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SENATE . . . . . No. 2447

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 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 1A. Section 16K of chapter 6A of the General Laws is hereby amended by striking out subsections (a) to (c), inclusive, as so appearing, and inserting in place thereof the following 3 subsections:-

(a) There shall be established a health care quality and cost council, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and shall seek to support the long term sustainability of health care reform in the commonwealth by developing recommendations for containing health care costs, while facilitating access to information on health care quality improvement efforts. The council shall disseminate health care quality and cost data to consumers, health care providers and insurers through a consumer health information website under subsections (e) and (g); establish cost containment goals under subsection (h); and coordinate ongoing quality improvement initiatives under subsection (i).

(b) The council shall consist of 18 members and shall be comprised of: (1) 9 ex-officio members, including the secretary of health and human services, the secretary of administration and finance, the state auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of health care finance and policy, the commissioner of public health and the executive director of the group insurance commission, or their designees; and (2) 9 representatives of nongovernmental organizations to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, Inc., 1 of whom shall be a representative of the

Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution, 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall be an organization representing the interests of small businesses and 1 of whom shall be an organization representing the interests of large businesses. At least 1 member of the council shall be a clinician licensed to practice in the commonwealth. Members of the council shall vote annually to elect a chair and an executive committee, which shall consist of 4 council members and the chair. The executive committee shall meet as required to fulfill the mission of the council. Members of the council shall be appointed for terms of 3 years and shall serve until the term is completed or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. All council members shall be subject to chapter 268A; provided, however, that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided further that such interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no council member having such interest or involvement may participate in any decision relating to such organization.

(c) All meetings of the council shall comply with chapter 30A. The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services.

The executive office of health and human services may provide staff and administrative support as requested by the council; provided, however, that all work completed by the executive

office of health and human services shall be subject to approval by the council . The council shall appoint an executive director to oversee the operation and maintenance of the website, ensure compliance with the requirements of this section, and coordinate work completed by the executive office of health and human services and may, subject to appropriation, employ such additional staff or consultants as it deems necessary.

The council shall promulgate rules and regulations and may adopt by-laws necessary for the administration and enforcement of this section.

SECTION 1B. Said section 16K of said chapter 6A is further amended by striking out subsections (h) and (i), as so appearing, and inserting in place thereof the following 2 subsections:-

(h) The council, in consultation with its advisory committee, shall develop annual health care cost containment goals. The goals shall be designed to promote affordable, high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The council shall also establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities. In establishing cost containment goals, the council shall utilize claims data collected from carriers under this section, and information gathered as part of the division of health care finance and policy's public hearings on health care costs under section 6 ½ of chapter 118G. For each goal, the council shall identify: the parties that will be impacted; the agencies, departments, boards or councils of the commonwealth responsible for overseeing and implementing the goal; the steps needed to achieve the goal; the projected costs associated with implementing the goal; and the potential cost savings, both short and long-term, attributable to

the goal. The council may recommend legislation or regulatory changes to achieve these goals. The council shall publish a report on the progress towards achieving the costs containment goals.

(i) The council, in consultation with its advisory committee, shall coordinate and compile data on quality improvement programs conducted by state agencies and public and private health care organizations. The council shall consider programs designed to: improve patient safety in all settings of care; reduce preventable hospital readmissions; prevent the occurrence of and improve the treatment and coordination of care for chronic diseases; and reduce variations in care. The council shall compile information on programs conducted by state agencies and public and private health care organizations and make such information available on the council's consumer health information website. The council may recommend legislation or regulatory changes as needed to further implement quality improvement initiatives.

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 and the secretary of health and human services, shall administer a reinsurance program for high-risk individuals covered under products issued under chapter 176J and shall approve the amounts assessed on payers under the methodology established in section 38 of chapter 118G. Those assessments 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 appoint 7

representatives of carriers issuing or renewing products in accordance with said chapter 176J to be a members of a board to develop a plan of operations of such high-risk reinsurance program and to monitor the functioning of the program. The commissioner of insurance, in consultation with the secretary of administration and finance and the secretary of health and human services, shall approve the plan of operations of the reinsurance program, the level of reinsurance sponsored by the program, any premium charged for reinsurance, the manner by which expenditures shall be made from the fund to reimburse carriers, as defined section 1 of said chapter 176J, for all costs that the carriers may incur in claims under section 12 of said chapter 176J and the level of assessments necessary to pay for costs that are not covered by any reinsurance premiums.

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 adopt regulations as necessary to implement this section. The commissioner of insurance shall, not later than October 1 of each year, file a written, detailed report on the reinsurance program with the joint committee on health care financing, the joint committee on financial services and the house and senate committees on ways and means specifying: (i) the methodology and mechanism used in ascertaining any assessments;(ii) the methodology used for reimbursing eligible carriers; and (iii) the disbursements made by carriers and the amount of those disbursements for the fiscal year ending on the preceding June 30.

SECTION 2A. Section 2 of chapter 32A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following subsection:-

(i) “Wellness program”, a program designed to measure and improve individual health by identifying risk factors, principally through diagnostic testing and establishing plans to meet specific health goals which include appropriate preventive measures. Risk factors may include but shall not be limited to demographics, family history, behaviors and measured biometrics.

SECTION 2B. Said chapter 32A is hereby further amended by adding the following section:-

Section 25. The commission shall, subject to appropriation, negotiate with and purchase, on such terms as it deems to be in the best interest of the commonwealth and its employees, from 1 or more entities that can manage a wellness program covering persons in the service of the commonwealth and their dependents, and shall execute all agreements or contracts pertaining to said program. The commission may negotiate a contract for such term not exceeding 5 years as it may, in its discretion, deem to be the most advantageous to the commonwealth; provided, however that said program must be able to evaluate individual and aggregate data, give employees access to their individual information confidentially and allow the commission to receive collective reports summarizing baseline and ongoing data regarding the behavior and well being of enrollees. The commission may reduce premiums or co-payments or offer other incentives to encourage enrollees to comply with the wellness program goals.

Beginning 1 year after the end of the fiscal year in which the commission has implemented the wellness program, the commission shall submit an annual report to the governor, the secretary of health and human services, the secretary of administration and finance, the chairs of the joint committee on health care financing, chairs of the house and senate committees on ways and means, the speaker of the house of representatives and the senate

president. The report shall include the collective results, including but not limited to, the level of participation among employees, incentives provided for participation, the number and type of screenings and diagnostic tests conducted, the instance of undiagnosed risks defined as out of range diagnostic tests and number of employees seeking and receiving preventative treatment. The commission shall use this information in the negotiating and purchasing, on such terms as it deems in the best interest of the commonwealth and its employees, from 1 or more insurance companies, savings banks or non-profit hospital or medical service corporations, of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth and group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance benefits covering persons in the service of the commonwealth and their dependents.

Beginning 1 year after the end of the fiscal year in which the commission has implemented the wellness program, the commission shall annually submit a report to the governor, secretary of administration and finance, the chairs of the joint committee on health care financing, the chairs of the house and senate committees on ways and means, the speaker of the house of representatives and the senate president on the savings that have been achieved in procuring such insurance policies since implementing the wellness program.

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

Section 25P Every health care provider, as defined by section 1 or otherwise licensed under chapter 112,shall track and report quality information at least annually under regulations promulgated by the department.

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

(7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of section 4 of chapter 176J; provided, however, that the office of patient protection may grant a waiver 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; and provided further, that the office shall establish by regulation standards and procedures for enrollment waivers.

SECTION 4A. Chapter 111 of the General Laws is hereby amended by adding the following section: -

Section 222. There shall be a commission on falls preventions within the department. The commission shall consist of the commissioner of public health or the commissioner’s designee, who shall chair the commission; the secretary of elder affairs or the secretary’s designee; the director of MassHealth or the director’s designee; and 8 members to be appointed by the governor, 1 of whom shall be a member of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a member of the AARP, 1 of whom shall be a member of the Massachusetts Senior Care Association, Inc., 1 of whom shall be a member of the Massachusetts Association of Councils on Aging, Inc. 1 of whom shall be a member of the Massachusetts Medical Society Alliance, Inc., 1 of whom shall be a member of the Massachusetts Assisted Living Facilities Association, 1 of whom shall be a member of Mass

Home Care and 1 of whom shall be a member of the Massachusetts Pharmacists Association Foundation, Inc.

The commission on falls prevention shall make an investigation and comprehensive study of the effects of falls on older adults and the potential for reducing the number of falls by older adults. The commission shall monitor the effects of falls by older adults on health care costs, the potential for reducing the number of falls by older adults and the most effective strategies for reducing falls and health care costs associated with falls. The commission shall:

(1) consider strategies to improve data collection and analysis to identify fall risk, health care cost data and protective factors;

(2) consider strategies to improve the identification of older adults who have a high risk of falling;

(3) consider strategies to maximize the dissemination of proven, effective fall prevention interventions and identify barriers to those interventions;

(4) assess the risk and measure the incidence of falls occurring in various settings;

(5) identify evidence-based strategies used by long-term care providers to reduce the rate of falls among older adults and reduce the rate of hospitalizations related to such falls;

(6) identify evidence-based community programs designed to prevent falls among older adults;

(7) review falls prevention initiatives for community-based settings; and

(8) examine the components and key elements of the above falls prevention initiatives, consider their applicability in the commonwealth and develop strategies for pilot testing, implementation and evaluation.

The commission on falls prevention shall submit to the secretary of health and human services and the joint committee on health care financing, not later than September 22, an annual report that includes findings from the commission's review along with recommendations and any suggested legislation to implement those recommendations. The report shall include recommendations for:

(1) intervention approaches, including physical activity, medication assessment and reduction of medication when possible, vision enhancement and home-modification strategies;

(2) strategies that promote collaboration between the medical community, including physicians, long-term care providers and pharmacist to reduce the rate of falls among their patients;

(3) programs that are targeted to fall victims who are at a high risk for second falls and that are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations;

(4) programs that encourage partnerships to prevent falls among older adults and prevent or reduce injuries when falls occur; and

(5) programs to encourage long-term care providers in the commonwealth to implement falls prevention strategies which use specific interventions to help all patients avoid the risks for falling in an effort to reduce hospitalizations and prolong a high quality of life.

SECTION 4B. Section 2 of chapter 111M of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following subsection:-

(d) In determining whether creditable coverage is affordable under subsection (a), the board of the connector shall consider expected enrollee expenditures as the ninetieth percentile of out of pocket costs plus premiums for those enrolled in creditable coverage. For the purposes of this subsection, "out of pocket costs" shall mean the amount paid by an enrollee to satisfy the applicable annual deductible, co–payments and coinsurance, not including monthly premiums.

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 and the regulations promulgated by the commissioner.

SECTION 6. Said section 1 of said chapter 118G, 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 said chapter 118G of the General Laws is hereby amended by striking out the fourth and fifth paragraphs, as so appearing, 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 provided, further that the division shall require the submission of data and other such information from each acute care hospital.

The division shall publicly report and place on its website 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; provided, that at least 10 days prior to the public posting or reporting of provider specific information the affected provider shall be provided the information for review. 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 amended by section 9 of chapter 65 of the acts of 2009, 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, sections 3, 6B and 18B of chapter 118H, and sections 3 to 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, as appearing in the 2008 Official Edition, is hereby amended by striking out clause (4) and inserting in place thereof the following clause:-

(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, type of provider licensure 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 inserting in place thereof the following section:-

Section 3A. The following shall be 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 claims incurred", medical claims paid during an applicable 12-month period which pertain only to that specific period, plus any reasonable unpaid claim reserve.

"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.

SECTION 12. Said section 1 of said chapter 176J, as so appearing, is hereby further 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 and other allowable expenses to direct premiums earned, expressed as a percentage, calculated using data reported by the carrier as prescribed under regulations promulgated by the commissioner;.

SECTION 13A. Said section 1 of said chapter 176J, as so appearing, is hereby amended by inserting after the definition of "Prototype plan" the following definition:-

"Qualified association", a Massachusetts nonprofit or not-for-profit corporation or other entity organized and maintained for the purposes of advancing the occupational, professional, trade or industry interests of its association members, other than that of obtaining health insurance, and that has been in active existence for at least 5 years, that comprises at least 100 association members and membership in which is generally available to potential association members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective association member or the employees and dependents of a prospective association member.

SECTION 13B. Said section 1 of said chapter 176J, as so appearing, is hereby amended by inserting after the definition of "Resident" the following definition:-

"Small business group purchasing cooperative", or "group purchasing cooperative", a Massachusetts nonprofit or not-for-profit corporation or association, approved as a qualified association by the commissioner under section 13, all the members of which are part of a qualified association which negotiates with 1 or more carriers for the issuance of health benefit

plans that cover employees, and the employees' dependents, of the qualified association's members.

SECTION 13C. Said section 1 of said chapter 176J, as so appearing, is hereby amended by adding the following definition:-

"Wellness program", or "health management program", an organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

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 shall 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 shall 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 shall not increase or decrease by more than an amount established biennially by the commissioner through regulation. The limit established by the commissioner shall 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 said chapter 176J, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following 3 sentences:-

Every carrier shall make available to every eligible small business every eligible health benefit plan, including a certificate that evidences coverage issued or renewed to a trust or association, that it makes available to any other eligible small business. A carrier that offers health benefit plans to eligible small groups, as defined by chapter 176J, shall: (i) participate in the nongroup health insurance market by selling nongroup insurance, and (ii) sell nongroup health insurance solely through the connector, as defined in chapter 176Q, and (iii) shall make available to every individual and their eligible dependents every health benefit plan that it makes available to any other eligible individual and small groups through said connector. A carrier may make available to eligible small businesses health benefit plans that are not made available to eligible individuals.

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

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

(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 such plan has been closed to enrollment for new individuals and small groups and the carrier has complied with the requirements of 42 U.S.C. Sec. 300gg-12; provided that, cancellation of the plan shall be effective on the individual or small group's next enrollment anniversary after such cancellation is approved by the division of insurance. The commissioner may 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 to be provided to eligible individuals or eligible small businesses and all changes to plan base rates, rating factors and administrative costs shall be submitted to the division of insurance and shall be subject to the approval 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 shall 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 may 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 per cent, and to limit the amount of any load in the rate for profit and surplus to no more than 1 per cent, 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. Nothing in this subsection shall be construed to limit the commissioner’s authority to disapprove rates under chapter 175, 176A, 176B, or 176G.

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 per cent over the applicable 12-month period, the carrier shall refund the excess premium to its eligible individuals and eligible small groups. A carrier shall 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 per cent, 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.

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.

The attorney general may 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.

(g) If the commissioner disapproves the rate submitted by a carrier under subsections (d) or (e), the commissioner shall notify the carrier in writing no later than 45 days prior to the

effective date of the carrier's rate. The carrier may request a hearing on the disapproval to be held within 15 days of the notice by filing a written request with the division of insurance within 10 days of its receipt of such notice. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The carrier may not implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval after a hearing or unless a court vacates the commissioner's decision.

SECTION 21. Said 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 under 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 in at least 1 geographic area 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 shall 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 or add new providers to its selective and tiered plans 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 affected 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, and

geographic 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 further 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 in at least 1 geographic area 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 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. 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 shall 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, including, 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 shall provide affected 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 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 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 further amended by adding the following 3 sections:-

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 13. (a) The commissioner shall promulgate regulations governing the establishment and oversight of small business group purchasing cooperatives. The regulations shall require: (i) that all state-mandated benefits are required under plans procured by approved small business group purchasing cooperatives; (ii) that all such plans offer its enrollees access to wellness programs which, at a minimum, shall be actuarially similar to wellness programs that may be offered through the commonwealth health insurance connector authority; (iii) that the group purchasing cooperative obtain a commitment from 50 per cent of its covered employees that the employees will enroll in the health management programs that the group purchasing cooperative provides; (iv) that the group purchasing cooperative establish reasonable systems, which shall comply with any applicable sections of the Americans with Disability Act and any other federal requirements, under which enrollees can record their participation in, and group purchasing cooperatives can monitor enrollees' participation in, available health management programs; (v) that denial of coverage due to the health condition, age, race or sex of the

employees and dependents of qualified association members in a group purchasing cooperative is prohibited; and (vi) that no eligible qualified association member of a small business group purchasing cooperative may be charged a premium rate higher than what the carrier would charge to a similarly-situated eligible small business that is not a participant in a small business group purchasing cooperative.

(b) The commissioner shall promulgate regulations governing the application and certification process that a proposed small business group purchasing cooperative shall undergo before the commissioner may certify the group purchasing cooperative as a small business group purchasing cooperative approved to operate in accordance with this section; provided, however, that the commissioner shall only certify 4 group purchasing cooperatives to operate at any given time; provided further, that the commissioner shall certify any application that meets the requirements of this section up to and until the commissioner has certified 4 group purchasing cooperatives. The commissioner shall limit the number of applications that are approved for each small business group cooperative so that in a given year, the total number of covered lives, for each approved group purchasing cooperative, shall not exceed 15,000 lives. Notwithstanding the provisions of this section, once the limit on covered lives is reached, the commissioner shall not approve the application of a new group purchasing cooperative until a previously approved group purchasing cooperative disbands or until the commissioner disapproves a group purchasing cooperative's annual renewal for failure to comply with the terms of this section and any regulations promulgated in accordance with this section.

(c) The commissioner shall annually certify that a small business group purchasing cooperative satisfies the requirements of this section. Only a small business group purchasing

cooperative that has been certified by the commissioner may procure health care coverage for the benefit of qualified association members.

(d) The commissioner shall review the books and records of a small business group purchasing cooperative and the methodology which it confirms the status of qualified associations.

(e) Health care coverage procured by a small business group purchasing cooperative shall be sold to qualified association members and may be sold through duly licensed agents, the commonwealth health insurance connector authority or brokers.

(f) Member-employers of qualified associations purchasing health coverage within a group purchasing cooperative shall not have more than 50 eligible employees.

(g) The commissioner, in consultation with the division of health care finance and policy and the commonwealth health insurance connector authority, shall report and make recommendations, as necessary, on the cost savings to the qualified association members that participate in small business group purchasing cooperatives, the impact, if any, on the establishment of small business group purchasing cooperatives to the risk pool and premium costs in the merged market, and whether the authority of the commissioner to certify small business group purchasing cooperatives should be renewed to the house and senate committees on ways and means and the joint committee on health care financing and financial services within 24 months of the first certification of a small business group purchasing cooperative as defined under this section.

Section 14. (a) As a condition of continued offer of small group health, a carrier that, as of the close of a preceding calendar year, has a combined total of at least 5,000 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 be annually required to file a plan with each group purchasing cooperative for its consideration if a group purchasing cooperative requests such health plan proposals for its next plan year.

(b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i) include all state-mandated benefits; (ii) apply preexisting condition limitations and waiting periods in the same manner as the carrier applies them to small group products offered outside the group purchasing cooperative; (iii) apply open enrollment periods for individuals in the same manner as the carrier applies them for individuals outside the group purchasing cooperative, provided, however that small business group purchasing cooperatives shall establish rules and open enrollment periods for qualified association members to enter or exit group purchasing cooperatives; (iv) apply continuation of coverage provisions in the same manner as the carrier applies those provisions to small group products offered outside the group purchasing cooperative; (v) apply managed care practices in the same manner as the carrier applies those practices to small group products offered outside the group purchasing cooperative; and (vi) apply rating rules, including rating bands, rating factors and the value of rating factors, in the same manner as the carrier applies those rules to small group products offered outside the group purchasing cooperative; provided, that such plans may make limited deviations from these rating factors with the prior approval of the commissioner.

(c) Carriers shall comply with a group purchasing cooperative’s wellness program’s data processing systems to provide information that will enable the group purchasing cooperative to effectively provide guidance to members on targeted wellness programs.

SECTION 28. Section 2 of chapter 176M of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word “renewal”, in lines 28 and 39, the following words:- , including renewal through the connector,.

SECTION 30. Said section 2 of said chapter 176M, as so appearing, is hereby further amended by inserting after the word “market”, in lines 137 and 138, the following words:- including the connector,.

SECTION 31. Section 3 of said Chapter 176M, 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 inserting in place thereof 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 of providers, including any health care provider type licensed under chapter 112 that provide identical services. 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 on its internet website 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 said section 6 of said 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 25P 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; provided, further, that the carrier shall prominently promote providers based on quality performance as

measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices.

SECTION 34. Said chapter 176O of the General Laws is hereby further 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 further 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 in chapter 176J;

direct claims incurred, as defined in said 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 (i) to (xix), 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 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 in said section 1 of said chapter 176J, for all of the carrier’s self-insured customers;

the aggregate value of direct claims incurred, as defined in said section 1 of said chapter 176J, for all of the carrier’s self-insured customers;

the aggregate medical loss ratio, as defined in said section of said 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 subsection, 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 36A. Subsection (s) of section 3 of said chapter 176Q, as so appearing, is hereby amended by adding the following words:- ; provided, that notwithstanding subsection (d) of section 2, no changes to the regulations defining minimum creditable coverage shall take effect until 90 days after the connector gives notice of the changes to the joint committee on

health care finance, the joint committee on public health, the senate and house of representatives committees on ways and means and the clerks of the senate and house of representatives.

SECTION 37. Section 5 of said chapter 176Q, as so appearing, is hereby amended by adding 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. Said chapter 176Q is hereby further 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 federal 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 38B. Section 8 of said chapter 176Q, as so appearing, is hereby amended by adding the following sentence: -

The connector shall not utilize any of the data received from the department of revenue for any solicitations or advertising.

SECTION 38C. Section 15A of said chapter 176Q, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:- The commission shall commence its meetings not later than September 1, 2010, and shall report its findings and recommendations, including recommendations for proposed legislation, at least annually, to the clerks of the senate and house of representatives; provided, that the first report shall be delivered not later than March 1, 2011.

SECTION 38D. Paragraph (n) of section 5 of chapter 614 of the acts of 1968, as appearing in section 18 of chapter 777 of the acts of 1981, is hereby amended by striking out, in line 2, the words “its administrative” and inserting in place thereof the following words:- fees, administrative.

SECTION 38E. Said section 5 of said chapter 614 is hereby further amended by inserting after paragraph (n), as so appearing, the following paragraph:-

(n1/2) to fund the capital reserves authorized under paragraph (g) of section 10 and to fund and administer loans and grant programs for community hospitals and community health centers;.

SECTION 38F. Section 10 of said chapter 614, as most recently amended by chapter 777 of the acts of 1981, is hereby further amended by adding the following paragraph:-

(g) (i) For the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health and meeting the definition of a community health center under 114.6 CMR 13.00 as either a community health center or a hospital licensed health center, the authority may create and establish special funds to be known as Community Hospital and Community Health Center Capital Reserve Funds and, to the extent so created, shall pay into each such fund any monies appropriated and made available by the commonwealth for the purposes of such fund, any proceeds from the sale of notes or bonds to the extent provided in the resolution, trust agreement or indenture of the authority authorizing issuance thereof, any other monies or funds of the authority that the authority determines to deposit in the fund and any other monies which may be available to the authority only for the purpose of such fund from any other source or sources. All monies held in the fund, except as hereinafter provided, shall be used solely for the payment of the principal of bonds of the authority which are secured by any such fund as the same mature, which herein shall include becoming payable by sinking fund installment, the purchase of such bonds, the payment of interest on such bonds, or the payment of any redemption premium required to be paid when such bonds are redeemed prior to maturity; provided however, that, monies in a Community Hospital and Community Health Center Capital Reserve Fund shall not be withdrawn therefrom at any time in such amount as would reduce the amount of the fund to less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on outstanding bonds which are secured by the fund, except for the purpose of paying the principal of and interest on such bonds maturing and becoming due or for the retirement of such bonds in accordance with the terms of a contract between the authority and its bondholders and for the payment of which other monies pledged to secure such bonds are not available. Any income or interest earned by,

or increment to, a Community Hospital and Community Health Center Capital Reserve Fund due to the investment thereof shall be used by the authority for the purposes of the fund.

(ii) The authority shall not issue bonds which are secured by a Community Hospital and Community Health Center Capital Reserve Fund at any time if the maximum amount of principal and interest maturing or becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by a fund will exceed the amount of such Community Hospital and Community Health Center Capital Reserve Fund at the time of issuance unless the authority, at the time of issuance of such bonds, shall deposit in such fund from the proceeds of the bonds so to be issued, or otherwise, an amount which, together with the amount then in the fund, will be not less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by any such fund.

(iii) To assure the continued operation and solvency of the authority for the carrying out of the public purposes of this act, provision is made in subparagraph (i) for the accumulation in a Community Hospital and Community Health Center Capital Reserve Fund of an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on all outstanding bonds which are secured by any such fund. In order to further assure the maintenance of a Community Hospital and Community Health Center Capital Reserve Fund, there shall be appropriated annually and paid to the authority for deposit in the fund such sum, if any, as shall be certified by the executive director of the authority to the governor as necessary to restore the fund to an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on the outstanding bonds

which are secured by any such fund. The executive director of the authority shall annually, on or before December 1, make and deliver to the governor a certificate stating the amount, if any, required to restore a Community Hospital and Community Health Center Capital Reserve Fund to the amount aforesaid and the amount so stated, if any, shall be appropriated and paid to the authority during the then current fiscal year of the commonwealth.

(iv) For the purposes of this paragraph, in computing the amount of a Community Hospital and Community Health Center Capital Reserve Fund, securities in which all or a portion of the fund are invested shall be valued at par or, if purchased at less than par, at their cost to the authority unless otherwise provided in the resolution, trust agreement or indenture authorizing the issuance of bonds secured by the fund.

(v) For the purposes of this paragraph, the amount of a letter of credit, insurance contract, surety bond or similar financial undertaking available to be drawn upon and applied to obligations to which money in the Community Hospital and Community Health Center Capital Reserve Fund may be applied shall be counted as money in the fund. For the purposes of this paragraph, in calculating the maximum amount of interest due in the future on variable rate bonds or bonds with respect to which the interest rate is not at the time of calculation determinable, the interest rate shall be calculated at the maximum interest rate on such bonds or such lesser interest rate as shall be certified by the authority as an appropriate proxy for such variable or nondeterminable interest rate.

(vi) Bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund shall be issued by the authority solely for the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health.

(vii) Notwithstanding any provision of this act to the contrary, no loan shall be made by the authority to a nonprofit community hospital or nonprofit community health center from the proceeds of bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund established under this paragraph unless: (a) the project to be financed by the loan has been approved by the secretary of health and human services; and (b) the loan and the issuance and terms of the related bonds have been approved by the secretary of administration and finance. In connection with any loan to a nonprofit community hospital or nonprofit community health center under this paragraph, the secretary of health and human services and the secretary of administration and finance may enter into an agreement with the authority and the nonprofit community hospital or nonprofit community health center to: (1) require that the nonprofit community hospital or nonprofit community health center provide financial statements or other information relevant to the financial condition of the nonprofit community hospital or nonprofit community health center and its compliance with the terms of the loan; (2) require that the nonprofit community hospital or nonprofit community health center reimburse the commonwealth for any amounts the commonwealth transfers to the fund under subparagraph (iii) to replenish the fund as a result of a loan payment default by the nonprofit community hospital or nonprofit community health center; and (3) require compliance by the nonprofit community hospital or nonprofit community health center or the authority with any other terms and conditions that the secretary of health and human services and the secretary of administration and finance considers appropriate in connection with the loan.

(viii) When the authority notifies the secretary of administration and finance in writing that an institution eligible to use the authority under this paragraph is in default as to the payment of principal or interest on any bonds issued by the authority on behalf of that institution or that

the authority has reasonable grounds to believe that the institution will not be able to make a full payment when that payment is due, the secretary of administration and finance shall direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the institution until the amount of the principal or interest due or anticipated to be due has been paid to the authority or the trustee for the bondholders, or until the authority notifies the secretary of administration and finance that satisfactory arrangements have been made for the payment of the principal and interest. Funds subject to withholding under this subparagraph shall include, but not be limited to, federal and state grants, contracts, allocations and appropriations.

(ix) If the authority further notifies the secretary of administration and finance in writing that no other arrangements are satisfactory, the secretary shall direct the comptroller to make available to the authority without further appropriation any funds withheld from the institution under subparagraph (viii). The authority shall apply the funds to the costs incurred by the institution, including payments required to be made to the authority or trustee for any bondholders of debt service on any bonds issued by the authority for the institution or payments to replenish the Community Hospital and Community Health Center Capital Reserve Fund or required by the terms of any other law or contract to be paid to the holders or owners of bonds issued on behalf of the institution upon failure or default, or upon reasonable expectation of failure or default, of the institution to pay the principal or interest on its bonds when due.

(x) Concurrent with any notice from the authority to the secretary of administration and finance under this paragraph, the authority may notify any other agency, department or authority of state government that exercises regulatory, supervisory or statutory control over the operations of the institution. Upon notification, the agency, department or authority shall immediately undertake reviews to determine what action, if any, that agency, department or authority should

undertake to assist in the payment by the institution of the money due or the steps that the agencies of the commonwealth, other than the comptroller or the authority, should take to assure the continued prudent operation of the institution or provision of services to the people served by the institution.

(xi) Notwithstanding any general or special law to the contrary, in the event that a nonprofit community hospital or nonprofit community health center fails to reimburse the commonwealth for any transfers made by the commonwealth to the authority to replenish the Community Hospital and Community Health Center Capital Reserve Fund under subparagraph (iii) within 6 months after any such transfer and as otherwise provided under the terms of the agreement among the nonprofit community hospital or nonprofit community health center, the authority and the commonwealth authorized under subparagraph (vii), the secretary of administration and finance may, in the secretary's sole discretion, direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the nonprofit community hospital or nonprofit community health center to cover all or a portion of the amount the nonprofit community hospital or nonprofit community health center has failed to pay to the commonwealth to reimburse the commonwealth for any such transfers. All contracts issued by the group insurance commission, the commonwealth health insurance connector authority and MassHealth to a third party for the purposes of providing health care insurance paid for by the commonwealth shall provide that, at the direction of the secretary of administration and finance, the third party shall withhold payments to a nonprofit community hospital or nonprofit community health center which fails to reimburse the commonwealth under the agreement authorized under subparagraph (vii) and shall transfer the withheld amount to the commonwealth. Any such withheld amounts shall be considered to have been paid to the

nonprofit community hospital or nonprofit community health center for all other purposes of law and the nonprofit community hospital or nonprofit community health center shall be considered to have reimbursed the commonwealth for all or a portion of any such transfers to the Community Hospital and Community Health Center Capital Reserve Fund for purposes of the agreement authorized under said subparagraph (vii).

(xii) For the purposes of this paragraph, a community hospital or community health center shall not include a hospital where the ratio of the number of physician residents-in-training to the number of inpatient beds exceeds 0.25.

SECTION 38G. Section 12 of said chapter 614 is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:- Except as otherwise provided in paragraph (g) of section 10, the issuance of revenue bonds under this act shall not directly, indirectly or contingently obligate the commonwealth or any political subdivision thereof to levy or to pledge any form of taxation therefor or to make any appropriation for payment of those bonds.

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 federal 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, the amount necessary for the assessment and deposit into the High Risk

Reinsurance Trust Fund established in section 2BBBB of chapter 29 of the General Laws, the appropriate level of reimbursement to carriers under section 12 of chapter 176J of the General Laws and the initial threshold and upper limit used in said chapter 176J. 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; and

(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. The report shall include a detailed analysis of the impact of said limits on a carrier's base rate premium and shall include estimates of the percentage increase to a carrier's base rate premiums attributable to a range of limits on adjustment factors.

(e) The commission shall also conduct a study, which shall examine the impact of limiting the availability of new individual health plans to those offered through the

commonwealth health insurance connector authority. The commission shall examine the current plan offerings available to individuals as compared to plan offerings available through the commonwealth health insurance connector authority. The study shall also examine the ability of the commonwealth health insurance connector authority to market the availability of individual plans in conjunction with an annual open enrollment period for eligible individuals. The study shall report on the impact, if any, on premium rates in the merged market as the result of this proposal. In conducting this study, the commission shall consult with the executive director of the commonwealth health insurance connector authority, a representative of an employer association, a representative of a health underwriters association and a representative of a health care consumer group.

(f) 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.

(g) 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 federal 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 health 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 of the General Laws 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 annual operating margin greater than 2.5 per cent in each of the past 2 years and that received more than 50 per cent of its net patient service revenue from private carriers; provided however, that the operating margin shall be calculated through a consolidated system financial statement.

(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 annual operating margin greater than 2.5 per cent in each of the past 2 years and that received more than 35 per cent and less than 50 per cent of its net patient service revenue from private carriers; provided however, that the operating margin shall be calculated through a consolidated system financial statement.

(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 shall 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. The division of health care finance and policy may audit the books and records of each such participating provider to assure compliance with this subsection.

(e) The division of health care finance and policy may exempt an acute care hospital from its total assessment obligation or a portion of the total 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 net working capital shall be exempt. The financial hardship criteria shall include, but shall not be limited to, a review of the participating provider's role in providing critical services within a geographic area, the

ability of the provider to finance necessary capital projects, the efficiency and relative prices of the provider, the amount of provider expenditures for community based programming, a provider's status as a community disproportionate share hospitals, the provider's level of reserves and endowments, any impact on the provider by the February 10, 2010 amendments to 211 CMR 43.08, any contract amendments or price reductions made on or after October 1, 2009, the percentage of net patient revenue from the Commonwealth Care Health Insurance Program and from organizations providing managed care under the Medicaid program defined in section 8 of chapter 118E, and the provider's activities to reduce health care costs through the better management of care and utilization.

(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, by September 30, 2010, 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 shall 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 may 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 either: (1) 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, or (2) amends its existing contracts carriers to limit the rate of increase of any inflation adjustment to rates equal to or less than to the most recent published rate for medical care inflation in the northeastern United States, by the Bureau of Labor Statistics. 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.

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.

(h) This section shall not be construed as a benchmark or other rationale to oppose continued efforts to constrain health care costs through negotiation between providers and carriers.

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 determining whether and to what extent an expenditure shall be considered a medical claims expenditure or an administrative costs expenditure, which shall include, but not be limited to, a determination of which of these classes of expenditures the following expenses fall into: (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 Massachusetts Medical Society Alliance, Inc.; the

Massachusetts Hospital Association, Inc.; Health Care for All, Inc.; 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, other health care providers licensed under chapter 112 of the General Laws, 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 25P 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, medical group, or provider 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 or provider association, 1 representative from a medical group, 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 annually recommend to the department of public health any updates to the Standard Quality Measure Set by November 1. For its recommendation beginning in 2011, the committee may solicit for consideration and recommend other nationally recognized quality measures not yet

developed or in use as of November 1, 2010, including recommendations from medical or provider 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 or provider 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 said chapter 176J that will expire after the end of open enrollment in 2010 established under section 4 of said 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 director of the office of Medicaid or the director'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, a representative of the Massachusetts Hospital Association, Inc., 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, including ways to reduce health care reporting requirements through maximizing the use of a single all-payer data base, as administered by the division of health care finance and policy. The group shall hold its first meeting not 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 interagency agreement to use where necessary, the all-payer claims data base, and to streamline and coordinate all requests for all other data requests 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; and a representative of an association of health care providers licensed under chapter 112 of the General Laws who is not a medical doctor.

SECTION 54. Notwithstanding any general or special law to the contrary, there shall be a special commission to study the impact of reducing the number of health benefit plans that a health care payer may maintain and offer to individuals and employers. The commission shall consist of the 12 members including: the commissioner of insurance, who shall serve as chair; the executive director of the commonwealth health insurance connector; a representative of the Massachusetts Hospital Association, the Massachusetts Medicaid 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, Associated Industries of Massachusetts, a heath care consumer group; and a representative of an association of health care providers licensed under chapter 112 of the General Laws who is not a medical doctor. In conducting its analysis, the commission shall examine:

(i) the administrative costs associated with paying claims and submitting claims for multiple health benefit plans on health care payers and providers;

(ii) the costs associated with reducing the number of health benefit plans on consumer and employer choice;

(iii) the impact of limiting the number of health benefit plans on competition between and among insurance payers, including but not limited to, tiered products, limited network products and products with a range of cost sharing options; and

(iv) the potential for disruption to the market resulting from closing a health care payer's existing health benefit plans.

The special commission shall convene not later than October 1, 2010 and shall submit a report to the clerks of the house and senate not later than December 31, 2010.

SECTION 54A. Notwithstanding any special or general law to the contrary, in implementing this act, the executive office of health and human services, the department of public health, the division of health care finance and policy, the division of insurance, the group insurance commission and any other relevant governmental entities or commissions may consider the special needs of children and of pediatric patients. In developing or utilizing data standards, quality measurement systems, wellness initiatives or making comparisons of costs and prices, policymakers shall consider the special needs of children and of pediatric patients and may require that comparative data and reports segregate pediatric patients and providers from adult patients and providers.

SECTION 54B. Notwithstanding any general or special law to the contrary, the division of insurance, in consultation with the attorney general, shall conduct a study to ensure that the carrier reporting deadlines included in subsections (b) and (c) of section 6 of chapter 176J of the General Laws are of the appropriate duration to enable carriers to collect sufficient information

with which to ensure the accuracy of proposed plan changes. If the division determines that a reporting date of 90 days prior to the effective date of plan changes is inappropriate, the division shall determine the appropriate length of time for carriers to report plan changes to the division of insurance and the attorney general and shall make such recommendation to the Legislature. The study shall be completed by July 31, 2011 and filed with the clerks of the house of representative and senate, the chairs of the joint committee on health care financing and the chairs of the house and senate committee on ways and means.

SECTION 54C. There shall be a special commission to identify the capital needs of the community hospital sector with regard to use of technology and adequacy of facilities, the ability of the sector to meet the health care needs of the general population in the next decade and potential sources of capital to meet those needs. The commission shall also evaluate the role of public programs, payments and regulations in supporting capital accumulation and make recommendations to advance the ability of the community hospital sector to meet the expected demand. The commission shall be comprised of the secretary of health and human services, the commissioner of public health, the secretary of administration and finance, a representative of the Massachusetts Council of Community Hospitals, a representative of the Massachusetts Hospital Association, a representative of the Associated Industries of Massachusetts, a representative of the Massachusetts Business Roundtable, the chief executive officer of the Massachusetts Health and Educational Facilities Authority, the chief executive officer of Mass Development, the chairs of the house and senate committees on ways and means, the house and senate chairs of the joint committee on health care financing, a member of the house of representatives who shall be chosen by the minority leader, a member of the senate who shall be chosen by the minority leader, a chief elected local official with a community hospital located in

said community who shall be appointed by the governor, an individual knowledgeable about demographic trends and hospital utilization who shall be appointed by the governor and an individual knowledgeable about hospital finance and construction who shall be appointed by the governor.

The commission shall hold hearings and file a report with the clerks of the house and senate not later than December 31, 2011.

SECTION 54D. Notwithstanding the provisions of any general or special law to the contrary, the department of public health shall conduct a study of the commonwealth's community hospitals, with a particular focus on outmigration of patients and related trends, including but not limited to an examination of observed effects and their potential causes with respect to the following:

(1) the impact on individual community hospitals caused by the opening of additional health care services by providers within the primary service areas of such community hospital, in terms of changes in the number and types of procedures performed and changes in revenues;

(2) recruitment and retention of personnel; and

(3) changes in payer mix.

The department shall issue a report summarizing its findings and making recommendations with respect to strengthening community hospitals not later than December 31, 2010, and shall file such report with the joint committee on health care financing.

SECTION 54E. The commissioner of insurance and the attorney general shall report to the house and senate committees on ways and means and the joint committees on health care

finance and policy not later than January 1, 2012 on the effectiveness of limited and tiered networks related to the small group market. The report shall include, but not be limited to, an analysis of the savings that tiered or limited networks create for the small group market, an analysis of consumer impacts including the desirability of enrollment, consumer access to primary, secondary and mental health care services, medical utilization and quality of care; an analysis on whether it is necessary to allow carriers to exclude providers of the same or similar level of quality, as measured by the standard quality measure set, from tiered or limited networks that will accept the same levels of geographically-adjusted reimbursement that providers in the tiered or limited network accept and analysis of whether it is financially necessary to exclude said providers and the implications on the financial stability of excluded providers; an analysis of whether said non-contracted providers should have the right to join the limited or tiered network if the provider willingly accepts the geographically-adjusted rates for services agreed to in the limited or tiered network; an analysis on the impact of allowing such non-contracted providers to join said limited or tiered networks to encourage consumer enrollment in said networks and the implications for enhanced cost savings through enhanced enrollment; and an analysis on the impact of allowing such non-contracted providers to join said limited or tiered networks on the sustainability of limited and tiered networks as a method of reducing premiums for the small group markets.

SECTION 54F. The commissioner’s authority to certify small business group purchasing cooperatives under section 13 of chapter 176J of the General Laws shall expire on December 31, 2014.

SECTION 55. Sections 1, 3 to 7, inclusive, 9 to 15, inclusive, 17, 19, 20, 23, sections 13 and 14 of chapter 176J of the General Laws as inserted by section 25, 31, 34, 39 to 42, inclusive, and 44 to 54F, inclusive, shall take effect on July 1, 2010.

SECTION 56. Sections 1A, 1B, 2 and section 12 of chapter 176J of the General Laws as inserted by section 25 shall take effect on October 1, 2010.

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

SECTION 58. Sections 4A, 18, 21, 24, 33 and 38 shall take effect on July 1, 2011.

SECTION 59. Sections 8, 16, 28, 30, 36, 37 to 43, inclusive, shall take effect on July 1, 2012.

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