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HOUSE . . . . . No. 4915

The Commonwealth of Massachusetts

In the Year Two Thousand Ten

An Act act to promote cost containment, transparency and efficiency in the provision of quality health insurance for individuals and 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:

of medical assistance or a designee; the commissioner of insurance or a designee; the commissioner of the division of health care finance and policy or a designee; 1 person appointed by the speaker of the house of representatives; 1 person appointed by the senate president; 1 person designated by the Massachusetts Association of Health Plans; 1 person designated by Blue Cross Blue Shield of Massachusetts; 2 persons designated by the Massachusetts Hospital Association, 1 of whom shall represent teaching hospitals and 1 of whom shall represent community hospitals; and 2 persons designated by the Massachusetts Medical Society. In addition, the regional administrator of the Centers for Medicare & Medicaid Services or a designee, and a member of the senior management of a Medicare administrative contractor will be invited to participate in the commission but without vote.

(c) The commission shall adopt rules and establish procedures it considers necessary for the conduct of its business. The commission may expend funds as may be appropriated or made available for its purposes. The division of health care finance and policy shall provide

administrative support to the commission. No action of the commission shall be considered official unless approved by a majority vote of the commission.

(d) The commission shall undertake a study of the feasibility of mandating a single claims administration system for all payers in the commonwealth, other than Medicare, and of the potential savings to be derived from doing so. For purposes of this section the term 'payer' shall mean both a private health care payer and a public health care payer, as those terms are defined in section 1 chapter 116G of the General Laws. In undertaking its responsibilities under this section, the commission shall (i) determine the feasibility of using a single claims administration system for all payers in the commonwealth, other than Medicare; (ii) analyze the effects of the implementation of section 55 of chapter 118E of the General Laws and of sections 5A and 5B of chapter 176O of the General Laws; (iii) undertake a detailed analysis of the merits and limits of the Medicare claims administration system; (iv) determine what models exist that might constitute the most efficient and effective consolidated claims administration system; (v) identify potential challenges associated with implementation of a single claims administration system for all payers in the commonwealth other than Medicare and also identify proposed solutions for such challenges; (vi) identify the costs being incurred by payers and providers as a result of multiple claims administration systems; (vii) estimate the potential cost savings to the commonwealth if the Medicaid program were to implement a uniform claims administration system based on Medicare's system, using regional Medicare administrative contractors; (viii) estimate the potential cost savings if all private health care payers in the commonwealth implemented a uniform claims administration system based on Medicare's system, using regional Medicare administrative contractors, including for their Medicare advantage programs; and (ix) determine the potential savings and costs associated with creating incentives or requiring

ERISA plans, Taft-Hartley plans and other self-funded health benefit plans to use regional Medicare administrative contractors for claims management.

(e) The commission shall hold its first meeting no later than December 1, 2010, and shall file the report of its findings and recommendations, together with recommended legislation, if any, with the clerks of the senate and the house of representatives and with the governor by no later than June 30, 2011.

SECTION 56. In order to facilitate the provision of cost effective health care services, enhance the quality of care and improve the coordination and efficiency of health care services in the commonwealth, the division of health care finance and policy, herein referred to as the division, shall undertake activities intended to foster the adoption by providers and payers in the commonwealth of arrangements by which providers will contract to accept payment on a bundled, rather than a fee-for-service, basis. To promote provider participation in such bundled payment arrangements, the division shall make technical support available to providers and payers, survey or undertake research concerning existing and proposed bundled payment models within the commonwealth and elsewhere and disseminate the results of such research; assess the effects of federal programs intended to promote use of bundled payment arrangements; and identify sources of funding to support providers in designing and implementing bundled payment initiatives. The division shall have as an objective, but not as a requirement, the implementation of pilot bundled payment programs relating to payment for at least 2 acute conditions or procedures commencing by no later than January 1, 2011, under the terms of which inpatient services, as well as certain services provided pre- and post-inpatient stay, will be paid on a bundled payment basis; and the implementation of pilot bundled payment programs relating to payment for at least 2 chronic conditions commencing by no later than July 1, 2011. The

division shall file reports on the efforts it undertakes to provide support for providers and payers to enter into bundled arrangements and on the progress made toward implementing the goals described in the preceding sentence of this section. Such reports shall be filed with the clerks of the senate and the house of representatives and with the governor not later than January 31, 2011, not later than July 29, 2011 and not later than December 30, 2011.

SECTION 57. It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until July 1, 2012. This moratorium shall not apply to any proposed mandated benefit that has been through the division of health care finance and policy process pursuant to section 38C of chapter 3 of the General Laws.

SECTION 58. Sections 1, 4 to 12, inclusive, 14 to 25, inclusive, 27 to 29, inclusive, 32, 34, 36 and 43 to 57, inclusive, shall take effect on August 1, 2010.

SECTION 59. Sections 2, 3, and 38 shall take effect on October 1, 2010.

SECTION 60. Section 13, 31, 36, 39 shall take effect on July 1, 2012.

SECTION 61. Sections 26, 30, 41, and 42 shall take effect on July 1, 2011.

SECTION 62. Section 33 and 40 shall take effect on January 1, 2011

SECTION 63. Section 35 shall take effect on December 31, 2014.”.