

HOUSE No. 4793

The Commonwealth of Massachusetts

By Ms. Stanley of West Newbury, for the committee on Health Care Financing, on sections 24-31 of House, No. 4490, a Bill providing for job creation by small businesses (House, No. 4793). June 23, 2010.

FOR THE COMMITTEE:

NAME:	DISTRICT/ADDRESS:
Harriett L. Stanley	2nd Essex

The Commonwealth of Massachusetts

In the Year Two Thousand and Ten

An Act PROVIDING FOR JOB CREATION BY SMALL BUSINESSES. .

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

CONTROLLING SMALL BUSINESS HEALTH CARE COSTS

Offering More Affordable Options: Plans with Reduced Networks of Providers;

also Create Open Enrollment Periods for Individuals Buying Coverage on Their Own

SECTION 24. Section 4 of chapter 176J of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(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 benefit plan may be offered to an eligible individual or an eligible small business unless it complies with this chapter.

14 Upon the request of an eligible small business or an eligible individual, a carrier must provide
15 that group or individual with a price for every health benefit plan that it provides to any eligible
16 small business or eligible individual. Except under the conditions set forth in paragraph (3) of
17 subsection (a) and paragraph (2) of subsection

18 (b), every carrier shall enroll any eligible small business or eligible individual which
19 seeks to enroll in a health benefit plan. Every carrier shall permit every eligible small
20 business group to enroll all eligible persons and all eligible dependents; provided that the
21 commissioner shall promulgate regulations which limit the circumstances under which
22 coverage must be made available to an eligible employee who seeks to enroll in a health
23 benefit plan significantly later than he was initially eligible to enroll in a group plan.

24 (2) A carrier shall enroll any person who meets the requirements of an eligible individual,
25 including any person who meets the definition of eligible person as defined in section 2741 of
26 the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b),
27 into a health benefit plan if such person requests coverage within 63 days after termination of
28 any prior creditable coverage. Coverage shall become effective within 30 days after the date of
29 application, subject to reasonable verification of eligibility.

30 (3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph
31 (2) into a health benefit plan during the mandatory open enrollment period commencing May 15
32 and ending June 30. All coverage is to become effective on the first day of the month following
33 enrollment. The commissioner shall promulgate regulations for the open enrollment period
34 permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible
35 Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more

36 than 6 months following the individual's effective date of coverage if the Trade Act/Health
37 Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage
38 before becoming eligible for the HCTC; or a break in coverage of over 62 days immediately
39 before the date of application for enrollment into the qualified health plan.

40 (4) As a condition of continued offer of small group health benefit plans in the commonwealth, a
41 carrier that offers a plan that (i) provides or arranges for the delivery of health care services
42 through a closed network of health care providers; and (ii) as of the close of any preceding
43 calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and
44 eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made
45 effective or renewed to qualified small businesses or eligible individuals, shall offer at least 1
46 product in the small group market that uses a reduced network of health care providers. The base
47 premium for the reduced network product shall be at least 10 percent lower than the base
48 premium of the most actuarially similar product with the carrier's most robust network of
49 providers.

50 SECTION 25. Paragraphs (1) and (2) of Section 24 shall take effect on July 1, 2010. Paragraph
51 (3) of Section 24 shall take effect on July 1, 2010. Paragraph (4) of Section 24 shall take effect
52 on July 1, 2010.

53 Moratorium on New Mandated Benefits

54 SECTION 26. It shall be the policy of the general court to impose a moratorium on all new
55 mandated health benefit legislation until July 1, 2012, with the exception of medical
56 care coordination services.

57 For the purposes of this section, medical care coordination services is defined as services
58 conducted by a licensed medical professional or licensed mental health professional in
59 conjunction with other licensed parties involved in the clinical care of a person or family in order
60 to make a diagnosis, design or implement a treatment plan, manage patient care, assure
61 continuity of care, promote effective and efficient organization and utilization of resources, or
62 connect patients with other necessary services.

63 SECTION 27. Section 38C of chapter 3 of the General Laws, is hereby amended by adding
64 after subsection (d) the following:

65 (e). The Division of Health Care Finance and Policy shall report by March 15 of the beginning of
66 the legislative session appropriate legislation to repeal those State Mandated Health Benefits
67 identified in its Comprehensive Review of Mandated Benefits in Massachusetts that no longer
68 conform to existing standards of care in terms of clinical appropriateness or evidence-based
69 medicine.

70 Allow Commissioner to Adjust Rating Rules to Save Administrative Costs

71 SECTION 28. Section 3 of said chapter 176J, as so appearing, is hereby amended by adding the
72 following 2 subsections:-

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

79 (g) For small group base rate factors applied between July 1, 2010 and June 30, 2012, a carrier
80 must limit the effect of the application of any single or combination of rate adjustment factors
81 identified in paragraphs (2) to (6), inclusive of subsection (a) used in the calculation of any
82 individual's or small group's premium so that the final annual premium charged to an individual
83 or small group does not increase by more than an amount established annually by the
84 commissioner by regulation.

85 SECTION 29. Section 28 shall take effect on July 1, 2010.

86 Strengthen DOI's Authority to Review Rates: Require Advance Filings of Small Group Health
87 Insurance Rates

88 SECTION 30. Said chapter 176J is hereby further amended by striking out section 6 and
89 inserting in place thereof the following section:-

90 Section 6. (a) Notwithstanding any general or special law to the contrary, the commissioner may
91 approve health insurance policies submitted to the division of insurance for the purpose of being
92 provided to eligible individuals or eligible small businesses. These health insurance policies shall
93 be subject to this chapter and may exclude coverages of mandated benefits and may include
94 networks that differ from those of a health plan's overall network. The commissioner shall adopt
95 regulations regarding eligibility criteria. These eligibility criteria shall require that health
96 insurance policies which exclude mandated benefits shall only be offered to small businesses
97 which did not provide health insurance to its employees as of April 1, 1992. These eligibility
98 criteria may require an employer contribution of at least 50 per cent of the health insurance
99 premium for employees. These eligibility criteria shall also provide that small businesses shall

100 not have any health insurance policies which exclude mandated benefits for more than a 5-year
101 period.

102 (b) Notwithstanding any general or special law to the contrary, the commissioner may
103 require carriers offering small group health insurance plans, including carriers licensed under
104 chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to
105 small group rating factors at least 90 days before their proposed effective date. The
106 commissioner shall disapprove any proposed changes to base rates that are excessive,
107 inadequate, or unreasonable in relation to the benefits charged. The commissioner shall
108 disapprove any change to small group rating factors that is discriminatory or not actuarially
109 sound. Rate filing materials submitted for review by the Division shall be deemed confidential
110 and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter
111 4. The commissioner shall adopt regulations to carry out this section.

112 (c) For small group base rate changes filed to be effective any time in the period between July 1,
113 2010 and June 30, 2012, inclusive, if a carrier files for an increase in a small group product's
114 base rate over the prior year's base rate by an amount that is more than 150 per cent of the prior
115 calendar year's percentage increase in the consumer price index for medical care services, as
116 identified by the division of health care finance and policy, or if a carrier files an initial base rate
117 request that is greater than the average base rate for actuarially equivalent policies offered by
118 other small group carriers by more than 150 per cent of the prior calendar year's base premium
119 rate, such carrier's rate, in addition to being subject to all other provisions of this chapter, shall
120 be presumptively disapproved as excessive by the commissioner as set forth in this subsection.

121 (1) A carrier must communicate to all employers and individuals covered under any small
122 group product that the proposed increase has been presumptively disapproved and is
123 subject to a hearing at the division of insurance.

124 (2) The commissioner shall conduct a public hearing and shall publicize it in mass media
125 outlets including, but not limited to, newspapers in Boston, Brockton, Fall River,
126 Pittsfield, Springfield, Worcester, New Bedford, Lawrence, Salem, and Lowell, and shall
127 notify such newspapers of the hearing.

128 (3) The commissioner shall adopt regulations to specify the scheduling of the hearings
129 required pursuant to this subsection.

130 SECTION 31. Section 30 shall take effect on July 1, 2010.

131 SECTION 32. Section 3 of Chapter 176M of the General Laws as appearing in the 2008 Official
132 Edition, is hereby amended by striking out subsection (d) and inserting in place thereof the
133 following subsection:-

134 (d) Notwithstanding any other provision in this section, a carrier may deny an eligible individual
135 in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to
136 discontinue selling that health benefit plan to new eligible individuals. The commissioner is
137 authorized to promulgate regulations on how a carrier may transition existing members in a plan
138 that the carrier intends to close and for prohibiting a carrier from using this paragraph to
139 circumvent the intent of this chapter.

140 SECTION 33. Chapter 118G of the General Laws is hereby amended by inserting after section
141 15 the following section:-

142 Section 15A. (a) No contract for payment for hospital, physician group practice, or imaging
143 services between a provider and a carrier as defined by chapter 176O for medical, diagnostic or
144 therapeutic services shall take effect until submitted to the division of health care finance and
145 policy. The contract must be submitted by the provider to the division for review at least 90 days
146 before the proposed effective date of the contract. The division shall review such contracts to
147 determine whether provider payments under the contract, adjusted for volume and patient acuity,
148 would increase by more than the twelve month change of the Consumer Price Index for Medical
149 Care Services as of December 31 of the preceding year. The division shall schedule a public
150 hearing on any proposed or existing contract.

151 (b) Any contract under which provider payments increase by an amount in excess of the
152 applicable Consumer Price Index for Medical Care Services shall be presumptively disapproved.
153 The division may conduct a hearing on any contract that is presumptively disapproved and will
154 approve or disapprove the contract based on its findings following the hearing.

155 (c) The division, in consultation with the division of insurance, shall adopt regulations within 90
156 days of the passage of this act and in accordance with chapter 30A to specify the criteria for
157 contract review. The regulations shall specify the applicable Consumer Price Index for Medical
158 Care Services, which will be used in the review process.

159 (d) Except as specifically provided otherwise by the division, information submitted to the
160 division under this section shall not be a public record under clause Twenty-sixth of section 7 of
161 chapter 4 or chapter 66.

162 (e) This section shall also apply to any contract in effect before April 1, 2010, for services
163 provided on or after April 1, 2010. The parties shall be afforded 30 days to renegotiate any
164 affected terms of these contracts.

165 (f) Providers may not shift costs to other health care payers as a result of the requirements in this
166 section. The division may adopt regulations to specify monitoring activities and enforcement
167 provisions, including financial penalties, for violation of this section.

168 (g) No contract between a carrier as defined in section 1 of chapter 176O of the General Laws
169 and a provider of medical, diagnostic, or therapeutic services shall require the carrier to contract
170 with all of a provider's affiliated network of providers. The attorney general may bring an action
171 to enforce this section to obtain restitution, civil penalties, injunctive relief or any other relief
172 necessary and shall promulgate regulations related to unfair and deceptive trade practices in
173 carrier and provider contracting as allowed under Chapter 93A of the General Laws.

174 SECTION 34. Section 33 shall take effect on April 1, 2010. Subsection (b) of Section 30 shall
175 cease to be effective on March 31, 2012.

176 SECTION 35. Notwithstanding any other general or special laws to the contrary, the
177 Commissioner of the Division of Insurance shall perform an analysis of carriers' network
178 adequacy while encouraging the use of lower cost providers and primary care providers and with
179 the goal of decreasing health care costs and increasing quality of care. The Commissioner is

180 hereby directed to issue recommendations for reforms to the joint committee on health care
181 financing, the house and senate committees on ways and means, and the joint committee on
182 financial services within 180 days of the passage of this act.