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SENATE . . . . . No. 2585

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 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 Section 16K of chapter 6A of the General Laws, as so appearing, is hereby amended by striking out subsections (a) to (c), inclusive, 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 19 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) 10 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 with fewer than 50 employees, 1 of whom shall be an organization representing the interests of large businesses with 50 or more employees and 1 of whom shall be a clinician licensed to practice in the commonwealth. At least 2 members of the council shall be clinicians 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 Said section 16K of said chapter 6A, as so appearing, is hereby 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: (i) the parties that will be impacted;(ii) the agencies, departments, boards or councils of the commonwealth responsible for overseeing and implementing the goals; (iii) the steps needed to achieve the goals;(iv) the projected costs

associated with implementing the goals; (v) and the potential cost savings, both short and long-term, attributable to the goals. 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: (i) improve patient safety in all settings of care; (ii) reduce preventable hospital readmissions; (iii) prevent the occurrence of and improve the treatment and coordination of care for chronic diseases; and (iv) reduce variations in care. The council shall 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 Section 2 of chapter 32A of the General Laws, as amended by section 64 of chapter 25 of the acts of 2009 , 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 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 the 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 the program shall 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 Subsection (b) of section 9of chapter 94C of the General Laws, as appearing in the 2008 Official Edition, is hereby by adding the following paragraph:-

This section shall not be construed to prohibit a physician or an optometrist from the in-office dispensing and sale of therapeutic contact lenses as long as the medication contained in such lenses is within the profession’s designated scope of practice.

For the purposes of this section, “therapeutic contact lenses” shall mean contact lenses which contain 1 or more medications and which deliver such medication to the eye.

SECTION 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 Section 217 of said chapter 111, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word “plans”, 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; provided further, that the office shall establish by regulation standards and procedures for enrollment waivers.

SECTION Said chapter 111 is hereby further 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, annually, a 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 pharmacists 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 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 Section 66B of chapter 112 of the General Laws is hereby amended after the third paragraph by inserting the following:-

This section shall not be construed to prohibit an optometrist from the in-office dispensing and sale of therapeutic contact lenses as long as the medication contained in such lenses is within the profession's designated scope of practice.

For the purposes of this section, "therapeutic contact lenses" shall mean contact lenses which contain 1 or more medications and which deliver such medication to the eye.

SECTION 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 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 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, but not limited to: (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; (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, but not limited to: (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.

The division shall require the submission of data and other such information from each acute care hospital on hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

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, however, 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 request from

the federal Centers for Medicare and Medicaid Services the health status adjusted total medical expenses of provider groups that serve Medicare patients.

SECTION 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. 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 Section 47H of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

SECTION Section 8K of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

SECTION Section 4J of chapter 176B of the General Laws, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

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

(4) Boycott, coercion and intimidation: (a) entering into an agreement to commit, or by concerted action committing, an act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; (b) an 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) an 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 Said chapter 176D is hereby further amended by striking out section 3A, as so appearing, 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; and (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 Section 1 of said chapter 176J, as so appearing, is hereby amended by striking out the definition of "Eligible individual" and inserting in place thereof the following definition:-

"Eligible individual", an individual who is a resident of the commonwealth and who is not seeking individual coverage to replace 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 Said section 1 of chapter 176J, as so appearing, is hereby further 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 Said section 1 of said chapter 176J, as so appearing, is hereby further 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 Said section 1 of said chapter 176J, as so appearing, is hereby further 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 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 Said section 3 of said chapter 176J, as so appearing, is hereby further amended by adding the following subsection:-

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

SECTION Subsection (a) of 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. For a Trade Act/HCTC-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/HCTC- 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 Said subsection (a) of said section 4 of said chapter 176J is hereby further amended by striking out paragraph (3), as appearing in section 26, 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 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: