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SENATE . . . . . No. 2437

The Commonwealth of Massachusetts

In the Year Two Thousand Ten

An 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:

SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding after subsection (d) the following subsection:-

(e) The division of health care finance and policy shall issue a comprehensive report at least once every 4 years on the cost and public health impact of all existing mandated benefits. In conjunction with this review, the division shall consult with the department of public health and the University of Massachusetts Medical School in a clinical review of all mandated benefits to ensure that all mandated benefits continue to conform to existing standards of care in terms of clinical appropriateness or evidence-based medicine. The division may file legislation that would amend or repeal existing mandated benefits that no longer meet these standards.

SECTION 2. Chapter 29 of the General Laws is hereby amended by inserting after section 2AAAA the following section:-

Section 2BBBB. There shall be established and set up on the books of the commonwealth a separate fund to be known as the High Risk Reinsurance Trust Fund. The

commissioner of insurance, in consultation with the secretary of administration and finance, shall determine the amount necessary for deposit into the fund and shall issue regulations to assess surcharge payers under the same methodology established in section 38 of chapter 118G. Those surcharges shall be collected in a manner consistent with said chapter 118G; provided, however, that to the extent federal financial participation is received, the commissioner shall adjust the amount assessed accordingly. The commissioner of insurance shall authorize expenditures from the fund to reimburse carriers, as defined section 1 of chapter 176J, for all costs that the carriers may incur in claims under section 12 of said chapter 176J. Nothing in this section shall prohibit the commissioner of insurance from contracting with a third party to administer the fund. The commissioner of insurance shall promulgate regulations necessary to implement this section. The commissioner of insurance shall, not later than October 1 of each year, file a written, detailed report with the joint committee on health care financing, the joint committee on financial services, and the house and senate committees on ways and means regarding the methodology and mechanism used in ascertaining any assessments, the methodology used for reimbursing eligible carriers, and the disbursements made by carrier and amount, for the fiscal year ending on the preceding June 30.

SECTION 3. Chapter 111 of the General Laws is hereby amended by inserting after section 25I the following section:-

Section 25J. Every health care provider, as defined by section 1 shall track and report quality information at least annually under regulations promulgated by the department.

SECTION 4. Section 217 said chapter 111, as appearing in the 2008 Official Edition, is hereby further amended by striking out, in line 33, the word “plan.” and inserting in place thereof the following words:–

plans; and

(7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of section 4 of chapter 176J.

The office of patient protection may grant waivers to an eligible individual who certifies, under penalty of perjury, that such individual did not intentionally forego enrollment into coverage for which the individual is eligible and that is at least actuarially equivalent to minimum creditable coverage. The office shall establish by regulation standards and procedures for enrollment waivers.

SECTION 5. Section 1 of chapter 118G of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Health maintenance organization” the following definition:-

“Health status adjusted total medical expenses”, the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims related payments to providers, adjusted by health status, and expressed on a per member per month basis, as calculated under section 6 of chapter 118G and the regulations promulgated by the commissioner.

SECTION 6. Said section 1 of said chapter 118, as so appearing, is hereby further amended by inserting after the definition of “Purchaser” the following definition:-

"Relative prices", the contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claims related payments and expressed in the aggregate relative to the payer's network-wide average amount paid to providers, as calculated under section 6 of chapter 118G and regulations promulgated by the commissioner.

SECTION 7. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out the fourth and fifth paragraphs and inserting in place thereof the following 3 paragraphs: -

The division shall require the submission of data and other information from each private health care payer offering small or large group health plans including, without limitation: (i) average annual individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations, and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology, and collected under section 21 of chapter 176O; (v) information concerning the payer's current level of reserves and surpluses; and (vi) information on provider payment methods and levels; (vii) health status adjusted total medical expenses by provider group and local practice group and zip code calculated according to a uniform methodology; (viii) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider and calculated according to a uniform

methodology; and (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

The division shall require the submission of data and other information from public health care payers including, without limitation: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs for each plan or program; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid; (vii) health status adjusted total medical expenses by provider group and local practice group and zip code calculated according to a uniform methodology; (viii) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider and calculated according to a uniform methodology; and (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

The division shall publicly report information on health status adjusted total medical expenses, relative prices, and hospital inpatient and outpatient costs, including direct and indirect costs under this section on an annual basis. The division shall coordinate with Centers for

Medicare and Medicaid Services to determine if Centers for Medicare and Medicaid Services can provide the health status adjusted total medical expenses of provider groups that serve Medicare patients.

SECTION 8. Section 6C of said chapter 118G is hereby amended by striking out subsection (c), as so appearing, and inserting in place thereof the following subsection:-

(c) Information that indentifies individual employees by name or health insurance status shall not be a public record, but the information shall be exchanged with the department of revenue, the commonwealth health insurance connector authority, and the health care access bureau in the division of insurance under an interagency services agreement for the purposes of enforcing this section and sections 3, 6B and 18B of chapter 118H, as well as sections 3to 7A, inclusive, of chapter 176Q. Nothing in this section shall prevent the implementation of section 304 of chapter 149 of the acts of 2004. An employer who knowingly falsifies or fails to file with the division any information required by this section or by any regulation promulgated by the division shall be punished by a fine of not less than $1,000 not more than $5,000.

SECTION 9. Section 3 of chapter 176D of the General Laws is hereby amended by striking out subsection (4), as so appearing, and inserting in place thereof the following new subsection:

(4) Boycott, coercion and intimidation: (a) entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; (b) any refusal by a nonprofit hospital service corporation, medical service corporation, insurance or health maintenance organization to negotiate, contract or affiliate with a health care facility or

provider because of such facility's or provider's contracts or affiliations with any other nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization; or (c) any nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization establishing the price to be paid to any health care facility or provider by reference to the price paid, or the average of prices paid, to such facility or provider under a contract or contracts with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or preferred provider arrangement.

SECTION 10. Said chapter 176D is hereby amended by striking out section 3A and replacing it with the following section:-

Section 3A. The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance by entities organized under chapters 176A, 176B, 176G, and 176I or licensed under chapter 175: (i) entering into any agreement to commit or by any concerted action committing any act of, boycott, coercion, intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; (ii) refusal to enter into a contract with a health care facility on the basis of the facility's religious affiliation; (iii) seeking to set the price to be paid to any health care facility or provider by reference to the price paid, or the average of prices paid, to that health care facility or provider under a contract or contracts with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or preferred provider arrangement; (iv) refusal to contract or affiliate with a health care facility solely because the facility does not provide a specific service or range of services; (v) selecting or contracting with a health care facility or provider not based primarily on cost, availability and quality of

covered services; (vi) refusal to enter into a contract with a health care facility solely on the basis of the facility's governmental affiliation; (vii) arranging for an individual employee to apply for individual health insurance coverage, as defined in chapter 176J, for the purpose of separating that employee from group health insurance coverage to reduce costs for an employer sponsored health plan provided in connection with the employee's employment.

SECTION 11. Section 1 of chapter 176J of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting, after the definition of "Date of enrollment" the following 2 definitions:-

"Direct premiums earned", premiums earned during an applicable 12-month period plus the unearned premiums at the beginning of the period less the unearned premiums at the end of the period.

"Direct claims incurred", medical claims paid during an applicable 12-month period which pertain only to that specific period, plus any reasonable unpaid claim reserve.

SECTION 12. Said section 1 of said chapter 176J, as so appearing, is hereby amended by striking out the definition of "Eligible individual" and inserting in place thereof the following definition:-

"Eligible individual", an individual who is a resident of the commonwealth and who is not seeking individual coverage to reduce costs for an employer sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

SECTION 13. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting, after the definition of “Mandated benefit” the following definition:-

“Medical loss ratio”, the ratio of direct claims incurred to direct premiums earned, expressed as a percentage, calculated using data reported by the carrier as prescribed under regulations promulgated by the commissioner;

SECTION 14. Subsection (a) of section 3 of said chapter 176J, as so appearing, is hereby amended by striking out clause (2) and inserting in place thereof the following clause:-

(2) A carrier may establish an age rate adjustment that applies to both eligible individuals and eligible small groups; provided, however, that the carrier applies the rate adjustment on a year-to-year basis for both eligible individuals and eligible small groups.

SECTION 15. Said section 3 of said chapter 176J, as so appearing, is hereby further 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 disproportionately increase the cost in relation to the risks of the affected small group. The commissioner may adopt changes to regulation promulgated under this chapter to modify the derivation of group base premium rates or of any factor used to develop individual group premiums; provided, however that the commissioner may only adopt such changes each July 1 for rates effective the following January 1.

(g) For small group base rate factors applied after July 1, 2010, a carrier must limit the effect of the application of any single or combination of rate adjustment factors identified in

clauses (2) to (6), inclusive, of subsection (a) used in the calculation of an individual's or small group's premium so that the final annual premium charged to an individual or small group does not increase or decrease by more than an amount established biennially by the commissioner through regulation. The limit established by the commissioner may not result in an aggregate increase to the base premium rate exceeding 1 per cent.

SECTION 16. Clause (1) of subsection (a) of section 4 of chapter 176J of the General Laws, as so appearing, is hereby amended by inserting after the word "every", in line 2, the following word:- eligible.

SECTION 17. Said subsection (a) of said section 4 of said chapter 176J, as so appearing, is hereby amended by striking out clauses (2) to (4), inclusive and inserting in place thereof the following 3 clauses:-

(2) A carrier shall enroll eligible individuals and eligible persons, 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 plan if such individuals or persons request 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 an eligible individual who does not meet the requirements of clause (2) into a health benefit plan during the mandatory biannual open enrollment period for eligible individuals and the eligible dependents of those individuals. Each year, the first open enrollment period shall begin on January 1 and end on February 15. The second open enrollment period shall begin on July 1 and end on August 15. All coverage shall become effective on the first day of the month following enrollment. The commissioner shall promulgate regulations for

the open enrollment periods 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 that 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 health coverage tax credit; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

(4) No policy may require any waiting period if the eligible individual has not had any creditable coverage for the 18 months prior to the effective date of coverage. Notwithstanding paragraph (3), an eligible individual who does not meet the requirements of paragraph (2) may seek an enrollment waiver to permit enrollment not during a mandatory open enrollment period. Enrollment waivers shall be administered and granted by the office of patient protection established by section 217 of chapter 111.

SECTION 18. Subsection (a) of said section 4 of said chapter 176J is hereby amended by striking out clause (3), as appearing in section 17, and inserting in place thereof the following clause:-

(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 annual open enrollment period for eligible individuals and their dependents. Each year, the open enrollment period shall begin on July 1 and end on August 15. A carrier shall only enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the open enrollment period. All coverage shall 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 that 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 health care tax credit; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

SECTION 19. Subsection (b) of said section 4 of said chapter 176J, as appearing in the 2008 Official Edition, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:-

(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. A health benefit plan closed to new members may be cancelled and discontinued to all members upon the approval of the Division of Insurance when it has been closed to enrollment for new individuals and small groups for at least 120 days and the aggregate membership in the closed plan reaches the greater of 25% of the membership at the time the plan was closed to new individuals and small groups or 1000 members. Cancellation of the plan would be effective at the individual or small group's next enrollment anniversary after the threshold has been reached and the cancellation is approved by the division. The commissioner is authorized to promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this chapter.

SECTION 20. Said chapter 176J is hereby 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, health benefit plans submitted to the division of insurance to be provided to eligible individuals or eligible small businesses shall be subject to the disapproval of the commissioner.

(b) Notwithstanding any general or special law to the contrary, the commissioner shall require carriers offering health benefit plans to eligible small businesses and eligible individuals to file all changes to plan base rates, rating factors and administrative costs, at least 90 days before the effective date of the proposed changes. Carriers shall submit information as required by the commissioner, which shall include the current and projected medical loss ratio for plans and the components of projected administrative expenses and financial information, including, but not limited to:

(i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(ii) marketing and sales expenses, including, but not limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants;

(iii) claims operations expenses, including but not limited to, adjudication, appeals, settlements and expenses associated with paying claims;

(iv) medical administration expenses including, but not limited to, disease management, utilization review and medical management;

(v) network operations expenses, including but not limited to, contracting, hospital and physician relations and medical policy procedures;

(vi) charitable expenses, including but not limited to, contributions to tax-exempt foundations and community benefits;

(vii) state premium taxes;

(viii) board, bureau and association fees;

(ix) depreciation; and

(x) miscellaneous expenses described in detail by expense, including any expense not included in clauses (i) to (ix), inclusive.

(c) Reporting of administrative expenses under subsection (b) shall be grouped as appropriate into (i) salary or payroll expenses; (ii) outside personnel expenses; or (iii) outsourced services. The commissioner shall disapprove any proposed change to administrative costs which is excessive, inadequate or unreasonable. The commissioner shall disapprove any change to rating factors that is discriminatory or not actuarially sound. The carriers shall provide the attorney general notice of any such proposed changes to plan base rates, rating factors and administrative costs at least 90 days before their proposed effective date and shall provide the attorney general copies of such information related to the proposed changes as the attorney general may request. The attorney general may make recommendations to the commissioner that proposed changes should be disapproved or that public hearings should be held to determine whether the proposed changes should be disapproved.

(d) For base rate changes filed under this section, if a carrier files for an increase in a plan'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 plans offered by other 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 this chapter, shall be presumptively disapproved as excessive by the commissioner as set forth in this section.

(1) A carrier must communicate to all employers and individuals covered under a 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 advertise it in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell or shall notify such newspapers of the hearing.(3) The attorney general shall be authorized to intervene in a public hearing or other proceeding under this subsection.

(e) Notwithstanding subsection (d), for base rate changes filed under this section, if a carrier elects to limit its aggregate medical loss ratio for all plans offered under this chapter to no less than 88 percent, and to limit the amount of any load in the rate for profit and surplus to no more than 1 percent, such plans shall not be presumptively disapproved as excessive under subsection (d). A carrier making such election shall do so, in writing, to the commissioner when the carrier files changes to base rates or to rating factors under this section. A carrier making such election shall notify all its eligible individuals and eligible small groups in writing at the time of making such election that it has made such election.

A carrier making an election under this subsection shall regularly and as requested by the commissioner file with the commissioner documentation reporting that the annual aggregate medical loss ratio for all plans offered under this chapter and the annual aggregate amount of any contribution to profit or surplus derived from all plans offered under this chapter complies with regulations promulgated by the commissioner.

If the annual aggregate medical loss ratio for all plans offered under this chapter is less than 88 percent over the applicable 12 month period, the carrier shall refund the excess premium to its eligible individuals and eligible small groups. A carrier must communicate within 30 days to all individuals and small groups that were covered under plans during the relevant 12 month period that such individuals and small groups qualify for a refund to be issued under this paragraph, which may take the form of either a refund on the premium for the applicable 12 month period, or if the individual or groups are still covered by the carrier, a credit on the premium for the subsequent 12 month period. The total of all refunds issued shall equal the amount of a carrier's earned premium that exceeds that amount necessary to achieve a medical loss ratio of 88 percent, calculated using data reported by the carrier as prescribed under regulations promulgated by the commissioner. The commissioner may authorize a waiver or adjustment of this requirement only if it is determined that issuing refunds would result in financial impairment for the carrier.

(1) The commissioner shall conduct an annual public hearing on the implementation of this subsection and shall advertise it in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell or shall notify such newspapers of the hearing.(2) The attorney general shall be authorized to intervene in any public hearing or other

proceeding under this subsection and may require additional information as the attorney general considers necessary to ensure compliance with this subsection.

(f) The commissioner shall adopt regulations required under this section.

SECTION 21. Section 6 of said chapter 176J, as amended by section 20, is hereby further amended by striking out the figure “88” each time that it appears and inserting in place thereof the following figure:- 90.

SECTION 22. Said chapter 176J is hereby amended by striking out section 6, as amended by section 21, and inserting in place thereof the following section:-

Section 6. (a) Notwithstanding any general or special law to the contrary, health benefit plans submitted to the division to be provided to eligible individuals or eligible small businesses shall be subject to review by the commissioner.

(b) Notwithstanding any general or special law to the contrary, the commissioner shall require carriers offering health benefit plans to eligible small businesses and eligible individuals to file all changes to plan base rates, rating factors and administrative costs, at least 90 days before their proposed effective date. Carriers shall submit information as required by the commissioner, which shall include the current and projected medical loss ratio for plans and the components of projected administrative expenses and financial information, including, but not limited to:

(i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(ii) marketing and sales expenses, including, but not limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants;

(iii) claims operations expenses, including but not limited to adjudication, appeals, settlements and expenses associated with paying claims;

(iv) medical administration expenses including but not limited to disease management, utilization review and medical management;

(v) network operations expenses, including but not limited to, contracting, hospital and physician relations and medical policy procedures;

(vi) charitable expenses, including but not limited to, any contributions to tax-exempt foundations and community benefits;

(vii) state premium taxes;

(viii) board, bureau and association fees;

(ix) depreciation; and

(x) miscellaneous expenses described in detail by expense, including any expense not included in clause (i) to (ix), inclusive.

(c) Reporting of administrative expenses under subsection (b) shall be grouped as appropriate into (i) salary or payroll expenses; (ii) outside personnel expenses; or (iii) outsourced services. The commissioner shall disapprove any change to rating factors that is discriminatory or not actuarially sound. The carriers shall provide the attorney general notice of any such

proposed changes to plan base rates, rating factors and administrative costs at least 90 days before their proposed effective date and shall also provide the attorney general copies of such information related to the proposed changes as the attorney general may request. The attorney general may make recommendations to the commissioner that proposed changes should be disapproved or that public hearings should be held to determine whether the proposed changes should be disapproved.

(d) The commissioner shall adopt regulations required pursuant to this section.

SECTION 23. Said chapter 176J is hereby amended by adding the following section:-

Section 11. (a) A carrier that offers a health benefit 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 to all eligible individuals and small businesses at least one plan with either a reduced or selective network of providers, or a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.

The base premium for the reduced or selective network, or tiered network plan shall be at least 10 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers.

(b) A tiered network plan may only include variations on member cost-sharing between provider tiers, which are reasonable in relation to the premium charged, as long as the carrier provides adequate access to covered services at lower patient cost sharing levels.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall tiered network plan .

(d) The commissioner shall determine network adequacy for a select network plan based on the availability of sufficient network providers in the carrier's select network of providers.

(e) In determining network adequacy under this section the commissioner may consider factors including: the location of providers participating in the plan; employers or members that enroll in the plan; the range of services provided by providers in the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) Carriers may (i) reclassify provider tiers or (ii) determine provider participation in selective and tiered plans no more than once per calendar year; provided, however, that carriers may reclassify providers from a higher cost tier to a lower cost tier at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including, but not limited to, the providers participating in the plan, the selection criteria for those providers and if applicable, the tier in which each provider is classified.

(g) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section The report shall include the number of members enrolled by plan type, de-identified aggregate demographic, geographic and socioeconomic information on all members and the average direct premium

claims incurred for selective and tiered network plans compared to non-selective and non-tiered plans.

SECTION 24. Said chapter 176J is hereby amended by striking out section 11 as inserted by section 23 and inserting in place thereof the following section:-

Section 11. (a) A carrier that offers a health benefit 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 to all eligible individuals and small businesses at least 1 plan with either a reduced or selective network of providers or a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.

The base premium for the reduced or selective or tiered network plan shall be at least 10% lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. The savings may be achieved by means including, but not limited to: (i) the exclusion of providers with similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices, as determined under section 6 of chapter 118G; or (ii) increased member cost-sharing for members who utilize providers for non-emergency services with similar or lower quality based on the standard quality measure set and with higher health status adjusted total medical expenses or relative prices, as determined under section 6 of chapter 118G.

(b) A tiered network plan may only include variations in member cost-sharing between provider tiers which are reasonable in relation to the premium charged and ensure adequate access to covered services. Carriers shall tier providers based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical expenses and relative prices. Where applicable quality measures are not available, tiering may be based solely on health status adjusted total medical expenses or relative prices or both.

The commissioner shall promulgate regulations requiring the uniform reporting of tiering information, included but not limited to requiring, at least 90 days before the proposed effective date of any tiered network plan, or any modification in the tiering methodology for any existing tiered network plan, the reporting of a detailed description of the methodology used for tiering providers, including: the statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description of how the methodology and resulting tiers will be communicated to each network provider, eligible individuals and small groups; and a description of the appeals process a provider may pursue to challenge the assigned tier level.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall network of providers.

(d) The commissioner shall determine network adequacy for a selective network plan based on the availability of sufficient network providers in the carrier's selective network.

(e) In determining network adequacy under this section the commissioner of insurance may take into consideration factors such as the location of providers participating in the plan and employers or members that enroll in the plan, the range of services provided by providers in the

plan and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) Carriers may (i) reclassify provider tiers and (ii) determine provider participation in selective and tiered plans no more than once per calendar year except that carriers may reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective network at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier must provide members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers must provide information on their websites about any tiered or selective plan, including but not limited to, the providers participating in the plan, the selection criteria for those providers and where applicable, the tier in which each provider is classified.

(g) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section. The report shall include the number of members enrolled by plan type, aggregate demographic, geographic and socioeconomic information on all members and the average direct premium claims incurred, as defined in section 6, for selective and tiered network products compared to non-selective and non-tiered products.

SECTION 25. Said chapter 176J is hereby amended by adding the following section:-

Section 12. (a) The commissioner shall reimburse a carrier in an amount equal to claims costs in a calendar year between an initial threshold and an upper limit attributable to an eligible individual or dependent of an eligible individual. The commissioner shall establish the threshold

and limit on an annual basis with increases allowable for 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 under this section.

(c) Reimbursements to carriers under this section shall be made from the High Risk Reinsurance Trust Fund established in section 2BBBB 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 26. Subsection (b) of section 2 of chapter 176M of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out clause 1 and inserting in place thereof the following clause:-

(1) A carrier that offers health benefit plans to eligible small groups, as defined by chapter 176J, shall participate in the nongroup health insurance market by selling nongroup insurance. A carrier shall sell nongroup health insurance solely through the connector, as defined in chapter 176Q.

SECTION 27. Said clause (1) of said subsection (b) of said section 2 of said chapter 176M, as amended by section 26 is hereby amended by striking out the figure 176Q and inserting in place thereof the following words:-176Q; provided, however, that carriers may sell nongroup plans solely on a renewal basis to individuals who had purchased nongroup plans prior to January 1, 2012.

SECTION 28. Clause (2) of said subsection (b) of said section 2 of said chapter 176M, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word “renewal”, in line 28, the following words:- including renewal through the connector,.

SECTION 29. Clause (3) of said subsection (b) of said section 2 of said chapter 176M, as so appearing, is hereby amended by inserting after the word “renewal”, in line 39, the following words:- including renewal through the connector,.

SECTION 30. Subsection (d) of said section 2 of said chapter 176M, as so appearing, is hereby amended by inserting after the word “market”, in lines 1 and 2, the following words:- including the connector,.

SECTION 31. Section 3 of Chapter 176M of the General Laws, as so appearing, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) As of July 1, 2007, a carrier shall no longer offer, sell or deliver a health plan to a person to whom it does not have such an obligation under 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 under regulations promulgated by the commissioner.

SECTION 32. Section 2 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out subsection (b) and replacing in with the following subsection:-

(b) In establishing said minimum standards, the bureau shall consult and use, where appropriate, standards established by national accreditation organizations. Notwithstanding the foregoing, the bureau shall not be bound by said standards established by such organizations, but wherever the bureau promulgates standards different from said national standards, it shall: (1) be subject to chapter 30A; (2) state the reason for such variation; and (3) take into consideration any projected compliance costs for such variation. In order to reduce health care costs and improve access to health care services, the bureau shall establish by regulation as a condition of accreditation that carriers use uniform standards and methodologies for credentialing. The division shall, before adopting regulations under this section, consult with the division of health care finance and policy, the department of public health, the group insurance commission, the Centers for Medicare and Medicaid Services and each carrier. Accreditation by the bureau shall be valid for a period of 24 months.

SECTION 33. Subsection (a) of section 7 of said chapter 176O, as so appearing, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:-

(1) a list of health care providers in the carrier's network, organized by specialty and by location and summarizing for each such provider: (i) the method used to compensate or reimburse such provider, including details of measures and compensation percentages tied to any incentive plan or pay for performance provision; (ii) the provider price relativity, as defined in and reported under section 6 of chapter 118G; (iii) the provider’s health status adjusted total medical expenses, as defined in and reported under section 6 of chapter 118G; and (iv) current measures of the provider’s quality based on measures from the Standard Quality Measure Set, as defined in the regulations promulgated by the department of public health under section 25J of chapter 111; provided, however, that if any specific providers or type of providers requested by

an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner;.

SECTION 34. Chapter 176O of the General Laws is hereby amended by inserting, after section 9, the following section:-

Section 9A. (a) A carrier shall not enter into an agreement or contract with a health care provider if the agreement or contract contains a provision that:

(i) limits the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis; or (iv) requires a provider to participate in a new select network or tiered network plan that the carrier introduces without granting the provider the right to opt-out of the new plan at least 60 days before the new plan is submitted to the commissioner for approval;

requires or permits the carrier or the health care provider to alter or terminate a contract or agreement, in whole or in part, to affect parity with an agreement or contract with other carriers or health care providers or based on a decision to introduce or modify a select network plan or tiered network plan; or

requires or permits the carrier to make any form of supplemental payment unless each such supplemental payment is publicly disclosed to the commissioner as a condition of accreditation, including the amount and purpose of each such payment, and whether or not each

such payment is included within the provider's reported relative prices and health status adjusted total medical expenses as under section 6 of chapter 118G

SECTION 35. Said chapter 176O is hereby amended by adding the following section: -

Section 21. (a) Each carrier shall submit an annual comprehensive financial statement to the division detailing carrier costs from the previous calendar year.

The annual comprehensive financial statement shall include all of the information in this section and shall be itemized, where applicable, by:

market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25 and 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

line of business, including, individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B; a health maintenance contract issued by a health maintenance organization under chapter 176G; insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I; and group health insurance plans issued by the commission under chapter 32A.

The statement shall include, but shall not be limited to, the following information:

direct premiums earned, as defined by chapter 176J;

direct claims incurred, as defined by chapter 176J;

medical loss ratio, as defined by chapter 176J;

number of members;

number of distinct groups covered;

number of lives covered;

realized capital gains and losses;

net income;

accumulated surplus;

accumulated reserves;

risk-based capital ratio, based on a formula developed by the National Association of Insurance Commissioners;

financial administration expenses, including underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

marketing and sales expenses, including advertising, member relations, member enrollment expenses;

distributions expenses, including commissions, producers, broker and benefit consultant expenses;

claims operations expenses, including adjudication, appeals, settlements and expenses associated with paying claims;

medical administration expenses, including disease management, utilization review and medical management expenses;

network operational expenses, including contracting, hospital and physician relations and medical policy procedures;

charitable expenses, including any contributions to tax-exempt foundations and community benefits

board, bureau or association fees;

any miscellaneous expenses described in detail by expense, including an expense not included in (a) to (s), inclusive;

payroll expenses and the number of employees on the carrier's payroll;

taxes, if any, paid by the carrier to the federal government or to the commonwealth; and

any other information deemed necessary by the commissioner.

(b)(1) In this subsection, the following words shall have the following meanings:-

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I;; or a third party administrator, a pharmacy benefit manager or other similar entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the commonwealth and health care provided by health care providers in the commonwealth provided however that "carrier" shall not include an entity that offers a policy, certificate or contract that provides coverage solely for

dental care services or visions care services “Self-insured customer”, a self-insured group for which a carrier provides administrative services.

“Self-insured group”, a self-insured or self-funded employer group health plan.

“Third-party administrator”, a person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the commonwealth.

(2) Any carrier required to report under this section, which provides administrative services to 1 or more self-insured groups shall include, as an appendix to such report, the following information:

the number of the carrier’s self-insured customers;

the aggregate number of members, as defined in section 1 of chapter 176J, in all of the carrier’s self-insured customers;

the aggregate number of lives covered in all of the carrier’s self-insured customers;

the aggregate value of direct premiums earned, as defined by chapter 176J, for all of the carrier’s self-insured customers;

the aggregate value of direct claims incurred, as defined by chapter 176J, for all of the carrier’s self-insured customers;

the aggregate medical loss ratio, as defined by chapter 176J, for all of the carrier’s self-insured customers;

net income;

accumulated surplus;

accumulated reserves;

the percentage of the carrier's self-insured customers that include each of the benefits mandated for health benefit plans under chapters 175, 176A, 176B and 176G;

administrative service fees paid by each of the carrier's self-insured customers; and

any other information deemed necessary by the commissioner.

(c) A carrier who fails to file this report on or before April 1 shall be assessed a late penalty not to exceed $100 per day. The division shall make public all of the information collected under this section. The division shall issue an annual summary report to the joint committee on financial services, the joint committee on health care financing and the house and senate committees on ways and means of the annual comprehensive financial statements by May 15. The information shall be exchanged with the division of health care finance and policy for use under section 6 of chapter 118G. The division shall, from time to time, require payers to submit the underlying data used in their calculations for audit.

The commissioner may adopt rules to carry out this subsection, including standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner, such as third-party administrators, and criteria for the standardized reporting and uniform allocation methodologies among carriers. The division shall, before adopting regulations under this section, consult with other agencies of the commonwealth and the federal government and affected carriers to ensure that the reporting requirements imposed under the regulations are not duplicative.

(d) If, in any year, a carrier reports a risk-based capital ratio under subsection (a) that exceeds 700 per cent, the division shall hold a public hearing within 60 days. The carrier shall submit testimony on its overall financial condition and the continued need for additional surplus. The carrier shall also submit testimony on how, and in what proportion to the total surplus accumulated, the carrier will dedicate any additional surplus to reducing the cost of health benefit plans or for health care quality improvement, patient safety or health cost containment activities not conducted in previous years. The division shall review such testimony and issue a final report on the results of the hearing.

SECTION 36. Section 1 of chapter 176Q of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out the definition of "eligible individuals" and inserting in place thereof the following definition:-

"Eligible individual", an individual who is a resident of the commonwealth not seeking individual coverage to reduce costs for an employer sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

SECTION 37. Section 5 of said chapter 176Q, as so appearing, is hereby amended by adding after subsection (d) the following subsection:-

(e) The connector shall be the sole entity authorized to market or sell nongroup health plans, as defined in section 1 of chapter 176M.

SECTION 38. Chapter 176Q of the General Laws is hereby amended by inserting after section 7 the following section:-

Section 7A. (a) There shall be a small group wellness incentive program to expand the prevalence of employee wellness initiatives by small businesses. The program shall be administered by the board of the connector, in consultation with the department of public health. The program shall provide subsidies and technical assistance for eligible small groups to implement evidence-based employee health and wellness programs to improve employee health, decrease employer health costs, and increase productivity.

(b) An eligible small group shall be qualified to participate in the program if:-

(1) the eligible small group purchases group coverage through the connector;

(2) the eligible small group is eligible for federal health care tax credits under the federal Patient Protection and Affordable Care Act;

(3) the eligible small group offers an evidence-based, employee wellness program, that meets certain minimum criteria, as determined by the connector board, in collaboration with the department of public health;

(4) the eligible small group meets certain minimum employee participation requirements in the qualified wellness program, as determined by the connector board, in collaboration with the department of public health;

(c) For eligible small groups participating in the program, the connector shall provide an annual subsidy not to exceed 5 per cent of eligible employer health care costs as calculated by the employer for credit by the federal government under the Patient Protection and Affordable Care Act. If the director determines that funds are insufficient to meet the projected costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the program.

(d) The connector shall coordinate with the department of public health to provide technical assistance, including grant-writing assistance, to participating eligible small groups in order to maximize federal grant funding provided under the Patient Protection and Affordable Care Act for the establishment of wellness initiatives by small employers.

(e) The connector shall seek to ensure that all necessary applications and filings coordinate with and conform to appropriate federal guidelines in order to minimize administrative burden on participating small groups.

(f) The connector shall report annually to the joint committee on community development and small business, the joint committee on health care financing and the house and senate committees on ways and means on the enrollment in the small business wellness incentive program and evaluate the impact of the program on expanding wellness initiatives for small groups.

(g) The connector shall promulgate regulations to implement this section.

SECTION 39. Notwithstanding any general or special law to the contrary, the commissioner of insurance, in consultation with the secretary of administration and finance and the secretary of health and human services, shall apply for and accept all available federal funding under section 1001 of the Patient Protection and Affordable Care Act to fund the High Risk Reinsurance Trust Fund established in section 2BBBB of chapter 29. The division of insurance shall file with the joint committee on health care financing and the house and senate committees on ways and means a copy of the state application requesting funding concurrently with the federal government. The commissioner shall also inform the joint committee on health care financing and the house and senate committees on ways and means in writing of the amount

of funds to be allocated as soon as the commissioner receives notification from the federal government.

SECTION 40. (a) Notwithstanding any general or special laws to the contrary, there shall be a special commission to examine proposals to reform the merged market to produce premium reductions, which shall include limitations on rating adjustment factors and the establishment of a reinsurance pool.

(b) The commission shall consist of the commissioner of insurance, who shall serve as chair; the secretary of administration and finance; the commissioner of health care finance and policy; and 4 members to be appointed by the governor, 3 of whom shall represent carriers, and 1 of whom shall be an actuary in good standing with the American Society of Actuaries.

(c) The commission shall conduct a study, which shall include examining the impact of establishing a reinsurance pool for carriers issuing health benefit plans under chapter 176J, including the potential impact of a carrier-funded reinsurance pool on individual carriers, the potential impact on the competitive balance in the marketplace, and the potential aggregate impact on premiums for eligible individuals and eligible small groups.

The commission shall make recommendations for a plan of operation for the reinsurance pool to be implemented under section 12 of chapter 176J of the General Laws that will maximize federal funding and provide the greatest reduction in premiums for eligible individuals and eligible small groups. The recommendations shall also include, but shall not be limited to: the source of the funding, the level of funding sufficient to produce reductions in premiums for the small-group health insurance market and the methodology used for reimbursing eligible carriers and the disbursements made by carrier and amount of such disbursements.

The report shall take into account the following factors:

(1) the financing of the pool through an assessment on surcharge payers under section 38 of chapter 118G of the General Laws;

(2) the availability of federal financing through the federal Patient Protection and Affordable Care Act;

(3) the experience of other states in designing and implementing reinsurance pools or high-risk pools;

(d) The commission shall also conduct a study, which shall review the rating factors as permitted by section 3 of chapter 176J of the General Laws to determine the impact of the application of each rating factor on premiums of eligible individuals and eligible small groups. As part of its analysis, the commission shall examine the extent to which establishing a limit on the application of any single or combination of rate adjustment factors identified in paragraphs (2) to (6), inclusive of subsection (a) of said section 3 of said chapter 176J, shall result in an increase to a carrier's base premium rate for the individual and small group insurance market.

(e) For the purpose of conducting these studies, the commission may contract with an outside organization with expertise in fiscal analysis of the private insurance market. The commission shall establish appropriate guidelines and assumptions regarding the health reforms authorized in this act before engaging an outside organization. In conducting its examination, the organization shall, to the extent possible, obtain and use actual health plan data; provided, however, that such data shall be confidential and shall not be a public record.

(f) The commission shall meet not later than July 15, 2010 and shall file a report with the clerks of the senate and house of representatives not later than September 30, 2010.

SECTION 41. Notwithstanding any special or general law to the contrary, the department of public health, in cooperation with the department of labor and workforce development and the division of health care finance and policy, shall establish a workplace wellness program to assist businesses in establishing evidence-based, comprehensive wellness programs for their employees. The program shall provide informational tools, trainings and direct assistance to businesses. The program shall also assess existing policies, practices and environmental supports and develop best practices for workplace wellness programs. The department may also provide technical assistance to businesses with fewer than 100 employees to apply for grants available in the federal Patient Protection and Affordable Care Act for the establishment of wellness programs. The department shall coordinate with the commonwealth connector authority in providing services to business eligible for a wellness subsidy under section 7A of chapter 176Q of the General Laws.

SECTION 42. Notwithstanding any general or special law to the contrary, the secretary of administration and finance, in consultation with the executive director of the commonwealth connector authority and the commissioner of insurance, shall study the federal requirements for states to establish a small business health options program through the state exchange by 2014 under the Patient Protection and Affordable Care Act. The study shall include an accelerated implementation plan, with legislation if necessary, for a pilot program to be administered by the commonwealth connector authority not later than January 1, 2011. The recommendations of the study shall be filed with the clerks of the house of representatives and senate by October 1, 2010.

SECTION 43. Notwithstanding any general or special law to the contrary, carriers, as defined in section 1 of chapter 176Q of the General Laws may sell nongroup health plans, as defined in section 1 of chapter 176M solely on a renewal basis to individuals who had purchased nongroup plans prior to January 1, 2012.

SECTION 44. Notwithstanding any special or general law to the contrary, the Massachusetts small business development center at the University of Massachusetts, as funded in item 7007-0800, shall develop and implement a small business health insurance assistance program to provide free and confidential, technical assistance, counseling and educational tools for eligible small businesses as defined in chapter 176J of the General Laws, seeking to purchase small group health insurance. The program shall, to the greatest extent possible, coordinate with existing chambers of commerce and other small business associations to develop common materials, conferences and educational seminars for small businesses.

SECTION 45. (a) Notwithstanding any special or general law to the contrary, tier 1 and tier 2 participating providers shall contract with a carrier to provide one-time supplemental funding for the purposes of issuing refunds for all health benefit plans issued to eligible individuals and small groups under chapter 176J of the General Laws. The refund may take the form of either a refund on the premium for the applicable 12 month period or another form agreed upon by the parties by contract.

(b) For purposes of this section a tier 1 participating provider is an acute care hospital licensed by the department of public health that, based on the most recent cost report it filed with the division of health care finance and policy, referred to in this section as the applicable cost

report, had an operating margin greater than 2.5 per cent and that received more than 50 per cent of its net patient service revenue from private carriers.

(c) For the purposes of this section a tier 2 participating provider is an acute care hospital licensed by the department of public health that based on the most recent cost report it filed with the division of health care finance and policy, had an operating margin greater than 2.5 per cent and that received more than 35 per cent and less than 50 per cent of its net patient service revenue from private carriers.

(d) The state-wide aggregate amount of one-time supplemental funding generated under this section from all contracts between participating providers and carriers may not exceed $100 million. Each tier 1 participating provider's pro rata share of this aggregate amount shall be equal to 1.25 per cent of such participating provider's net patient service revenue, as determined from the applicable cost report, or such lesser percentage as may be determined by the division of health care finance and policy. Each tier 2 participating provider's pro rata share of the state-wide aggregate amount will be equal to 0.75 per cent of such participating providers net patient service revenue, as determined from the applicable cost report, or such lesser percentage as may be determined by the division of health care finance and policy.

(e) The division of health care finance and policy may exempt an acute care hospital from its assessment obligation based on financial hardship criteria to be developed within 30 days of the effective date of this act; provided however, that a participating provider with less than 25 days of operational financing shall be exempt.

(f) Funds generated under this section shall be designated for the purpose of reducing health insurance premiums for eligible individuals and small groups in the commonwealth.

Participating providers and carriers may develop a schedule for transfers by contract, provided that all transfers are completed on or before September 30, 2012. The division of insurance shall require the filing of such contracts after execution for the purposes of ensuring distribution as provided in the contracts. Each carrier that is a party to such a contract shall report to the division of insurance, at least quarterly and in such form as the division of insurance shall require, the amount of one-time supplemental funding it has received from each participating provider and how such supplemental funding is to be refunded to eligible individuals and small groups under chapter 176J of the General Laws; and shall certify to the division of insurance, at least quarterly in such form as the division of insurance shall require, that it has made distribution of such supplemental funding in accordance with the terms of the applicable contracts. The division of insurance shall have the right to audit the books and records of each such carrier to assure compliance with the terms of each certification that it files. The division of insurance shall issue a public report by October 1, 2010 detailing the participating providers who have entered into such contracts, the amount of one-time supplemental funding by participating provider and the estimated aggregate refunds to be provided to eligible individuals and small groups. The commissioner of insurance may promulgate regulations as necessary to implement this section.

(g) A tier 1 or tier 2 participating provider shall be exempt from payment obligations under this section, if such provider amends its existing contracts with carriers to provide the same level of financial relief as the assessment obligation defined by the division of health care finance and policy. The tier 1 and tier 2 participating provider and relevant carrier shall jointly provide the division of insurance with a statement that the parties to the contract have amended their contract such that the total economic value of the adjustment is equal to or greater than the economic value of the assessment based on current payment rates and service volumes controlled

by the contract.The method of payments and specific adjustments required to qualify for the exemption shall be determined by the parties to the contract. The division of insurance shall establish procedures to assure that the financial value of an amendment to a contract under this subsection benefits employers and individuals purchasing health care coverage from a carrier on or before September 30, 2012.

The division of insurance may require additional information from participating providers as necessary to ensure compliance with this section.

SECTION 46. Notwithstanding any special or general law to the contrary, the division of insurance, in consultation with the division of health care finance and policy, shall promulgate regulations on or before October 1, 2010 to establish a uniform methodology for calculating and reporting by carriers for the medical loss ratios of health benefit plans under section 6 of chapter 176J, section 21 of chapter 176O and section 6 of chapter 118G of the General Laws. The uniform methodology for calculating and reporting medical loss ratios shall, at a minimum specify a uniform method for allocating expenditures as medical claims or administrative expenses, including, but not limited to: (i) financial administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses; (iv) claims operations expenses; (v) medical administration expenses, such as disease management, utilization review and medical management activities; (vi) network operation expenses; (vii) charitable expenses; (viii) board, bureau or association fees; (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other miscellaneous expenses not included in one of the previous categories. The methodology shall conform with applicable federal statutes and regulations to the maximum extent possible. The division shall, before adopting regulations under this section, consult with: the group insurance commission; the Centers for Medicare and Medicaid Services; the national

association of insurance commissioners; the attorney general; representatives from the Massachusetts Association of Health Plans; the Blue Cross and Blue Shield of Massachusetts; the Massachusetts Health Information Management Association; the Massachusetts Health Data Consortium; a representative from a small business association; and a representative from a health care consumer group.

SECTION 47. Notwithstanding any special or general law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before October 1, 2010 to establish a uniform methodology for calculating and reporting the health status adjusted total medical expenses, under section 6 of chapter 118G of the General Laws. The uniform methodology shall apply to a uniform list of provider groups and their constituent local practice groups and for each zip code in the commonwealth. The uniform methodology for calculating and reporting total medical expenses under this section shall, at a minimum: (i) specify a uniform method for calculating total medical expenses based on allowed claims for all categories of medical expenses, including, but not limited to, acute inpatient, hospital outpatient, sub-acute such as skilled nursing and rehabilitation, professional, pharmacy, mental/behavioral health and substance abuse, home health, durable medical equipment, laboratory, diagnostic imaging and alternative care such as chiropractic and acupuncture claims, incurred under all fully-insured and self-insured plans; (ii) specify a uniform method for including in the calculation all non-claims related payments to providers, including supplemental payments of any type, such as pay-for-performance, infrastructure payments, grants, surplus payments, lump sum settlements, signing bonuses and government payer shortfall payments; infrastructure, medical director and health information technology payments; (iii) specify a uniform method for adjusting total medical expenses by health status; (iv) designate the

minimum patient membership in a local practice group for individual reporting of total medical expenses by local practice group; (v) specify a uniform method for reporting total medical expenses in aggregate for all local practice groups that fall below the minimum patient membership; (vi) specify a uniform method for reporting total medical expenses by zip code separately for patient members whose plans require them to select a primary care provider, and patient members whose plans do not require them to select a primary care provider; (vii) designate and annually update the comprehensive list of provider groups and local practice groups and zip codes for which payers shall report total medical expenses; and (viii) specify a uniform format for reporting that includes the raw and adjusted health status score and patient membership for each local practice group and zip code. The division shall from time to time require payers to submit the underlying data used in their calculation of total medical expenses for audit.

SECTION 48. Notwithstanding any special or general law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before October 1, 2010 to establish uniform methodology for calculating and reporting relative prices paid to hospitals, physician groups, freestanding surgical centers by each private and public health care payer under section 6 of chapter 118G of the General Laws. The uniform methodology for calculating and reporting relative prices under this section shall, at a minimum: (i) specify a method for basing the calculation on a uniform mix of products and services by payer that is case mix neutral; (ii) specify a uniform method for including in the calculation all non-claims related payments to providers, including supplemental payments of any type, such pay-for-performance, infrastructure payments, grants, surplus payments, lump sum settlements, signing bonuses, and government payer shortfall payments; (iii) permit

reporting of relative price in the aggregate for all physician groups whose price equals the payer's standard fee schedule rates; and (vi) designate and annually update the comprehensive list of physician groups for which payers shall report relative prices.

SECTION 49. Notwithstanding any special or general law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before October 1, 2010 to establish uniform methodology for calculating and reporting inpatient and outpatient costs, including direct and indirect costs, for all hospitals under section 6 of chapter 118G of the General Laws. The division shall, as necessary and appropriate, promulgate regulations or amendments to its existing regulations to require hospitals to report cost and cost trend information in a uniform manner including, but not limited to, uniform methodologies for reporting the cost and cost trend for categories of direct labor, debt service, depreciation, advertising and marketing, bad debt, stop-loss insurance, malpractice insurance, health information technology, medical management, development, fundraising, research, academic costs, charitable contributions, and operating margins for all commercial business and for all state and federal government business, including but not limited to Medicaid, Medicare, insurance through the group insurance commission and Champus. The division shall, before adopting regulations under this section, consult with the group insurance commission, the Centers for Medicare and Medicaid Services, the attorney general and representatives from the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association the Massachusetts Health Data Consortium.

SECTION 50. The department of public health shall promulgate regulations under section 25J of chapter 111 of the General Laws by December 31, 2010 requiring the uniform reporting of a standard set of health care quality measures for each health care provider facility or medical group in the commonwealth hereinafter referred to as the "Standard Quality Measure Set."

The department of public health shall convene a statewide advisory committee which shall recommend to the department by November 1, 2010 the Standard Quality Measure Set. The statewide advisory committee shall consist of the commissioner of health care finance and policy or the commissioner's designee, who shall serve as the chair; and up to 8 members, including the executive director of the group insurance commission and the Medicaid director, or the directors designees; and up to 6 representatives of organizations to be appointed by the governor including at least 1 representative from an acute care hospital or hospital association, 1 representative from a provider group or medical association, 1 representative from a private health plan or health plan association, 1 representative from an employer association and 1 representative from a health care consumer group.

In developing its recommendation of the Standard Quality Measure Set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures. The committee shall recommend to the department of public health any updates to the Standard Quality Measure Set on an annual basis by November 1. For its recommendation beginning in 2011, the committee may solicit for consideration and recommend quality measures not yet developed or in use as of

November 1, 2010, including recommendations from medical specialty groups as to appropriate quality measures for that group's specialty. At a minimum, the Standard Quality

Measure Set shall consist of the following quality measures:

the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention;

the Hospital Consumer Assessment of Healthcare Providers and Systems survey;

the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical group; and

the Ambulatory Care Experiences Survey.

SECTION 51. Notwithstanding and special or general law to the contrary, eligible individuals as defined in chapter 176J with existing coverage issued under chapter 176J that will expire after the end of open enrollment in 2010 established under section 4 of chapter 176J may renew coverage on the date that the eligible individual's coverage expires for a term of less than 1 year until the beginning of open enrollment period in 2011.

SECTION 52. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall convene an administrative simplification working group consisting of the following members: the secretary of consumer affairs and business regulation or the secretary's designee, the commissioner of health care finance and policy or the commissioner's designee, the commissioner of public health or the commissioner's designee, the commissioner of insurance or the commissioner's designee, the commissioner of revenue or the commissioner's designee, the attorney general or the attorney general's designee, the inspector

general or the inspector general's designee, a representative of the Massachusetts Health Data Consortium, a representative of the Health Care Quality and Cost Council, and the executive director of the commonwealth health connector authority or the executive director's designee. The group shall identify ways to streamline state created or mandated administrative requirements in health care. The group shall hold its first meeting no later than January 1, 2011 and shall issue a report on or before April 1, 2011. The report shall include specific steps to be taken by each agency and the agencies collectively to reduce administrative and filing requirements on health carriers and health care providers, which shall include, but not be limited to, an inter-agency agreement to use best efforts to streamline all requests for membership and claims data from health care providers and health plans in the commonwealth.

SECTION 53. Notwithstanding any special or general law to the contrary, the division of insurance, in consultation with the secretary of health and human services, shall promulgate regulations on or before December 1, 2010 to promote administrative simplification in the processing of claims for health care services under health benefit plans by carriers, as defined in section 1 of chapter 176O of the General Laws. At a minimum, the regulations shall: (1) establish uniform standards and processes for determining health benefit plan member eligibility by health care providers; (2) establish standards and processes for providers appeals of denied claims; and (3) establish a standard authorization form to be submitted by health care providers to obtain authorization to provide health care services to a member. The division shall, before adopting regulations under this section, consult with a statewide advisory committee, including but not limited to, a representative of the Massachusetts Hospital Association, a representative of the Massachusetts Medical Society, a representative of the Massachusetts Association of Health Plans, a representative of Blue Cross and Blue Shield of Massachusetts, a representative of the

group insurance commission, the attorney general, a representative of the Centers for Medicare and Medicaid Services, a representative from an employer association and a representative from a health care consumer group.

SECTION 54. Notwithstanding any general or special law to the contrary, for the purposes of decreasing the administrative burden on health care payers and providers associated with pricing, paying claims and submitting claims for multiple unique health benefit plans, the commissioner of insurance may limit the number of health benefit plans that a health care payer may maintain in the commonwealth. For purposes of this section, a health benefit plan shall mean a health insurance policy, subscriber agreement or contract between the covered person and an organization which defines the covered services and benefit levels available including specific levels of cost sharing.

The commissioner, after consultation with a statewide advisory committee including, but not limited to, a representative of: the Massachusetts Hospital Association; the Massachusetts Medical Society; the Massachusetts Association of Health Plans; the Blue Cross and Blue Shield of Massachusetts; the Massachusetts Health Information Management Association; the Massachusetts Health Data Consortium; a MassHealth contracted managed care organization; the executive office of health and human services; the division of health care finance and policy; the health care quality and cost council; and a representative from an employer association and a representative from a health care consumer group, may adopt regulations that establish a maximum number of health benefit plans which a health care payer may maintain in the commonwealth. The regulations shall ensure that each health care payer shall be able to provide a range of insurance products so as to preserve consumer and employer choice and competition between health insurance payers, including but not limited to: (i) tiered products; (ii) selective

network products; and (iii) products with a range of cost sharing options. The division shall convene the advisory committee not later than October 1, 2010, and shall issue regulations under this section not later than December 1, 2010.

The commissioner may specify, by regulation, an orderly process for the closure of a health care payer's existing health benefit plans if such health care payer's existing products exceed the number of products permitted in the commonwealth under the regulations promulgated by the commissioner consistent with this section. The orderly process for closure of a health care payer's existing health benefit plans shall include, but not be limited to, a process that provides affected consumers and employers with a notice period adequate to identify and transition to a new health benefit plan.

SECTION 55. Sections 1, 3 to7, inclusive, 9 to 17, inclusive, 19, 20, 23, 31, 34, 39 to 42, inclusive and 44 to 54, inclusive, shall take effect on July 1, 2010.

SECTION 56. Sections 2 and 25 shall take effect on October 1, 2010.

SECTION 57. Sections 32 and 35 shall take effect on January 1, 2011.

SECTION 58. Sections 18, 21, 24, 33 and 38 shall take effect on July 1, 2011.

SECTION 59. Sections 8, 26 to 30, inclusive, 36, 37 and 43 shall take effect on January 1, 2012.

SECTION 60. Section 22 shall take effect on July 1, 2012.