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HOUSE . . . . . No. 4452

The Commonwealth of Massachusetts

In the Year Two Thousand Ten

An Act Relative to an Affordable Health Plan..

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

SECTION 1. Chapter 176J of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-

Section 11. As used in this section, the following words shall have the following meanings:

"Statutory reimbursement rate," with respect to payment to a health care provider for services rendered to any person covered under an "Affordable Health Plan", 110 percent of the Medicare reimbursement rate for those services as if they were rendered to a Medicare beneficiary not taking into consideration any beneficiary cost sharing. For services or supplies for which there is no Medicare reimbursement amount, the amount as determined by the commissioner of the division of health care finance and policy is to be consistent with Medicare payment policies at a 110 percent level and set in consultation with the commissioner of insurance.

“Medical loss ratio,” the ratio of claims incurred to premiums earned, expressed as a percentage.

(a) As a condition of doing business in the commonwealth, a carrier that offers health benefit plans to eligible small businesses and eligible individuals, as defined by chapter 176J, shall offer an "Affordable Health Plan" to all eligible individuals and small businesses, both within the connector, for such carriers participating in the connector, and for all such carriers outside the connector. This "Affordable Health Plan" shall contain benefits that are actuarially equivalent to the lowest level benefit plan available to the general public within the connector, other than the young adult plan. Payment for all services, other than outpatient pharmacy benefits, for all providers under "Affordable Health Plans" shall be consistent with the requirements as included in paragraph (b).

(b) Claims for services shall be adjudicated at the in-network benefit level or, if applicable under the terms of the plan, the out-of-network benefit level based on the participation status of the provider in the carrier’s network. Every health care provider licensed in the commonwealth which provides covered services to a person covered under "Affordable Health Plans" must provide such service to any such person, as a condition of their licensure, and must accept payment at the lowest of the statutory reimbursement rate, an amount equal to the actuarial equivalent of the statutory reimbursement rate, or the applicable contract rate with the carrier for the carrier’s product offering with the lowest level benefit plan available to the general public within the connector, other than the young adult plan, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles.

(c) Providers shall not attempt to recoup such excess amounts by increasing charges to other health benefit plans or other payers. The division of health care finance and policy shall monitor provider charges to ensure compliance with this section and shall report any non-compliance to the attorney general. The division of health care finance and policy shall promulgate regulations enforcing this subsection, which shall include penalties for noncompliance.

(d) Existing contracts between providers and carriers shall comply with the requirements of this section as to the reimbursement rate and providers shall provide services to individuals under "Affordable Health Plans" under such existing contracts with carriers. A provider that participates in a carrier's network or any health benefit plan shall not refuse to participate in the carrier's network with respect to the "Affordable Health Plan".

(e) Carriers that offer health benefit plans to eligible small businesses and eligible individuals, as defined by chapter 176J shall maintain an aggregate medical loss ratio for all coverage offered under said chapter 176J that does not exceed 85 percent, and shall limit aggregate post-tax underwriting surpluses for all coverage offered under said chapter 176J to 2 percent.

The division of insurance shall promulgate regulations to monitor and ensure compliance with this subsection.

SECTION 2. Section 11 of Chapter 176J is hereby repealed.

SECTION 3. Section 2 of this act shall take effect on January 1, 2013.