expenses, including, but not limited to, contributions to tax-exempt foundations
437 and community benefits;

438 (vii) state premium taxes;

439 (viii) board, bureau and association fees;

440 (ix) depreciation; and

441 (x) miscellaneous expenses described in detail by expense, including any expense not included in
442 clauses (i) to (ix), inclusive.

443 (c) Notwithstanding any general or special law to the contrary, the commissioner may require
444 carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A,
445 176B or 176G, to file all changes to small group product base rates and to small group rating factors at

446 least 90 days before their proposed effective date. The commissioner shall disapprove any proposed
447 changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged.
448 The commissioner shall disapprove any change to small group rating factors that is discriminatory or not
449 actuarially sound. Rate filing materials submitted for review by the division shall be deemed confidential
450 and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The
451 commissioner shall adopt regulations to carry out this section.

452 (d) For base rate changes filed under this section, if a carrier files a base rate whose
453 administrative expense loading component, not including taxes and assessments, increases by more than
454 the most recent calendar year's percentage increase in the New England medical CPI or if a carrier's
455 reported contribution to surplus exceeds 1.9 per cent or if the aggregate medical loss ratio for all plans
456 offered under this chapter is less than 88 per cent, such carrier's rate, in addition to being subject to all
457 other provisions of this chapter, shall be presumptively disapproved as excessive by the commissioner as
458 set forth in this subsection, with the exception of any carrier whose Risk Based Capital Ratio falls below
459 300% for the most recent four consecutive quarters. For such carriers the reported contribution to surplus
460 may not exceed 2.5 per cent.

461 If, however, a carrier's base rates are presumptively disapproved for failure to meet only the
462 aggregate medical loss ratio threshold of 88 per cent, the carrier's base rates shall nevertheless not be
463 presumptively disapproved as excessive by the commissioner if the carrier's aggregate medical loss ratio
464 for all plans offered under this chapter is not less than 1 per cent greater than the carrier's equivalent
465 medical loss ratio was 12-months prior to the carrier's present rate filing.

466 If the annual aggregate medical loss ratio for all plans offered under this chapter is less than 88
467 per cent, or less than the medical loss ratio that was not presumptively disapproved by the commissioner
468 for being in excess of 1% of the carrier's prior year base rate, over the applicable 12-month period, the
469 carrier shall refund the excess premium to its eligible individuals and eligible small groups. A carrier shall

470 communicate within 30 days to all individuals and small groups that were covered under plans during the
471 relevant 12-month period that such individuals and small groups qualify for a refund to be issued under
472 this paragraph, which may take the form of either a refund on the premium for the applicable 12-month
473 period, or if the individual or groups are still covered by the carrier, a credit on the premium for the
474 subsequent 12-month period. The total of all refunds issued shall equal the amount of a carrier's earned
475 premium that exceeds that amount necessary to achieve a medical loss ratio of 88 per cent, calculated
476 using data reported by the carrier as prescribed under regulations promulgated by the commissioner. The
477 commissioner may authorize a waiver or adjustment of this requirement only if it is determined that
478 issuing refunds would result in financial impairment for the carrier.

479 (e) If a proposed base rate change has been presumptively disapproved:

480 (1) A carrier shall communicate to all employers and individuals covered under a small
481 group product that the proposed increase has been presumptively disapproved and is subject to a hearing
482 at the division of insurance.

483 (2) The commissioner shall conduct a public hearing and shall advertise it in newspapers
484 in the cities of Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell,
485 or shall notify such newspapers of the hearing.

486 (3) The attorney general may intervene in a public hearing or other proceeding under this
487 subsection and may require additional information as the attorney general consider necessary to ensure
488 compliance with this subsection.

489 The commissioner shall adopt regulations to specify the scheduling of the hearings required
490 pursuant to this section.

491 (f) If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify
492 the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The

493 carrier may submit a request for hearing with the division of insurance within 10 days of such notice of
494 disapproval. The division must schedule a hearing within 15 days of receipt. The commissioner shall
495 issue a written decision within 30 days after the conclusion of the hearing. The carrier may not
496 implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval
497 after a hearing or unless a court vacates the commissioner's decision.

498 **SECTION 30.** Said section 6 of said chapter 176J, as appearing in section 29, is hereby further
499 amended by striking out the figure "88", each time it appears, and inserting in place thereof the following
500 figure:- 90.

501 **SECTION 31.** Said section 6 of said chapter 176J is hereby further amended by striking out
502 clause (d), (e), and (f), as appearing in section 29, inserting in place thereof the following 2 subsections:-

503 (d) If a proposed base rate change has been disapproved:

504 (1) A carrier shall communicate to all employers and individuals covered under a small
505 group product that the proposed increase has been presumptively disapproved and is subject to a hearing
506 at the division of insurance.

507 (2) The commissioner shall conduct a public hearing and shall advertise it in newspapers
508 in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell, or shall
509 notify such newspapers of the hearing.

510 (3) The attorney general may intervene in a public hearing or other proceeding under this
511 subsection and may require additional information as the attorney general consider necessary to ensure
512 compliance with this subsection.

513 (e) If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify
514 the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The
515 carrier may submit a request for hearing with the division of insurance within 10 days of such notice of

516 disapproval. The division must schedule a hearing within 15 days of receipt. The commissioner shall
517 issue a written decision within 30 days after the conclusion of the hearing. The carrier may not
518 implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval
519 after a hearing or unless a court vacates the commissioner's decision.

520 **SECTION 32.** Said chapter 176J is hereby amended by adding the following section:-

521 Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the
522 delivery of health care services through a closed network of health care providers; and (ii) as of the close
523 of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible
524 employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made
525 effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible
526 individuals and small businesses in at least 1 geographic area at least one plan with either a reduced or
527 selective network of providers, or a plan in which providers are tiered and member cost sharing is based
528 on the tier placement of the provider.

529 The base premium for the reduced or selective network, or tiered network plan shall be at least 12
530 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-
531 selective or non-tiered network of providers.

532 (b) A tiered network plan shall only include variations on member cost-sharing between provider
533 tiers, which are reasonable in relation to the premium charged, as long as the carrier provides adequate
534 access to covered services at lower patient cost sharing levels.

535 (c) The commissioner shall determine network adequacy for a tiered network plan based on the
536 availability of sufficient network providers in the carrier's overall tiered network plan .

537 (d) The commissioner shall determine network adequacy for a select network plan based on the
538 availability of sufficient network providers in the carrier's select network of providers.

539 (e) In determining network adequacy under this section the commissioner may consider factors
540 including: the location of providers participating in the plan; employers or members that enroll in the
541 plan; the range of services provided by providers in the plan; and any plan benefits that recognize and
542 provide for extraordinary medical needs of members that may not be adequately dealt with by the
543 providers within the plan network.

544 (f) Carriers may: (i) reclassify provider tiers; or (ii) determine provider participation in selective
545 and tiered plans no more than once per calendar year; provided, however, that carriers may reclassify
546 providers from a higher cost tier to a lower cost tier or add new providers to its selective and tiered plans
547 at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during
548 the course of an account year, the carrier shall provide affected members of the account with information
549 regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide
550 information on their websites about any tiered or selective plan, including, but not limited to, the
551 providers participating in the plan, the selection criteria for those providers and if applicable, the tier in
552 which each provider is classified.

553 (g) The division of insurance shall report annually on utilization trends of eligible employers and
554 eligible individuals enrolled in plans offered under this section The report shall include the number of
555 members enrolled by plan type, de-identified aggregate demographic, and geographic information on all
556 members and the average direct premium claims incurred for selective and tiered network plans compared
557 to non-selective and non-tiered plans.

558 **SECTION 33.** Said chapter 176J is hereby further amended by striking out section 11, as
559 inserted by section 23, and inserting in place thereof the following section:-

560 Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the
561 delivery of health care services through a closed network of health care providers; and (ii) as of the close
562 of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible

563 employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made
564 effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible
565 individuals and small businesses in at least 1 geographic area at least 1 plan with either a reduced or
566 selective network of providers or a plan in which providers are tiered and member cost sharing is based
567 on the tier placement of the provider.

568 The base premium for the reduced or selective or tiered network plan shall be at least 12 per cent
569 lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective
570 or non-tiered network of providers. The savings may be achieved by means including, but not limited to:
571 (i) the exclusion of providers with similar or lower quality based on the standard quality measure set with
572 higher health status adjusted total medical expenses or relative prices, as determined under section 6 of
573 chapter 118G; or (ii) increased member cost-sharing for members who utilize providers for non-
574 emergency services with similar or lower quality based on the standard quality measure set and with
575 higher health status adjusted total medical expenses or relative prices, as determined under section 6 of
576 chapter 118G.

577 (b) A tiered network plan shall only include variations in member cost-sharing between provider
578 tiers which are reasonable in relation to the premium charged and ensure adequate access to covered
579 services. Carriers shall tier providers based on quality performance as measured by the standard quality
580 measure set and by cost performance as measured by health status adjusted total medical expenses and
581 relative prices. Where applicable quality measures are not available, tiering may be based solely on
582 health status adjusted total medical expenses or relative prices or both.

583 The commissioner shall promulgate regulations requiring the uniform reporting of tiering
584 information, including, but not limited to requiring, at least 90 days before the proposed effective date of
585 any tiered network plan or any modification in the tiering methodology for any existing tiered network
586 plan, the reporting of a detailed description of the methodology used for tiering providers, including: the

587 statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description
588 of how the methodology and resulting tiers will be communicated to each network provider, eligible
589 individuals and small groups; and a description of the appeals process a provider may pursue to challenge
590 the assigned tier level.

591 (c) The commissioner shall determine network adequacy for a tiered network plan based on the
592 availability of sufficient network providers in the carrier's overall network of providers.

593 (d) The commissioner shall determine network adequacy for a selective network plan based on
594 the availability of sufficient network providers in the carrier's selective network.

595 (e) In determining network adequacy under this section the commissioner of insurance may take
596 into consideration factors such as the location of providers participating in the plan and employers or
597 members that enroll in the plan, the range of services provided by providers in the plan and plan benefits
598 that recognize and provide for extraordinary medical needs of members that may not be adequately dealt
599 with by the providers within the plan network.

600 (f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in selective
601 and tiered plans no more than once per calendar year except that carriers may reclassify providers from a
602 higher cost tier to a lower cost tier or add providers to a selective network at any time. If the carrier
603 reclassifies provider tiers or providers participating in a selective plan during the course of an account
604 year, the carrier shall provide affected members of the account with information regarding the plan
605 changes at least 30 days before the changes take effect. Carriers shall provide information on their
606 websites about any tiered or selective plan, including but not limited to, the providers participating in the
607 plan, the selection criteria for those providers and where applicable, the tier in which each provider is
608 classified.

609 (g) The division of insurance shall report annually on utilization trends of eligible employers and
610 eligible individuals enrolled in plans offered under this section. The report shall include the number of

611 members enrolled by plan type, aggregate demographic, geographic information on all members and the
612 average direct premium claims incurred, as defined in section 6, for selective and tiered network products
613 compared to non-selective and non-tiered products.

614 **SECTION 34.** Said chapter 176J is hereby further amended by adding the following 2 sections:-

615 Section 12. (a) The commissioner shall promulgate regulations governing the establishment and
616 oversight of small business group purchasing cooperatives. The regulations shall require: (i) that all state-
617 mandated benefits are required under plans procured by approved small business group purchasing
618 cooperatives; (ii) that all such plans offer its enrollees access to wellness programs which, at a minimum,
619 shall be actuarially similar to wellness programs that may be offered through the commonwealth health
620 insurance connector authority; (iii) that the group purchasing cooperative obtain a commitment from 33
621 per cent of its covered employees that the employees will enroll in the health management programs that
622 the group purchasing cooperative provides; (iv) that the group purchasing cooperative establish
623 reasonable systems, which shall comply with any applicable sections of the Americans with Disability
624 Act and any other federal requirements, under which enrollees can record their participation in, and group
625 purchasing cooperatives can monitor enrollees' participation in, available health management programs;
626 (v) that denial of coverage due to the health condition, age, race or sex of the employees and dependents
627 of qualified association members in a group purchasing cooperative is prohibited; and (vi) that no eligible
628 qualified association member of a small business group purchasing cooperative may be charged a
629 premium rate higher than what the carrier would charge to a similarly-situated eligible small business that
630 is not a participant in a small business group purchasing cooperative.

631 (b) The commissioner shall promulgate regulations governing the application and certification
632 process that a proposed small business group purchasing cooperative shall undergo before the
633 commissioner may certify the group purchasing cooperative as a small business group purchasing
634 cooperative approved to operate in accordance with this section; provided, however, that the

635 commissioner shall certify up to 6 group purchasing cooperatives to operate at any given time; provided
636 further, that the commissioner shall certify any application that meets the requirements of this section up
637 to and until the commissioner has certified 6 group purchasing cooperatives. The commissioner shall
638 limit the number of applications that are approved for each small business group cooperative so that in a
639 given year, the total number of covered lives, for each approved group purchasing cooperative, in the
640 aggregate, shall not exceed 85,0000 covered lives. Notwithstanding the provisions of this section, once
641 the limit on covered lives is reached, the commissioner shall not approve the application of a new group
642 purchasing cooperative until a previously approved group purchasing cooperative disbands or until the
643 commissioner disapproves a group purchasing cooperative's annual renewal for failure to comply with
644 the terms of this section and any regulations promulgated in accordance with this section.

645 (c) The commissioner shall annually certify that a small business group purchasing cooperative
646 satisfies the requirements of this section. Only a small business group purchasing cooperative that has
647 been certified by the commissioner may procure health care coverage for the benefit of qualified
648 association members.

649 (d) The commissioner shall review the books and records of a small business group purchasing
650 cooperative and the methodology which it confirms the status of qualified associations.

651 (e) Health care coverage procured by a small business group purchasing cooperative shall be sold
652 to qualified association members and may be sold through duly licensed agents, the commonwealth health
653 insurance connector authority or brokers.

654 (f) Member-employers of qualified associations purchasing health coverage within a group
655 purchasing cooperative shall not have more than 50 eligible employees.

656 (g) The commissioner, in consultation with the division of health care finance and policy and the
657 commonwealth health insurance connector authority, shall report and make recommendations, as
658 necessary, on the cost savings to the qualified association members that participate in small business

659 group purchasing cooperatives, the impact, if any, on the establishment of small business group
660 purchasing cooperatives to the risk pool and premium costs in the merged market, and whether the
661 authority of the commissioner to certify small business group purchasing cooperatives should be renewed
662 to the house and senate committees on ways and means and the joint committee on health care financing
663 and financial services within 24 months of the first certification of a small business group purchasing
664 cooperative as defined under this section.

665 Section 13. (a) As a condition of continued offer of small group health, a carrier that, as of the
666 close of a preceding calendar year, has a combined total of at least 5,000 eligible individuals, eligible
667 employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made
668 effective or renewed to qualified small businesses or eligible individuals shall be annually required to file
669 a plan with each group purchasing cooperative for its consideration if a group purchasing cooperative
670 requests such health plan proposals for its next plan year.

671 (b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i) include all
672 state-mandated benefits; (ii) apply preexisting condition limitations and waiting periods in the same
673 manner as the carrier applies them to small group products offered outside the group purchasing
674 cooperative; (iii) apply open enrollment periods for individuals in the same manner as the carrier applies
675 them for individuals outside the group purchasing cooperative, provided, however that small business
676 group purchasing cooperatives shall establish rules and open enrollment periods for qualified association
677 members to enter or exit group purchasing cooperatives; (iv) apply continuation of coverage provisions in
678 the same manner as the carrier applies those provisions to small group products offered outside the group
679 purchasing cooperative; (v) apply managed care practices in the same manner as the carrier applies those
680 practices to small group products offered outside the group purchasing cooperative; and (vi) apply rating
681 rules, including rating bands, rating factors and the value of rating factors, in the same manner as the
682 carrier applies those rules to small group products offered outside the group purchasing cooperative;

683 provided, that such plans may make limited deviations from these rating factors with the prior approval of
684 the commissioner.

685 (c) Carriers shall comply with a group purchasing cooperative's wellness program's data
686 processing systems to provide information that will enable the group purchasing cooperative to
687 effectively provide guidance to members on targeted wellness programs.

688 **SECTION 35.** Section 2 of chapter 176M of the General Laws, as appearing in the 2008 Official
689 Edition, is hereby amended by inserting after the word "renewal", in lines 28 and 39, each time it appears,
690 the following words:- , including renewal through the connector,.

691 **SECTION 36.** Section 3 of said chapter 176M, as so appearing, is hereby amended by striking
692 out subsection (d) and inserting in place thereof the following subsection:-

693 (d) A carrier shall no longer offer, sell or deliver a health plan to a person to whom it does not
694 have such an obligation under an individual policy, contract or agreement with an employer or through a
695 trust or association; provided, however, that a closed guaranteed issue plan or a closed health plan shall be
696 subject to all the other requirements of this chapter. A carrier shall be obligated to renew a closed
697 guarantee issue health plan and a closed plan. A carrier may discontinue a closed guarantee issue health
698 plan or a closed under regulations promulgated by the commissioner.

699 **SECTION 37.** Section 2 of chapter 176O of the General Laws, as so appearing, is hereby
700 amended by striking out subsection (b) and inserting in place thereof the following subsection:-

701 (b) In establishing the minimum standards, the bureau shall consult and use, where appropriate,
702 standards established by national accreditation organizations. Notwithstanding the foregoing, the bureau
703 shall not be bound by the standards established by such organizations, provided, however, that wherever
704 the bureau promulgates standards different from the national standards, it shall: (1) be subject to chapter

705 30A; (2) state the reason for such variation; and (3) take into consideration any projected compliance
706 costs for such variation. In order to reduce health care costs and improve access to health care services,
707 the bureau shall establish by regulation as a condition of accreditation that carriers use uniform standards
708 and methodologies for credentialing of providers, including any health care provider type licensed under
709 chapter 112 that provide identical services. The division shall, before adopting regulations under this
710 section, consult with the division of health care finance and policy, the department of public health, the
711 group insurance commission, the Centers for Medicare and Medicaid Services and each carrier.
712 Accreditation by the bureau shall be valid for a period of 24 months.

713 **SECTION 38.** Subsection (a) of section 7 of said chapter 176O, as so appearing, is hereby
714 amended by striking out clause (1) and inserting in place thereof the following clause:-

715 (1) a list of health care providers in the carrier's network, organized by specialty and by location
716 and summarizing on its internet website for each such provider: (i) the method used to compensate or
717 reimburse such provider, including details of measures and compensation percentages tied to any
718 incentive plan or pay for performance provision; (ii) the provider price relativity, as defined in and
719 reported under section 6 of chapter 118G; (iii) the provider's health status adjusted total medical
720 expenses, as defined in and reported under said section 6 of said chapter 118G; and (iv) current measures
721 of the provider's quality based on measures from the Standard Quality Measure Set, as defined in the
722 regulations promulgated by the department of public health under section 25P of chapter 111; provided,
723 however, that if any specific providers or type of providers requested by an insured are not available in
724 said network, or are not a covered benefit, such information shall be provided in an easily obtainable
725 manner; provided, further, that the carrier shall prominently promote providers based on quality
726 performance as measured by the standard quality measure set and cost performance as measured by health
727 status adjusted total medical expenses and relative prices.

728 **SECTION 39.** Said chapter 176O is hereby further amended by inserting after section 9 the
729 following section:-

730 Section 9A. A carrier shall not enter into an agreement or contract with a health care provider if
731 the agreement or contract contains a provision that:

732 (a) (i) limits the ability of the carrier to introduce or modify a select network plan or tiered
733 network plan by granting the health care provider a guaranteed right of participation; (ii) requires the
734 carrier to place all members of a provider group, whether local practice groups or facilities, in the same
735 tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether
736 local practice groups or facilities, in a select network plan on an all-or-nothing basis; or (iv) requires a
737 provider to participate in a new select network or tiered network plan that the carrier introduces without
738 granting the provider the right to opt-out of the new plan at least 60 days before the new plan is submitted
739 to the commissioner for approval; or

740 (b) requires or permits the carrier or the health care provider to alter or terminate a contract or
741 agreement, in whole or in part, to affect parity with an agreement or contract with other carriers or health
742 care providers or based on a decision to introduce or modify a select network plan or tiered network plan;
743 or

744 (c) requires or permits the carrier to make any form of supplemental payment unless each
745 supplemental payment is publicly disclosed to the commissioner as a condition of accreditation, including
746 the amount and purpose of each payment and whether or not each payment is included within the
747 provider's reported relative prices and health status adjusted total medical expenses under section 6 of
748 chapter 118G.

749 **SECTION 40.** Said chapter 176O is hereby further amended by adding the following section: -

750 Section 21. (a) Each carrier shall submit an annual comprehensive financial statement to the
751 division detailing carrier costs from the previous calendar year.

752 The annual comprehensive financial statement shall include all of the information in this section
753 and shall be itemized, where applicable, by:

754 (i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25 and 26 to 50;
755 large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

756 (ii) line of business, including individual, general, blanket or group policy of health, accident or
757 sickness insurance issued by an insurer licensed under chapter 175; a hospital service plan issued by a
758 nonprofit hospital service corporation under chapter 176A; a medical service plan issued by a nonprofit
759 hospital service corporation under chapter 176B; a health maintenance contract issued by a health
760 maintenance organization under chapter 176G; insured health benefit plan that includes a preferred
761 provider arrangement issued under chapter 176I; and group health insurance plans issued by the
762 commission under chapter 32A.

763 The statement shall include, but shall not be limited to, the following information:

764 (i) direct premiums earned, as defined in chapter 176J; direct claims incurred, as defined in said
765 chapter 176J;

766 (ii) medical loss ratio;

767 (iii) number of members;

768 (iv) number of distinct groups covered;

769 (v) number of lives covered;

770 (vii) realized capital gains and losses;

771 (viii) net income;

772 (ix) accumulated surplus;

773 (x) accumulated reserves;

774 (xi) risk-based capital ratio, based on a formula developed by the National Association of
775 Insurance Commissioners;

776 (xii) financial administration expenses, including underwriting, auditing, actuarial, financial
777 analysis, treasury and investment expenses;

778 (xiii) marketing and sales expenses, including advertising, member relations, member enrollment
779 expenses;

780 (xiv) distributions expenses, including commissions, producers, broker and benefit consultant
781 expenses;

782 (xv) claims operations expenses, including adjudication, appeals, settlements and expenses
783 associated with paying claims;

784 (xvi) medical administration expenses, including disease management, utilization review and
785 medical management expenses;

786 (xvii) network operational expenses, including contracting, hospital and physician relations and
787 medical policy procedures;

788 (xviii) charitable expenses, including any contributions to tax-exempt foundations and
789 community benefits;

790 (xix) board, bureau or association fees;

791 (xx) any miscellaneous expenses described in detail by expense, including an expense not
792 included in (i) to (xix), inclusive;

793 (xxi) payroll expenses and the number of employees on the carrier's payroll;

794 (xxii) taxes, if any, paid by the carrier to the federal government or to the commonwealth; and

795 (xxiii) any other information deemed necessary by the commissioner.

796 (b)(1) In this subsection, the following words shall have the following meanings:-

797 "Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance
798 under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit
799 medical service corporation organized under chapter 176B; a health maintenance organization organized
800 under chapter 176G; and an organization entering into a preferred provider arrangement under chapter
801 176I; or a third party administrator, a pharmacy benefit manager or other similar entity with claims data,
802 eligibility data, provider files and other information relating to health care provided to residents of the
803 commonwealth and health care provided by health care providers in the commonwealth; provided,
804 however, that "carrier" shall include an entity that offers a policy, certificate or contract that provides
805 coverage solely for dental care services or visions care services.

806 "Self-insured customer", a self-insured group for which a carrier provides administrative services.

807 "Self-insured group", a self-insured or self-funded employer group health plan.

808 "Third-party administrator", a person who, on behalf of a health insurer or purchaser of health
809 benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for
810 residents of the commonwealth.

811 (2) Any carrier required to report under this section, which provides administrative services to 1
812 or more self-insured groups shall include, as an appendix to such report, the following information:

- 813 (i) the number of the carrier's self-insured customers;
- 814 (ii) the aggregate number of members, as defined in section 1 of chapter 176J, in all of
815 the carrier's self-insured customers;
- 816 (iii) the aggregate number of lives covered in all of the carrier's self-insured customers;
- 817 (iv) the aggregate value of direct premiums earned, as defined in said section 1 of said
818 chapter 176J, for all of the carrier's self-insured customers;
- 819 (v) the aggregate value of direct claims incurred, as defined in said section 1 of said
820 chapter 176J, for all of the carrier's self-insured customers;
- 821 (vi) the aggregate medical loss ratio, as defined in said section of said chapter 176J, for
822 all of the carrier's self-insured customers;
- 823 (vii) net income;
- 824 (viii) accumulated surplus;
- 825 (ix) accumulated reserves;
- 826 (x) the percentage of the carrier's self-insured customers that include each of the benefits
827 mandated for health benefit plans under chapters 175, 176A, 176B and 176G;
- 828 (xi) administrative service fees paid by each of the carrier's self-insured customers; and
- 829 (xii) any other information deemed necessary by the commissioner.

830 (c) A carrier who fails to file this report on or before April 1 shall be assessed a late penalty not to
831 exceed \$100 per day. The division shall make public all of the information collected under this section.
832 The division shall issue an annual summary report to the joint committee on financial services, the joint
833 committee on health care financing and the house and senate committees on ways and means of the

834 annual comprehensive financial statements by May 15. The information shall be exchanged with the
835 division of health care finance and policy for use under section 6 of chapter 118G. The division shall,
836 from time to time, require payers to submit the underlying data used in their calculations for audit.

837 The commissioner may adopt rules to carry out this subsection, including standards and
838 procedures requiring the registration of persons or entities not otherwise licensed or registered by the
839 commissioner, such as third-party administrators, and criteria for the standardized reporting and uniform
840 allocation methodologies among carriers. The division shall, before adopting regulations under this
841 subsection, consult with other agencies of the commonwealth and the federal government and affected
842 carriers to ensure that the reporting requirements imposed under the regulations are not duplicative.

843 (d) If, in any year, a carrier reports a risk-based capital ratio on a combined entity basis under
844 subsection (a) that exceeds 700 per cent, the division shall hold a public hearing within 60 days. The
845 carrier shall submit testimony on its overall financial condition and the continued need for additional
846 surplus. The carrier shall also submit testimony on how, and in what proportion to the total surplus
847 accumulated, the carrier will dedicate any additional surplus to reducing the cost of health benefit plans or
848 for health care quality improvement, patient safety or health cost containment activities not conducted in
849 previous years. The division shall review such testimony and issue a final report on the results of the
850 hearing.

851 **SECTION 41.** Section 1 of chapter 176Q of the General Laws, as appearing in the 2008 Official
852 Edition, is hereby amended by striking out the definition of “Eligible individuals” and inserting in place
853 thereof the following definition:-

854 “Eligible individual”, an individual who is a resident of the commonwealth and who is not
855 seeking individual coverage to replace an employer sponsored health plan for which the individual is
856 eligible and which provides coverage that is at least actuarially equivalent to minimum creditable
857 coverage.

858 **SECTION 42.** Section 2 of said chapter 176Q, as so appearing, is hereby amended by striking
859 out subsection (b) and inserting in place thereof the following subsection:-

860 (b) There shall be a board, with duties and powers established by this chapter, which shall govern
861 the connector. The connector board shall consist of 11 members: the secretary for administration and
862 finance, or a designee, who shall serve as chairperson; the director of Medicaid or a designee; the
863 commissioner of insurance or a designee; the executive director of the group insurance commission; 4
864 members appointed by the governor, 1 of whom shall be a member in good standing of the American
865 Academy of Actuaries, 1 of whom shall be a health economist, 1 of whom shall represent the interests of
866 small businesses and 1 of whom shall be a member of the Massachusetts chapter of the National
867 Association of Health Underwriters ; and 3 members appointed by the attorney general, 1 of whom shall
868 be an employee health benefits plan specialist, 1 of whom shall be a representative of a health consumer
869 organization and 1 of whom shall be a representative of organized labor. No appointee shall be an
870 employee of any licensed carrier authorized to do business in the commonwealth. All appointments shall
871 serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired term.
872 An appointed member of the board shall be eligible for reappointment. The board shall annually elect 1 of
873 its members to serve as vice-chairperson.

874 **SECTION 43.** Section 3 of said chapter 176Q, as so appearing, is hereby amended by inserting
875 after the figure “111M”, in line 118, the following words:- ; provided, however, that notwithstanding
876 subsection (d) of section 2, no changes to the regulations defining minimum creditable coverage shall take
877 effect until 90 days after the connector gives notice of the changes to the joint committee on health care
878 finance, the joint committee on public health, the senate and house of representatives committees on ways
879 and means and the clerks of the senate and house of representatives.

880 **SECTION 44.** Said chapter 176Q is hereby further amended by inserting after section 7 the
881 following section:-

882 Section 7A. (a) There shall be a small group wellness incentive pilot program to expand the
883 prevalence of employee wellness initiatives by small businesses. The program shall be administered by
884 the board of the connector, in consultation with the department of public health. The program shall
885 provide subsidies and technical assistance for eligible small groups to implement evidence-based
886 employee health and wellness programs to improve employee health, decrease employer health costs, and
887 increase productivity.

888 (b) An eligible small group shall be qualified to participate in the program if:-

889 (1) the eligible small group purchases group coverage through the connector;

890 (2) the eligible small group is eligible for federal health care tax credits under the federal
891 Patient Protection and Affordable Care Act, Pub. L. 111-148 ;

892 (3) the eligible small group offers an evidence-based, employee wellness program, that
893 meets certain minimum criteria, as determined by the connector board, in collaboration with the
894 department of public health;

895 (4) the eligible small group meets certain minimum employee participation requirements
896 in the qualified wellness program, as determined by the connector board, in collaboration with the
897 department of public health;

898 (c) For eligible small groups participating in the program, the connector shall provide an annual
899 subsidy not to exceed 5 per cent of eligible employer health care costs as calculated by the employer for
900 credit by the federal government under the federal Patient Protection and Affordable Care Act. Aggregate
901 expenditures made by the connector for the subsidy program shall not exceed \$15,000,000 in any fiscal
902 year. If the director determines that funds are insufficient to meet the projected costs of enrolling new
903 eligible employers, the director shall impose a cap on enrollment in the program.

904 (d) The connector shall coordinate with the department of public health to provide technical
905 assistance, including grant-writing assistance, to participating eligible small groups in order to maximize
906 federal grant funding provided under the federal Patient Protection and Affordable Care Act for the
907 establishment of wellness initiatives by small employers.

908 (e) The connector shall seek to ensure that all necessary applications and filings coordinate with
909 and conform to appropriate federal guidelines in order to minimize administrative burden on participating
910 small groups.

911 (f) The connector shall report annually to the joint committee on community development and
912 small business, the joint committee on health care financing and the house and senate committees on
913 ways and means on the enrollment in the small business wellness incentive program and evaluate the
914 impact of the program on expanding wellness initiatives for small groups.

915 (g) The connector shall promulgate regulations to implement this section.

916 **SECTION 45.** Section 8 of said chapter 176Q, as appearing in the 2008 Official Edition, is
917 hereby amended by adding the following sentence: -

918 The connector shall not utilize any of the data received from the department of revenue for any
919 solicitations or advertising.

920 **SECTION 46.** Paragraph (n) of section 5 of chapter 614 of the acts of 1968, as appearing in
921 section 18 of chapter 777 of the acts of 1981, is hereby amended by striking out, in line 2, the words “its
922 administrative” and inserting in place thereof the following words:- fees, administrative.

923 **SECTION 47.** Said section 5 of said chapter 614 is hereby further amended by inserting after
924 paragraph (n), as so appearing, the following paragraph:-

925 (n1/2) to fund the capital reserves authorized under paragraph (g) of section 10 and to fund and
926 administer loans and grant programs for community hospitals and community health centers under
927 paragraph (g) of section 10 and to fund any reimbursement of the commonwealth required by paragraph
928 (g)(xii) of section 10;

929 **SECTION 48.** Section 10 of said chapter 614, as most recently amended by chapter 777 of the
930 acts of 1981, is hereby further amended by adding the following paragraph:-

931 (g) (i) For the benefit of nonprofit community hospitals and nonprofit community health centers
932 licensed by the department of public health and meeting the definition of a community health center under
933 114.6 CMR 13.00 as either a community health center or a hospital licensed health center, the authority
934 may create and establish special funds to be known as Community Hospital and Community Health
935 Center Capital Reserve Funds and, to the extent so created, shall pay into each such fund any monies
936 appropriated and made available by the commonwealth for the purposes of such fund, any proceeds from
937 the sale of notes or bonds to the extent provided in the resolution, trust agreement or indenture of the
938 authority authorizing issuance thereof, any other monies or funds of the authority that the authority
939 determines to deposit in the fund and any other monies which may be available to the authority only for
940 the purpose of such fund from any other source or sources. All monies held in the fund, except as
941 hereinafter provided, shall be used solely for the payment of the principal of bonds of the authority which
942 are secured by any such fund as the same mature, which herein shall include becoming payable by sinking
943 fund installment, the purchase of such bonds, the payment of interest on such bonds, or the payment of
944 any redemption premium required to be paid when such bonds are redeemed prior to maturity; provided
945 however, that, monies in a Community Hospital and Community Health Center Capital Reserve Fund
946 shall not be withdrawn therefrom at any time in such amount as would reduce the amount of the fund to
947 less than the maximum amount of principal and interest maturing and becoming due in a succeeding
948 calendar year on outstanding bonds which are secured by the fund, except for the purpose of paying the
949 principal of and interest on such bonds maturing and becoming due or for the retirement of such bonds in

950 accordance with the terms of a contract between the authority and its bondholders and for the payment of
951 which other monies pledged to secure such bonds are not available. Any income or interest earned by, or
952 increment to, a Community Hospital and Community Health Center Capital Reserve Fund due to the
953 investment thereof shall be used by the authority for the purposes of the fund.

954 (ii) The authority shall not issue bonds which are secured by a Community Hospital and
955 Community Health Center Capital Reserve Fund at any time if the maximum amount of principal and
956 interest maturing or becoming due in a succeeding calendar year on such bonds then to be issued and on
957 all other outstanding bonds of the authority which are secured by a fund will exceed the amount of such
958 Community Hospital and Community Health Center Capital Reserve Fund at the time of issuance unless
959 the authority, at the time of issuance of such bonds, shall deposit in such fund from the proceeds of the
960 bonds so to be issued, or otherwise, an amount which, together with the amount then in the fund, will be
961 not less than the maximum amount of principal and interest maturing and becoming due in a succeeding
962 calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which
963 are secured by any such fund.

964 (iii) To assure the continued operation and solvency of the authority for the carrying out of the
965 public purposes of this act, provision is made in subparagraph (i) for the accumulation in a Community
966 Hospital and Community Health Center Capital Reserve Fund of an amount equal to the maximum
967 amount of principal and interest maturing and becoming due in a succeeding calendar year on all
968 outstanding bonds which are secured by any such fund. In order to further assure the maintenance of a
969 Community Hospital and Community Health Center Capital Reserve Fund, there shall be appropriated
970 annually and paid to the authority for deposit in the fund such sum, if any, as shall be certified by the
971 executive director of the authority to the governor as necessary to restore the fund to an amount equal to
972 the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year
973 on the outstanding bonds which are secured by any such fund. The executive director of the authority
974 shall annually, on or before December 1, make and deliver to the governor a certificate stating the

975 amount, if any, required to restore a Community Hospital and Community Health Center Capital Reserve
976 Fund to the amount aforesaid and the amount so stated, if any, shall be appropriated and paid to the
977 authority during the then current fiscal year of the commonwealth.

978 (iv) For the purposes of this paragraph, in computing the amount of a Community Hospital and
979 Community Health Center Capital Reserve Fund, securities in which all or a portion of the fund are
980 invested shall be valued at par or, if purchased at less than par, at their cost to the authority unless
981 otherwise provided in the resolution, trust agreement or indenture authorizing the issuance of bonds
982 secured by the fund.

983 (v) For the purposes of this paragraph, the amount of a letter of credit, insurance contract, surety
984 bond or similar financial undertaking available to be drawn upon and applied to obligations to which
985 money in the Community Hospital and Community Health Center Capital Reserve Fund may be applied
986 shall be counted as money in the fund. For the purposes of this paragraph, in calculating the maximum
987 amount of interest due in the future on variable rate bonds or bonds with respect to which the interest rate
988 is not at the time of calculation determinable, the interest rate shall be calculated at the maximum interest
989 rate on such bonds or such lesser interest rate as shall be certified by the authority as an appropriate proxy
990 for such variable or non-determinable interest rate.

991 (vi) Bonds secured by a Community Hospital and Community Health Center Capital Reserve
992 Fund shall be issued by the authority solely for the benefit of nonprofit community hospitals and
993 nonprofit community health centers licensed by the department of public health.

994 (vii) Notwithstanding any provision of this act to the contrary, no loan shall be made by the
995 authority to a nonprofit community hospital or nonprofit community health center from the proceeds of
996 bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund established
997 under this paragraph unless: (a) the project to be financed by the loan has been approved by the secretary
998 of health and human services; and (b) the loan and the issuance and terms of the related bonds have been

999 approved by the secretary of administration and finance. In connection with any loan to a nonprofit
1000 community hospital or nonprofit community health center under this paragraph, the secretary of health
1001 and human services and the secretary of administration and finance may enter into an agreement with the
1002 authority and the nonprofit community hospital or nonprofit community health center to: (1) require that
1003 the nonprofit community hospital or nonprofit community health center provide financial statements or
1004 other information relevant to the financial condition of the nonprofit community hospital or nonprofit
1005 community health center and its compliance with the terms of the loan; (2) require that the nonprofit
1006 community hospital or nonprofit community health center reimburse the commonwealth for any amounts
1007 the commonwealth transfers to the fund under subparagraph (iii) to replenish the fund as a result of a loan
1008 payment default by the nonprofit community hospital or nonprofit community health center; and (3)
1009 require compliance by the nonprofit community hospital or nonprofit community health center or the
1010 authority with any other terms and conditions that the secretary of health and human services and the
1011 secretary of administration and finance considers appropriate in connection with the loan.

1012 (viii) When the authority notifies the secretary of administration and finance in writing that an
1013 institution eligible to use the authority under this paragraph is in default as to the payment of principal or
1014 interest on any bonds issued by the authority on behalf of that institution or that the authority has
1015 reasonable grounds to believe that the institution will not be able to make a full payment when that
1016 payment is due, the secretary of administration and finance shall direct the comptroller to withhold any
1017 funds in the comptroller's custody that are due or payable to the institution until the amount of the
1018 principal or interest due or anticipated to be due has been paid to the authority or the trustee for the
1019 bondholders, or until the authority notifies the secretary of administration and finance that satisfactory
1020 arrangements have been made for the payment of the principal and interest. Funds subject to withholding
1021 under this subparagraph shall include, but not be limited to, federal and state grants, contracts, allocations
1022 and appropriations.

1023 (ix) If the authority further notifies the secretary of administration and finance in writing that no
1024 other arrangements are satisfactory, the secretary shall direct the comptroller to make available to the
1025 authority without further appropriation any funds withheld from the institution under subparagraph (viii).
1026 The authority shall apply the funds to the costs incurred by the institution, including payments required to
1027 be made to the authority or trustee for any bondholders of debt service on any bonds issued by the
1028 authority for the institution or payments to replenish the Community Hospital and Community Health
1029 Center Capital Reserve Fund or required by the terms of any other law or contract to be paid to the
1030 holders or owners of bonds issued on behalf of the institution upon failure or default, or upon reasonable
1031 expectation of failure or default, of the institution to pay the principal or interest on its bonds when due.

1032 (x) Concurrent with any notice from the authority to the secretary of administration and finance
1033 under this paragraph, the authority may notify any other agency, department or authority of state
1034 government that exercises regulatory, supervisory or statutory control over the operations of the
1035 institution. Upon notification, the agency, department or authority shall immediately undertake reviews to
1036 determine what action, if any, that agency, department or authority should undertake to assist in the
1037 payment by the institution of the money due or the steps that the agencies of the commonwealth, other
1038 than the comptroller or the authority, should take to assure the continued prudent operation of the
1039 institution or provision of services to the people served by the institution.

1040 (xi) Notwithstanding any general or special law to the contrary, in the event that a nonprofit
1041 community hospital or nonprofit community health center fails to reimburse the commonwealth for any
1042 transfers made by the commonwealth to the authority to replenish the Community Hospital and
1043 Community Health Center Capital Reserve Fund under subparagraph (iii) within 6 months after any such
1044 transfer and as otherwise provided under the terms of the agreement among the nonprofit community
1045 hospital or nonprofit community health center, the authority and the commonwealth authorized under
1046 subparagraph (vii), the secretary of administration and finance may, in the secretary's sole discretion,
1047 direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the

1048 nonprofit community hospital or nonprofit community health center to cover all or a portion of the
1049 amount the nonprofit community hospital or nonprofit community health center has failed to pay to the
1050 commonwealth to reimburse the commonwealth for any such transfers. All contracts issued by the group
1051 insurance commission, the commonwealth health insurance connector authority and MassHealth to a third
1052 party for the purposes of providing health care insurance paid for by the commonwealth shall provide
1053 that, at the direction of the secretary of administration and finance, the third party shall withhold
1054 payments to a nonprofit community hospital or nonprofit community health center which fails to
1055 reimburse the commonwealth under the agreement authorized under subparagraph (vii) and shall transfer
1056 the withheld amount to the commonwealth. Any such withheld amounts shall be considered to have been
1057 paid to the nonprofit community hospital or nonprofit community health center for all other purposes of
1058 law and the nonprofit community hospital or nonprofit community health center shall be considered to
1059 have reimbursed the commonwealth for all or a portion of any such transfers to the Community Hospital
1060 and Community Health Center Capital Reserve Fund for purposes of the agreement authorized under said
1061 subparagraph (vii).

1062 (xii) Notwithstanding any general or special law to the contrary, if the commonwealth has not
1063 been fully reimbursed the amount of any transfer made pursuant to this subsection (g) as of the one year
1064 anniversary of such transfer, the authority shall pay to the commonwealth an amount equal to that portion
1065 of the transfer for which the commonwealth has not yet received reimbursement as of said anniversary.
1066 The reimbursement shall be completed under a schedule determined by the secretary of administration
1067 and finance. The reimbursement shall not interfere with the obligations of a nonprofit community hospital
1068 or nonprofit community health center pursuant to subsection (g) (xi). Funds received by the
1069 commonwealth under subsection (g) (xi) which exceed the full reimbursement to the commonwealth from
1070 the authority required by this subsection (g) (xii), shall be paid to the authority.

1071 (xiii) For the purposes of this paragraph, a community hospital or community health center shall
1072 not include a hospital where the ratio of the number of physician residents-in-training to the number of
1073 inpatient beds exceeds 0.25.

1074 **SECTION 49.** Section 12 of said chapter 614 is hereby amended by striking out the last sentence
1075 and inserting in place thereof the following sentence:- Except as otherwise provided in paragraph (g) of
1076 section 10, the issuance of revenue bonds under this act shall not directly, indirectly or contingently
1077 obligate the commonwealth or any political subdivision thereof to levy or to pledge any form of taxation
1078 therefor or to make any appropriation for payment of those bonds.

1079 **SECTION 50.** Notwithstanding any special or general law to the contrary, the division of
1080 insurance, in consultation with the division of health care finance and policy, shall promulgate regulations
1081 on or before October 1, 2010 to establish a uniform methodology for calculating and reporting by carriers
1082 for the medical loss ratios of health benefit plans under section 6 of chapter 176J, section 21 of chapter
1083 176O and section 6 of chapter 118G of the General Laws. The uniform methodology for calculating and
1084 reporting medical loss ratios shall, at a minimum, specify a uniform method for determining whether and
1085 to what extent an expenditure shall be considered a medical claims expenditure or an administrative costs
1086 expenditure, which shall include, but not be limited to, a determination of which of these classes of
1087 expenditures the following expenses fall into: (i) financial administration expenses; (ii) marketing and
1088 sales expenses; (iii) distribution expenses; (iv) claims operations expenses; (v) medical administration
1089 expenses, such as disease management, care management, utilization review and medical management
1090 activities; (vi) network operation expenses; (vii) charitable expenses; (viii) board, bureau or association
1091 fees; (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other
1092 miscellaneous expenses not included in one of the previous categories. The methodology shall conform
1093 with applicable federal statutes and regulations to the maximum extent possible. The division shall,
1094 before adopting regulations under this section, consult with: the group insurance commission; the Centers
1095 for Medicare and Medicaid Services; the national association of insurance commissioners; the attorney

1096 general; representatives from the Massachusetts Association of Health Plans; the Massachusetts Medical
1097 Society Alliance, Inc.; the Massachusetts Hospital Association, Inc.; Health Care for All, Inc.; the Blue
1098 Cross and Blue Shield of Massachusetts; the Massachusetts Health Information Management Association;
1099 the Massachusetts Health Data Consortium; a representative from a small business association; and a
1100 representative from a health care consumer group.

1101 **SECTION 51.** Notwithstanding any special or general law to the contrary, the division of health
1102 care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or
1103 before October 1, 2010 to establish a uniform methodology for calculating and reporting the health status
1104 adjusted total medical expenses, under section 6 of chapter 118G of the General Laws. The uniform
1105 methodology shall apply to a uniform list of provider groups and their constituent local practice groups
1106 and for each zip code in the commonwealth. The uniform methodology for calculating and reporting total
1107 medical expenses under this section shall, at a minimum:

1108 (i) specify a uniform method for calculating total medical expenses based on allowed claims for
1109 all categories of medical expenses, including, but not limited to, acute inpatient, hospital outpatient, sub-
1110 acute such as skilled nursing and rehabilitation, professional, pharmacy, mental health and behavioral
1111 health and substance abuse, home health, durable medical equipment, laboratory, diagnostic imaging and
1112 alternative care such as chiropractic and acupuncture claims, incurred under all fully-insured and self-
1113 insured plans;

1114 (ii) specify a uniform method for including in the calculation all non-claims related payments to
1115 providers, including supplemental payments of any type, such as pay-for-performance, care management
1116 payments, infrastructure payments, grants, surplus payments, lump sum settlements, signing bonuses and
1117 government payer shortfall payments; infrastructure, medical director and health information technology
1118 payments;

1119 (iii) specify a uniform method for adjusting total medical expenses by health status;

1120 (iv) designate the minimum patient membership in a local practice group for individual reporting
1121 of total medical expenses by local practice group;

1122 (v) specify a uniform method for reporting total medical expenses in aggregate for all local
1123 practice groups that fall below the minimum patient membership; (vi) specify a uniform method for
1124 reporting total medical expenses by zip code separately for patient members whose plans require them to
1125 select a primary care provider, and patient members whose plans do not require them to select a primary
1126 care provider;

1127 (vii) designate and annually update the comprehensive list of provider groups and local practice
1128 groups and zip codes for which payers shall report total medical expenses; and

1129 (viii) specify a uniform format for reporting that includes the raw and adjusted health status score
1130 and patient membership for each local practice group and zip code.

1131 The division shall from time to time require payers to submit the underlying data used in their
1132 calculation of total medical expenses for audit.

1133 **SECTION 52.** Notwithstanding any special or general law to the contrary, the division of health
1134 care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or
1135 before October 1, 2010 to establish uniform methodology for calculating and reporting relative prices
1136 paid to hospitals, physician groups, other health care providers licensed under chapter 112 of the General
1137 Laws, freestanding surgical centers by each private and public health care payer under section 6 of
1138 chapter 118G of the General Laws. The uniform methodology for calculating and reporting relative
1139 prices under this section shall, at a minimum: (i) specify a method for basing the calculation on a uniform
1140 mix of products and services by payer that is case mix neutral; (ii) specify a uniform method for including
1141 in the calculation all non-claims related payments to providers, including supplemental payments of any
1142 type, such pay-for-performance, care management payments, infrastructure payments, grants, surplus
1143 payments, lump sum settlements, signing bonuses, and government payer shortfall payments; (iii) permit

1144 reporting of relative price in the aggregate for all physician groups whose price equals the payer's
1145 standard fee schedule rates; and (vi) designate and annually update the comprehensive list of physician
1146 groups for which payers shall report relative prices.

1147 **SECTION 53.** Notwithstanding any special or general law to the contrary, the division of health
1148 care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or
1149 before October 1, 2010 to establish uniform methodology for calculating and reporting inpatient and
1150 outpatient costs, including direct and indirect costs, for all hospitals under section 6 of chapter 118G of
1151 the General Laws. The division shall, as necessary and appropriate, promulgate regulations or
1152 amendments to its existing regulations to require hospitals to report cost and cost trend information in a
1153 uniform manner including, but not limited to, uniform methodologies for reporting the cost and cost trend
1154 for categories of direct labor, debt service, depreciation, advertising and marketing, bad debt, stop-loss
1155 insurance, malpractice insurance, health information technology, medical management, development,
1156 fundraising, research, academic costs, charitable contributions, and operating margins for all commercial
1157 business and for all state and federal government business, including but not limited to Medicaid,
1158 Medicare, insurance through the group insurance commission and federal Civilian Health and Medical
1159 Program of the Uniformed Services. The division shall, before adopting regulations under this section,
1160 consult with the group insurance commission, the Centers for Medicare and Medicaid Services, the
1161 attorney general and representatives from the Massachusetts Hospital Association, the Massachusetts
1162 Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of
1163 Massachusetts, the Massachusetts Health Information Management Association the Massachusetts Health
1164 Data Consortium.

1165 **SECTION 54.** The department of public health shall promulgate regulations under section 25P
1166 of chapter 111 of the General Laws by December 31, 2010 requiring the uniform reporting of a standard
1167 set of health care quality measures for each health care provider facility, medical group, or provider group
1168 in the commonwealth hereinafter referred to as the "Standard Quality Measure Set."

1169 The department of public health shall convene a statewide advisory committee which shall
1170 recommend to the department by November 1, 2010 the Standard Quality Measure Set. The statewide
1171 advisory committee shall consist of the commissioner of health care finance and policy or the
1172 commissioner's designee, who shall serve as the chair; and up to 8 members, including the executive
1173 director of the group insurance commission and the Medicaid director, or the directors designees; and up
1174 to 6 representatives of organizations to be appointed by the governor including at least 1 representative
1175 from an acute care hospital or hospital association, 1 representative from a provider group or medical
1176 association or provider association, 1 representative from a medical group, 1 representative from a private
1177 health plan or health plan association, 1 representative from an employer association and 1 representative
1178 from a health care consumer group.

1179 In developing its recommendation of the Standard Quality Measure Set, the advisory committee
1180 shall, after consulting with state and national organizations that monitor and develop quality and safety
1181 measures, select from existing quality measures and shall not select quality measures that are still in
1182 development or develop its own quality measures. The committee shall annually recommend to the
1183 department of public health any updates to the Standard Quality Measure Set by November 1. For its
1184 recommendation beginning in 2011, the committee may solicit for consideration and recommend other
1185 nationally recognized quality measures not yet developed or in use as of November 1, 2010, including
1186 recommendations from medical or provider specialty groups as to appropriate quality measures for that
1187 group's specialty. At a minimum, the Standard Quality Measure Set shall consist of the following quality
1188 measures: (i) the Centers for Medicare and Medicaid Services hospital process measures for acute
1189 myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (ii) the
1190 Hospital Consumer Assessment of Healthcare Providers and Systems survey; (iii) the Healthcare
1191 Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of
1192 the individual measures by medical or provider group; and (iv) the Ambulatory Care Experiences Survey.

1193 **SECTION 55.** Notwithstanding and special or general law to the contrary, eligible individuals as
1194 defined in chapter 176J with existing coverage issued under said chapter 176J that will expire after the
1195 end of open enrollment in 2010 established under section 4 of said chapter 176J may renew coverage on
1196 the date that the eligible individual's coverage expires for a term of less than 1 year until the beginning of
1197 open enrollment period in 2011.

1198 **SECTION 56.** Notwithstanding any general or special law to the contrary, the secretary of
1199 health and human services shall convene an administrative simplification working group consisting of the
1200 following members: the secretary of consumer affairs and business regulation or the secretary's designee,
1201 the commissioner of health care finance and policy or the commissioner's designee, the commissioner of
1202 public health or the commissioner's designee, the commissioner of insurance or the commissioner's
1203 designee, the commissioner of revenue or the commissioner's designee, the director of the office of
1204 Medicaid or the director's designee, the attorney general or the attorney general's designee, the inspector
1205 general or the inspector general's designee, a representative of the Massachusetts Health Data
1206 Consortium, a representative of an association of health care providers licensed under chapter 112 who is
1207 not a medical doctor, a representative of the Health Care Quality and Cost Council, a representative of the
1208 Massachusetts Hospital Association, Inc., a representative of BC/BS of Massachusetts, a representative of
1209 the Massachusetts Association of Health Plans, a representative of the Massachusetts Medical Society,
1210 and the executive director of the commonwealth health insurance connector authority or the executive
1211 director's designee. The group shall identify ways to streamline state created or mandated administrative
1212 requirements in health care, including ways to reduce health care reporting requirements through
1213 maximizing the use of a single all-payer data base, as administered by the division of health care finance
1214 and policy. The group shall hold its first meeting not later than January 1, 2011 and shall issue a report on
1215 or before April 1, 2011. The report shall include specific steps to be taken by each agency and the
1216 agencies collectively to reduce administrative and filing requirements on health carriers and health care
1217 providers, which shall include, but not be limited to, an interagency agreement to use where necessary,

1218 the all-payer claims data base, and to streamline and coordinate all requests for all other data requests
1219 from health care providers and health plans in the commonwealth.

1220 **SECTION 57.** (a) Notwithstanding any special or general law to the contrary, the division of
1221 insurance, in consultation with the secretary of health and human services, shall promulgate regulations
1222 on or before December 1, 2011 to promote administrative simplification in the processing of claims for
1223 health care services under health benefit plans by carriers, as defined in section 1 of chapter 176O of the
1224 General Laws. At a minimum, the regulations shall: (1) establish uniform standards and processes for
1225 determining health benefit plan member eligibility by health care providers; (2) establish standards and
1226 processes for provider appeals of denied claims; and (3) establish a standard authorization form to be
1227 submitted by health care providers to obtain authorization to provide health care services to a member.
1228 The division shall, before adopting regulations under this section, consult with a statewide advisory
1229 commission charged with investigating and studying the relative value of a uniform claims administration
1230 system for all payers in the commonwealth.

1231 (b) The commission shall be comprised of: the director of the office of Medicaid or a designee;
1232 the commissioner of insurance or a designee; the commissioner of health care finance and policy or a
1233 designee; 1 person appointed by the speaker of the house of representatives; 1 person appointed by the
1234 senate president; 1 person appointed by the minority leader of the house of representatives; 1 person
1235 appointed by the minority leader of the senate; 1 person designated by the Massachusetts Association of
1236 Health Plans, Inc.; 1 person designated by Blue Cross Blue Shield of Massachusetts, Inc.; 2 persons
1237 designated by the Massachusetts Hospital Association, Inc., 1 of whom shall represent teaching hospitals
1238 and 1 of whom shall represent community hospitals; 1 person designated by the Massachusetts Public
1239 Health Association; and 2 persons designated by the Massachusetts Medical Society. In addition, the
1240 regional administrator of the federal Centers for Medicare & Medicaid Services or a designee, and a
1241 member of the senior management of a Medicare administrative contractor will be invited to participate in
1242 the commission, but shall not have a vote.

1243 (c) The commission shall undertake a study of the feasibility of mandating a single claims
1244 administration system for all payers in the commonwealth, other than Medicare, and of the potential
1245 savings to be derived from doing so. For purposes of this section, the term ‘payer’ shall mean both a
1246 private health care payer and a public health care payer, as those terms are defined in section 1 chapter
1247 118G of the General Laws. In undertaking its responsibilities under this section, the commission shall (i)
1248 determine the feasibility of using a single claims administration system for all payers in the
1249 commonwealth, other than Medicare; (ii) (ii) undertake a detailed analysis of the merits and limits of the
1250 Medicare claims administration system; (iii) determine what models exist that might constitute the most
1251 efficient and effective consolidated claims administration system; (iv) identify potential challenges
1252 associated with implementation of a single claims administration system for all payers in the
1253 commonwealth other than Medicare and also identify proposed solutions for such challenges; (v) identify
1254 the costs being incurred by payers and providers as a result of multiple claims administration systems;
1255 (vi) estimate the potential cost savings to the commonwealth if the Medicaid program were to implement
1256 a uniform claims administration system based on Medicare’s system, using regional Medicare
1257 administrative contractors; (vii) estimate the potential cost savings if all private health care payers in the
1258 commonwealth implemented a uniform claims administration system based on Medicare’s system, using
1259 regional Medicare administrative contractors, including for their Medicare advantage programs; and (viii)
1260 determine the potential savings and costs associated with creating incentives or requiring ERISA plans,
1261 Taft-Hartley plans and other self-funded health benefit plans to use regional Medicare administrative
1262 contractors for claims management.

1263 **SECTION 58.** Notwithstanding any general or special law to the contrary, there shall be a
1264 special commission to make an investigation and study relative to the impact of reducing the number of
1265 health benefit plans that a health care payer may maintain and offer to individuals and employers. The
1266 commission shall consist of the 13 members including: the commissioner of insurance, who shall serve as
1267 chair; the executive director of the commonwealth health insurance connector authority; a representative

1268 of the Massachusetts Hospital Association, the Massachusetts Medicaid Society, the Massachusetts
1269 Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health
1270 Information Management Association, the Massachusetts Health Data Consortium, a MassHealth
1271 contracted managed care organization, Associated Industries of Massachusetts, a health care consumer
1272 group, and the Massachusetts chapter of the National Federation of Independent Business; and a
1273 representative of an association of health care providers licensed under chapter 112 of the General Laws
1274 who is not a medical doctor. In conducting its analysis, the commission shall examine:

1275 (i) the administrative costs associated with paying claims and submitting claims for multiple
1276 health benefit plans on health care payers and providers;

1277 (ii) the costs associated with reducing the number of health benefit plans on consumer and
1278 employer choice;

1279 (iii) the impact of limiting the number of health benefit plans on competition between and among
1280 insurance payers, including but not limited to, tiered products, limited network products and products
1281 with a range of cost sharing options; and

1282 (iv) the potential for disruption to the market resulting from closing a health care payer's existing
1283 health benefit plans.

1284 The special commission shall convene not later than October 1, 2010 and shall submit a report to
1285 the clerks of the house and senate not later than December 31, 2010.

1286 **SECTION 59.** Notwithstanding any special or general law to the contrary, in implementing this
1287 act, the executive office of health and human services, the department of public health, the division of
1288 health care finance and policy, the division of insurance, the group insurance commission and any other
1289 relevant governmental entities or commissions may consider the special needs of children and of pediatric
1290 patients. In developing or utilizing data standards, quality measurement systems, wellness initiatives or

1291 making comparisons of costs and prices, policymakers shall consider the special needs of children and of
1292 pediatric patients and may require that comparative data and reports segregate pediatric patients and
1293 providers from adult patients and providers.

1294 **SECTION 60.** There shall be a special commission to make an investigation and study relative
1295 to the capital needs of the community hospital sector with regard to use of technology and adequacy of
1296 facilities, the ability of the sector to meet the health care needs of the general population in the next
1297 decade and potential sources of capital to meet those needs. The commission shall also evaluate the role
1298 of public programs, payments and regulations in supporting capital accumulation and make
1299 recommendations to advance the ability of the community hospital sector to meet the expected demand.
1300 The commission shall be comprised of the secretary of health and human services, the commissioner of
1301 public health, the secretary of administration and finance, a representative of the Massachusetts Council
1302 of Community Hospitals, a representative of the Massachusetts Hospital Association, a representative of
1303 the Associated Industries of Massachusetts, a representative of the Massachusetts Business Roundtable,
1304 the chief executive officer of the Massachusetts health and educational facilities authority, the chief
1305 executive officer of the Massachusetts development finance agency, the chairs of the house and senate
1306 committees on ways and means, the house and senate chairs of the joint committee on health care
1307 financing, a member of the house of representatives who shall be chosen by the minority leader, a
1308 member of the senate who shall be chosen by the minority leader, a chief elected local official with a
1309 community hospital located in said community who shall be appointed by the governor, an individual
1310 knowledgeable about demographic trends and hospital utilization who shall be appointed by the governor
1311 and an individual knowledgeable about hospital finance and construction who shall be appointed by the
1312 governor.

1313 The commission shall hold hearings and file a report with the clerks of the house and senate not
1314 later than December 31, 2011.

1315 **SECTION 61.** Notwithstanding any general or special law to the contrary, the department of
1316 public health shall conduct a study of the commonwealth's community hospitals, with a particular focus
1317 on outmigration of patients and related trends, including but not limited to an examination of observed
1318 effects and their potential causes with respect to the following:

1319 (i) the impact on individual community hospitals caused by the opening of additional health care
1320 services by providers within the primary service areas of such community hospital, in terms of changes in
1321 the number and types of procedures performed and changes in revenues;

1322 (ii) recruitment and retention of personnel; and

1323 (iii) changes in payer mix.

1324 The department shall issue a report summarizing its findings and making recommendations with
1325 respect to strengthening community hospitals not later than December 31, 2010, and shall file such report
1326 with the joint committee on health care financing.

1327 **SECTION 62.** Notwithstanding any general or special law to the contrary nothing in subsection
1328 (c) of section 6C of chapter 118G of the General Laws shall prevent the annual preparation of the public
1329 health access program beneficiary employer report under section 304 of chapter 149 of the acts of 2004.

1330 **SECTION 63.** Notwithstanding the provisions of any general or special law to the contrary, the
1331 Division of Medical Assistance shall promulgate regulations on or before January 1, 2011 that are
1332 designed to conform the ordering of treatment related urine drug screens with both Chapter 160 of the
1333 Acts of 2006 governing independent clinical laboratory services and the Department of Public Health
1334 regulations at 105 CMR 164 et. seq. governing the provisions of substance abuse treatment services, by
1335 revising its definition of 'authorized prescriber' at 130 CMR 401.402 to separately include, for the
1336 purpose of ordering treatment related random urine drug screens, substance abuse treatment programs that
1337 are licensed by the Department of Public Health's Bureau of Substance Abuse Services.

1338 **SECTION 64.** In order to facilitate the provision of cost effective health care services, enhance
1339 the quality of care and improve the coordination and efficiency of health care services in the
1340 commonwealth, the division of health care finance and policy, herein referred to as the division, shall
1341 undertake activities intended to foster the adoption by providers and payers in the commonwealth of
1342 arrangements by which providers will contract to accept payment on a bundled, rather than a fee-for-
1343 service, basis. To promote provider participation in such bundled payment arrangements, the division
1344 shall make technical support available to providers and payers, survey or undertake research concerning
1345 existing and proposed bundled payment models within the commonwealth and elsewhere and disseminate
1346 the results of such research; assess the effects of federal programs intended to promote use of bundled
1347 payment arrangements; and identify sources of funding to support providers in designing and
1348 implementing bundled payment initiatives. The division shall have as an objective, but not as a
1349 requirement, the implementation of pilot bundled payment programs relating to payment for at least 2
1350 acute conditions or procedures commencing by no later than January 1, 2011, under the terms of which
1351 inpatient services, as well as certain services provided pre- and post-inpatient stay, will be paid on a
1352 bundled payment basis; and the implementation of pilot bundled payment programs relating to payment
1353 for at least 2 chronic conditions commencing by no later than July 1, 2011. The division shall file reports
1354 on the efforts it undertakes to provide support for providers and payers to enter into bundled arrangements
1355 and on the progress made toward implementing the goals described in the preceding sentence of this
1356 section. Such reports shall be filed with the clerks of the senate and the house of representatives and with
1357 the governor not later than January 31, 2011, not later than July 29, 2011 and not later than December 30,
1358 2011.

1359 **SECTION 65.** The division of insurance shall conduct a study to ensure that the carrier reporting
1360 deadlines included in subsections (b) and (c) of section 6 of chapter 176J of the General Laws are of the
1361 appropriate duration to enable carriers to collect sufficient information with which to ensure the accuracy
1362 of proposed plan changes. If the division determines that a reporting date of 90 days prior to the effective

1363 date of plan changes is inappropriate, the division shall determine the appropriate length of time for
1364 carriers to report plan changes to the division of insurance and the attorney general and shall make such
1365 recommendation to the general court. The study shall be completed by July 31, 2011 and filed with the
1366 clerks of the house of representative and senate, the chairs of the joint committee on health care financing
1367 and the chairs of the house and senate committee on ways and means.

1368 **SECTION 66.** For small group base rate factors applied under section 3 of chapter 176J
1369 between October 1, 2010 and June 30, 2012, a carrier shall limit the effect of the application of any single
1370 or combination of rate adjustment factors identified in paragraphs (2) to (6), inclusive, of subsection (a) of
1371 said chapter 3 of said chapter 176J of the General Laws that are used in the calculation of an individual's
1372 or small group's premium so that the final annual premium charged to an individual or small group does
1373 not increase by more than an amount established annually by the commissioner by regulation.

1374 **SECTION 66A.** Notwithstanding any general or special law to the contrary, a participating
1375 provider, as defined in chapter 176O of the General Laws, may contract with a carrier, as defined in
1376 chapter 176J of the General Laws, to provide one-time supplemental funding for the purposes of issuing
1377 refunds for all health benefit plans issued to its current eligible individuals and small groups under said
1378 chapter 176J. The refund may take the form of either a refund on the premium for the applicable 12-
1379 month period or any other form determined by the parties by contract. The division of insurance may
1380 require the filing of such contracts after execution for the purposes of ensuring distribution as provided in
1381 the contracts. The division shall issue a public report by December 31, 2010 detailing the participating
1382 providers who have entered into such contracts in calendar year 2010, the amount of one-time
1383 supplemental funding by participating provider, and the estimated aggregate refunds to be provided to
1384 eligible individuals and small groups. The commissioner may issue further regulations as necessary to
1385 implement this section.

1386 **SECTION 67.** (a) Notwithstanding any general or special law to the contrary, there shall be a
1387 special commission on provider price reform that shall investigate the rising cost of health care insurance
1388 and the impact of reimbursement rates paid by health insurers to providers. The commission shall
1389 examine policies aimed at enhancing competition, fairness and cost-effectiveness in the health care
1390 market though the reduction of reimbursement disparities. Any recommendations shall consider, and be
1391 consistent with, the recommendations of the special commission on payment system as authorized in
1392 section 44 of chapter 305 of the acts of 2008.

1393 (b) The commission shall consist of the secretary of administration and finance and the
1394 commissioner of health care finance and policy, who shall serve as co-chairs, the executive director of the
1395 group insurance commission, 1 person to be appointed by the senate president, 1 person to be appointed
1396 by the speaker of the house, and 5 members to be appointed by the Governor, 1 of whom shall be a
1397 representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative
1398 of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the
1399 Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts
1400 Medical Society, and 1 of whom shall be a health economist or expert in the area of payment
1401 methodology. The commission shall adopt rules and establish procedures it considers necessary for the
1402 conduct of its business. The commission may expend funds as may be appropriated or made available for
1403 its purposes. No action of the commission shall be considered official unless approved by a majority vote
1404 of the commission members.

1405 (c) The commission shall examine: (i) the variation in relative prices paid to providers within
1406 similar provider groups; (ii) the variation in costs of providers for services of comparable acuity, quality
1407 and complexity; (iii) the variation in volume of care provided at providers with low and high levels of
1408 relative prices or health status adjusted total medical expenses; (iv) the correlation between price paid to
1409 providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider's payor mix,
1410 (4) the provision of unique services, including specialty teaching services and community services, and

1411 (5) operational costs, including labor costs; (iii) the correlation between price paid to providers and, in the
1412 case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty
1413 hospital or as an academic teaching hospital; and (v) policies to promote the use of providers with low
1414 health status adjusted total medical expenses.

1415 (d) In making its investigation, the commission shall consult with the attorney general, the health
1416 care quality and cost council, the division of health care finance and policy, health care economists, and
1417 other individuals or organizations with expertise in state and federal health care payment methodologies
1418 and reforms. The commission shall use data and recommendations gathered in the course of these
1419 consultations as a basis for its findings and recommendations.

1420 (e) The commission shall file a report of its findings and recommendations.

1421 Before a final vote on any recommendations, the commission shall consult with a reasonable
1422 variety of parties likely to be affected by its recommendations, including, but not limited to, the office of
1423 Medicaid, the division of health care finance and policy, the commonwealth health insurance connector,
1424 the Massachusetts Council of Community Hospitals, Inc., the Massachusetts League of Community
1425 Health Centers, Inc., 1 or more academic medical centers, 1 or more hospitals with a high proportion of
1426 public payors, 1 or more Taft-Hartley plans, 1 or more self-insured plans with membership of more than
1427 500, the Massachusetts Municipal Association, Inc. and organizations representing health care consumers.
1428 The commission shall file the report of its findings and recommendations, with the clerks of the senate
1429 and the house of representatives and with the governor not later than February 1, 2011.

1430 **SECTION 68.** Sections 1, 2, 3, 10, 11, 12, 13, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 34,
1431 36, 39, 43, 46, 47, 48, 49, 51, 60, 61, 65, 66 shall take effect on October 1, 2010.

1432 **SECTION 69.** Section 30 shall take effect on October 1, 2011.

1433 **SECTION 70.** Section 31 shall take effect on October 1, 2012.

1434 **SECTION 71.** Sections 14, 35, 41, 62 shall take effect on July 1, 2012.

1435 **SECTION 72.** Sections 38, 42, 44, 45 shall take effect on July 1, 2011.

1436 **SECTION 73.** Sections 32, 37, 40 shall take effect on January 1, 2011.