[House Emergency Preamble] *Whereas,* The deferred operation of this act would tend to defeat its purpose which is forthwith to expand access to health care for Massachusetts residents, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

SECTION 1. [Senate 1A.REV] To provide for supplementing certain items in the general appropriation act and other appropriation acts for fiscal year 2006, the sums set forth in section 2 are hereby appropriated from the General Fund unless specifically designated otherwise in this act or in those appropriation acts, for the several purposes and subject to the conditions specified in this act or in those appropriation acts and subject to the laws regulating the disbursement of public funds for the fiscal year ending June 30, 2006. These sums shall be in addition to any amounts previously appropriated and made available for the purposes of these items.

SECTION 2.

Comment [AS1]: For now, I just used the copy off the Internet. We will provide improved formatting before we go to print.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES.

Office of the Secretory.

4000-0352.....3 ,000,000

Massachusetts Rehabilitation Commission.

4120-6000.....1 ,500,000

Department of Public Health.

4510-0600.....500,000

4513-1026.....1,000,000

4513-1112.....1,000,000

4513-1114.....1,250,000

4513-1115.....500,000

4513-1121.....300,000

4530-9000.....1,500,000

4570-1500.....5,500,000

4590-0300.....6,000,000

SECTION 2A. To provide for certain unanticipated obligations of the commonwealth; to provide for alterations of purposes for current appropriations and to meet certain requirements of law, the sums set forth in this section are hereby appropriated from the General Fund unless specifically designated otherwise in this section, for the several purposes and subject to the conditions specified in this section, and subject to the laws

regulating the disbursement of public funds for the fiscal year ending June 30, 2006. These sums shall be in addition to any amounts previously appropriated and made available for the purposes of these items.

EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE.

Reserves.

1599-0041 For the special commission studying end of life care services established in section 480 of chapter 159 of the acts of 2000.....50,000

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES.

Office of the Secretary.

4000-0140 For the operation of the Betsy Lehman center for patient safety and medical error reduction established in section 16E of chapter 6A of the General Laws.....
500,000

4000-0301 For the costs of MassHealth provider and member audit and utilization review activities including, but not limited to, eligibility verification, disability evaluations, provider financial and clinical audits and other initiatives intended to enhance program integrity; provided, that $150,000 shall be expended for the operation of the Medicaid fraud control unit within the office of the attorney general; and provided further, that $150,000 shall be expended for MassHealth auditing within the office of the state auditor.....
..1,500,000

Department of Public Health.

4513-1111 For an osteoporosis education and prevention program; provided, that the program shall include, but not be limited to: (1) development or identification of educational materials to promote public awareness of the cause of osteoporosis, options for prevention and the value of early detection and possible treatments, including their benefits and risks, to be made available to consumers, particularly targeted to high risk groups; (2) development or identification of professional education programs for health care providers; (3) development and maintenance of a list of current providers of specialized services for the prevention and treatment of osteoporosis; and (4) a program for awareness, prevention and treatment of hip fractures.....175,000

4513-1116 For a renal disease program; provided, that not less than $250,000 shall be expended for renal disease programs administered by the National Kidney Foundation of Massachusetts, Rhode Island, Vermont and New Hampshire, including organ donor awareness, nutritional supplements and early intervention services for those affected with renal disease and those at risk of renal disease.....250,000

4515-1113 For a bladder cancer screening, education and treatment program; provided, that no funds shall be expended in the AA object class for any personnel-related costs.....500,000

4515-1114 For an ovarian cancer screening, education and treatment program; provided, that no funds shall be expended in the AA object class for any personnel-related costs.....500,000

4516-0264 For a diabetes screening and outreach program to raise public awareness and provide outreach and education for high risk individuals, including, but not limited to, targeted populations of adolescents and the elderly.....500,000

4570-1501 For the funding of a pilot cooperative agreement with Seven Hills Foundation and UMASS Memorial Health Center for the development of a residential intermediate care facility to serve the needs of Massachusetts veterans, including members of the Massachusetts National Guard, Armed Forces of the United States or Reserves who served during Operation Iraqi Freedom, Operation Enduring Freedom and Combined Forces Command —Afghanistan, with traumatic head injuries received on active duty; provided, that every effort shall be made to secure resources and financial support from the United States Veterans Administration or other federal agencies and from third party sources including, but not limited to, Medicaid; and provided further, that the Institute of Commonwealth Medicine at the University of Massachusetts Medical School shall receive funding from this appropria tion to evaluate the success of the pilot project.....
..1,500,000

4570-1502 For the purposes of implementing a proactive statewide infection prevention and control program; provided, that notwithstanding any general or special law to the contrary, the department of public health shall, through its division of health care quality, develop a proactive statewide infection prevention and control program in licensed health care facilities following protocols of the Centers for Disease Control for the purposes of

implementation and adherence to infection control practices that are the keys to preventing the transmission of infectious diseases, including respiratory diseases spread by droplet or airborne routes; provided further, that recommended infection control practices shall include, but not be limited to, hand hygiene; standard precautions and transmission-based precautions, including contact, droplet and airborne, and respiratory hygiene; and provided further, that the infection prevention and control program shall include mandatory education in the recommended infection control practices for licensed health care personnel and employees of licensed health care facilities and penalties for individual and institutional noncompliance with Centers for Disease Control protocols.....1,000,000

4590-1503 For the pediatric palliative care program established in section 24K of chapter 111 of the General Laws.....950,000

EXECUTIVE OFFICE OF ECONOMIC DEVELOPMENT.

Department of Labor.

7002-0900 For the cost of health insurance premium subsidies paid to employees of small businesses participating in the insurance reimbursement program pursuant to section 9C of chapter 118E of the General Laws; provided, that said program shall be administered by the director of labor, in collaboration with the executive office of health and human services; provided further, that all federal reimbursements received for expenditures from this item pursuant to the provisions of Title XIX and Title XXI of the federal Social Security Act shall be credited to the Children's and Seniors' Health Care Assistance

Fund; and provided further, that expenditures made for the purposes of this item shall not exceed the amount appropriated in this item 10,000,000

7002-0901 For the cost of health insurance subsidies paid to employers participating in the insurance reimbursement program under section 9C of chapter 118E of the General Laws; provided, that the director of labor, in collaboration with the executive office of health and human services, shall administer the program and shall directly market the program to small business and private human service providers that deliver human and social services under contract with departments within the executive office of health and human services and the executive office of elder affairs for the purpose of mitigating health insurance costs to the employers and their employees; provided further, that the director of labor, in collaboration with the executive office, shall report quarterly to the house and senate committees on ways and means and the executive office of administration and finance, monthly expenditure data for the program, including the total number of employers participating in the program, the percentage of the employers who purchased health insurance for employees prior to participating in the program and the total monthly expenditures delineated by payments to small employers and self-employed persons for individual, 2-person family and family subsidies; provided further, that the executive office of health and human services shall seek federal reimbursement for the payments to employers; and provided further, that all federal reimbursements received for expenditures from this item, under Title XIX and Title XXI of the federal Social Security Act shall be credited to the Children's and Seniors' Health Care Assistance Fund.....10,000,000

Division of Insurance.

7006-0201 For the funding of the consumer health care costs information board, pursuant to chapter 28B of the General Laws.....2,000,000

SECTION 3. [House 1, Senate 4, Conference Comp] Chapter 6A of the General Laws is hereby amended by inserting after section 16G the following new section:-

Section 16H. Massachusetts health care quality and cost council

Section 1. There shall be established a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall establish health care quality improvement and cost containment goals for the commonwealth. The goals shall be designed to promote high-quality, safe, effective, timely, efficient, equitable, and patient-centered health care. The council shall receive staff assistance from the executive office of health and human services, and may, subject to appropriation, employ such additional staff or consultants as may be deemed necessary by the Council. The council shall consist of the secretary of health and human services, *the Auditor of the Commonwealth or his designee, the Inspector General or his designee, the Attorney General or his designee,* the commissioner of insurance, the executive director of the group insurance commission, and seven members appointed by the governor, one of whom shall be a representative of a health care quality improvement organization (QIO) recognized by the federal Centers for Medicare and Medicaid services, one of whom shall be a representative of the Institute for Healthcare Improvement, Inc. recommended by the organization's board of directors, one of whom shall be a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, one of whom shall be a representative of the Massachusetts Association of Health Underwriters, one of whom shall be a representative of the Massachusetts Medicaid Policy Institute, one of whom shall be an expert in health care policy from a foundation or academic institution, and one of whom shall represent a non-governmental purchaser of health insurance. The representatives of non-governmental organizations shall serve staggered three-year terms. The council shall be chaired by the secretary of health and human services.

Section 1A. Definitions.

As used in this section, the following terms shall have the following meanings unless the context clearly requires otherwise:
"Council", the health care quality and cost council established in section 2.
"Clinician", any health care professionals licensed pursuant to chapter 112 of the General Laws.

"Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health agency.
"Health care provider", a clinician, a facility or a physician group practice.
"Insurer", a carrier authorized to transact accident and health insurance pursuant to chapter 175, a nonprofit hospital service corporation licensed pursuant to chapter 176A, a nonprofit medical service corporation licensed pursuant to chapter 176B, a dental service corporation organized pursuant to chapter 176E, an optometric service corporation organized pursuant to chapter 176F and a health maintenance organization licensed pursuant to chapter 176G.
"Physician group practice", 2 or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income by a prearranged formula.

Section 2. The duties of the council shall include the following:

(1) (a) The council shall develop and coordinate the implementation of health care quality improvement goals for the commonwealth that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities. For each such goal, the Council shall identify the steps needed to achieve the goal; estimate the cost of implementation; project the anticipated short-term or long-term financial savings achievable to the health care industry and the Commonwealth, and estimate the expected improvements in the health status of health care consumers in Massachusetts.

(b) The council may, subject to the provisions of chapter 30B of the general laws, contract with an independent health care organization to provide the council with technical assistance related to its duties including, but not limited to development of health care quality goals, cost containment goals, performance measurement benchmarks, the design and implementation of health quality interventions, the construction of a consumer health information web site as well as the preparation of reports including any reports as required by this section, The independent health care organizations shall have a history of demonstrating the skill and expertise necessary to; (i) collect, analyze and aggregate data related to costs and quality across the health care continuum; (ii) identify through data analysis quality improvement areas; (iii) work with Medicare, Mass Health, other payers' data and clinical performance measures; (iv) collaborate in the design and implementation of quality improvement measures; establish and maintain security measures necessary to maintain confidentiality and preserve the integrity of the data; (vi) design and implement health care quality improvement interventions with health care service providers and (vii) identify and, when necessary, develop appropriate measures of cost and quality for inclusion in the web site.

To the extent possible, the independent organization shall collaborate with other organizations that develop, collect and publicly report health care cost and quality measures.

(c) Any independent organization under contract with the board shall develop and update on an annual basis a reporting plan specifying the cost and quality measures to be included on the internet site. The reporting plan shall be consistent with the requirements of subsections (1)(a and b). The organization shall give consideration to those measures that are already available in the public domain and to whether it is cost effective for the board to license commercially available comparative data and consumer decision support tools. If the organization determines that making available through the internet site only those measures already available in the public domain would not fully comply with subsection 1(b) or would not provide consumers with sufficient information to make informed health care choices, the organization shall develop appropriate measures for inclusion on the internet site and shall specify in the reporting plan the sources from which it proposes to obtain the data necessary to construct those measures and any specifications for reporting of that data by insurers and health care providers.

As part of the reporting plan, the organization shall determine for each service that comparative information is to be included on the internet site whether it is more practical and useful to: (1) list that service separately or as part of a group of related services; and (2) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

The independent organization shall submit the reporting plan, and any periodic revisions, to the council. The council shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the board shall state its reasons therefore. The reporting plan and any revisions adopted by the board shall be promulgated by the board.

(d). Insurers and health care providers shall submit data to the council or to the independent organization on behalf of the council, as required by regulations promulgated pursuant to subsection 8. Any insurer or health care provider failing, without just cause, to submit required data to the council on a timely basis may be required, after notice and hearing, to pay a penalty of $1,000 for each week's delay. The maximum penalty under this section shall be $50,000.

(e) The Council may promulgate additional rules and regulations relative to the type of information that may be required and the format in which it should be provided for the implementation the quality improvement and cost containment goals.

(2) The council may adopt by-laws for itself and for its advisory committee for the efficient operation of both organizations, and may recommend that public or private health care organizations be responsible for overseeing implementation of a goal, and may assist these organizations in developing implementation plans.

(3) The council shall develop performance measurement benchmarks for its goals and publish such benchmarks annually, after consultation with lead agencies and organizations and the council's advisory committee. Such benchmarks shall be developed in a way that advances a common national framework for quality measurement and reporting, including, but not limited to measures that are approved

by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality. Performance benchmarks should be clinically important and include both process and outcome data; and be standardized, timely, and allow and encourage physicians, hospitals and other health care professionals to improve their quality of care. Any data reported by the council should be accurate and evidence-based, and not imply distinctions where comparisons are not statistically significant. Members of the advisory committee should have reasonable opportunity to review and comment on all reports before public release.

(4) (a) The council shall establish and maintain a consumer health information website. The website shall contain information comparing the cost and quality of health care services and may also contain general information related to health care as the council determines to be appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices between health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website site and make available written documentation available upon request and as necessary.

(b)Not later than July 1, 2006, the internet site shall be operational and, at a minimum, include links to other internet sites that display comparative cost and quality information.

(c) Not later than January 1, 2007, the internet site shall, at a minimum, include comparative cost information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, high-volume elective surgical procedures, high-volume diagnostic tests and high-volume therapeutic procedures. Cost information shall include, at a minimum, the average payment for each service or category or service received by each facility, clinician or physician practice on behalf of insured patients. Cost information shall be aggregated for all insurers and the board shall not publicly release the payment rates of any individual insurer which shall not be deemed to be public records as defined in chapter 66 of the general laws.

(d) The internet site shall provide updated information on a regular basis, at least annually, and additional comparative cost and quality information shall be posted as determined by the board. To the extent possible, the internet site shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided, (ii) general information related to each service or category of service for which comparative information is provided; and (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction.

(5) The council shall conduct annual public hearings to obtain input from health care industry stakeholders, health care consumers, and the general public regarding the

goals and the performance measurement benchmarks. The council shall invite the stakeholders involved in implementing or achieving each goal to assist with the implementation and evaluation of progress for each goal.

(6) The council shall review and file a report, not less than annually, with the clerks of the House and Senate on its progress in achieving the goals of improving quality and containing or reducing health care costs in the Commonwealth. Reports of the council shall be made available electronically through an internet site.

(7) The council shall establish an advisory committee to allow the broadest possible involvement of health care industry and other stakeholders in the establishment of its goals and the review of its progress. The advisory committee shall include one member representing the Massachusetts Medical Society, one member representing the Massachusetts Hospital Association, one member representing the Massachusetts Association of Health Plans, one member representing Blue Cross Blue Shield of Massachusetts, one member representing the Massachusetts AFL-CIO, one member representing the Massachusetts League of Community Health Centers, one member representing Health Care For All, one member representing the Massachusetts Public Health Association, one member representing the Massachusetts Association of Behavioral Health Systems, one member representing the Massachusetts Extended Care Federation, one member representing the Massachusetts Council of Human Service Providers, one member representing the Home and Health Care Association of Massachusetts, one member representing Associated Industries of Massachusetts, one member of the Massachusetts Business Roundtable, one member of the Massachusetts Taxpayers Foundation, one member of the Massachusetts Chapter of the National Federation of Independent Business, the Massachusetts Biotechnology Council, one member representing the Blue Cross/Blue Shield Foundation, one member representing the Massachusetts chapter of the American Association of Retired Persons, one member representing the Massachusetts Coalition of Taft Hartley Trust Funds, and additional members appointed by the Governor, which shall include, but not be limited to, a representative of the mental health field, a representative of pediatric health care, a representative of primary care, a representative of medical education, a representative of racial or ethnic minority groups concerned with health care, a representative of hospice care, a representative of the nursing profession, and a representative of the pharmaceutical field.

(8) The council may recommend any legislation or regulatory changes including recommendations concerning the methodology for reimbursement payments necessary to carry out its goals, and the council shall have the authority to promulgate regulations under this section.

(9) Subject to appropriation, the council may disburse funds in the form of grants or loans to assist members of the health care industry in implementing the goals of the council.

(10) All meetings of the council shall conform to the provisions of chapter 30A of the general laws, except that the council, through its bylaws, may provide for executive sessions of the council. No act of the council shall be taken in an executive session.

(11) The members of the council shall not receive a salary or per diem allowance for serving as members of the council but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. Said expenses may include reimbursement of travel and living expenses while engaged in council business.

(12) The council may, subject to the provisions of chapter 30B of the general laws, and subject to appropriation, procure equipment, office space, goods and services, including the development and maintenance of the web site provided in subsection 4.

SECTION 4. [Senate SECTION 3A] Section 35M of chapter 10 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in lines 10 and 11, the words:— "and administration; but, any unexpended balance at the end of the fiscal year shall revert to the General Fund." and inserting in place thereof the following words:— ", administration and the statutory and regulatory responsibilities of the board including patient protection, physician education and health care quality improvement."

SECTION 5. [House 2; Senate 3A Conference Comp] (a) Chapter 17 of the General Laws is hereby amended by striking out section 3, as so appearing, and inserting in place thereof the following sections:--

Section 3. There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 16 members appointed by the governor for terms of 6 years in accordance with this section. The governor shall appoint members within 60 days of the effective date of this act. The commissioner may designate 1 of the members as vice chairperson and may appoint subcommittees or special committees as needed.

Four of the appointed members shall be the chancellor of the University of Massachusetts Medical School or his designee; the dean of the University of Massachusetts Amherst School of Public Health and Health Sciences, or his designee; the dean of the Harvard University School of Public Health or his designee; and the dean of the Boston University School of Public Health or his designee.

Six of the appointed members shall be providers of health services: 1 shall be the chief executive officer of an acute care hospital nominated by the Massachusetts Hospital Association; 1 shall be the chief executive officer of a skilled nursing facility nominated by the Massachusetts Extended Care Federation; 2 shall be registered nurses, 1 of whom shall be a nurse executive, nominated by the board of registration of nurses who shall be the highest vote-getters on a mail ballot sent to the address of record of all registered

nurses licensed by the board of registration of nurses; and 2 shall be physicians appointed by the Massachusetts Medical Society, one of whom shall be a primary care physician.

Six of the appointed members shall be non-providers: 1 shall be nominated by the secretary of elder affairs; 1 shall be nominated by the secretary of veterans' services; 1 shall be nominated by Health Care For All, Inc.; 1 shall be nominated by the Coalition for the Prevention of Medical Errors, Inc.; 1 shall be nominated by the Massachusetts Public Health Association; and 1 shall be nominated by the Massachusetts Community Health Worker Network.

(b) For the purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he or she is qualified to act on the council in the public interest, who, and whose spouse, parents, siblings or children, have no financial interest in a health care facility, who, and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established in accordance with chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals, and who, and whose spouse, is not licensed to practice medicine.

(c) Upon the expiration of the term of office of an appointive member, his or her successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his or her successor. The council shall meet at least once a month, and at such other times as it shall determine by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 a day while in conference, and their necessary traveling expenses while in the performance of their official duties.

Section 3A. Notwithstanding any general or special law to the contrary, the members of the public health council established in section 3 of chapter 17 of the General Laws shall be appointed not later than 60 days from the effective date of this act. If, at any time, the council shall consist of fewer than 16 members, the attorney general shall appoint such members after 60 days, so that the council consists of 16 members as provided in said chapter 17.

SECTION 6. [House 3; Senate 3D, Conf Staff compromise]
Chapter 26 of the General Laws is hereby amended by inserting after section 7 the following sections:—
Section 7A. There shall be in the division of insurance **a health care access bureau overseen by a deputy commissioner for health care access**, whose duties shall include, subject to the direction of the commissioner of insurance, administration of the division's statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers relative to health insurance coverage and access to affordable products. The commissioner shall appoint all employees of the health care access bureau, **with the approval of the governor**. The bureau shall consist of at least the following employees who shall devote their full time to the duties of their office and shall be exempt from chapters 30 and 31

and shall serve at the pleasure of the commissioner: a deputy commissioner for health access, a health care finance expert, an actuary, and a research analyst. The commissioner may appoint such other employees as the bureau may require.

~~Section 7B. For the purposes of implementing the provisions of chapter 111M, the health care access bureau in the division of insurance shall maintain a database of members of health benefit plans. Carriers licensed under chapters 175, 176A, 176B, and 176G and the office of Medicaid shall report on the first day of each month to the bureau the names, and any other identifying information as determined by the division of insurance, of each resident of the commonwealth for whom creditable coverage, as defined in chapter 111M, was provided during the previous month. The division shall enter into an inter-agency agreement with the department of revenue for purposes of implementing chapter 111M and, in consultation with the department of revenue, shall promulgate regulations defining the content of such reports, which shall be limited to the minimum amount of personal information necessary for the purposes of chapter 111M. These reports shall not contain any information pertaining to previous or current health conditions or treatments. The division of insurance is authorized to transfer the content of the database to the department of revenue for the purposes of implementing chapter 111M.~~

SECTION 7. [House 4] ~~Said~~ Section 8H of said chapter 26 is hereby further amended by inserting after the second paragraph the following paragraph:—
The division of insurance, in consultation with the commonwealth health insurance ~~connector~~exchange, established by chapter 176Q, shall establish and publish minimum standards and guidelines at least annually for each type of health benefit plans, except qualified student health insurance plans as set forth in section 18 of chapter 15A, provided by insurers and health maintenance organizations doing business in the commonwealth.

SECTION 8. [House 5; Senate 5.5]
Chapter 29 of the General Laws is hereby amended by inserting after section 2NNN the following section:-

Section 2*OOO*. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the commonwealth care fund, hereinafter referred to as the fund. There shall be credited to the fund (a) all health care contributions collected pursuant to **[the employer assessment and the free rider surcharge]**, (b) any federal reimbursement received for benefits and payments provided pursuant to chapters **118G** and 118H, (c) all amounts paid by hospitals and surcharge payors as defined in chapter 118G; ~~and~~ (d) all Title XIX federal financial participation revenue generated by hospital payments funded by the Uncompensated Care Trust, whether the payments are made by the division of health care finance and policy or the executive office of health and human services; (e) any other appropriations or monies made available by law for the purposes of the demonstration program approved the Secretary of the United States Department of Health and Human Services pursuant to section 1115 of the Social Security Act, as extended or renewed from time to time; and

(f) all property and securities acquired by and through the use of monies belonging to said fund and all interest thereon. All interest earned on the amounts in said fund shall be deposited or retained by the fund.~~.~~ Amounts credited to the fund shall be expended, subject to appropriation, for ~~(a)~~ programs designed to increase health coverage, including a program of subsidized health insurance provided to low-income residents of the commonwealth pursuant to chapter 118H~~, and (b) a program of health assistance provided to adults pursuant to clause (j) of subsection (2) of section 9A of chapter 118E,~~ **[add language allowing use for rate increases??]**, a program of increasing provider rates, and including a program of reimbursing carriers, as defined in section 1 of chapter 176J, for all costs which that the carriers may incur in claims pursuant to section 10 of said chapter 176J and section 7 of chapter 176M; provided however that monies from the fund may be transferred to the ~~health safety net~~uncompensated care trust fund~~, established by section 57 of chapter 118E,~~ established in chapter 118G **as necessary to provide payments to acute hospitals and community health centers for reimbursable health services**. Not later than January first, the comptroller shall report an update of revenues for the current fiscal year and prepare estimates of revenues to be credited to the fund in the subsequent fiscal year. Said report shall be filed with the secretary of administration and finance, the ~~commissioner of medical assistance~~director of the office of Medicaid, the joint committee on health care financing, and the house and senate committees on ways and means. In the event that revenues credited to the fund are less than the amounts estimated to be credited to the fund, the comptroller shall duly notify said secretary, commissioner and committees that said revenue deficiency shall require proportionate reductions in expenditures from the revenues available to support programs appropriated from the fund. No expenditure made from the fund shall cause the fund to be in deficit at the close of each fiscal year.
~~[effective date: July 1, 2006]~~

SECTION 9. [Senate 4] The General Laws are hereby further amended by inserting after chapter 28A the following chapter:—

Comment [AS2]: RR is unsure if we still want to include this, so I included it for now.

CHAPTER 28B.

CONSUMER HEALTH CARE COSTS

INFORMATION BOARD.

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

"Board", the consumer health care costs information board established in section 2.

"Clinician", any of the following health care professionals licensed pursuant to chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist and a mental health counselor.

"Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health agency.

"Health care provider", a clinician, a facility or a physician group practice.

"Insurer", a carrier authorized to transact accident and health insurance pursuant to chapter 175, a nonprofit hospital service corporation licensed pursuant to chapter 176A, a nonprofit medical service corporation licensed pursuant to chapter 176B, a dental service corporation organized pursuant to chapter 176E, an optometric service corporation organized pursuant to chapter 176F and a health maintenance organization licensed pursuant to chapter 176G.

"Physician group practice", 2 or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income by a prearranged formula.

Section 2. There shall be a consumer health care costs information board. The board shall consist of the secretary of health and human services, the commissioner of insurance, the executive director of the group insurance commissioner, the chief of the public protection bureau of the office of the attorney general, a representative, of the Massachusetts Medicaid policy institute, a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, a representative of the Massachusetts Association of Health Underwriters, a representative of Healthcare For All and a private

purchaser of insurance appointed by the governor. The board shall be chaired by the commissioner of insurance. The board shall make available to the public, primarily through an internet site, comparative information on the cost and quality of health care services and that recognizes and makes adjustments for socioeconomic demographic data.

Section 3. (a) The board shall establish and maintain a consumer health information internet site. The website shall contain information comparing the cost and quality of health care services and that recognizes and makes adjustments for socioeconomic demographic data and may also contain general information related to health care as the board determines to be appropriate.

The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices between health care providers. Information shall be presented in a format that is understandable to the average consumer. The board shall take appropriate action to publicize the availability of its internet site and make available written documentation available upon request and as necessary.

(b) Not later than January 1, 2006, the internet site shall be operational and, at a minimum, include links to other internet sites that display comparative cost and quality information.

(c) Not later than January 1, 2007, the internet site shall, at a minimum, include comparative cost information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, high-volume elective surgical procedures, high-volume diagnostic tests and high-volume therapeutic

procedures. Cost information shall include, at a minimum, the average payment for each service or category or service received by each facility, clinician or physician practice on behalf of insured patients. Cost information shall be aggregated for all insurers and the board shall not publicly release the payment rates of any individual insurer.

(d) The internet site shall be provide updated information on a regular basis, at least annually, and additional comparative cost and quality information shall be posted as determined by the board. To the extent possible, the internet site shall include: (1) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided, (2) general information related to each service or category of service for which comparative information is provided; and (3) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction.

Section 4. The board shall contract with an independent organization to provide the board with technical assistance related to its duties including, but not limited to, development and maintenance of the internet site and the reporting plan required pursuant to section 5. The independent organization shall have a history demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to cost and quality; (ii) identify, through data analysis, quality improvement areas; (iii) work with Medicare, MassHealth, other payers' data and clinical performance measures; (iv) collaborate in the design and implementation of quality improvement measures; (v) establish and maintain security measures necessary to preserve the data; (vi) design and implement health care quality improvement interventions with health care service providers; (vii) identify and,

when necessary, develop appropriate measures of cost and quality for inclusion on the website; and (viii) present data on the internet site in a format understandable to consumers. To the extent possible, the organization shall collaborate with other organizations that develop, collect and publicly report cost and quality measures.

Section 5. Any independent organization under contract with the board shall develop and update on an annual basis a reporting plan specifying the cost and quality measures to be included on the internet site. The reporting plan shall be consistent with the requirements of section 3. The organization shall give consideration to those measures that are already available in the public domain and to whether it is cost effective for the board to license commercially available comparative data and consumer decision support tools. If the organization determines that making available through the internet site only those measures already available in the public domain would not fully comply with section 3 or would not provide consumers with sufficient information to make informed health care choices, the organization shall develop appropriate measures for inclusion on the internet site and shall specify in the reporting plan the sources from which it proposes to obtain the data necessary to construct those measures and any specifications for reporting of that data by insurers and health care providers.

(b) As part of the reporting plan, the organization shall determine for each service that comparative information is to be included on the internet site whether it is more practical and useful to: (1) list that service separately or as part of a group of related services; and (2) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

(c) The independent organization shall submit the reporting plan, and any periodic

revisions, to the board. The board shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the board rejects the reporting plan or any revisions, the board shall state its reasons therefor. The reporting plan and any revisions adopted by the board shall be promulgated as a regulation by the commissioner.

Section 6. Insurers and health care providers shall submit data to the board or to the independent organization on behalf of the board, as required by regulations promulgated pursuant to section 5. Any insurer or health care provider failing, without just cause, to submit required data to the board on a timely basis may be required, after notice and hearing, to pay a penalty of $1,000 for each week's delay. The maximum penalty under this section shall be $50,000.

SECTION 10. [Senate 5A] Section 1 of chapter 32 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting after the word "Authority", in line 191, the following words:— , Commonwealth Care Health Insurance Exchange ~~Corporation~~Authority.

SECTION 11. [Senate 6A, Conference Comp] Section 2 of chapter 32B of the General Laws, as so appearing, is hereby amended by inserting after the word "commonwealth", in line 65, the following words: —, and any federally recognized Indian Tribe as referenced in 25 U.S.C. section 1771 et seq.

SECTION 12. [House 7; Senate 7, House Language] Section 1 of chapter 62 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out paragraph (c) and inserting in place thereof the following paragraph:—
(c) "Code", the Internal Revenue Code of the United States, as amended on January 1, 2005 and in effect for the taxable year; provided, however, that Code shall mean the Code as amended and in effect for the taxable year for sections 62(a)(1), 72, 223, 274(m), 274(n), 401 through 420, inclusive, 457, 529, 530, 3401 and 3405 but excluding sections 402A and 408(q).

SECTION 13. [House 8; New Senate bill, Conf Staff Compromise]
The General Laws are hereby amended by inserting after chapter 111L the following chapter:-

CHAPTER 111M
INDIVIDUAL HEALTH COVERAGE

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

———"Board", the board of directors of the Commonwealth Care Health Insurance Exchange Authority, established by section 2 of chapter 176Q.

"Creditable coverage", coverage of an individual under any of the following health plans or as a named beneficiary receiving coverage on another's plan with no lapse of coverage for more than 63 days: (a) a group or nongroup health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. section 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); ~~(k) coverage for young adults pursuant to section 10 of chapter 176J; (l) a nongroup health plan or~~ (k) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996 as it is amended, or by regulations promulgated under that act.

Comment [RLW3]: (l) A nongroup health plan, or <*depending on merger/nonmerger*>

"Resident", a person who has

(1) obtained an exemption pursuant to clause Seventeenth, Seventeenth C, Seventeenth C ½, Seventeenth D, Eighteenth, Twenty-second, Twenty-second A, Twenty-second B, Twenty-second C, Twenty-second D, Twenty-second E, Thirty- seventh, Thirty-seventh A, Forty-first, Forty-first A, Forty-first B, Forty-first C, Forty-second or Forty-third of section 5 of chapter 59;

(2) obtained an exemption pursuant to section 5C of said chapter 59;

(3) filed a Massachusetts resident income tax return pursuant to chapter 62;

(4) obtained a rental deduction pursuant to subparagraph (9) of paragraph (a) of Part B of section 3 of chapter 62;

(5) declared in a home mortgage settlement document that the mortgaged property located in the commonwealth would be occupied as his principal residence;

(6) obtained homeowner's liability insurance coverage on property that was declared to be occupied as a principal residence;

(7) filed a certificate of residency and identified his place of residence in a city or town in the commonwealth in order to comply with a residency ordinance as a prerequisite for employment with a governmental entity;

(8) paid on his own behalf or on behalf of a child or dependent of whom the person has custody, resident in-state tuition rates to attend a state-sponsored college, community college or university;

(9) applied for and received public assistance from the commonwealth for himself or his child or dependent of whom he has custody;
(10) has a child or dependent of whom he has custody who is enrolled in a public school in a city or town in the commonwealth, unless the cost of such education is paid for by him, such child or dependent, or by another education jurisdiction;
(11) is registered to vote in the commonwealth;
(12) obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by claiming principal residence in the commonwealth; or
(13) is a resident under any other written criteria under which the commissioner of revenue may determine residency in the commonwealth.

Section 2. (a) ~~As of January 1, 2007, t~~The following individuals age 18 and over shall obtain and maintain creditable coverage: (1) residents of the commonwealth or (2) individuals who become residents of the commonwealth within 63 days, in the aggregate, and for whom creditable coverage is deemed affordable under the schedule set by the board, ~~of the connector.~~ Residents who within 63 days have terminated any prior creditable coverage, shall obtain and maintain creditable coverage within 63 days of such termination.

(b) Every person who files an individual income tax return as a resident of the commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the commissioner of revenue, whether such person had creditable coverage in force for each of the twelve months of the taxable year for which the return is filed as required under paragraph (a) whether covered as an individual or as a named beneficiary of a policy covering multiple individuals. If the person does not so indicate, or indicates that did not have such coverage in force, then the tax shall be computed on the return without benefit of the personal exemption set forth in paragraph (b) of Part B of section 3 of chapter 62, or, in the case of a person who files jointly with a spouse, without benefit of one-half of the personal exemption set forth in such paragraph. If the person indicates that he had such coverage in force but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall compute the tax for the taxable year without benefit of the personal exemption set forth in paragraph (b) of Part B of section 3 of chapter 62, or, in the case of a person who files jointly with a spouse, without benefit of one-half of the personal exemption set forth in such paragraph, first giving notice to such person of his intent to do so and an opportunity for a hearing, in accordance with rules prescribed by the commissioner. ~~If the person fails to indicate or indicates that he did not have such coverage in force, then a penalty shall be assessed on the return. If the person indicates that he had such coverage in force but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall assess the penalty.~~

(c) ~~If in any taxable year, in whole or in part, a taxpayer does not comply with the requirement of paragraph (a), the commissioner shall retain any amount overpaid by the taxpayer for purposes of making payments described in paragraph (d); provided, however, that the amount retained shall not exceed 50 per cent of the minimum insurance premium for creditable coverage for which the individual would have qualified during the previous year. The penalty will be assessed for each of the months the individual did not~~

~~meet the requirement of paragraph (a); provided that any lapse in coverage of 63 days or less shall not be counted in calculating the penalty; and provided further that nothing in this paragraph shall be considered to authorize the commissioner to retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies as debts described in subsections (i) to (vii), inclusive, of section 13 of chapter 62D. If the amount retained is insufficient to meet the penalty assessed, the commissioner shall notify the taxpayer of the balance due on the penalty and related interest. The penalty shall be treatable as taxes due under chapter 62A.~~

~~(d)~~ The commissioner shall deposit all penalties collected into the commonwealth care fund, established by section *2000* of chapter 29.

Section 3. (a) **An individual subject to Section 2, who disputes the determination of ~~compliance~~ affordability as enforced by the department of revenue, may seek a review of this determination through ~~an appeal~~a review panel established by the board ~~of the commonwealth health insurance connector, pursuant to chapter 176Q.~~** The board may adopt regulations to carry out the exemption review process~~; provided, however, that,~~ **n~~N~~o additional penalties shall be enforced against an individual seeking review until the review is complete and any subsequent appeals are exhausted.**

(b) An individual subject to section 2 may seek an exemption from these provisions if imposition of the penalty would create extreme hardship. The board shall determine criteria for this hardship exemption.

Section 4. The commissioner of revenue, in consultation with the board ~~of the commonwealth health insurance connector established by Chapter 176Q~~, shall ~~promulgate such~~ adopt rules and regulations~~, as necessary,~~ to carry out the purposes of this chapter.

Section 5. The division of health care finance and policy shall adopt a form labeled "Health Insurance Disclosure Statement" to be completed and signed, under oath, by every employer and employee doing business in the commonwealth. The form shall indicate whether the employer has offered the purchase of health care insurance, whether the employee has accepted or declined such coverage and whether the employee has an alternative source of health insurance coverage. The form shall contain a statement that an employee who chooses to decline health insurance coverage offered by an employer shall be legally responsible for that employee's health care costs, if any, and shall be charged for the use of any health services. The division may make arrangements with other agencies of the commonwealth, including the department of revenue and the board, to distribute and collect forms to all employers and employees in the commonwealth.~~;~~

~~SECTION 14. [House 9; Senate 12, Conf Comp] Subsection (2) of section 9A of chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out clause (c) and inserting in place thereof the following clause:— (c) children and adolescents, from birth to 18 years, inclusive, whose financial eligibility as determined by the division exceeds 133 per cent but is not more than 300 per cent of~~

~~the federal poverty level, including such children and adolescents made eligible for medical benefits under this chapter by Title XXI of the Social Security Act.~~
~~**Effective: 7/1/06**~~

SECTION 15. [House 11; Senate 13E, Conf Comp] Clause (h) of subsection (2) of section 9A of chapter 118E of the General Laws, as so appearing, is hereby amended by inserting after the word "eligibility", in line 112, the following words:— ; provided, however, that the division shall not establish disability criteria for applicants or recipients which are more restrictive than those criteria authorized by Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

~~SECTION 16. [House 12; Senate 12A] Subsection (2) of section 9A of chapter 118E of the General Laws, as so appearing, is further amended in line 115 by striking out the figure "133" and inserting in place thereof the following figure:— "200".~~

~~SECTION 17. [House 14, in part] Said section 9A of said chapter 118E, as so appearing, is hereby amended by adding the following subsection:—~~

~~(15) The office of Medicaid shall report to the director of the group insurance commission~~ ~~health care access bureau in the division of insurance, as established by chapter 26, section 7A, monthly a listing of all individuals for whom creditable coverage is provided as of the first day of the month.~~

SECTION 18. [House 15; Senate 13] Section 9C of said chapter 118E is hereby amended by striking the definition "Eligible employee" appearing in lines 16 to 21 and inserting in place thereof the following words:--

"Eligible employee", (i) an employee of an eligible employer; (ii) who resides in the commonwealth; (iii) who has not attained age 65; (iv) whose employer or family member's employer has not in the last 6 months provided insurance coverage for which the individual is eligible; and (v) who meets the financial and other eligibility standards set forth in regulations promulgated by the division, provided, however, that the gross family income standard shall not exceed 300 per cent of the federal poverty level.

SECTION 19. [House 15; Senate 13] Section 9C of said chapter 118E is hereby amended by inserting after the words "eligible employees" in line 56 the following words:- "provided further, that the amount of said subsidy shall not be greater than that of the subsidy the employee would have received if the employee had enrolled in the subsidized insurance program created in chapter 118H.

SECTION 20. [House 16, Senate 13A, Conf Comp] The fourth paragraph of section 12 of said chapter 118E, as so appearing is hereby amended by adding the following sentence:— Rules and regulations which restrict eligibility or covered services require a public hearing in accordance with section 2 of chapter 30A.

Comment [AS4]: See section, below, authorizing expansion as a waiver population

Comment [SAN5]: As redrafted, this section would maintain the current IP program and would expand the income eligibility threshold for employees from 200 to 300 FPL (for self-employed the level would remain 200). It would not change the size of the employer subsidy, and would maintain the current business size criterion at 50 employees. New crowd out language is also added—the goal is to use IP to cover employees whose employers won't agree to the provisions of the subsidy program, but to avoid cost-shifting by employers.

Comment [SAN6]: More new IP language. **MAY NEED MORE LANGUAGE??**

SECTION 21. [House 17; Senate 41] Said chapter 118E is hereby further amended by inserting after section 13A the following section:— Section 13B. Hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance benchmarks~~, including the reduction of racial and ethnic disparities in the provision of health care~~. Such benchmarks shall be developed or adopted by the executive office of health and human services to be effective commencing on October 1, 2007, so as to advance a common national framework for quality measurement and reporting, drawing on measures that are endorsed and supported by governmental programs, including but not limited to those developed by the Hospital Quality Alliance and endorsed by the United States Department of Health and Human Services Centers for Medicare & Medicaid Services; but, hospital measures shall not be utilized that have not been adopted as a voluntary consensus standard for hospital care by the National Quality Forum, ~~approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality, in addition to the Boston Public Health Commission Disparities Project Hospital Working Group Report Guidelines.~~ The office of Medicaid may also use recommended benchmarks from the health care quality and cost council established by section 16H of chapter 6A. ~~[Implementation date October 1, 2007]~~

Formatted: Font: Not Bold

~~SECTION 22. Notwithstanding any general or special law to the contrary, for hospital rate year commencing October 1, 2007 only, hospitals may appeal to the division of health care finance and policy to receive medicaid hospital rate increases without meeting the quality standards and achieving performance benchmarks established by the executive office of health and human services pursuant to section 13B of chapter 118E. [Implementation date October 1, 2007] [repeal October 1, 2008]~~

~~SECTION 23. [House 18; Senate 13B, Conf Comp] Section 16C of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 4 and 20, the figure "200", each time it appears, and inserting in place thereof, in each instance, the following figure: 300.~~

SECTION 24. [House 19; Senate 13B 3/5]
Section 16D of said chapter 118E, as so appearing, is hereby amended by adding the following subsection:—
(7) Notwithstanding subsection (3), a person who is not a citizen of the United States but who is either a qualified alien within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or is otherwise permanently residing in the United States under color of law shall be eligible to receive benefits under MassHealth Essential if such individual meets the categorical and financial eligibility requirements pursuant to MassHealth; provided, further, that such individual is either age 65 or older or age 19 to 64, inclusive, and disabled; provided, further, that any such individual shall not be subject to sponsor income deeming or related restrictions.

~~SECTION 25. [House 20]~~
~~The seventh paragraph of section 23 of said chapter 118E, as appearing in the 2004 Official Edition, is hereby amended by striking out clause (2) and inserting in place~~

~~thereof the following clause:--persons for whom hospitals and community health centers claim payments from the health safety net fund under chapter 118E.~~
~~[effective date=Oct 1, 2007]~~

SECTION 26. [House 21; Senate 13B 4/5, Conf. staff compromise]
Said chapter 118E is hereby further amended by adding the following section:—
Section 53. The division shall include within its covered services for adults all federally optional services that were included in its state plan in effect on January 1, 2002.

~~Section 54. The executive office of health and human services shall implement, in cooperation with the department of public health, a wellness program for MassHealth enrollees to encourage activities that lead to desired health outcomes, including smoking cessation, diabetes screening for early detection, teen pregnancy prevention, cancer screening for early detection, and stroke education for enrolled individuals. To the extent enrollees comply with the goals of the wellness program, the executive office shall reduce MassHealth premiums and/or copayments proportionally. The executive office shall report annually on the number of enrollees who meet at least one wellness goal, the premiums collected from the enrollees, and the reduction of premiums due to enrollees meeting wellness goals to the joint committee on health care financing and the house and senate committees on ways and means.~~

SECTION 27. [House 22]
Said chapter 118E is hereby amended by adding the following ~~six~~ [HOW MANY?] new sections:-

Section 54. The executive office of health and human services shall implement, in cooperation with the department of public health, a wellness program for MassHealth enrollees to encourage activities that lead to desired health outcomes, including smoking cessation, diabetes screening for early detection, teen pregnancy prevention, cancer screening for early detection, and stroke education for enrolled individuals. To the extent enrollees comply with the goals of the wellness program, the executive office shall reduce MassHealth premiums and/or copayments proportionally. The executive office shall report annually on the number of enrollees who meet at least one wellness goal, the premiums collected from the enrollees, and the reduction of premiums due to enrollees meeting wellness goals to the joint committee on health care financing and the house and senate committees on ways and means.

Section 55. As used in sections 55 through 60 the following words shall, unless the context clearly requires otherwise, have the following meanings:--

"Acute hospital", the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under section fifty-one of chapter one hundred and eleven and which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the department of public health.

"Allowable reimbursement", payment to acute hospitals and community health centers for health services provided to uninsured patients of the commonwealth **in**

Comment [AS7]: A major conference issue is whether and how to re-structure the Pool – if the conferees decide not to accept the House's proposal to re-locate the Pool on the Office of Medicaid and fund it from the HSN Trust Fund, we may still want to use some of the language in these sections. RR has not looked at this language in detail – conferees should provide guidance first.

Comment [SAN8]: A number of new definitions have been added to this section to support language in following sections and to reflect changes in conference bill, such as reinstatement of surcharge payor language.

accordance with the provisions of section 60 of this chapter~~, provided that such payments shall be made in accordance with~~ **and any further** regulations promulgated by the office.

"Bad debt", an account receivable based on services furnished to any patient which (i) is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the division, which regulations shall allow third party payers to negotiate with hospitals to collect the bad debt of its enrollees, (ii) is charged as a credit loss, (iii) is not the obligation of any governmental unit or of the federal government or any agency therof, and (iv) is not free care.

"Community health center", a health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626, ~~and shall~~ including all community health centers which file cost reports as requested by the division **of health care finance and policy**.

"Director", the director of the health safety net office.

"DRG", a patient classification scheme which provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost incurred by the hospital.

"Emergency bad debt", ~~an account receivable based on~~ **bad debt resulting from emergency** services provided by an acute hospital to an uninsured **or underinsured** patient or other individual who has an emergency medical condition that is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office.

"Emergency medical condition", a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1295dd(e)(1)(B).

"Emergency services", medically necessary health care services provided to an individual with an emergency medical condition.

"Essential Community Provider", a community health center, a community health center-based managed care organization, or an acute hospital that exhibits a payer mix where a minimum of sixty-three per cent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act or other governmental payors, including reimbursements from the Health Safety Net Fund.

Financial requirements", a hospital's requirement for revenue which shall include, but not be limited to, reasonable operating, capital and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

"Fund", the health safety net **trust** fund, established by section 57.

"Fund fiscal year", the twelve month period starting in October and ending in September.

Comment [AS9]: RR suggests that we not put the creation of that successor into statute, and that it be handled through the budget – the conferees will know better what agreement was made on Friday. The state may not always be able to fund this program – for instance, the current bill balance sheet is silent on the issue. The program should be allocated and supported through the state budget.

Comment [SAN10]: New def relevant to creation of a successor to the distressed provider fund.

"Gross Patient Service Revenue", the total dollar amount of a hospital's charges for services rendered in a fiscal year.

"Health services" medically necessary inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Health services shall not include (1) non-medical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy; and (7) the provision of whole blood; and provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

"Office", the health safety net office, as established by section 56.

"Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health services and ambulatory surgical centers for ambulatory surgical center services, as defined in section 1 of chapter 118G on or after the effective date of this section; provided, however, that "payments subject to surcharge" shall not include (i) payments, settlements, and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies, (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries, or persons enrolled in policies issued pursuant to chapter 176K or similar policies issued on a group basis; and provided further, that "payments subject to surcharge" may exclude amounts established in regulations promulgated by the division for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

"Private sector charges", gross patient service revenue attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other public aided patients, reimbursable health services, and bad debt.

"Reimbursable health services", health services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or part, pursuant to applicable regulations of the office**; provided that such services shall not be eligible for reimbursement by any other public or private third-party payer; and** provided **further** that non-emergency and **non-**urgent services shall be provided at a community health center unless no community or hospital licensed health center **providing both adult and pediatric primary care** is located within five miles of a hospital campus, as determined by the office **or if the patient's medical condition is so severe or complex that appropriate care cannot be adequately provided in a community health center setting,** as determined by the office.

Comment [SAN11]: MHA proposal

Comment [SAN12]: Also MHA proposal

"Resident", a person living in the commonwealth, as defined by the office by regulation; provided, however, that such regulation shall not define as a resident a person who moved into the commonwealth for the sole purpose of securing health insurance under this chapter. Confinement of a person in a nursing home, hospital or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

"Surcharge payor", an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers, as defined in

section 1 of chapter 118G; provided, however, that the term "surcharge payor" shall not include TitleXVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients, and the workers compensation program established pursuant to chapter 152.

"Underinsured patient", a patient whose health insurance plan or self-insurance health plan does not pay for health services that are eligible for reimbursement ~~under this section~~ **from the health safety net trust fund**, provided that such patient meets income eligibility standards set by the office.

"Uninsured patient", a patient who is a resident of the commonwealth and who is not covered by a health insurance plan, a self-insurance health plan, and is not eligible for a medical assistance program.

Section 56. (a) There is hereby established a health safety net office within the office of Medicaid. The director of the office of Medicaid shall, in consultation with the secretary of health and human services, appoint the director of the health safety net office. The director shall have such educational qualifications and administrative and other experience as the commissioner and secretary determine to be necessary for the performance of the duties of director, including but not limited to experience in the field of health care financial administration.

(b) The office shall have the following powers and duties:-

(1) to administer the Health Safety Net Trust Fund established by section 57 of this chapter and to require payments to the fund consistent with acute hospitals' liability to the fund, as determined pursuant to section 58, and any further regulations promulgated by the office;

(2) to set, after consultation with the division of health care finance and policy established by section 2 of chapter 118G, reimbursement rates for payments from the fund to acute hospitals and community health centers for **reimbursable** health services provided to uninsured **and underinsured** patients and to disburse monies from the fund consistent with such rates; ~~provided that said rates are set established by section 2 of chapter 118G;~~ provided ~~further~~ that the office shall implement a fee-for-service reimbursement system for acute hospitals;

(3) to promulgate regulations further defining (a) eligibility criteria for reimbursable health services, (b) the scope of health services that are eligible for reimbursement by the Health Safety Net Trust Fund, (c) standards for medical hardship, and (d) standards for reasonable efforts to collect payments for the costs of emergency care. The office shall implement procedures for verification of eligibility using the eligibility system of the office of Medicaid and other appropriate sources to determine the eligibility of uninsured **and underinsured** patients for reimburs~~ed~~**able** health services and shall establish other procedures to ensure that payments from the fund are made for health services for which there is no other public or private third party payer, including disallowal of payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources; and

(4) to develop programs and guidelines to encourage maximum enrollment of uninsured individuals who receive health services reimbursed by the fund into health care

plans and programs of health insurance offered by public and private sources, and (b) to promote the delivery of care in the most appropriate setting, provided that said programs and guidelines are developed in consultation with the commonwealth health insurance connector, established by chapter 176Q. Such programs shall not deny payments from the fund because services should have been provided in a more appropriate setting if the hospital was required to provided such services pursuant to 42 USC 1395 (dd);

(5) to conduct a utilization review program designed to monitor the appropriateness of services for which payments were made by the fund and to promote the delivery of care in the most appropriate setting; and to administer demonstration programs that reduce health safety net **trust** fund liability to acute hospitals, including a demonstration program to enable disease management for patients with chronic diseases, substance abuse and psychiatric disorders through enrollment of patients in community health centers and community mental health centers, and through coordination between these centers and acute hospitals, **provided that the office shall report the results of such reviews annually to the joint committee on health care financing and the House and Senate committees on ways and means.**

(6) to administer the separate account established in section 57 and to make expenditures from that account without further appropriation for the purpose of improving and enhancing the ability of essential community providers to serve populations in need of community-based care, including, but not limited to, clinical support, care coordination services, and pharmacy management services. In awarding the grants, the office shall consider, but not be limited to, criteria such as the financial requirements of the provider, the percentage of patients with mental or substance abuse disorders served by a provider, the numbers of patients served by a provider who are chronically ill, elderly, or disabled, and the cultural and linguistic challenges presented by the populations served by the provider.

(7) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity; and to make contracts and execute all instruments necessary or convenient for the carrying on of its business;

(8) to secure payment, without imposing undue hardship upon any individual, for unpaid bills owed to acute hospitals by individuals ~~that~~ **for health services that** are ineligible for reimbursement from the health safety net trust fund which have been accounted for as bad debt by the hospital and which are voluntarily referred by a hospital to the department for collection; provided, however that such unpaid charges shall be considered debts owed to the commonwealth and that all payments received shall be credited to the health safety net trust fund; and provided, further, that all actions to secure such payments shall be conducted in compliance with a protocol previously submitted by the office to the joint committee on health care financing; and

(9) to make, amend, and repeal rules and regulations to effectuate the efficient use of monies from the Health Safety Net Trust Fund. Such regulations shall be adopted only after notice and hearing and only upon consultation with the board of the connector, the secretary of the executive office of health and human services, the director of the office of Medicaid, and representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts Safety Net Hospitals, and the Massachusetts League of Community Health Centers.

Comment [SAN13]: Adjust to reflect any language changes re: connector.

Comment [AS14]: See RR comment above, recommending against putting this program into statute. IF we're going to put it into statute, this language needs substantial revision.

Comment [SAN15]: This would replace the current Distressed Provider Fund which receives MCO supp $$.

Section 57. (a) There is hereby established a Health Safety Net Trust Fund, hereinafter referred to as the fund, which shall be administered by the health safety net office established pursuant to section 56. Expenditures from said Trust Fund shall not be subject to appropriation unless otherwise required by law. The purpose of the fund is to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of services provided to low-income, uninsured or underinsured residents of the commonwealth and by providing support for essential community providers. The office shall administer the fund using such methods, policies, procedures, standards and criteria that it deems necessary for the proper and efficient operation of the fund and programs funded thereby in a manner designed to distribute the fund resources as equitably as possible.

(b) The fund shall consist of all amounts paid by acute hospitals **and surcharge payors pursuant to sections 58 and 59;** all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured **and underinsured** residents; amounts paid by employers pursuant to.. **[ADD LANGUAGE RE: FREE RIDER SURCHARGE BEING DEPOSITED HERE]**; any transfers from the commonwealth care fund established by section 2*OOO* of chapter 29; and all property and securities acquired by and through the use of monies belonging to said fund and all interest thereon. Amounts placed in the fund shall, except for amounts transferred to the commonwealth care fund, be expended by the office for the purpose of payments to hospitals and community health centers for reimbursable health services provided to uninsured **and underinsured** residents of the commonwealth, consistent with the requirements of this section and section 60 and regulations promulgated by the office, provided that $6,000,000 shall be expended annually from the fund for demonstration projects that use case management and other methods to reduce the liability of the fund to acute hospitals, and **provided further that any annual balance remaining in the fund after such payments have been made shall be transferred to the Commonwealth Care Fund established in section 2*OOO* of Chapter 29. [ADD LANGUAGE RE: MAXIMIZING FEDERAL REIMBURSEMENT AND STIPULATING THAT FEDERAL REIMBURSEMENT GENERATED FROM EXPENDITURES FROM THIS FUND SHOULD BE DEPOSITED IN THE COMMONWEALTH CARE FUND??].** All interest earned on the amounts in the fund shall be deposited or retained in the fund. The director shall from time to time requisition from said fund such amounts as the director deems necessary to meet the current obligations of the office for the purposes of the fund and estimated obligations for a reasonable future period. **[ADD LANGUAGE ALLOWING USE OF SOME AMOUNT OF FUNDS TO BE USED FOR ADMINISTRATION OF OFFICE??]**

(c) Within said fund the office shall establish a separate account for the purpose of providing grants to essential community providers. This separate account shall consist of amounts transferred from the Safety Net Trust Fund, amounts transferred from the Commonwealth Care, and any funds that may be appropriated for deposit into this account. The office of shall administer this account and disburse funds from this account for the purpose of payments to essential community providers in accordance with provisions of clause (6) of paragraph b of section 56 and any further regulations promulgated by the office.

Comment [AS16]: RR does not understand the need to create this fund and this complex set of inter-fund transfers. We have an uncompensated care trust fund already.

Comment [SAN17]: to allow a portion of safety net funds to be used for distressed provider activities (assuming transfer of DP fund to within new pool).

Comment [SAN18]: Moved this language up from below in earlier draft.

Comment [AS19]: RR recommends no.

Comment [AS20]: Again, see RR comment above recommending against putting this into statute. For one thing, I don't agree that this should necessarily be run through the Pool.

Comment [SAN21]: This section establishes a separate account within the fund that would be used to provide grants to essential community providers—a.k.a. distressed providers. This would replace the current distressed provider fund. This account would be funded either via a transfer from regular free care funds or with new federal SN dollars, since a portion of these can be used for infrastructure, etc. Note this language also eliminates the current separate account set up to pay for IP (which I believe is dormant).

Section 58. (a) An acute hospital's liability to the fund shall equal the product of (1) the ratio of its private sector charges to all acute hospitals' private sector charges; and (2) the acute hospital liability **to the fund** as determined by law. Before October 1 of each year, the office, in consultation with the division of health care finance and policy, shall establish each acute hospital's liability to the fund using the best data available, as determined by the division and shall update each acute hospital's liability to the fund as updated information becomes available. The office shall specify by regulation an appropriate mechanism for interim determination and payment of an acute hospital's liability to the fund.

(b) An acute hospital's liability to the fund shall in the case of a transfer of ownership be assumed by the successor in interest to the acute hospital.

(c) The office shall establish by regulation an appropriate mechanism for enforcing an acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled payment to the fund. Such enforcement mechanisms may include (1) notification to the office of Medicaid requiring an offset of payments on the Title XIX claims of any such acute hospital or any health care provider under common ownership with the acute care hospital or any successor in interest to the acute hospital, and (2) the withholding by the office of Medicaid of the amount of payment owed to the fund, including any interest and late fees, and the transfer of the withheld funds into the Fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be deemed to be in breach of contract or any other obligation for the payment of noncontracted services, and providers ~~to which~~ **whose** payment is offset under order of the division shall serve all Title XIX recipients in accordance with the contract then in effect with the office of Medicaid, or, in the case of a noncontracting or disproportionate share hospital, in accordance with its obligation for providing services to Title XIX recipients pursuant to this chapter. In no event shall the office direct the office of Medicaid to offset claims unless an acute hospital has maintained an outstanding obligation to the health safety net fund for a period longer than 45 days and has received proper notice that said division intends to initiate enforcement actions in accordance with the regulations of the office.

Section 59. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge on all payments subject to surcharge as defined in section 1. The surcharge shal be distinct from any other amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge percentage and (ii) amounts paid for said services by a surcharge payor. The office shall calculate the surcharge percentage by dividing $160,000,000 by the projected annual aggregate payments subject to the surcharge, provided that beginning on October 1, 2008 and in each year thereafter this amount shall be adjusted to reflect increases in the consumer price index calculated by the United States Bureau of Labor Statistics for all urban consumers nationally during the most recent 12 month period for which data are available. The office shall determine the surcharge percentage before the effective date of this section and may redetermine the surcharge percentage before the following April 1 if the office projects that the initial surcharge established the previous October will

Comment [SAN22]: This is same language as current 118G:18A, surcharge amount is changed to codify current practice of assessing $160 million and inflation-adj language is added.

produce less than $150,000,000 or more than $170,000,000. Before each succeeding October 1, the office shall redetermine the surcharge percentage incorporating any adjustments from prior years. In each determination or redetermination of the surcharge percentage, the office shall use the best data available as determined by the division and may consider the effect on projected surcharge payments of any modified or waived enforcement under subsection (e). The office shall incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts by prospective adjustment rather than by retrospective payments or assessments.

Section 60. (a) Reimbursements from the Fund to hospitals and community health centers for health services provided to uninsured individuals shall be made in the following manner, and shall be subject to further rules and regulations promulgated by the office.

(1) Reimbursements made to acute hospitals shall be based on actual claims for health services provided to uninsured and underinsured patients that are submitted to the office, and shall be made only after determination that the claim is eligible for reimbursement in accordance with this chapter and any additional regulations promulgated by the office, provided that reimbursements for health services provided to residents of other states and foreign countries shall be prohibited, and provided further that the office shall make payments to acute hospitals using fee-for-service rates calculated as provided in subparagraph (2) below.

(2) The office shall, in consultation with the office of Medicaid, develop and implement procedures to verify the eligibility of individuals for whom health services are billed to the fund and to ensure that other coverage options are utilized fully before services are billed to the fund, **including procedures adopted pursuant to section 35 of this chapter**. The office shall review all claims billed to the fund to determine whether the patient is eligible for medical assistance pursuant to this chapter and whether any third party is financially responsible for the costs of care provided to the patient. In making such determinations, the office shall verify the insurance status of each individual for whom a claim is made using all sources of data available to the office. The office shall refuse to allow payments or shall disallow payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources.

Comment [SAN23]: Reference to current Medicaid statute re: procedures for ensuring that reimbursements are made only when there is no other payor.

(3) The office shall require acute hospitals and community health centers to screen each applicant for reimbursed care for other source of coverage and for potential eligibility for government programs, and to document the results of such screening. If an acute hospital or community health center determines that an applicant is potentially eligible for Medicaid or for the commonwealth care program established pursuant to chapter 118H or another assistance program, the acute hospital or community health center shall assist the applicant in applying for benefits under such program. The office shall audit the accounts of acute hospitals and community health centers to determine compliance with this section and shall deny payments from the fund for any acute hospital or community health center that fails to document compliance with this section.

(4) The office shall reimburse acute hospitals for health services provided to individuals based on the payment systems in effect for acute hospitals used by the United

States Department of Health and Human Services Centers for Medicare & Medicaid Services to administer the Medicare Program under Title XVIII of the Social Security Act, including all of Medicare's adjustments for direct and indirect graduate medical education, disproportionate share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of the annual increase in the Medicare hospital market basket index. The division shall modify such payment systems ~~only~~ to account for: the differences between the program administered by the office and the Title XVIII Medicare program, including the services and benefits covered, and, for purposed of calculating the payment rates for covered hospital services, the office shall use a grouper and DRG relative weights that have been determined by the office, in consultation with the division of health care finance and policy and the Massachusetts Hospital Association, to reimburse acute hospitals at rates no less than the rates they are reimbursed by Medicare; the extent and duration of such coverage; the populations served; **and any other adjustments as specified in regulations promulgated by the office**. ~~; and the assurance that providers will be held harmless at their current reimbursement levels~~. Following implementation of the provisions of this section, the office shall ensure that the ~~rates paid~~ **allowable reimbursement rates** pursuant to this section for health services provided to uninsured individuals shall not thereafter be less than rates of payment for comparable services under the Medicare program, taking into account the adjustments required by this section.

(5) For the purposes of paying community health centers for health services provided to uninsured individuals under this section, the office shall pay community health centers a base rate that shall be no less than the then-current Medicare Federally Qualified Health Center rate as required under 42 USC section 13951 (a)(3), the office shall add payments for additional services not included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent care, and emergency room diversion services.

(6) Reimbursements to acute hospitals and community health centers for bad debt shall be made upon submission of evidence, in a form to be determined by the office, that reasonable efforts to collect the debt have been made.

(b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after consultation with the Division of Health Care Finance and Policy, and using the best data available, provide an estimate of the projected total reimbursable health services provided by acute hospitals and community health centers and emergency bad debt costs, the total funding available, and any projected shortfall after adjusting for reimbursement payments to community health centers. In the event that a shortfall in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health services, the office shall allocate said shortfall in a manner**, including, but not limited to, the establishment of a graduated reimbursement system** that reflects each hospital's proportional **financial** requirement for reimbursements from the fund, in accordance with regulations promulgated by the office, **provided further that in the two years following implementation of this section any acute hospital receiving payments for reimbursable health services that, when measured on a comparable basis according to criteria established by the office, are not equivalent to reimbursements for free care received in the two years preceding implementation of this section shall be**

Comment [SAN24]: As drafted, this could be taken to mean hospitals should get same dollar amount as 06 or 07. See new protective language below.

Comment [SAN25]: Replaces hold harmless language in (a) 2 above—goal is to create smooth transition period to new reimbursement system by allowing hospitals to receive funds that allow them to be held harmless compared to previous reimbursement levels—but we don't want to measure these simply as a dollar amount.

eligible to receive supplemental funding from the Health Safety Net Trust Fund upon application to said office.

(c) The division shall enter into interagency agreements with the department of revenue to verify income data for patients ~~who receive reimbursed~~ **whose** health care services **are reimbursed by the Health Safety Net Fund** and to recover payments made by the fund for services provided to individuals who are ineligible ~~for~~ **to receive** reimburse~~d~~**able** health services or on whose behalf the fund has paid for emergency bad debt. The division shall promulgate regulations requiring acute hospitals to submit data that will enable the department of revenue to pursue recoveries from individuals who are ineligible for reimbursed health services and on whose behalf the fund has made payments to acute hospitals for emergency bad debt. Any amounts recovered shall be deposited in the Health Safety Net Trust Fund.

(d) The office shall not at any time make payments from the fund for any period in excess of amounts that have been paid into or are available in the fund for such period; provided, however, that the office may temporarily prorate payments from the fund for cash flow purposes.
[effective date=Oct 1, 2007]

SECTION 28. [House 23]
Section 1 of chapter 118G of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking the definition of "Pool".
[effective date=Oct 1, 2007]

Comment [AS26]: The comment to the House's major Pool reform section applies to this and next 9 sections as well.

SECTION 29. [House 23A]
Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of "Payments subject to surcharge".
[effective date=Oct 1, 2007]

SECTION 30. [NEW]
Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of "Private sector charges".
[effective date=Oct 1, 2007]

SECTION 31. [NEW]
Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of "Surcharge payor".
[effective date=Oct 1, 2007]

SECTION 32. [Senate 13C, 13D, 14, 15, 16, 18]
FREE RIDER PLACEHOLDER; SW&M TO SUPPLY LANGUAGE – what is the current status of the Free Rider draft?

SECTION 33. [House 24]

Clause (a) of section 2 of said chapter 118G, as so appearing, is hereby amended by inserting after the **word** "services", in line 19, the following word: and — and by striking out clause (c).
[effective date=Oct 1, 2007]

SECTION 34. [House 25]
Section 3 of said chapter 118G, as so appearing, is hereby amended by striking out clause (g).
[effective date=Oct 1, 2007]

SECTION 35. [NEW]
Section 5 of said chapter 118G is hereby amended by striking the first two sentences and inserting in place thereof the following:—

Each acute hospital shall pay to the commonwealth an amount for the estimated expenses of the division and of the health safety net office established in section 56 of chapter 118E. Such amount shall be equal to the amount appropriated by the general court for the expenses of the division of health care finance and policy and of the health safety net office minus amounts collected from (1) filing fees, (2) fees and charges generated by the division's publication or dissemination of reports and information, (3) federal matching revenues received for such expenses or received retroactively for expenses of predecessor agencies, and (4), any amounts allocated from the health safety net fund, established in section 57 of chapter 118E for the purposes of administrative costs of the health safety net office, provided that a share of the revenues raised under this section shall be transferred to the safety net office.
[effective date=Oct 1, 2007]

Comment [SAN27]: Would continue to fund a portion of admin expenses via assessment on hospitals (changes current DHCFP language to include safety net care office)

SECTION 36. [House 27]
Section 18 of said chapter 118G is hereby repealed.
[effective date=Oct 1, 2007]

SECTION 37. [House 28]
Section 18A of said chapter 118G is hereby repealed.
[effective date=Oct 1, 2007]

SECTION 38. [House 29; New Senate bill] The General Laws are hereby amended by inserting after chapter 118G the following chapter:—

CHAPTER 118H.
THE COMMONWEALTH CARE HEALTH INSURANCE PROGRAM.

Section 1. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:—
"Board", the board of directors of the Commonwealth Care Health Insurance Exchange Authority, established by section 2 of chapter 176Q. ~~commonwealth health insurance connector, established by section 3 of chapter 176Q.~~

"Eligible health insurance plan", a health insurance plan that meets the criteria for receiving premium assistance payments, established by the board ~~of the commonwealth health insurance connector~~.

"Eligible individual", an individual who meets the eligibility requirements set out in section 3, including an individual who is a sole proprietor.

"Exchange," the commonwealth care health insurance exchange established in section 3 of chapter 176Q.

"Fund", the Commonwealth Care Fund, established by section 2*OOO* of chapter 29.

"Premium contribution payments", payments made by enrollees in the program according to a fee schedule established by the board ~~of the commonwealth health insurance connector~~.

"Premium assistance payments", payments on behalf of enrollees in the program for health insurance premiums, according to a schedule established by the board ~~of the commonwealth health insurance connector~~.

"Resident", a person living in the commonwealth, as defined by the ~~office~~ division of health care finance and policy by regulation; provided, however, that such regulation shall not define a resident as a person who moved into the commonwealth for the sole purpose of securing health insurance under this chapter; and provided further, that a person who is not a citizen of the United States but who is either a qualified alien within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or is otherwise permanently residing in the United States under color of law shall be eligible to receive benefits under this chapter. Confinement of a person in a nursing home, hospital or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

Section 2. For the purpose of reducing uninsurance in the commonwealth, there shall be a Commonwealth Care Health Insurance program (hereunder "the program") within the commonwealth health insurance ~~connector~~ exchange established in chapter 176Q. The program shall be administered by the board ~~of the connector~~, in consultation with the directors of the office of Medicaid and the ~~health safety net office~~commissioner of health care finance and policy. The board ~~of the connector shall~~ shall ~~procure health insurance plans that are eligible for premium assistance payments in accordance with criteria set by the board, provided that such criteria shall include consideration of appropriate geographic distribution of providers, and shall~~ determine a sliding-scale premium contribution payment schedule for enrollees, provided that no premiums shall be required for single adults whose annual household income is less than 100 per cent of the federal poverty level, and shall establish procedures for determining eligibility and enrolling residents, in coordination with procedures used by the office of Medicaid. In order to maximize enrollment of low-income uninsured residents, the board ~~of the connector~~ shall develop a plan for outreach and education that is designed to reach ~~these~~is populations. In developing this plan, the board shall consult with the director of the office of Medicaid, representatives of any carrier eligible to receive premium subsidy payments under this chapter, representatives of hospitals that serve a high number of uninsured individuals, and representatives of low-income health care advocacy organizations.

Section 3. (a) An u~~U~~ninsured residents of the commonwealth shall be eligible to participate in the commonwealth care program, provided that:—
(1) an individual or family's household income does not exceed 300 per cent of the federal poverty level;
(2) the individual has been a resident of the commonwealth for the previous 6 months;
(3) the individual is not eligible for any MassHealth program, for Medicare, or for the child health insurance program pursuant to section 16C of chapter 118E;
(4) the individual's or family member's employer has not in the last 6 months provided insurance coverage for which the individual is eligible and for which the employer covers at least 20 per cent of the annual premium cost of a family health insurance plan or at least 33 per cent of an individual health insurance plan; and
(5) the individual has not accepted a financial incentive from his employer to decline his employer's subsidized health insurance plan.
(b) The board may waive the provisions of ~~section 4~~clause (a) (4), above, provided:
(1) the individual's employer pays the employer's health insurance premium contribution to the exchange; and
(2) the employer's health insurance premium contribution for the applying individual is not less than the median health insurance premium contribution made by the employer to all of its full-time employees participating in the employer sponsored health plan.
~~that the individual's employer is in compliance with section 110 of chapter 175, section 8½ of chapter 176, section 3B of chapter 176B or section 7A of chapter 176G; provided, further, that the employer's health insurance premium contribution for the applying individual, which shall be the median health insurance premium contribution made by the employer to all of its full-time employees participating in the employer-sponsored health plan, must be paid to the connector. The connector shall use the employer's health insurance premium contribution for the individual to first offset the commonwealth's premium assistance for the individual with any residual amount offsetting the individual.~~ The exchange shall use the employer's health insurance premium contribution for the individual first to offset the commonwealth's premium assistance payment. Any residual amount may be used to offset the individual's premium contribution payment.

Section 4. All residents shall have the right to apply for the program established in this ~~section~~chapter, the right to receive written determinations detailing denial of eligibility, and the right to appeal any eligibility decision to the office of patient protection established in chapter 176O, provided such appeal is conducted pursuant to ~~the~~ a process jointly established by the bBoard ~~of the Commonwealth Health Insurance Connector, pursuant to chapter 176Q~~ and the office of patient protection. All participants receiving premium assistance payments under this section shall be entitled to consumer protections pursuant to chapter 176O.

Section 5. Premium assistance payments shall be made in accordance with a schedule ~~set~~ published annually on or before September 30 by the board ~~of the connector~~, in consultation with the directors of the office of Medicaid and the ~~health safety net office~~commissioner of health care finance and policy. ~~; provided that this schedule shall be published on or before September 30, starting in 2006.~~ Premium assistance payments shall be subject to appropriation from the Commonwealth Care Fund, established by

section 2*OOO* of chapter 29, and other appropriation of state monies, and shall be made directly by the ~~connector~~ exchange and sub-exchanges to eligible health insurance plans, in accordance with the provisions of chapter 176Q. ~~; provided, further, that p~~Premium assistance payments shall only be made on behalf of enrollees who purchase health plans with no annual deductible. If the ~~director~~ secretary determines that amounts in the fund are insufficient to meet the projected costs of enrolling new eligible individuals, the ~~director~~ secretary shall impose a cap on enrollment in the program.

Section 6. (a) There shall be established a program for any resident with a household income that does not exceed 100 percent of the federal poverty level, in which the board of the connector shall procure health insurance plans that include, but are not limited to, inpatient services; outpatient services and preventative care in participating doctors' offices or community health centers; prescription drugs as provided under the MassHealth formulary; provided, however, that enrollees shall be responsible for a copayment of one dollar for each interchangeable drug prescription, and three dollars for each brand name drug prescription; medically necessary inpatient and outpatient mental health services and substance abuse services; and medically necessary dental services, including preventative and restorative procedures.

(b) Notwithstanding prescription drug costs established by this section, no enrollee with a household income that does not exceed 100 percent of the federal poverty level shall be subject to any premium, deductible, or other cost sharing under this program.

Comment [AS28]: This needs to be considered more thoroughly – dental as a mandated benefit? Any other mandated benefits? The Senate did not create a distinct program for this population – do we want to?

Section 7. All expenses incurred in conducting the program shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the commonwealth care health insurance program hereunder beyond the extent to which monies shall have been provided under this chapter.

SECTION 39. [Senate 19]
Placeholder for Free Rider employee protection language [SW&M].

SECTION 40. [House 68, 69, 70}
Placeholder for per employee assessment language [SW&M].

SECTION 41. [House SECTION 33, Senate SECTION 20][Conference committee compromise language.]
Paragraph (a) of subdivision 2) of section 108 of chapter 175 of the General Laws, as appearing in the 2004 Official
Edition, is hereby amended by striking out clause (3) and inserting in place thereof the following clause:—
(3) It purports to insure only 1 person, except that a policy must insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, 2 or more eligible members of that family, including

husband, wife, dependent children or any children under a specified age which shall not exceed 25 years or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first, provided that the individual has no access to any other form or type of health insurance, and any other person dependent upon the policyholder; provided, however, that if a policy provides for termination of a dependent child's coverage at a specified age and if such a child is mentally or physically incapable of earning his own living on the termination date, the policy shall continue to insure such child while the policy is in force and so long as such incapacity.

SECTION 42. [Senate 22.REV].Said chapter 175 is hereby amended by inserting after section 111H, the following section:—

Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(4) diabetes-related services, medications, and supplies as defined in section 47N;

(5) early intervention services as set forth in said section 47C;

(6) infertility or pregnancy-related benefits as set forth in section 47H

(7) patient care services provided in a qualified clinical trial, as set forth in section 110L; and

(8) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

coverage for at least 1 mandated benefit unless the carrier continues to offer at least 1 policy that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.

SECTION 43. [Senate 23.REV] Chapter 176A of the General Laws is hereby amended by inserting after section 1D the following section:

Section 1E. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 8B;

(2) prenatal care, childbirth and postpartum care as set forth in section 8H;

(3) cytologic screening and mammographic examination as set forth in section 8J;

(4) diabetes-related services, medications, and supplies as defined in section 8P;

(5) early intervention services as set forth in said section 8B;

(6) infertility or pregnancy-related benefits as set forth in section 8K;

(7) patient care services provided in a qualified clinical trial, as set forth in section 8X; and

(8) mental health services as set forth in section 8A; provided however, that if the contract limits coverage for outpatient physician office visits, the commissioner shall not disapprove the contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 8A, as long as such coverage is at least as extensive as coverage under the contract for outpatient physician services.

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

(c) The commissioner shall not approve a contract that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least 1 contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months.

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

~~SECTION 44. [House SECTION 34.] Section 110 of said chapter 175, as so appearing, is hereby amended by adding the following subdivision:—~~
~~(O) An insurer authorized to issue or deliver within the commonwealth any general or blanket policy of insurance under this section may only contract to sell any general or blanket policy of insurance with an employer if said insurance is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees. Notwithstanding the forgoing, a carrier may enter into a general or blanket policy of insurance with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.~~

~~SECTION 45. [House SECTION 35.] Said chapter 175 is hereby amended by inserting after section 110L the following section:—~~
~~Section 110M. Carriers shall report to the health care access bureau in the division of insurance, as established by chapter 26, section 7A, executive director of the group insurance commission on the first day of each month a listing of all individuals for whom creditable coverage was provided for the previous month.~~

SECTION 46. [Senate SECTION 24] [Conference committee compromise language.] Chapter 176A of the General Laws is hereby amended by inserting after section 8Y the following section:—
Section 8Z. Any subscription certificate under a group nonprofit hospital service agreement, except certificates which provide supplemental coverage to Medicare or other governmental programs which shall be delivered, issued or renewed in the commonwealth, shall provide, as benefits to all group members having a principal place of employment within the commonwealth, coverage to persons who are age 25 and under

or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first, provided that the individual has no access to any other form or type of health insurance.

~~SECTION 47. [House SECTION 36] Chapter 176A of the General Laws is hereby amended by inserting after section 8 the following section:—~~
~~Section 8½. A corporation organized under this chapter may only contract to sell a group non-profit hospital service contract to an employer if the group non-profit hospital service contract is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees. Notwithstanding the foregoing, a carrier may enter into a contract to sell a group non-profit hospital service contract with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.~~

~~SECTION 48. [House SECTION 37] Said chapter 176A is hereby further amended by adding the following section:—~~
~~Section 34. Any corporation subject to this chapter shall report to the director of the group insurance commission~~ ~~health care access bureau in the division of insurance, as established by chapter 26, section 7A, on the first day of each month a listing of all individuals for whom creditable coverage was provided for the previous month.~~

SECTION 49. [Senate SECTION 25][Conference committee compromise language] Chapter 176B of the General Laws is hereby amended by inserting after section 4Y the following section:—
Section 4Z. Any subscription certificate under an individual or group medical service agreement which shall be delivered or issued or renewed in this commonwealth shall provide as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth, coverage to persons who are age 25 and under or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first, provided that the individual has no access to any other form or type of health insurance.

SECTION 50. [Senate 26] Said chapter 176B is hereby further amended by inserting after section 6B, the following section:—

Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for:

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

(1) pregnant women, infants and children as set forth in section 4C;

(2) prenatal care, childbirth and postpartum care as set forth in section 4H;

(3) cytologic screening and mammographic examination;

(4) diabetes-related services, medications and supplies as defined in section 4S;

(5) early intervention services as set forth in said section 4C;

(6) infertility or pregnancy-related benefits as set forth in section 4J;

(7) patient care services provided in a qualified clinical trial, as set forth in section 4X; and

(8) mental health services as set forth in section 4A; provided however, that if the subscription certificate limits coverage for outpatient physician office visits, the commissioner shall not disapprove the subscription certificate on the basis that coverage for outpatient mental health services is not as extensive as required by said section 4A, as long as such coverage is at least as extensive as coverage under the subscription certificate for outpatient physician services.

(c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least 1 subscription certificate that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.

~~SECTION 51. [House SECTION 38] Chapter 176B of the General Laws is hereby amended by inserting after section 3A the following section: — Section 3B. A medical service corporation organized under this chapter may only enter into a group medical service agreement with an employer if the group medical service agreement is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general~~

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

~~blanket policy of insurance for all employees. Notwithstanding the forgoing, a carrier may enter into a group medical service agreement with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.~~

~~SECTION 52. [House SECTION 39] Said chapter 176B is hereby further amended by adding the following section:—~~
~~Section 22. Carriers shall report to the director of the group insurance commission health care access bureau in the division of insurance, as established by chapter 26, section 7A, on the first day of each month a listing of all individuals for whom creditable coverage was provided for the previous month.~~

SECTION 53. [Senate SECTION 27][Conference Committee compromise language] Chapter 176G of the General Laws is hereby amended by inserting after section 4Q the following section:—
Section 4R. A health maintenance contract shall provide coverage to persons who are age 25 and under or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first, provided that the individual has no access to any other form or type of health insurance.

SECTION 54. [Senate 28,rev] Said chapter 176G of the General Laws is hereby amended by inserting after section 16 the following 2 sections:

Section 16A. (a) The commissioner shall not disapprove or reject a health maintenance contract solely on the basis that it includes any of the following provisions:

(1) a deductible that is consistent with the requirements set forth in section 223 of the Internal Revenue Code, or any successor statute;

(2) reasonable and actuarially sound co-insurance for covered services; or

(3) reasonable annual limits on coverage for physician office visits, outpatient laboratory and diagnostic services and other outpatient services; provided, however, that an annual unit of service limit on coverage for a particular category of services shall be deemed to be reasonable if the health maintenance organization submits an actuarial memorandum demonstrating that the unit of service limit is not less than 2 times the average expected utilization for that category of services, and that an annual dollar limit on coverage for a particular category of services shall be deemed to be reasonable if the carrier submits an actuarial memorandum demonstrating that the dollar limit is not less than 4 times the average expected level of incurred claims for that category of services.

(b) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

Section 16B. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a health maintenance contract unless it provides coverage for:

(1) pregnant women, infants and children as set forth in section 4;

(2) prenatal care, childbirth and postpartum care as set forth in said section 4 and section 4I;

(3) cytologic screening and mammographic examination as set forth in said section 4;

(4) diabetes-related services, medications and supplies as defined in section 4H;

(5) early intervention services as set forth in said section 4;

(6) infertility or pregnancy-related benefits as set forth in section 4;

(7) patient care services provided in a qualified clinical trial, as set forth in section 4P; and

(8) mental health services as set forth in section 4M; provided however, that if the health maintenance contract limits coverage for outpatient physician office visits pursuant to section 16, the commissioner shall not disapprove the health maintenance contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 4M as long as such coverage is at least as extensive as coverage under the health maintenance contract for outpatient physician services.

(c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least 1 mandated benefit unless the health maintenance organization continues to offer at least 1 health maintenance contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a health maintenance contract, to any employee within 12 months.

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

~~SECTION 55. [House SECTION 40] Chapter 176G of the General Laws is hereby amended by inserting after section 6 the following section:—~~
~~Section 7A. A health maintenance organization may only enter into a group health maintenance contract with an employer if the group health maintenance contract is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees. Notwithstanding the forgoing, a health maintenance organization may enter into a group health maintenance contract with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.~~

~~SECTION 56. [House SECTION 41] Said chapter 176G is hereby further amended by inserting after section 16 the following section:—~~
~~Section 16A. The commissioner shall not disapprove a health maintenance contract on the basis that it includes a deductible that is consistent with the requirements for a high deductible plan as defined in section 223 of the Internal Revenue Code and implementing regulations or guidelines; provided, however, the maximum deductible shall not be greater than the maximum annual contribution to a health savings account permitted under section 223 of the Internal Revenue Code.~~

~~SECTION 57. [House SECTION 42] Said chapter 176G is hereby further amended by adding the following section:—~~
~~Section 30. Carriers shall report to the director of the group insurance commission health care access bureau in the division of insurance, as established by chapter 26, section 7A, monthly a listing of all individuals for whom creditable coverage is provided as of the first day of the month.~~

SECTION 58. [House SECTION 42A] Said chapter 176G is hereby further amended by inserting after section 16 the following section:—
Section 16A. The commissioner shall not disapprove a health maintenance contract offered as coverage for young adults as long as the health maintenance contract complies with the minimum standards established pursuant to section 10 of chapter 176J.

SECTION 59. [Senate ~~SECTION 59. [House SECTION 43] Section 1 of chapter 176J of the General Laws,~~
~~as appearing in the 2004 Official Edition, is hereby amended by striking out, in line 10, the words "case characteristics" and inserting in place thereof the following words:— rate basis type.~~

~~SECTION 60. [House SECTION 44] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Adjusted average market premium price" the following definition:—~~
~~"Base premium rate", the midpoint rate within a modified community rate band for each rate basis type of each health benefit plan of a carrier.~~

SECTION 61. [House SECTION 45] Said section 1 of chapter 176J, as so appearing, is hereby further amended by striking out the definition of "Case Characteristics".

SECTION 62. [House SECTION 46] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of "Benefit level" and inserting in place thereof the following definition:—
"Benefit level", the health benefits, including the benefit payment structure of or service delivery and network of, provided by a health benefit plan.

SECTION 63. [House SECTION 47] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of "Carrier" and inserting in place thereof the following definition:—
"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

SECTION 64. [House SECTION 48] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Commissioner" the following 3 definitions:—
"Connector", the Commonwealth Health Insurance Connector, established by chapter 176Q.
"Connector seal of approval", the connector's approval that a health benefit plan which it offers meets certain standards regarding quality and value.
"Creditable coverage", coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h)a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults as offered under section 10 of chapter 176J; or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

SECTION 65. [House SECTION 49] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition "Eligible dependent" the following definition:—
"Eligible individual", an individual who is a resident of the commonwealth.

SECTION 66. [House SECTION 50] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out, in lines 48 to 50, inclusive, the words "companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one business" and inserting in place thereof the following words: — a business shall be considered to be 1 eligible small business or group if (1) it is eligible to file a combined tax return for purpose of state taxation or (2) its companies are affiliated companies through the same corporate parent.

SECTION 67. [House SECTION 51] The definition of "Eligible small business" in said section 1 of said chapter 176J, as so appearing, is hereby amended by adding the following sentence: — An eligible small business that exists within a MEWA shall be subject to this chapter.

SECTION 68. [House SECTION 52] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition "Emergency services" and inserting in place thereof the following definition: —
"Emergency services," services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S. C. 1395dd(e)(1)(B).

SECTION 69. [House SECTION 53] Said section 1 of chapter 176J, as so appearing, is hereby further amended by striking out, in line 70, the word "employee" and inserting in place thereof the following word: — employees, and by inserting after the word "dependents" in lines 70 and 71, the following words: — or eligible individuals and their dependents.

SECTION 70. [House SECTION 54] Said section 1 of chapter 176J, as so appearing, is hereby further amended by inserting, after the word "rate", the first time it appears, in line 76," the following words: — , tobacco usage.

SECTION 71. [House SECTION 55] Said section 1 of chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Group base premium rates" the following definition: — "Group health plan'', an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002, to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement or otherwise. For the purposes of this chapter, medical care means amounts paid for (i) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (ii) amounts paid for transportation

primarily for and essential to medical care referred to in clause (i); and (iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii). Any plan, fund or program which would not be, but for section 2721(e) of the federal Public Health Service Act, an employee welfare benefit plan, and which is established or maintained by a partnership, to the extent that such plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to clause (a), as an employee welfare benefit plan which is a group health plan; (a) in the case of a group health plan, the term "employer" also includes the partnership in relation to any partner; and (b) in the case of a group health plan, the term "participant" also includes:—

(1) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

(2) in connection with a group health plan maintained by a self employed individual, under which one or more employees are participants, the self employed individual; if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

SECTION 72. [House SECTION 56] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of "Health benefit plan" and inserting in place thereof the following definition:—

"Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter%176A; a group medical service plan issued by a nonprofit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G. Health benefit plan shall not include accident only, credit only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a

qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter 15A and the regulations promulgated thereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

SECTION 73. [House SECTION 57] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition "Mandated benefit" the following 2 definitions:— "Member", any person enrolled in a health benefit plan. "Modified community rate", a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a health benefit plan is the same without regard to health status; provided, however, that premiums may vary due to factors such as age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level for each rate basis type as permitted by this chapter.

SECTION 74. [House SECTION 58] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of "Pre-existing conditions provision" and inserting in place thereof the following definition:— "Pre-existing conditions provision", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information.

SECTION 75. [House SECTION 59] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition "Rate basis type" the following definition:— "Rating factor", characteristics including, but not limited to, age, industry, rate basis type, geography, wellness program usage or tobacco usage.

SECTION 76. [House SECTION 60] Said section 1 of said chapter 176J, as so appearing, is further amended by inserting after the definition "Rating period" the following 2 definitions:— "Resident", a natural person living in the commonwealth; provided, however, that the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify such person as a resident. "Trade Act/HCTC eligible persons", any eligible trade adjustment assistance recipient or any eligible alternative trade adjustment assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient who is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, pursuant to Public Law 107-210.

SECTION 77. [House SECTION 61] Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the word "expenses", in line 192, the following words:— , but in all cases pays for emergency services.

SECTION 78. [House SECTION 62] Said chapter 176J is hereby further amended by striking out section 2, as so appearing, and inserting in place thereof the following section:— Section 2. Except as otherwise provided, this chapter applies to all health benefit plans issued, made effective, delivered or renewed to any eligible small business after April 1, 1992, and all health benefit plans issued, made effective, delivered or renewed to any eligible individual on or after July 1, 2006, whether issued directly by a carrier, through the connector, or through an intermediary. Nothing in this chapter shall be construed to require a carrier that does not issue health benefit plans subject to the chapter to issue health benefit plans subject to this chapter.

SECTION 79. [House SECTION 63] Said chapter 176J is hereby further amended by striking out section 3, as so appearing, and inserting in place thereof the following section:— Section 3. (a) Premiums charged to every eligible small business for a health benefit plan issued or renewed on or after April 1, 1992, or eligible individuals for a health benefit plan issued or renewed on or after July 1, 2006, shall satisfy the following requirements:— (1) For every health benefit plan issued or renewed to eligible small groups on or after April 1, 1992 and to eligible individuals on or after July 1, 2006, including a certificate issued to an eligible small group or eligible individual that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, a carrier shall develop a group base premium rate for a class of business. The group base premium rates charged by a carrier to each eligible group or eligible individual during a rating period shall not exceed 2 times the group base premium rate which could be charged by that carrier to the eligible group or eligible individual with the lowest group base premium rate for that rate basis type within that class of business in that group's or individual's geographic area. In calculating the premium to be charged to each eligible small group or eligible individual, a carrier shall develop a group base premium rate for each rate basis type and may develop and use any of the rate adjustment factors identified in paragraphs (2) to (6), inclusive, of this subsection, provided that after multiplying any of the used rate adjustment factors by the group base premium, the resulting product for all adjusted group base premium rate combinations fall within rate bands ranging between sixty-six one-hundredths and one and thirty-two one-hundredths that is required of all products offered to eligible small groups and eligible individuals. In addition, carriers may apply additional factors, identified in subsection (b) that would apply outside the sixty-six one-hundredths to one and thirty-two one-hundredths rate band. All other rating adjustments are prohibited. Carriers may offer any rate basis types, but rate basis types that are offered to any eligible small employer or eligible individual shall be offered to every eligible small employer or eligible individual for all coverage issued or renewed on and after July 1, 2006. If an eligible small business does not meet a carrier's minimum participation or contribution requirements, the carrier may separately rate each employee as an eligible individual. (2) A carrier may establish an age rate adjustment that applies to both eligible individuals and eligible small groups. (3) A carrier may establish an industry rate adjustment. If a carrier chooses to establish industry rate adjustments, every eligible

~~small group in an industry shall be subject to the applicable industry rate adjustment. The industry rate adjustment applicable to an eligible individual shall be based on the industry of the eligible individual's primary employer and shall be the same adjustment applied to eligible small groups in the same industry. A carrier may not apply an industry rate to an eligible individual who is not employed. (4) A carrier may establish participation rate rate adjustments that apply only to eligible small groups for any health benefit plan or plans for any ranges of participation rates below the minimum participation requirements established in accordance with the definition of participation requirement in section 1, the value of which shall be expressed as a number. Alternatively, a carrier may separately rate each employee enrolling through such a group as an eligible individual. The participation rate rate adjustments must be based upon actuarially sound analysis of the differences in the experience of groups with different participation rates. If a carrier chooses to establish participation rate rate adjustments, every eligible small group with a participation rate within the ranges defined by the carrier shall be subject to the applicable participation rate rate adjustment. (5) A carrier may apply a wellness program rate discount that applies to both eligible individuals and eligible small groups who follow those wellness programs that have been approved by the commissioner. The value of the wellness program rate discount shall be up to 5 per cent. If a carrier establishes a wellness program rate discount every eligible insured following the wellness program shall be subject to the applicable wellness program rate discount. (6) A carrier may apply a tobacco use rate discount that applies to both eligible small groups and eligible individuals who can certify, in a method approved by the commissioner, that eligible individuals and their eligible dependents or eligible small group employees and their eligible dependents have not used tobacco products within the past year. (b) (1) A carrier may establish a benefit level rate adjustment for all eligible individuals and eligible small groups that shall be expressed as a number. The number shall represent the relative actuarial value of the benefit level, including the health care delivery network, of the health benefit plan issued to that eligible small group or eligible individual as compared to the actuarial value of other health benefit plans within that class of business. If a carrier chooses to establish benefit level rate adjustments, every eligible small group and every eligible individual shall be subject to the applicable benefit level rate adjustment. (2) The commissioner shall establish not less than 5 distinct regions of the state for the purposes of area rate adjustments. A carrier may establish an area rate adjustment for each distinct region, the value of which shall range from eight tenths to one and one fifth. If a carrier chooses to establish area rate adjustments, every eligible small group and every eligible individual within each area shall be subject to the applicable area rate adjustment. (3) A carrier shall establish a rate basis type adjustment factor for eligible individuals which shall be expressed as a number. The number shall represent the relative actuarial value of the rate basis type, which shall include at least the following 4 categories: single, two adults, one adult and children, and family. (4) A carrier may establish a group size rate adjustment that apply to both eligible individuals and eligible small groups, the value of which shall range from ninety five one hundredths to one and ten one hundredths. If a carrier chooses to establish group size rate adjustments, every eligible individual and eligible small group shall be subject to the applicable group size rate adjustment. If an eligible small business does not meet a carrier's participation~~

or contribution requirements, the carrier may apply the group size adjustment that applies to eligible individuals to each employee who enrolls through the eligible small business. (c) (1) A carrier that, as of the close of the calendar year 2004, had a combined total of 5,000 or more eligible employees and eligible dependents as defined by chapter 176J and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its license under chapter 176G, shall be required to file a plan with the connector, for its consideration, which could attain the connector seal of approval. (2) As of January 1, 2007, a carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under chapter 176G, shall be required annually to file a plan with the connector for its consideration, which could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year. (d) (1) A carrier that, as of the close of the calendar year 2004 had a combined total of 5,000 or more eligible employees and eligible dependents as defined by chapter 176J and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its authority under chapter 175, chapter 176A or chapter 176B shall be required to file a plan with the connector for its consideration, which could attain the connector seal of approval. (2) As of January 1, 2007, a carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, and who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the connector for its consideration, which could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year. (e) For the purposes of this section, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under chapter 175, 176A or 176B if said health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under chapter 176G.

SECTION 80. [House SECTION 64] Said chapter 176J is hereby amended by striking out, section 4, as appearing in the 2004 Official Edition, and inserting in place thereof the following section: — Section 4. (a) (1) Every carrier shall make available to every eligible individual and every small business, including an eligible small group or eligible individual a certificate that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, as well as to their eligible dependents, every health benefit plan that it provides to any other eligible individual or eligible small business. No health plan may be offered to an eligible individual or an eligible small business unless it complies with the requirements of this chapter. Upon the request of an eligible small business or an eligible individual, a carrier must provide that group or individual with a price for every health benefit plan that it provides to any eligible small business or eligible individual. Except under the

~~conditions set forth in paragraph (3) of subsection (a) and paragraph (2) of subsection (b), every carrier shall accept for enrollment any eligible small business or eligible individual which seeks to enroll in a health benefit plan. Every carrier shall permit every eligible small business group to enroll all eligible persons and all eligible dependents; provided that the commissioner shall promulgate regulations which limit the circumstances under which coverage must be made available to an eligible employee who seeks to enroll in a health benefit plan significantly later than he was initially eligible to enroll in a group plan. (2) A carrier shall enroll any person who meets the requirements of an eligible individual into a health plan if such person requests coverage within 63 days of termination of any prior creditable coverage. Coverage shall become effective within 30 days of the date of application, subject to reasonable verification of eligibility. (3) A carrier shall enroll any eligible individual who does not meet the requirements of subsection (2) into a health benefit plan; provided, however, that a carrier may impose a pre-existing condition exclusion for no more than 6 months or a waiting period, which shall be applied uniformly without regard to any health status-related factors, for no more than 4 months following the individual's effective date of coverage. If a policy includes a waiting period, emergency services shall be covered. In determining whether a pre-existing condition exclusion or a waiting period applies, all health plans shall credit the time such person was covered under prior creditable coverage if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage and if the previous coverage was reasonably actuarially equivalent to the new coverage. Coverage shall become effective within 30 days of the date of application. The commissioner shall promulgate regulations relative to pre-existing condition exclusions and waiting periods permissible pursuant to this section. (4) No policy may provide for any waiting period if the eligible individual has not had any creditable coverage for the 18 months prior to the effective date of coverage. (b) (1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. The commissioner is authorized to promulgate regulations, which ensure that a carrier cannot use the provisions of this paragraph to circumvent the intent of this chapter. (2) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible individual or eligible small business has repeatedly failed to pay on a timely basis the required health premiums; or, (b) the eligible individual or eligible small business has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented other information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or (c) the eligible individual or eligible small business has failed to comply in a material manner with a health benefit plan provision, including for an eligible small business, compliance with carrier requirements regarding employer contributions to group premiums; or (d) the eligible individual voluntarily ceases coverage under a health benefit plan; provided that the carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to~~

the date of the request for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the individual or small business fails to comply with the carrier's requests for information which the carrier deems necessary to verify the application for coverage under the health benefit plan. (3) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that: (a) the small business fails at the time of issuance or renewal to meet a participation requirement established in accordance with the definition of participation rate in section 1; or, (b) acceptance of an application or applications would create for the carrier a condition of financial impairment, and the carrier makes such a demonstration to the same commissioner. (4) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or an eligible small business with five or fewer eligible employees enrollment in a health benefit plan unless the eligible individual or eligible small business enrolls through an intermediary or the connector. If an eligible individual or an eligible small business with five or fewer eligible employees elects to enroll through an intermediary or the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all similarly situated eligible individuals and eligible small businesses in a similar manner. (c) (1) Every health benefit plan shall be renewable as required by the Health Insurance Portability and Accountability Act of 1996 as amended, or by regulations promulgated under that act. (2) A carrier shall not be required to renew the health benefit plan of an eligible individual or eligible small business if the individual or small business: (a) has not paid the required premiums; or, (b) has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented information necessary to determine the size of a group, the participation of a group, or the premium rate for a group; or, (c) failed to comply in a material manner with health benefit plan provisions including, for employers, carrier requirements regarding employer contributions to group premiums; or, (d) fails, at the time of renewal, to meet the participation requirements of the plan; or, (e) fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or, (f) in the case of a group, is not actively engaged in business. (3) A carrier may refuse to renew enrollment for an eligible individual, eligible employee or eligible dependent if: (a) the eligible individual, eligible employee or eligible dependent has committed fraud, misrepresented whether or not he or she is an eligible individual, eligible employee or eligible dependent, or misrepresented information necessary to determine his eligibility for a health benefit plan or for specific health benefits; or, (b) the eligible individual, eligible employee or eligible dependent fails to comply in a material manner with health benefit plan provisions. (d) Nothing in this chapter shall be construed to prohibit a carrier from offering coverage in a group to a person, and his dependents, who does not satisfy the hours per week or period employed portions of the definition of eligible employee. (e) The commissioner shall promulgate rules and regulations to enforce this section.

SECTION 81. [House SECTION 65] Said chapter 176J is hereby further amended by striking out section 5, as so appearing, and inserting in place thereof the following section: — Section 5. (a) No policy shall exclude any eligible individual, eligible

employee or eligible dependent on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition of such person. (b) Pre-existing conditions provisions shall not exclude coverage for a period beyond 6 months following the individual's effective date of coverage and may only relate to conditions which had, during the 6 months preceding an eligible individual's, eligible employee's or eligible dependent's effective date of coverage and may only relate to a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Pre-existing condition provisions may not apply to a pregnancy existing on the effective date of coverage. A carrier may not impose a pre-existing condition exclusion or waiting period for more than 3 months following the effective date of coverage for Trade Act/Health Coverage Tax Credit Eligible Persons. (c) No policy may provide for a waiting period of more than four months beyond the insured's effective date of coverage under the health benefit plan; provided, that an eligible individual who has not had creditable coverage for the 18 months prior to the effective date of coverage shall not be subject to a waiting period; provided further however, that a carrier may not impose any waiting period upon a new employee who had creditable coverage under a previous qualifying health plan immediately prior to, or until, employment by the eligible small business. If a policy includes a waiting period, emergency services must be covered during the waiting period. In determining whether a waiting period applies to an eligible individual, eligible employee or dependent, all health benefit plans shall credit the time such person was covered under a previous qualifying health plan if the insured experiences only a temporary interruption in coverage, and if the previous qualifying coverage was reasonably actuarially equivalent to the new coverage, both as determined by the commissioner. The waiting period may only apply to services which the new plan covers, but which were not covered under the old plan. The commissioner shall promulgate regulations to enforce the provisions of this section.

SECTION 82. [House SECTION 66] Section 6 of said chapter 176J, as so appearing, is hereby amended by inserting after the word "eligible", in line 3, the following words: — individuals or eligible, and by inserting after the word "benefit", in line 5, the following words: — "or include networks that differ from those of a health plan's overall network.

SECTION 83. [House SECTION 67] Said chapter 176J is hereby further amended by striking out section 7, as so appearing, and inserting in place thereof the following section: — Section 7. Every carrier shall make reasonable disclosure to prospective small business insureds, as part of its solicitation and sales material of: (a) the surcharge, if any, which shall be applied to a group's premium if one or more members are covered in the plan set forth in section 8; and, (b) the participation requirements or participation rate adjustments of the carrier with regard to each health benefit plan. (c) Every carrier, as a condition of doing business under the jurisdiction of this chapter on and after January 1, 2006, shall electronically file with the commissioner an annual actuarial opinion that the carrier's rating methodologies and rates to be applied in the upcoming calendar year comply with the requirements of this chapter and any

regulations promulgated under the authority of this chapter. In addition, every carrier shall file electronically an annual statement of the number of eligible individuals, eligible employees and eligible dependents, as of the close of the preceding calendar year, enrolled in a health benefit plan offered by the carrier. A carrier that may require eligible individuals or eligible small groups with 5 or fewer eligible employees to obtain coverage through an intermediary or the connector shall file a list of those intermediaries, with associated contact information, prior to requiring those small groups to go through an intermediary to obtain small group health coverage. Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of this chapter. Such information shall be made available to the commissioner upon request, but shall remain confidential. (d) Every carrier shall notify the commissioner regarding any material changes or additions to the actuarial methodology at least 30 days prior to the effective date of the change or addition, including amendments to rate basis types, rating factors, intermediary relationships, distribution networks and products offered within this market. If the commissioner determines that a carrier is not complying with the provisions of this chapter, the commissioner may disapprove the rating methodologies and the rates which the carrier uses.

SECTION 84. [House SECTION 68] Said chapter 176J is hereby further amended by striking out section 8, as so appearing, and inserting in place thereof the following section:— Section 8. The division of insurance shall monitor the competitiveness of the health insurance market and make an annual determination if a reinsurance program is necessary. If such a program is determined to be necessary, the division shall establish a program in accordance with the following recommendations: (a) There is hereby established a nonprofit entity to be known as the Massachusetts Health Reinsurance Plan. Any carrier issuing health benefit plans on or after January 1, 2006 shall be a member of the plan. (b) The plan shall be prepared and administered by a 5 member governing committee to be appointed by the governor. Such appointees shall represent carriers selling health benefit plans in the commonwealth, of which at least 1 appointee shall represent a foreign carrier. The initial appointment of 2 such appointees shall be for a term of 3 years. The initial appointment of 2 such appointees shall be for a term of 2 years. The initial appointment of the remaining appointee shall be for a term of 1 year. All appointments thereafter shall be for a term of 3 years. The governing committee shall be responsible for the hiring of any employees or contractors of the plan. (c) One month following the establishment of the governing committee, the governing committee shall submit to the commissioner a plan of operation. The commissioner shall, after notice and hearing, approve, disapprove or modify the plan of operation. Subsequent amendments to the plan shall be deemed approved by the commissioner if not expressly disapproved in writing by the commissioner within 30 days from the date of the filing. The commissioner shall establish the plan of operation 3 months following establishment of the governing committee, if the governing committee does not propose such a plan. (d) Meetings of the governing committee of the plan shall be conducted in accordance with the provisions of section 11A½ of chapter 30A. (e) The plan shall not reimburse a

carrier with respect to the claims of a reinsured individual or dependent in any calendar year until the carrier has paid an amount determined by the governing board and approved by the commissioner for benefits otherwise covered by the plan during the calendar year. (f) Premium rates charged for coverage reinsured by the plan shall be established by the governing committee and shall be subject to the approval of the commissioner. (g) Any member of the reinsurance plan may only reinsure the coverage of an eligible individual or any eligible dependent of such an individual or eligible employees or any eligible dependent of such an employee, who enrolls in a health benefit plan on or after 3 months following approval of the plan of operation. The reinsurance plan shall reinsure the level of coverage provided by the health benefit plan. (h) Following the close of the fiscal year established in the plan of operation, the governing committee shall determine the premiums charged for reinsurance coverage, the reinsurance plan expenses for administration and the incurred losses, if any, for the fiscal year, taking into account investment income and other appropriate gains and losses. Any net loss for the year shall be recouped by assessment of the members which shall be apportioned in proportion to each such members' respective shares of the total premiums earned in the commonwealth from health plans, but in no event shall such assessments exceed 1 per cent of the premiums earned from such health plans. (i) If the assessment level is inadequate, the governing committee may adjust reinsurance thresholds, retention levels or consider other forms of reinsurance. The governing committee shall report annually to the commissioner, the joint committee on health care financing, and the joint committee on financial services on its experience, the effect of the reinsurance plan on rates and shall make recommendations, if necessary, relative to sustaining the viability of the reinsurance plan. The committee may enter into negotiations with plan members to resolve any deficit through reductions in future payment levels for reinsurance plans. Any such recommendations shall take into account the findings of an actuarial study to be undertaken after the first 3 years of the plan's operation to evaluate and measure the relative risks assumed by differing types of carriers. The study shall be conducted by 3 actuaries appointed by the commissioner, one of whom shall represent risk assuming carriers, one of whom shall represent reinsuring carriers and one of whom shall represent the commissioner.

SECTION 85. [House SECTION 69] Section 9 of chapter 176J, as so appearing, is hereby amended by inserting after the word "eligible", in line 186, the first time it appears, the following words: — individual or eligible.

SECTION 86. [House SECTION 70] Said chapter 176J is hereby amended by adding the following: — Section 10. The division of insurance, with the advice and consent of the director of the connector, shall issue regulations to define coverage for young adult health benefit plans, and to implement the provisions of this section. Eligibility for enrollment in a qualifying young adult health insurance program will be restricted to individuals between the ages of 19 and 26, inclusive, who do not otherwise have access to health insurance coverage subsidized by an employer. Coverage for young adults shall: (a) provide reasonably comprehensive coverage of inpatient and outpatient hospital services and physician services for physical and mental illness; (b) provide all services which a carrier is required to include under applicable division of insurance statutes and

~~regulations, including, but not limited to: mental health services, emergency services, and any health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plans. Any carrier offering young adult health plans must offer at least one product that includes coverage for outpatient prescription drugs. Coverage for young adults may: (a) impose reasonable copayments, coinsurance and deductibles; (b) use cost control techniques commonly used in the health insurance industry, including tiered provider networks and selective provider contracting. Such plans shall only be issued through the commonwealth health insurance connector as defined in chapter 176Q. Premium rates for young adult health plans shall be consistent with the requirements of section 3 of chapter 176J.~~

~~SECTION 87. [House SECTION 71] Section 1 of chapter 176M, as so appearing, is hereby amended by inserting after the definition of "Conversion nongroup health plan" the following definition: — "Closed guaranteed issue health plan", a nongroup health plan issued by a carrier to an individual, as well as any covered dependents, after November 1, 1997 but before January 1, 2006. A carrier may permit an individual to continue to add new dependents to a policy issued under a closed guaranteed issue health plan.~~

~~SECTION 88. [House SECTION 72] Section 3 of chapter 176M of the General Laws, as so appearing, is amended by inserting after the word "section", in line 8, the following words: — through December 31, 2005, and by striking out subsections (d) and (e) and inserting in place thereof the following 2 subsections: — (d) As of January 1, 2006, a carrier shall no longer offer, sell, or deliver a health plan to any person to whom it does not have such an obligation pursuant to an individual policy, contract or agreement with an employer or through a trust or association; provided, however, that a closed guaranteed issue plan or a closed health plan shall be subject to all the other requirements of this chapter. A carrier shall be obligated to renew a closed guarantee issue health plan and a closed plan. A carrier may discontinue a closed guarantee issue health plan or a closed plan when the number of subscribers in a closed guaranteed issue plan or a closed plan is less than 25 per cent of the plan's subscriber total as of December 31, 2004. (e) Carriers shall notify all members, at the direction of the commissioner, at least once annually, of all health benefit plans and pursuant premiums for which the member is eligible according to Chapter 176J.~~

~~SECTION 89. [House SECTION 73] Section 6 of said chapter 176M, as so appearing, is hereby amended by adding the following paragraph: — By no later than July 1, 2006, the governing board for the Massachusetts nongroup health reinsurance plan shall establish a proposal to phase out the operations of the plan and submit a copy of said proposal to the commissioner for approval. The proposal shall include a method for closing the nongroup health reinsurance plan by June 30, 2007. The governing committee shall be charged with executing the phase-out plan.~~

291 Chapter 176J of the General Laws is hereby amended by adding the following section: —

Formatted: Font: Not Bold

Section 10. (a) The commissioner shall reimburse a carrier an amount equal to 90 per cent of claims costs in any calendar year between the reinsurance threshold and the reinsurance limit attributable to any eligible employee or dependent of an eligible small business with not more than 5 eligible employees. The initial reinsurance threshold shall be $100,000. The initial reinsurance limit shall be $500,000. The commissioner shall increase the reinsurance threshold and limit on an annual basis by an amount consistent with medical cost trends in the small group market.

(b) A carrier's cost and utilization trends applicable to premiums charged to eligible small businesses shall reflect anticipated reimbursements pursuant to this section.

(c) Reimbursements to carriers pursuant to this section shall be made from the Commonwealth Care Fund established in section 2OOO of chapter 29.

(d) The commissioner shall promulgate regulations necessary to implement this section. Nothing in this section shall prohibit the commissioner of insurance from contracting with a third party to administer the fund.

SECTION 90. [Senate 30] Section 2 of chapter 176M of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:—

(d) A carrier that participates in the nongroup health insurance market shall make available to eligible individuals a standard guaranteed issue health plan established pursuant to subsection (c) and may make available to eligible individuals up to 6 alternative guaranteed issue health plans with benefits and cost-sharing requirements, including deductibles, that differ from the standard guaranteed issue health plan. A carrier may offer 1 alternative plan that is the alternative plan that was offered by the carrier as of January 1, 2006, as modified from time to time in the ordinary course of business. A carrier may offer not more than 3 alternative benefit plans that satisfy the requirements set forth in section 223 of the Internal Revenue Code, or any successor statute. A carrier may offer not more than 2 alternative benefit plans that include reasonable and medically appropriate annual limits on coverage for physician office visits and outpatient services. A carrier shall not make available an alternative plan unless the plan has been filed with and approved by the commissioner of insurance. The commissioner shall approve an alternative plan if it: (1) is consistent with the requirements of the carrier's licensing statute; (2) contains a disclosure form, which shall be provided to a potential insured, that clearly and concisely states the limitations on the scope of health services and any other benefits to be provided, including an explanation of any deductible, co-insurance or co-payment feature; and (3) offers a 10-day free look period in compliance with chapter 176D and any regulations promulgated thereunder. A carrier shall adhere to all other provisions of this chapter when offering any guaranteed issue health plan. The commissioner shall promulgate regulations relative to the alternative plans permissible pursuant to this section. The regulations shall establish parameters for cost-sharing and benefit limits applicable to alternative plans so as to reduce the potential for adverse selection between carriers offering the same type of alternative plan. The regulations

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

shall permit a health maintenance organization to offer alternative guaranteed-issue health plans that are consistent with sections 16A and 16B of chapter 176G.

SECTION 91. [Senate 31] Said chapter 176M is hereby further amended by striking out section 7, as so appearing, and inserting in place thereof the following section:—

Section 7. (a) The commissioner shall reimburse a carrier an amount equal to 90 per cent of claims costs in any calendar year between the reinsurance threshold and the reinsurance limit attributable to an eligible individual or dependent. The initial reinsurance threshold shall be $100,000. The initial reinsurance limit shall be $500,000. The commissioner shall increase the reinsurance threshold and limit on an annual basis by an amount consistent with medical cost trends in the nongroup market.

(b) A carrier's cost and utilization trends applicable to premiums charged for guaranteed-issue health plan shall reflect anticipated reimbursements pursuant to this section.

(c) Reimbursements to carriers pursuant to this section shall be made from the Commonwealth Care Fund established in section 2OOO of chapter 29.

(d) The commissioner shall promulgate regulations necessary to implement this section. Nothing in this section shall prohibit the commissioner of insurance from contracting with a third party to administer the fund.

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

SECTION 92. [House SECTION 74] Section 1 of chapter 176N of the General Laws, as so appearing, is hereby amended by striking out the definition of "Emergency services" and "Health plan" and inserting in place thereof the following 2 definitions:— "Emergency services", services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B). "Health plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a nonprofit hospital service corporation under chapter 176A; a group medical service plan issued by a non profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; The words "health plan'' shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the

commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

SECTION 93. [House SECTION 75] Section 2 of said chapter 176N, as so appearing, is hereby amended by striking out, in lines 12 and 13, the words "or (2) a pregnancy existing on the effective date of coverage", — and by striking out, in line 16, the word "thirty" and inserting in place thereof the following figure:— 63.

SECTION 94. [House SECTION 76] Said section 2 of chapter 176N, as so appearing, is hereby further amended by striking out, in line 21, the word "six" and inserting in place thereof the following figure 4, and by inserting after the word "plan", in line 22, the following words:— ; provided that an eligible individual who has not had creditable coverage for the 18 months prior to the effective date of coverage shall not be subject to a waiting period.

~~SECTION 95. [House SECTION 77] The General Laws are hereby amended by inserting the following chapter: — CHAPTER 176Q. COMMONWEALTH HEALTH INSURANCE CONNECTOR.~~

~~Section 1. As used in this chapter the following words shall unless the context clearly requires otherwise have the following meanings:—~~
~~"Board", board of the commonwealth health insurance connector.~~
~~"Business entity", a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.~~
~~"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a non-profit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G.~~
~~"Commissioner", the commissioner of the division of insurance.~~
~~"Commonwealth care health insurance program enrollees", individuals and their dependents eligible to enroll in the commonwealth care health insurance program.~~

~~"Commonwealth care health insurance program", program administered pursuant to chapter 118H.~~

~~"Connector", the Commonwealth Health Insurance connector.~~

~~"Connector seal of approval", board approval indicating that the health benefit plan meets certain standards regarding value and quality.~~

~~"Division", the division of health care finance and policy.~~

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

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

~~"Health benefit plan," any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; a coverage for young adults health insurance plan under section 10 of chapter 176J. The words "health benefit plan'' shall not include accident only, credit only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.~~

~~"Mandated benefits", a health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plan.~~

"Participating institution", eligible groups that purchase health benefit plans through the connector.
"Premium assistance payments", payments made to carriers by the connector.
"Rating factor", characteristics including, but not limited to, age, industry, rate basis type, geography, wellness program usage or tobacco usage.
"Sub-connector", a locally incorporated and governed organization, with demonstrated experience in the small business health insurance and benefit market and which has been authorized to function in conjunction with the board of the Connector.
Section 2. (a). There shall be established within the executive office of administration and finance, an entity known as the commonwealth health insurance connector. The purpose of the connector is to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups as described in this chapter.
(b) There shall be a board, with duties and powers established herein, that will govern the connector. The connector board shall consist of 11 members: the director of the office of Medicaid, ex-officio; the secretary for administration and finance, ex-officio; the commissioner of insurance, ex-officio; 7 additional members appointed by the governor including 1 of whom shall be a member in good standing of the American Academy of Actuaries, 1 shall be an employee health benefits plan specialist, 1 shall be a health economist, 1 shall be a representative of a health consumer organization, and 2 shall represent the interests of small businesses; and 1 additional member appointed by the attorney general. No appointee may be an employee of any licensed carrier authorized to do business in the commonwealth. Upon the initial appointments, the governor shall designate three appointed members for a term of 3 years; three appointed members for a term of 4 years; and two appointed members for a term of 5 years. Thereafter, all appointments shall serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The governor shall appoint the chairperson and the board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board serving ex-officio may appoint a designee pursuant to section 6A of chapter 30.
(c) Six members of the board shall constitute a quorum, and the affirmative vote of six members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the connector. Members shall serve without pay, but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court no less than annually.
(d) Any action of the connector may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the connector shall be subject to section 11A½ of chapter 30A; but, said section 11A½ shall not apply to any meeting of members of the connector serving ex-officio in the exercise of their duties as officers of the commonwealth so long as no matters relating to the official business of the connector are discussed and decided at the meeting. The connector shall be subject to all other provisions of said chapter 30A, and records pertaining to the administration of the connector shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the connector shall be considered to be public funds for purposes of chapter 12A. The operations of the connector shall be subject to chapter 268A and chapter 268B.

(e) The board shall hire an executive director to supervise the administrative affairs and general management and operations of the connector and also serve as secretary of the connector, ex officio. The executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the connector necessary to the functioning of the connector. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the connector. The executive director shall, with the approval of the board: (i) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board; (ii) employ professional and clerical staff as necessary; (iii) report to the board on all operations under his control and supervision; (iv) prepare an annual budget and manage the administrative expenses of the connector; and (v) undertake any other activities necessary to implement the powers and duties set forth in this chapter.

(f) Within 120 days of the effective date of this act, the executive director shall submit a plan of operation to the board and any recommended amendments to this chapter or other general laws to assure the fair, reasonable and equitable administration of the connector that is consistent with the provisions of this chapter and any other applicable laws and regulations, which shall provide for the effective operation of the connector.

(g) As of January 1, 2007, the connector shall commence offering health benefit plans pursuant to section 5 of this chapter.

Section 3. The purpose of the board of the connector shall be to implement the Commonwealth health insurance connector. The goal of the board is to facilitate the purchase of health care insurance products through the connector at an affordable price by eligible individuals, groups and commonwealth care insurance plan enrollees. For these purposes, the board is authorized and empowered: —

(a) To develop a plan of operation for the connector, this shall include, but not be limited to, the following:

(1) establish procedures for operations of the connector;

(2) establish procedures for communications with an executive director;

(3) establish procedures for the selection of and the seal of approval certification for health benefit plans to be offered through the connector;

(4) establish procedures for the enrollment of eligible individuals, groups and Commonwealth care health insurance program enrollees;

(5) establish procedures for appeals of eligibility decisions for the Commonwealth Care Health Insurance Program, established by chapter 118H;

(6) establish appeals procedures for enforcement actions taken by the department of revenue pursuant to chapter 111M, including standards to govern appeals based on the assertion that imposition of the penalty under chapter 111M would create extreme hardship;

(7) establish a plan for operating a health insurance service center to provide eligible individuals, groups and commonwealth care insurance program enrollees, with information on the connector and manage connector enrollment;

(8) establish and manage a system of collecting all premium payments made by, or on behalf of, individuals obtaining health insurance coverage through the connector, including any premium payments made by enrollees, employees, unions or other organizations;

Formatted: Font: Not Bold

(9) establish and manage a system of remitting premium assistance payments to the carriers;
(10) establish a plan for publicizing the existence of the connector and the connector's eligibility requirements and enrollment procedures;
(11) develop criteria for determining that certain health benefit plans shall no longer be made available through the connector, and to develop a plan to decertify and remove the seal of approval from certain health benefit plans; and
(12) develop a standard application form for eligible individuals, groups seeking to purchase health insurance through the connector, and commonwealth care insurance program enrollees, seeking a premium assistance payment which shall include information necessary to determine an applicant's eligibility, previous health insurance coverage history and payment method.
(b) To determine each applicant's eligibility for purchasing insurance offered by the connector, including eligibility for premium assistance payments.
(c) To seek and receive any grant funding from the federal government, departments or agencies of the commonwealth, and private foundations.
(d) To contract with professional service firms as may be necessary in its judgment, and to fix their compensation.
(e) To contract with companies which provide third-party administrative and billing services for insurance products.
(f) To charge and equitably apportion among participating institutions its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter.
(g) To adopt by-laws for the regulation of its affairs and the conduct of its business.
(h) To adopt an official seal and alter the same at pleasure.
(i) To maintain an office at such place or places in the commonwealth as it may designate.
(j) To sue and be sued in its own name, plead and be impleaded.
(k) To establish lines of credit, and establish one or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974.
(l) To approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations.
(m) To enter into interdepartmental agreements with the department of revenue, the executive office of health and human services, the division of insurance and any other state agencies the board deems necessary for the purposes of implementing the provisions of chapter 111M, chapter 118H and chapter 111M.
(n) to create and deliver to the department of revenue a form for that the department to distribute to every person to whom it distributes information regarding personal income tax liability, including, without limitation, every person who filed a personal income tax return in the most recent calendar year, informing the recipient of the requirements to establish and maintain health care coverage.
(n) To create for publication by the 30th of each September, the Commonwealth Care Insurance Program commonwealth care insurance program consumer price schedule.

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

(o) To maintain membership lists from carriers in an electronic form that will provide such lists on a monthly basis.
(o) To create for publication by the 1st of each December, a premium schedule, which, accounting for maximum pricing in all rating factors with an exception for age, shall include the lowest premium on the market for which an individual would be eligible for "creditable coverage" as defined in Chapter 111M. Said schedule shall publish premiums allowing variance for age and rate basis type. The premium schedule shall be delivered to the department of revenue for use in establishing compliance with section 2 of Chapter 111M.
(p) To review annually the publication of the income levels for the federal poverty guidelines and devise a schedule of a percentage of income for each 50 per cent increment of the federal poverty level at which an individual could be expected to contribute said percentage of income towards the purchase of health insurance coverage. The director shall consider contribution schedules, such as those set for government benefits programs. The report shall be published annually on December 1 beginning on December 1, 2006. Prior to publication, the schedule shall be reported to the house and senate committee on ways and means and the joint committee on health care financing.
(q) To establish criteria, accept applications, and approve or reject licenses for certain sub-connectors which shall be authorized to offer health benefit plans offered by the connector. The board shall establish and maintain a procedure for coordination with said sub-connectors.
Section 4. (a) The connector may only offer health benefit plans to eligible individuals, and groups as defined in this chapter. Sub-connectors shall be authorized to offer all health benefit plans that the connector may offer, including all health benefit plans offered through the Commonwealth Care Health Insurance Program.
(b) An eligible individual or small group's participation in the connector shall cease if coverage is cancelled pursuant to section 4 of chapter 176J.
Section 5. (a) Only health insurance plans that have been authorized by the commissioner and underwritten by a carrier may be offered through the connector.
(b) Each health plan offered through the connector shall contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits.
(c) No health plan shall be offered through the connector that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.
(d) The connector may only make available health benefit plans as defined in chapter 176J, which include the following categories of coverage:
(1) preventive and primary care;
(2) emergency services;
(3) surgical benefits;
(4) hospitalization benefits;
(5) ambulatory patient benefits;
(6) mental health benefits; and
(7) maternity benefits.
(e)) Plans receiving the connector seal of approval shall meet all requirements of health benefit plans as defined in section 1 of chapter 176J; provided, however, in order to encourage lower cost, high quality health benefit plans, that plans shall not be required to

meet health care delivery network design provisions in any other law or regulation, and shall be free to contract on a mutually agreed basis with, or determine not to contract with, any provider for covered services; provided, however, that the contracted network meets the requirements set forth by the board of the connector. Any health benefit plan receiving the connector seal of approval may exclude any new mandated benefit coverage implemented after January 1, 2006.

Section 6. Eligible small groups seeking to be a participating institution shall, as a condition of participation in the connector, enter in a binding agreement with the connector which, at a minimum, shall stipulate the following:—

(a) that the employer agrees that, for the term of agreement, the employer will not offer to eligible individuals to participate in the connector any separate or competing group health plan offering the same, or substantially the same, benefits provided through the connector;

(b) that the employer reserves the right to determine, subject to applicable law, the criteria for eligibility, enrollment and participation in the connector and the amounts of the employer contributions, if any, to such health plan, provided that, for the term of the agreement with the connector, the employer agrees not to change or amend any such criteria or contribution amounts at anytime other than during a period designated by the connector for participating employer health plans;

(c) that the employers will participate in a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under 26 U.S.C. sections 104, 105, 106 and 125; and

(d) that the employer agrees to make available, in a timely manner, for review by the executive director, any of the employer's documents, records or information that the connector reasonably determines is necessary for the executive director to:—

(1) verify that the employer is in compliance with applicable federal and commonwealth laws relating to group health insurance plans, particularly those provisions of such laws relating to non-discrimination in coverage; and

(2) verify the eligibility, under the terms of the health plan, of those individuals enrolled in the employer's participating health plan.

Section 7. (a) The connector shall administer the commonwealth care health insurance program as described in chapter 118H and remit premium assistance payments beginning on October 1, 2006 to those carriers providing health plans to Commonwealth Care enrollees.

(b) The connector after an affirmative vote by the board shall from time to time requisition funds from the Commonwealth Care Trust established in section 2OOO of chapter 29 by notifying the secretary for administration and finance, in a form prescribed by the secretary, such amounts as the connector deems necessary to meet the current and future obligations and expenses of the commonwealth care health insurance program; provided future obligations do not exceed 30 days.

Section 8. (a) The connector shall enter into interagency agreements with the department of revenue to verify income data for participants in the commonwealth care health insurance program. Such written agreements shall include provisions permitting the connector to provide a list of individuals participating in or applying for the commonwealth care health insurance program, including any applicable members of the

households of such individuals, which would be counted in determining eligibility, and to furnish relevant information including, but not limited to, name, social security number, if available, and other data required to assure positive identification. Such written agreements shall include provisions permitting the department of revenue to examine the data available under the wage reporting system established under section 3 of chapter 62E. The department of revenue is hereby authorized to furnish the connector with information on the cases of persons so identified, including, but not limited to, name, social security number and other data to ensure positive identification, name and identification number of employer, and amount of wages received and gross income from all sources.

Section 9. The commonwealth, through the group insurance commission board, shall enter into an agreement with the connector whereby employees and contractors of the commonwealth who are ineligible for group insurance commission enrollment may elect to purchase a health benefit plan through the connector. The group insurance commission will develop a protocol for making pro-rated contributions to the chosen plan on behalf of the commonwealth.

Section 10. The connector seal of approval shall be assigned to health benefit plans that the board determines (1) meets the requirements of section 5(d); (2) provides good value to consumer; (3) offers high quality; and (4) is offered through the connector.

Section 11. (a) When an eligible individual or group is enrolled in the connector by a producer licensed in the commonwealth, the health plan chosen by each eligible individual or group shall pay the producer a commission that shall be determined by the board.

(b) Any labor union, educational, professional, civic, trade, church, not-for-profit or social organization may enroll its individual eligible members, or the individual members of its member organizations, in health benefit plans offered through the connector., and shall receive a payment amount determined by the board from each health plan for persons who are enrolled unless the payment is prohibited under any applicable provision of the Employee Retirement Income Security Act of 1974.

(c) Notwithstanding any general law to the contrary, membership organizations that enroll eligible individuals or groups in health benefit plans offered through the connector do not have to be licensed as an insurance producer unless such an arrangement is prohibited under any applicable provision of the Employee Retirement Income Security Act of 1974.

Section 12. (a) The connector shall be authorized to apply a surcharge to all health benefit plans which shall be used only to pay for administrative and operational expenses of the connector; provided that such a surcharge shall be applied uniformly to all health benefit plans offered through the connector and sub-connectors; provided further that a sub-connector may charge an additional fee to be used only to pay for additional administrative and operational expenses of the sub-connector. These surcharges shall not be used to pay any premium assistance payments pursuant to the commonwealth care insurance program as described in chapter 118H.

(b) Each carrier participating in the connector shall be required to furnish such reasonable reports as the board determines necessary to enable the executive director to carry out his or her duties under this chapter.

(c) The board may withdraw a health plan from the connector only after notice to the carrier.

Section 13. (a) All expenses incurred in carrying out this chapter shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the connector hereunder beyond the extent to which monies shall have been provided under this chapter.

(b) The connector shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer, or employee of the connector acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances; provided, however, that the connector shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.

(c) No person shall be liable to the commonwealth, to the connector or to any other person as a result of his activities, whether ministerial or discretionary, as a member, officer or employee of the connector except for willful dishonesty or intentional violation of the law; provided, however, that such person shall provide reasonable cooperation to the connector in the defense of any claim. Failure of such person to provide reasonable cooperation shall cause him to be jointly liable with the connector, to the extent that such failure prejudiced the defense of the action.

(d) The connector may indemnify or reimburse any person, or his personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from such person's activities, whether ministerial or discretionary, as a member, officer or employee of the connector; provided that the defense of settlement thereof shall have been made by counsel approved by the connector. The connector may procure insurance for itself and for its members, officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

(e) No civil action hereunder shall be brought more than 3 years after the date upon which the cause thereof accrued.

(f) Upon dissolution, liquidation or other termination of the connector, all rights and properties of the connector shall pass to and be vested in the commonwealth, subject to the rights of lien holders and other creditors. In addition, any net earnings of the connector, beyond that necessary for retirement of any indebtedness or to implement the public purpose or purposes or program of the commonwealth, shall not inure to the benefit of any person other than the commonwealth.

Section 14. The connector shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its board, to the governor, to the general court, and to the state auditor, such reports to be in a form prescribed by the board, with the written approval of the auditor. The board or the auditor may investigate the affairs of the connector, may severally examine the properties and records of the connector, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the connector. The connector shall be subject to biennial audit by the state auditor.

Section 15. No later than 1 year after the connector begins operation and every year thereafter, the connector shall conduct a study of the connector and the persons enrolled

~~in the connector and shall submit a written report to the governor, the president of the senate, the speaker of the house of representatives, the chairs of the joint committee on health care financing, and the house and senate committees on ways and means on status and activities of the connector based on data collected in the study. The report shall also be available to the general public upon request. The study shall review:~~
~~(1) the operation and administration of the connector, including surveys and reports of health benefits plans available to eligible individuals and on the experience of the plans. The experience on the plans shall include data on enrollees in the connector and enrollees purchasing health benefit plans as defined by chapter 176J outside of the connector, the operation and administration of the commonwealth care health insurance program described in chapter 118H, expenses, claims statistics, complaints data, how the connector met its goals, and other information deemed pertinent by the connector; and~~
~~(2) any significant observations regarding utilization and adoption of the connector.~~
~~Section 16. The connector may promulgate such rules and regulations as necessary to implement this chapter.~~
~~Section 17. The chapter, being necessary for the welfare of the commonwealth and its inhabitants, shall be liberally construed to affect the purposes hereof.~~

SECTION 96. [Senate emerg bill 5]. The General Laws are hereby amended by inserting after chapter 176P the following chapter:—

CHAPTER 176Q.
COMMONWEALTH CARE HEALTH INSURANCE EXCHANGE.

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

"Authority", the Commonwealth Care Health Insurance Exchange.

"Board", the board of directors of the Commonwealth Care Health Insurance Exchange Authority, established by section 2.

"Business entity", a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, a non-profit medical service corporation organized under chapter 176B or a health maintenance organization organized under chapter 176G.

"Commissioner", the commissioner of insurance.

"Commonwealth care health insurance program", the program established in chapter 118H.

Comment [A529]: It is unilluminating, but expedient, to insert the Senate's entire section rather than go through the changes individually line-by-line. Once the conferees agree on a proposal, staffs will need to review the two sets of language line-by-line.

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

"Commonwealth care health insurance program enrollees", individuals and their dependents eligible to enroll in the commonwealth care health insurance program.

"Commonwealth care seal of approval", board approval that the health benefit plan meets certain standards regarding value.

"Eligible individual", an individual who is a resident of the commonwealth; provided that the individual is not offered subsidized health insurance by an employer with more than 50 employees or is employed by an employer that is signatory to or obligated under a negotiated, bona-fide collective bargaining agreement between the employer and bona-fide employee representative, which agreement governs the employment conditions of that person and is not enrolled for coverage under: (i) Part A or Part B of Title XVIII of the federal Social Security Act; or (ii) a state plan under Title XIX of such act or any successor program.

"Eligible small group," shall have the same meaning as "Eligible small business" as defined in chapter 176J.

"Exchange", Commonwealth Care Health Insurance Exchange.

"Health benefit plans," any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group or individual hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group or individual medical service plan issued by a non-profit hospital service corporation under chapter 176B; a group or individual health maintenance contract issued by a health maintenance organization under chapter 176G; The words "health benefit plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which, for the purposes of this chapter, shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meet any requirements the commissioner, by regulation, may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self- insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or similar policy issued on a group basis, a Medicare Advantage plan or a Medicare Prescription Drug plan. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A shall not be considered a health plan for

the purposes of this chapter and shall be governed by said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

"Mandated benefits", a health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plan. "Participating institution", eligible groups that purchase health benefit plans through the Exchange.

"Premium assistance payment", payment made to carriers by the Exchange.

"Sub-exchange", authorized by the division of insurance to offer all health benefit plans that the Exchange may offer, including all health benefit plans with the commonwealth care seal of approval, to eligible small employers and individuals. A sub-exchange shall be a locally incorporated and governed organization with at least 10 years experience in the small businesses health insurance market, and which has served as a health insurance intermediary in the small group health insurance market under chapter 176J, and is acting on behalf of the Exchange under this chapter.

Section 2. (a). There shall be a body politic and corporate and a public instrumentality to be known as the Commonwealth Care Health Insurance Exchange Authority, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the Authority of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the Authority is to implement the Commonwealth Care Health Insurance Exchange, the purpose of which is to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups as described in this chapter.

(b) The board of directors of the Authority shall consist of: the commissioner of the division of health care finance and policy; the director of the office of Medicaid; the commissioner of insurance; the secretary for administration and finance; the executive director of the group insurance commission; the attorney general; 3 members to be appointed by the governor, 1 of whom shall be a member in good standing of the American Academy of Actuaries, 1 of whom shall be an employee health benefits plan specialist, and 1 of whom shall be an attorney specializing in employee benefit plans; and 3 members appointed by the attorney general, 1 of whom shall be a representative of organized labor, 1 of whom shall represent the interests of small businesses and 1 of whom shall be a representative of a health consumer organization.. An appointed member of the board shall not be an employee of any licensed carrier authorized to do business in the commonwealth. Upon the initial appointments, the governor shall designate 2 of the appointed members for a term of 3 years; 2 of the appointed members for a term of 4 years; and 1 of the appointed members for a term of 5 years. Thereafter, all appointments shall serve a term of 5 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for

reappointment. The governor shall appoint the chairperson and the board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board serving ex officio may appoint a designee pursuant to section 6A of chapter 30.

(c) Six members of the board shall constitute a quorum, and the affirmative vote of 6 members of the board shall be necessary and sufficient for any action taken by the board. A vacancy in the membership of the board shall not impair the right of a quorum to exercise all the rights and duties of the Authority. Members shall serve without pay, but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court no less than annually.

(d) Any action of the Authority may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the Authority shall be subject to section 11A½ of chapter 30A, however, said section 11A½ shall not apply to any meeting of members of the Authority serving ex officio in the exercise of their duties as officers of the commonwealth so long as no matters relating to the official business of the Authority are discussed and decided at the meeting. The Authority shall be subject to all other provisions of said chapter 30A, and records pertaining to the administration of the Authority shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the Authority shall be considered to be public funds for purposes of chapter 12A. The operations of the Authority shall be subject to chapter 268A and chapter 268B.

(e) The board shall appoint an executive director, who shall supervise the administrative affairs and general management and operations of the Authority and who shall also serve as secretary of the Authority, ex officio. The executive director shall receive a salary commensurate with the duties of the office, and may be removed by the board for cause. The executive director may appoint other officers and employees of the Authority necessary to the functioning of the Authority. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the Authority. The executive director shall, with the approval of the board:

(1) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board;
(2) employ professional and clerical staff as necessary,
(3) report to the board on all operations under his control and supervision;
(4) prepare an annual budget and manage the administrative expenses of the Authority; and
(5) undertake any other activities necessary to implement the powers and duties set forth in this chapter.

Section 3. The purpose of the Authority shall be to implement the Commonwealth Care Health Insurance Exchange. The goal of the Exchange is to facilitate the purchase of health care insurance products through the Exchange at an affordable price by eligible individuals, eligible small groups and commonwealth care health insurance program enrollees. For these purposes the Authority may:

(1) develop a plan of operation for the Exchange which shall include, but not be limited to:

(i) establish procedures for operations of the Authority directly or through one or more sub-contracted entities;
(ii) establish procedures for selecting an executive director;
(iii) establish procedures for the selection of and the seal of approval certification for health benefit plans to be offered through the Exchange;
(iv) establish procedures directly or through one or more Exchanges for the enrollment of eligible individuals, eligible small groups and commonwealth care health insurance program enrollees;
(v) establish a plan directly or through one or more Exchanges for operating a health insurance service center to provide eligible individuals, eligible small groups and commonwealth care health insurance program enrollees with information on the Exchange and manage Exchange enrollment;
(vi) establish and manage directly or through one or more exchanges a system of collecting all premium payments made by, or on behalf of individuals obtaining health insurance coverage through the Exchange, including any premium payments made by enrollees, employees, unions or other organizations;
(vii) establish and manage directly or through one or more exchanges a system of remitting premium assistance payments to carriers;
(viii) establish a plan directly or through one or more exchanges for publicizing the existence of the Exchange and the Exchange's and sub-exchanges' eligibility requirements and enrollment procedures;
(ix) develop criteria for determining that certain health benefit plans shall no longer be made available through the Exchange, and to develop a plan to decertify and remove the seal of approval from certain health benefit plans; and
(x) develop a standard application form for eligible individuals and groups seeking to purchase health insurance through the Exchange and commonwealth care health insurance program enrollees seeking a premium assistance payment, which shall include information necessary to determine an applicant's eligibility, previous health insurance coverage history and payment method;

(2) determine each applicant's eligibility for the Exchange, MassHealth or other programs administered by the commonwealth and to direct the individual to the appropriate commonwealth agency;
(3) seek and receive any grant funding from the Federal government, departments or agencies of the commonwealth and private foundations;
(4) contract with professional service firms as may be necessary in its judgment, and to fix their compensation;
(5) contract with companies that provide third-party administrative and billing services for insurance products;
(6) charge and equitably apportion among participating institutions its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter;

(7) adopt by-laws for the regulation of its affairs and the conduct of its business;
(8) adopt an official seal and alter the same at pleasure;
(9) maintain an office at such place or places in the commonwealth as it may designate;
(10) sue and be sued in its own name, plead and be impleaded;
(11) establish lines of credit, and establish 1 or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974;
(12) approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations;
(13) publish annually on or before September 30, after public notice and hearing, the commonwealth care health insurance program price schedule and individual contribution schedule. The individual contribution schedule shall establish a percentage of income for each 50 per cent increment of the federal poverty level at which an individual could be expected to contribute that percentage of income towards the purchase of health insurance coverage; provided that no individual contribution shall be required for single adults at or under 100 per cent of the federal poverty level.
(14) require registration with the Exchange by any business entity in the commonwealth having at least one employee who is ineligible to participate in an employer sponsored health benefit plan;
(15) create and deliver to the department of revenue a form that the department shall distribute to every person to whom it distributes information regarding personal income tax liability, including, without limitation, every person who filed a personal income tax return in the most recent calendar year that informs the recipient of the requirements to establish and maintain health care coverage;
(16) create for publication by the December 1 of each year, a premium schedule, which, accounting for maximum pricing in all rating factors with an exception for age, shall include the lowest premium on the market for which an individual would be eligible for creditable coverage, as defined in chapter 111M. This schedule shall publish premiums allowing variance for age and rate basis type. The premium schedule shall be delivered to the department of revenue for use in establishing compliance with section 2 of chapter 111M;
(17) ensure maximum coordination with and participation by employers and employees in the insurance partnership program, established by section 9C of chapter 118E; and
(18) do all things necessary to carry out the purposes of this chapter.

Section 4A. The division of insurance shall establish criteria, accept applications, and approve or reject licenses for certain sub-exchanges with which the Exchange shall contract for the provision of health benefit plans offered by the Exchange to eligible individuals, eligible small groups and commonwealth care health insurance program enrollees.

Sub-exchanges hereunder may offer all health benefit plans that the Exchange may offer, including all health benefit plans with the commonwealth care seal of approval. The sub-exchanges shall provide the same or greater services as offered through the Exchange.

Section 4. (a) The Authority may only sell health benefit plans to eligible individuals and groups.
(b) An eligible individual or small group's participation in the Exchange shall cease if coverage is cancelled pursuant to section 3 of chapter 176M and section 4 of chapter 176J.

Section 5. (a) Only health benefit plans that have been authorized by the commissioner and underwritten by a properly licensed carrier may be offered through the Exchange. Premium rates charges to eligible small groups shall comply with chapter 176J. If an eligible small group does not meet a carrier's participation or contribution requirements, each employee enrolling through the eligible small group shall be considered an eligible individual and the carrier shall calculate each eligible individual's premium rate pursuant to chapter 176M.
(b) Each health benefit plan offered through the Exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits.
(c) No health benefit plan shall be offered through the Exchange that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income or age.
(d) The Authority may only make available health benefit plans as defined in chapter 176J, or chapter 176M, as applicable, which include the following categories of coverage:

(1) preventive and primary care;
(2) emergency services;
(3) surgical benefits;
(4) hospitalization benefits;
(5) ambulatory care benefits;
(6) mental health services equivalent to those set forth in section 47B of chapter 175,but if the policy limits coverage for outpatient physician office visits, the coverage shall be at least as extensive as coverage under the policy for outpatient physician services;
(7) pregnant women, infants and children services equivalent to those set forth in section 47C of chapter 175;
(8) prenatal care, childbirth and postpartum care services equivalent to those set forth in section 47F of chapter 175;
(9) cytologic screening and mammographic examination services equivalent to those set forth in section 47G of chapter 175;
(10) infertility and pregnancy-related benefits as set forth in section 47H of chapter 175;
(11) patient care services provided in a qualified clinical trial, as set forth in section 110L of chapter 175;
(12) early intervention services equivalent to those set forth in section 47C of chapter 175; and
(13) diabetes-related services, medications and supplies as defined in section 47N of chapter 175.

(e) Except as otherwise provided in this section, a health benefit plan receiving the Commonwealth Care Seal of Approval shall not be disapproved solely on the basis that it does not include coverage for at least 1 mandated benefit, but the carrier shall offer a health benefit plan that includes a prescription drug benefit option. Any health benefit plan receiving the Commonwealth Care Seal of Approval may exclude through December 31, 2008 any new mandated benefit coverage implemented after January 1, 2006.

(f) Notwithstanding any provision of chapter 176G to the contrary, the commissioner or the director shall not disapprove a group or individual health maintenance contract to be offered through the Exchange on the basis that it includes:

(1) a deductible that is consistent with the requirements set forth in section 223 of the Internal Revenue Code, or any successor statute;
(2) reasonable and actuarially sound co-insurance for covered services; or
(3) reasonable annual limits on coverage for physician office visits, outpatient laboratory and diagnostic services and other outpatient services; provided, however, that an annual unit of service limit on coverage for a particular category of services shall be deemed to be reasonable if the health maintenance organization submits an actuarial memorandum demonstrating that the unit of service limit is not less than 2 times the average expected utilization for that category of services, and that an annual dollar limit on coverage for a particular category of services shall be deemed to be reasonable if the carrier submits an actuarial memorandum demonstrating that the dollar limit is not less than 4 times the average expected level of incurred claims for that category of services.

(g) Notwithstanding any provision in chapter 176M to the contrary, the commissioner or the director shall not disapprove a health benefit plan or plans to be offered by a carrier to eligible individuals through the exchange on the basis that the plan or plans contain a benefit design that differs the carrier's standard guaranteed-issue health plan and alternative guaranteed-issue health plan.

Section 6. Eligible small groups seeking to be participating institutions shall, as a condition of participation in the exchange, enter into a binding agreement with the exchange which, at a minimum, shall stipulate the following:

(1) that the employer agrees that, for the term of agreement, the employer will not offer to eligible individuals participating in the exchange any separate or competing group health plan offering the same, or substantially the same, benefits provided through the exchange;
(2) that the employer reserves the right to determine, subject to applicable law, the criteria for eligibility, enrollment and participation in the exchange and the amounts of the employer contributions, if any, to the health plan,but for the term of the agreement with the exchange, the employer agrees not to change or amend any such criteria or contribution amounts at any time other than during a period designated by the exchange for participating employer health plans;
(3) that employers will participate in a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from

deductibility of gross income under federal law, 26 USC §§104, 105, 106 and 125; and (4) that the employer agrees to make available, in a timely manner, for review by the executive director, any of the employer's documents, records or information that the exchange reasonably determines are necessary for the executive director to: (i) verify that the employer is in compliance with applicable federal and state laws relating to group health insurance plans, particularly those laws relating to non-discrimination in coverage; and (ii) verify the eligibility, under the terms of the health plan, of those individuals enrolled in the employer's participating health plan.

Section 7. (a) The Exchange shall administer the commonwealth care health insurance program described in chapter 118H and remit premium assistance payments beginning on October 1, 2006 to those carriers providing health benefit plans to commonwealth care enrollees.

(b) The Exchange, after an affirmative vote by the board, shall from time to time

requisition funds from the Commonwealth Care Fund established in section 2*OOO* of chapter 29 by notifying the secretary of administration and finance, in a form prescribed by the secretary, of the amounts that the Exchange considers necessary to meet the current and future obligations and expenses of the commonwealth care health insurance program, but future obligations shall not exceed 30 days.

Section 8. The Exchange shall enter into interagency agreements with the department of revenue to verify income data for participants in the commonwealth care health insurance program. These written agreements shall permit the Exchange to provide a list of individuals participating in or applying for the commonwealth care health insurance program, including any applicable members of the households of these individuals who would be counted in determining eligibility, and to furnish relevant information including, but not limited to, name, social security number, if available, and other data required to assure positive identification. These written agreements shall permit the department of revenue to examine the data available under the wage reporting system established under section 3 of chapter 62E. The department of revenue may furnish the Exchange with information on the persons so identified, including, but not limited to, name, social security number and other data to ensure positive identification, name and identification number of employer, and amount of wages received and gross income from all sources.

Section 9. The commonwealth, through the group insurance commission shall enter into an agreement with the exchange under which employees and contractors of the commonwealth who are ineligible for group insurance commission enrollment may elect to purchase a health benefit plan through the exchange. The group insurance commission shall develop a protocol for making pro-rated contributions to the chosen plan on behalf of the commonwealth.

Section 10. Commonwealth Care Seal of Approval shall be assigned to health benefit plans that the board determines (1) meet the requirements of section 5; (2) provide

good value and high quality to consumers; and (3) are offered through the exchange.

Section 11. (a) When an eligible individual or group is enrolled in the exchange or sub-exchange by a producer licensed in the commonwealth, the carrier chosen by each eligible individual or group shall pay the producer a commission that shall be determined by the board.

Section 12. (a) The exchange and sub-exchanges may apply a surcharge to individual premiums which shall be used only to pay for administrative and operational expenses of the exchange. This surcharge shall be applied uniformly to all health benefit plans offered through the exchange and shall not be used to pay any premium assistance payments under the commonwealth care health insurance program.
(b) Each carrier participating in the exchange shall furnish reasonable reports that the board determines necessary to enable the executive director to carry out his duties under this chapter.
(c) The board may withdraw a health plan from the exchange only after notice to the carrier.

Section 13. (a) All expenses incurred in carrying out this chapter shall be payable solely from funds provided under this chapter, and no liability or obligations shall be incurred by the Authority in excess of monies provided under this chapter.
(b) The Authority shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer, or employee of the Authority acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances, but the Authority shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.
(c) A person shall not be liable to the commonwealth, to the Authority or to any other person as a result of his activities, whether ministerial or discretionary, as a member, officer or employee of the Authority except for willful dishonesty or intentional violation of the law; but the person shall provide reasonable cooperation to the Authority in the defense of any claim. Failure of the person to provide reasonable cooperation shall cause him to be jointly liable with the Authority to the extent that the failure prejudiced the defense of the action.
(d) The Authority may indemnify or reimburse any person, or his personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from that person's activities, whether ministerial or discretionary, as a member, officer or employee of the Authority if the defense or settlement shall have been made by counsel approved by the Authority. The Authority may procure insurance for itself and for its members, officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or other law.
(e) A civil action under this section shall not be brought more than 3 years after the date upon which the cause of action accrued.
(f) Upon dissolution, liquidation or other termination of the Authority, all rights and

properties of the Authority shall pass to and be vested in the commonwealth, subject to the rights of lien holders and other creditors. In addition, any net earnings of the Authority, beyond that necessary for retirement of any indebtedness or to implement the public purpose or purposes or program of the commonwealth, shall not inure to the benefit of any person other than the commonwealth.

Section 14. The Authority shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report of its activities as of the end of its fiscal year to its members, to the governor and to the state auditor, in a form prescribed by the members, with the written approval of the state auditor. The members or the state auditor may investigate the affairs of the Authority, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the Authority. The Authority shall be subject to biennial audit by the state auditor.

Section 15. No later than 2 years after the exchange begins operation and every following year, the Authority shall conduct a study of the exchange and the persons enrolled in the exchange and shall submit a written report to the governor, the president of the senate and the speaker of the house of representatives on the status and activities of the Authority based on data collected in the study. The report shall also be available to the general public upon request. The study shall review:
(1) the operation and administration of the exchange, including surveys and reports of health benefits plans available to eligible individuals and the experience of the plans, which shall include data on enrollees in the exchange and enrollees purchasing health benefit plans as defined by chapter 176J outside of the exchange, the operation and administration of the commonwealth care health insurance program, expenses, claims statistics, complaints data, how the exchange met its goals, and other information considered pertinent by the Authority; and (2) any significant observations regarding use and adoption of the exchange.

Section 16. The chapter, being necessary for the welfare of the commonwealth and its inhabitants, shall be liberally construed to effect its purposes.

SECTION 97. [House 78]
Chapter 241 of the acts of 2004 is hereby repealed.

~~SECTION 98. [House 79; Senate 58F, 58G] Section 2 of chapter 45 of the acts of 2005 is hereby amended by inserting after item 1108-5500 the following item:—~~
~~1102-0000 For start-up costs and marketing efforts associated with implementation of the Commonwealth Health Insurance Connector and Commonwealth Care Health Insurance Program, so-called; provided, that all sums appropriated for this item shall not revert and shall be available for expenditure until June 30, 2007..... $25,000,000~~

Comment [AS30]: This is accomplished by virtue of transfers, which were in the Senate's emergency bill – since these would go to an Authority under the Senate's plan. If we use House structure for the Connector/Exchange, this appropriation should be included in section 2A of the bill, as this bill will be an appropriations bill by virtue of the public health spending.

SECTION 99. [House 80; Senate 2] Item 4000-0352 of chapter 45 of the acts of 2005 is hereby amended by inserting after the word "office" the following:--

provided further, that grants shall be awarded to groups statewide, including areas in which the United States Census deems a high percentage of uninsured individuals and areas in which there are limited health care providers; provided further, that that funds shall be awarded as grants to community and consumer-focused public and private nonprofit groups to provide enrollment assistance, education and outreach activities directly to consumers who may be eligible for MassHealth or subsidized health care coverage, and who may require individualized support due to geography, ethnicity, race, culture, immigration or disease status and representative of communities throughout the commonwealth; provided further, that funds shall be allocated to provide informational support and technical assistance to recipient organizations and to promote appropriate and effective enrollment activities through the statewide health access network; provided further, that the cost of information support and technical assistance shall not exceed ten percent of the appropriation and shall in no case be used to defray current state obligations to provide this assistance.

SECTION 100. [House 9; Senate 12, Conf Comp] Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to [expand eligibility for children from 200% to 300% -- DMS to provide precise language]

[SECTION 101.[House 81; Senate 54. Conf Comp] Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 1,600 people, for a maximum total of 15,600 enrollees, in the CommonHealth program, so-called, funded in item 4000-0430 in section 2 of chapter 45 of the acts of 2005.

SECTION 102. [House 82; Senate 55, Conf Comp] Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 250 people, for a maximum total of 1,300 enrollees, in the Family Assistance HIV positive program, so-called, funded in item 4000-1400 in section 2 of chapter 45 of the acts of 2005.

SECTION 103. [House 83; Senate 56, Conf Comp] Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 16,000 people, for a maximum total of 60,000 enrollees, in the MassHealth Essential program, so-called, funded in item 4000-1405 in section 2 of chapter 45 of the acts of 2005.

SECTION 104. [House 84; Senate 53, Conf Comp] Notwithstanding any general or special law to the contrary, the executive office of health and human services shall create a 2-year pilot program for smoking and tobacco use cessation treatment and information to include within its MassHealth covered services. Smoking and tobacco use cessation treatment and information benefits shall include nicotine replacement therapy, other evidence-based pharmacologic aids to quitting smoking, and accompanying counseling by a physician, certified tobacco use cessation counselor, or other qualified clinician.

The executive office shall report annually on the number of enrollees who participate in smoking cessation services, number of enrollees who quit smoking, and Medicaid expenditures tied to tobacco use by Medicaid enrollees. The comptroller shall transfer $7 million from the Health Care Security Trust, established by section 1 of chapter 29D of the General Laws, to the General Fund in fiscal year 2007 and fiscal year 2008 to fund said program.

SECTION 105. [House 85, Conf Comp] The executive office of health and human services shall investigate and study the creation of selective provider networks, including geography and cultural competence of providers. The executive office shall report the results of this study to the joint committee on health care financing and the house and senate committees on ways and means no later than January 1, 2007.

SECTION 106. [House 86; Senate 8, Conf Staff Compromise] The department of public health shall make an investigation and study relative to (a) utilizing and funding of community health workers by public and private entities in the commonwealth, (b) increasing access to health care, particularly Medicaid-funded health and public health services, and (c) eliminating health disparities among vulnerable populations. Said department shall convene a statewide advisory council to assist in developing said investigation, interpreting its results, and developing recommendations for a sustainable community health worker program involving: public and private partnerships to improve access to health care, elimination of health disparities, increased use of primary care and a reduction in inappropriate use of hospital emergency rooms, and stronger workforce development in the commonwealth, including a training curriculum and community health worker certification program to insure high standards, cultural competency and quality of services. Said advisory council shall be chaired by the commissioner of public health or his designee and shall include 14 additional members, including the chief executives or their designees of the following agencies or organizations: office of Medicaid, department of labor and workforce development, Massachusetts Community Health Workers Network, Outreach Worker Training Institute of Central Massachusetts Area Health Education Center, Community Partners' Health Access Network, the Massachusetts Public Health Association , Boston Public Health Commission, Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, Massachusetts Nurses Association, Massachusetts Medical Society, Massachusetts Hospital Association, the Massachusetts League of Community Health Centers and the MassHealth Technical Forum.

Said department shall report to the general court the results of its study and its recommendations to the clerks of the house and senate, who shall forward the same to the joint committee on health care financing and to the house and senate committees on ways and means on or before January 1, 2007.

SECTION 107. [House 87; Senate 57, Conf Comp] The secretary of health and human services shall seek to obtain federal SCHIP reimbursement, pursuant to the provisions of Title XXI, for all persons eligible. To the extent SCHIP funds are not available for all eligible programs, the secretary shall first seek SCHIP reimbursement for Title XXI

eligible programs prior to claiming SCHIP reimbursement for Title XIX eligible programs. The secretary shall report quarterly to the joint committee on health care financing and the house and senate committees on ways and means on the status of federal SCHIP reimbursement.

~~SECTION 108. [House 88; Senate 36, Conf Comp] The secretary of health and human services shall seek an amendment to the MassHealth Demonstration Waiver granted by the United States Department of Health and Human Services under section 1115(a) of the Social Security Act, as authorized by chapter 203 of the acts of 1996, to implement the provisions of this act. The secretary shall seek to obtain maximum federal reimbursement for all provisions, of this act for which federal financial participation is available. The secretary shall report quarterly to the joint committee on health care financing and the house and senate committees on ways and means on the status of the waiver application.~~

SECTION 109. Senate emerg 9] The secretary of health and human services shall seek an amendment to the MassHealth Demonstration Waiver granted by the United States Department of Health and Human Services under section 1115(a) of the Social Security Act and authorized by chapter 203 of the acts of 1996 to implement this act and shall seek to obtain maximum federal reimbursement for any provision of this act for which federal financial participation is available. The secretary shall report quarterly to the joint committee on health care financing and the house and senate committees on ways and means on the status of the waiver application.

SECTION 110. [House 89, Senate 51, Conf Comp] Notwithstanding the provisions of any general or special law to the contrary, the executive office of health and human services shall not make any change to the financing, operation or regulation of, or contracts pertaining to, the provision of behavioral health services to persons receiving services administered, provided , paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI S-CHIP, and any MassHealth expansion population served under Section 1115 waivers, so-called, nor shall it recommend or procure, by request for response or otherwise, any such changes, nor shall it seek approval from the Centers for Medicare and Medicaid Services for any such changes, until it has submitted a report outlining the proposed changes, together with reasons therefore and an explanation of the benefits of such changes, to the joint committees on mental health and substance abuse and health care financing, and in no case prior to February 15, 2006; and further, all managed care organizations contracting or delivering behavioral health services to persons receiving services administered, provided , paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI S-CHIP, and any MassHealth expansion population served under Section 1115 waivers, so-called, and any and all youth in the care and custody of the department of social services or the department of youth services, including any specialty behavioral health managed care organization contracted to administer said behavioral health

services, shall be required to obtain the approval of the commissioner of the department of mental health for all of the behavioral health benefits, including but not limited to policies, protocols, standards, contract specifications, utilization review and utilization management criteria and outcome measurements. For purposes of this section, specialty behavioral health managed care organization shall mean a managed care organization whose primary line of business is the management of mental health and substance abuse services.

SECTION 111. [House 90; Conf Comp] Notwithstanding the provisions of any general or special law to the contrary, the office of Medicaid shall make a report to the committee on health care financing and to house and senate committees on ways and means no later than October 1 of each year on the previous state fiscal year's activities of the medical care advisory committee, as established in section 6 of chapter 118E of the General Laws. The report shall include, but not be limited to, the names and titles of committee members, dates of committee meetings, agendas and minutes or notes from such meetings, and any correspondence, memorandum, recommendations or other product of the committee's work.

SECTION 112. [House 91] There shall be an open enrollment period for eligible individuals and their dependents as defined in section 1 of chapter 176J of the General Laws. The open enrollment period shall begin on February 1, 2007 and end on April 30, 2007. No carrier shall impose a pre-existing condition provision or waiting period provision for any eligible individual who enrolls during the open enrollment period.

SECTION 113. [House 92]
Notwithstanding any general or special law to the contrary, in fund fiscal years 2007 and 2008 hospital liability to the health safety net fund, established in section 57 of chapter 118E of the General Laws, shall equal $160,000,000.

Comment [AS31]: RR thinks this should be left for the budget.

Comment [SAN32]: Should this be left for budget?? Or if we keep it here, add revenue max languae?

~~SECTION 114. [House 93]~~
~~Notwithstanding the provisions of any general or special law to the contrary, on October 1, 2006 the comptroller shall transfer any balance remaining in the uncompensated care trust fund to the Health Safety Net Fund established in section 57 of chapter 118E of the General Laws.~~
~~[effective date: September 30, 2007]~~

SECTION 115. [House 94]
[Placeholder for language re: funding for Uncompensated Care in FY07—needs to reflect fact that bill leaves UCP unchanged until Oct 2007, that we want to maintain $70 million pool offset currently part of MCO supps, and that we want to use 30-40 million for successor to Distressed Provider fund.] [redacted]

~~SECTION 116. [House 95]~~

~~All monies remaining in the distressed provider expendable trust fund, as established by chapter 241 of the acts of 2004, shall be transferred by the comptroller to the Safety Net Care Fund established in section 57 of chapter 118E.~~
~~**[effective date: Sept 30, 2007]**~~

SECTION 117. [House 97; Senate 58A, Comp language] Notwithstanding any general or special law or any provisions of this act to the contrary, the division of health care finance and policy shall continue in effect and enforce the following regulations in effect on September 15, 2005, promulgated pursuant to chapter 118G of the General Laws: 114:6 CMR 12.00 regarding services eligible for payment from the Uncompensated Care Trust Fund

SECTION 118. [House 98] Section of this act is repealed.
[effective date: October 1, 2007]

SECTION 119. [NEW appeal for pay-for-performance] Notwithstanding any general or special law to the contrary, for hospital rate year commencing October 1, 2007 only, hospitals may appeal to the division of health care finance and policy to receive medicaid hospital rate increases without meeting the quality standards and achieving performance benchmarks established by the executive office of health and human services pursuant to section 13B of chapter 118E.

SECTION 120. [new appeal for pay-for-performance repeal] Section XXX [NEW appeal for pay-for-performance] is hereby repealed.

SECTION 121. [House 99; Senate 49, Conf Staff Compromise] It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until the later of either January 1, 2008, or until the division of health care finance and policy has concluded review of and published results from a comprehensive review of mandated health benefits in effect on January 1, 2006.

SECTION 122. [House 100] The commonwealth health insurance ~~connector~~ exchange shall, in consultation with the executive office of economic development, design and administer a pilot program designed to assist businesses with 50 or fewer employees in purchasing health insurance for their employees, provided that said program may include economic and other incentives for employers who provide health insurance coverage for employees with household incomes below 400 percent of the federal poverty level.

SECTION 123. [House 101]
Placeholder re: possible MCO exclusivity [redacted]

~~SECTION 124.[House 107]~~
~~Notwithstanding any general or special law to the contrary, during fiscal year 2007, the comptroller shall transfer 50 percent of the earnings generated in fiscal year 2007 from~~

~~the Health Care Security Trust, as certified by the comptroller pursuant to paragraph (f) of section 3 of chapter 29 of the General Laws, to the Commonwealth Care Trust Fund.~~

SECTION 125. [House 112; Senate 58L; Compromise language] Notwithstanding any general or special law to the contrary there shall be a demonstration program pertaining to health care coverage for fishermen administered by the Health Safety Net Office.

SECTION 126. [House 114; Senate 57F, 57G] Notwithstanding any general or special law, rule or regulation to the contrary, in fiscal years 2007, 2008 and 2009, the comptroller shall transfer, not later than October 15 of each year, $90,000,000 from the Commonwealth Care Fund to the General Fund ~~shall be made available from the General Fund~~ to pay for an increase in the Medicaid rates paid to hospitals, physicians, and community health centers. [Distribution of rate increase among providers]

Comment [AS33]: This continues to need a lot of work.

SECTION 127. [Senate 48] RW LOOK AT

SECTION 128. [Senate 52]
Notwithstanding any general or special law to the contrary, during fiscal years 2007 and 2008, the secretary of the executive office of health and human services shall implement actuarially sound rates which shall reimburse certain publicly-operated entities operated by the Cambridge public health commission and the Boston public health commission that provide Title XIX reimbursable services, directly or through contracts with hospitals under an agreement with the executive office of health and human services.

Comment [SAN34]: Senate language, with changes.

SECTION 129. [Senate 58; Conf Comp] There shall be a Massachusetts health disparities council, located within, but not subject to the control of, the executive office of health and human services. The council shall make recommendations regarding reduction and elimination of racial and ethnic disparities in health care and health outcomes within the commonwealth. The disparities shall include, but not be limited to breast, cervical, prostate and colorectal cancers, stroke and heart attack, heart disease, diabetes, infant mortality, lupus, HIV/AIDS, asthma and other respiratory illnesses. The council shall address diversity in the health care workforce, including but not limited to, doctors, nurses and physician assistants and shall make recommendations on methods to increase the health care workforce pipeline. The council may also make recommendations on other matters impacting upon and relevant to health disparities including but not limited to the environment and housing.

The council shall initially consist of: 1 member representing the secretary of health and human services, 1 member representing the commissioner of the department of public health, 1 member representing the director of the office of Medicaid services, 3 members of the house of representatives, 1 of whom shall be designated by the speaker of the house as co-chair of the commission, 3 members of the senate, 1 of whom shall be designated by the senate president as co-chair of the commission, 1 member representing the American Cancer Society Massachusetts Division, 1 member representing the American Heart Association New England Division, 1 member representing Massachusetts General Hospital, 1 member representing Brigham and Women's Hospital,

1 member representing the Dana Farber Cancer Center, 1 member representing the Massachusetts League of Community Health Centers, 1 member representing the Massachusetts Medical Society, 1 member representing Boston Public Health Commission, 1 member representing the Office of Multicultural Health in the Department of Public Health, 1 member representing the Springfield Health Department, 1 member representing the Worcester Health Department, 2 members representing the nursing profession, one of whom shall be designated by Massachusetts School Nurses Organization and one of whom shall be designated by the Massachusetts Association of Public Health Nurses, 1 member representing the Massachusetts Association of Health Plans, 1 member representing the Program to Eliminate Health Disparities at the Harvard School of Public Health, 1 member representing Boston Medical Center, 1 member from the Massachusetts Public Health Association, 4 members from communities disproportionately affected by health disparities to be appointed by the speaker of the house, and 4 members from communities disproportionately affected by health disparities to be appointed by the senate president. At the end of the first fiscal year following the effective date of this act, the council membership shall be re-determined by the speaker of the house of representatives, the president of the senate and the governor.

The council shall file an annual report at the end of each fiscal year with the office of the governor, the clerk of the house of representatives, and the clerk of the senate. The report shall include, but not be limited to, recommendations for designing, implementing and improving programs and services, and proposing appropriate statutory and regulatory changes to reduce and eliminate disparities in access to health care services and quality care, and the disparities in medical outcomes in the commonwealth, and to address diversity and cultural competency in the health care workforce, including but not limited to, doctors, nurses and physician assistants.

SECTION 130. [Senate 58C, Conf Comp] The secretary of the executive office of health and human services shall conduct a study to determine the costs of allowing primary care givers to obtain MassHealth benefits if they care for on a full-time basis, elderly parents or immediate family members who are disabled. The secretary shall submit the report to the senate president, senate minority leader, chair of the senate ways and means committee, speaker of the house of representatives, house minority leader and chair of the house ways and means committee no later than July 1, 2007.

SECTION 131. [Senate 58M]
There is hereby established a MassHealth provider payment account, administered by the secretary of the executive office of health and human services. Subject to the availability of federal financial participation, funds shall be expended from this account for supplemental Medicaid payments to qualifying providers.

SECTION 132. [Senate 58N]
The comptroller shall transfer $251,000,000 from the General Fund to the MassHealth provider payment account established to make supplemental Medicaid rate payments to qualifying providers.

Comment [SAN35]: Deals with hospital IGTs. Intent is to maintain traditional level of payment; ie, 74 for Cambridge, 52 for Boston, $125 for UMass.

SECTION 133. [Senate emerg 6] Notwithstanding any general or special law to the contrary, 30 days after the effective date of this act, the state comptroller shall transfer $10,000,000 from the General Fund to the commonwealth care health insurance exchange Authority established under chapter 176Q for the purposes of educating and increasing the awareness of uninsured residents of the commonwealth as to their options for becoming insured through the exchange.

SECTION 134. [Senate emerg 7] Notwithstanding any general or special law to the contrary, 30 days after the effective date of this act, the state comptroller shall transfer $15,000,000 from the General Fund to the commonwealth care health insurance exchange Authority established under chapter 176Q for administrative and operating expenses of the Authority.

SECTION 135. [Senate emerg 8] There shall be an open enrollment period for eligible individuals, as defined in section 1 of chapter 118H, seeking enrollment in the Commonwealth Care Health Insurance Program. The open enrollment period shall begin on October 1, 2006 and end on Dec. 30, 2006. No carrier shall impose a preexisting condition provision or waiting period provision on any eligible individual who enrolls during the open enrollment period.

SECTION 136. [COMMONWEALTH CARE FUND EFFECTIVE DATE] Section xxx [House 5; Senate 5.5] shall take effect on July 1, 2006.

SECTION 137. [appeal for PAY-FOR-PERFORMANCE repeal EFFECTIVE DATE] Section XXX [new appeal for pay-for-performance repeal] shall take effect on October 1, 2008.

SECTION 138. [RESTORATION EFFECTIVE DATE] Section XXX [House 21; Senate 13B 4/5, Conf. staff compromise] shall take effect on July 1, 2006.

SECTION 139. [Reinsurance Eff. Date] Sections XXX [Senate 29] and XXX [Senate 31] shall take effect on July 1, 2007.

SECTION 140. [IM Eff. Date] Section XXX [House 8; New Senate bill, Conf Staff Compromise] shall take effect on . . . [triggers?]

SECTION 141. [Effective date for insurance changes] Sections ~~50~~ XXX [House SECTION 33, Senate SECTION 20][Conference committee compromise language.] through ~~83~~ XXX [House SECTION 76] shall take effect on April 1, 2007.

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold