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HOUSE . . . . . No. 4793

The Commonwealth of Massachusetts

In the Year Two Thousand 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. 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 enroll 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, including any person who meets the definition of eligible person as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b), into a health benefit plan if such person requests coverage within 63 days after termination of any prior creditable coverage. Coverage shall become effective within 30 days after the date of application, subject to reasonable verification of eligibility.

(3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the mandatory open enrollment period commencing May 15 and ending June 30. All coverage is to become effective on the first day of the month following enrollment. The commissioner shall promulgate regulations for the open enrollment period permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more than 6 months following the individual’s effective date of coverage if the

Trade Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible for the HCTC; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

(4) As a condition of continued offer of small group health benefit plans in the commonwealth, a carrier that offers a plan that (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) 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, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer at least 1 product in the small group market that uses a reduced network of health care providers. The base premium for the reduced network product shall be at least 10 percent lower than the base premium of the most actuarially similar product with the carrier's most robust network of providers.

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

Moratorium on New Mandated Benefits

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

For the purposes of this section, medical care coordination services is defined as services conducted by a licensed medical professional or licensed mental health professional in

conjunction with other licensed parties involved in the clinical care of a person or family in order to make a diagnosis, design or implement a treatment plan, manage patient care, assure continuity of care, promote effective and efficient organization and utilization of resources, or connect patients with other necessary services.

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

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

Allow Commissioner to Adjust Rating Rules to Save Administrative Costs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Notwithstanding any other provision in this section, a carrier may deny an eligible individual 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. The commissioner is authorized to promulgate regulations on how a carrier may transition existing members in a plan that the carrier intends to close and for prohibiting a carrier from using this paragraph to circumvent the intent of this chapter.

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

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

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

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

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

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

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

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

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

SECTION 35. Notwithstanding any other general or special laws to the contrary, the Commissioner of the Division of Insurance shall perform an analysis of carriers' network adequacy while encouraging the use of lower cost providers and primary care providers and with the goal of decreasing health care costs and increasing quality of care. The Commissioner is hereby directed to issue recommendations for reforms to the joint committee on health care financing, the house and senate committees on ways and means, and the joint committee on financial services within 180 days of the passage of this act.