HOUSE DOCKET, NO. 3455 FILED ON: 1/21/2011

HOUSE . . . . . No. 2784

The Commonwealth of Massachusetts

PRESENTED BY:

Harriett L. Stanley

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to begin to contain health care costs.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Harriett L. Stanley	*2nd Essex*	*1/21/2011*

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HOUSE . . . . . No. 2784

By Ms. Stanley of West Newbury, a petition (accompanied by bill, House, No. 2784) of Harriett L. Stanley relative to the determination of need process. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to begin to contain health care costs.

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. Chapter 305 of the Acts of 2008 is hereby amended by deleting Section 7 and replacing it with the following new language:

"Expenditure minimum with respect to substantial capital expenditures", with respect to expenditures and acquisitions made by or for: (1) acute care hospitals and comprehensive cancer centers as defined in section 1 of chapter 118G, only, $7,500,000, except that expenditures for, or the acquisition of, major movable equipment not otherwise defined by the department as new technology or innovative services shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; and (2) health care facilities, other than acute care hospitals, and facilities subject to licensing under chapter 111B, with respect to: (a) expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, $400,000; and (b) all other expenditures and acquisitions, $800,000; provided, however, that expenditures for, or the acquisition of, any replacement of medical, diagnostic or therapeutic equipment defined as new technology or innovative services for which a determination of need has issued or

which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $7,500,000, in which case a determination of need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

Chapter 305 of the Acts of 2008 is hereby further amended by in Section 11 deleting the last paragraph and replacing it with the following new language:

Section 53G. Any entity that is certified or seeking certification as an ambulatory surgical center by the Centers for Medicare and Medicaid Services for participation in the Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the department determines provides reasonable assurances that such conditions are met. No original license shall be issued pursuant to said section 51 to establish any such ambulatory surgical clinic unless there is a determination by the department that there is a need for such a facility. For purposes of this section, “clinic” shall include a clinic conducted by a hospital licensed under said section 51 or by the federal

government or the commonwealth. The department shall promulgate regulations to implement this section.

SECTION 2. Section 25C of Chapter 111 of the General Laws is amended by inserting after the first paragraph the following new paragraph:

"The Department shall conduct a statewide planning initiative for the purposes of studying and coordinating the availability and delivery of health care services within the commonwealth. The initiative shall examine the current supply of inpatient and outpatient services, and technologies and develop a plan for the provision of new services, beds, technologies, and structural expansions throughout the commonwealth, and develop a plan for the continued role of community hospitals and health centers within the commonwealth. The Department shall utilize this plan in its evaluation of all applications for a determination of need, as required by this section, in order to determine whether the proposed expansion construction, or acquisition of health care facilities or services is needed in the Commonwealth, or whether the proposed expansion construction, or acquisition of health care facilities or services will unnecessary duplicate ongoing services and increase health care costs in the Commonwealth."

SECTION 3. Section 25C of Chapter 111 of the General Laws is amended by inserting at the end of the section the following new paragraph:

"Any hospital seeking to expand its emergency department shall file a determination of need with the department. In addition to the information required pursuant to this section, the department shall require hospitals seeking emergency department expansions to demonstrate that prior to filing a determination of need application, the hospital has implemented measures to

reduce emergency room overcrowding. The department shall promulgate regulations defining the measures hospitals may take to reduce emergency room overcrowding."

Section 25C of Chapter 111 of the General Laws is further amended by inserting at the end of the 2nd paragraph the following language:

"Each person or agency of the commonwealth or any political subdivision thereof filing a determination of need to acquire new technology shall, in addition to the information required by this section, file with the department documentation of programs implemented by the health care facility designed to ensure utilization of all new technology in a manner that is consistent with state and national guidelines. The department shall annually publish a list of state and national guidelines governing the utilization of new technology. The department shall promulgate regulations necessary to enforce this section."

Section 25C of Chapter 111 of the General Laws is further amended by deleting the last sentence of the 7th paragraph and replacing it with the following new language:

"A reasonable fee, established by the department, shall be paid upon the filing of such application. The department shall be adjusted annually as necessary to accommodate the volume of new applications."

Section 3 of Chapter 17 of the General Laws is hereby amended by deleting Section 3 in its entirety and replacing it with the following new language:

Section 3. (a) There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 17 members appointed for terms of 6 years

under this section. The commissioner may designate 1 of the members as vice chairperson and may appoint subcommittees or special committees as needed.

(b) Four of the members shall be appointed by the governor: 1 shall be appointed from among the chancellor of the University of Massachusetts Medical School and a list of 3 nominated by said chancellor; 1 shall be appointed from among the dean of the University of Massachusetts Amherst School of Public Health or Health Sciences and a list of 3 nominated by said dean; 1 shall be appointed from among the heads of the non-public schools of medicine in the commonwealth or their nominees; and 1 shall be appointed from among the heads of the non-public schools or programs in public health in the commonwealth or their nominees.

(c) Four of the appointed members shall be providers of health services, appointed by the governor: 1 of whom shall have expertise in acute care hospital management; 1 of whom shall have expertise in long term care management; 1 of whom shall have expertise in home or community-based care management, and 1 of whom shall have expertise in the practice of primary care medicine or public health nursing.

(d) Six of the appointed members shall be non-providers: 1 shall be appointed by the secretary of elder affairs; 1 shall be appointed by the secretary of veterans' services; 1 shall be appointed by the governor from a list of 3 nominated by Health Care For All, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Coalition for the Prevention of

Medical Errors, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Public Health Association; and 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Community Health Worker Network. Whenever an organization nominates a list of candidates for appointment by the governor under this subsection, the organization may nominate additional candidates if the governor declines to appoint any of those originally nominated.

(e) Three of the appointed members shall be payers of health care, appointed by the governor: 1 shall represent a health plan licensed in the Commonwealth; 1 shall represent small businesses; and one shall represent large businesses.

(f) For purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he is qualified to act on the council in the public interest; who, and whose spouse, parents, siblings or children, have no financial interest in a health care facility; who, and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established under chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals; and who, and whose spouse, is not licensed to practice medicine.

(g) Upon the expiration of the term of office of an appointive member, his successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his successor. The members shall be appointed not later than 60 days after a vacancy. The council shall meet at least once a month, and at such other times as it shall

determine by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 per day that the council meets, and their reasonably necessary traveling expenses while in the performance of their official duties.

SECTION 4. Chapter 111 is hereby amended by inserting the following new section:

Section 51 ½. Hospital Billing and Licensure.

As used in this section the following terms shall have the following meanings:

"Facility of Primary Licensure" means the single physical structure and location where the majority of the hospital's licensed beds are located.

(a) Every acute-care hospital that provides any services at a location other than its "Facility of Primary Licensure" is prohibited from operating a Secondary Facility pursuant to the original license of the Facility of Primary Licensure and is hereby required to obtain from the Department a new license for that location if the facility constitutes a Secondary Facility. A facility constitutes a Secondary Facility if:

a. The facility is physically located a distance greater than 500 yards, or

b. The facility requires or maintains separate heating, cooling, electric, sewer systems from the Facility of Primary Licensure.

(b) The licensed Secondary Facility shall obtain from the federal Centers for Medicare and Medicaid Services a separate National Provider Identification Number.

(c) Every health care facility, ambulatory surgical center, or outpatient facility shall bill all public and private payors for services using the National Provider Identification Number assigned to the specific facility and physical locations where the services were provided.

(d) No public or private payor shall be required to pay a claim billed by a health care facility, ambulatory surgical center, or outpatient facility not billed in accordance with this section.

(e) Subject to any agreement between the parties, a Secondary facility shall bill a carrier for services at a rate negotiated by the parties separately from the rates for the Facility of Primary Licensure or in the absence of an agreement, 110% of Medicare.

(f) Notwithstanding the provisions of this chapter the Department shall not grant a license to any Secondary Facility unless there is a determination by the department that there is a need for such a facility pursuant to Section 25C. Secondary Facilities in operation as of the effective date of this section shall be exempt from the Department's determination of need requirements.

(g) The Department along with the Office of the Attorney General shall have the authority to enforce the requirements of this section.

SECTION 5. Chapter 111: Section 70G. Reduction of Duplicate Diagnostic Services

Section 70G. Each hospital in the Commonwealth shall file with the department, within thirty (30) days of the start of the hospital fiscal year, a written plan designed to eliminate the duplication of unnecessary diagnostic services performed on a patient by another hospital or diagnostic facility when there is knowledge of a prior test. The plan shall include the following:

1) Current procedures for sending and receiving diagnostic, imaging and other test results from or to another hospital or provider of care;

2) A defined procedure for determining whether any such test results can be appropriately used in the patient's treatment;

3) A plan to improve the hospital's ability to send and receive such test results from or to other providers of care. The Department shall notify the hospital that the plan has been approved or disapproved within thirty (30) days after filing, based on a determination as to whether the plan adequately addresses the issues of patient safety and costs of duplicating diagnostic tests. If such plan has not been acted upon by the department within thirty (30) days, the plan shall be deemed approved. If the department disapproves of such plan, the hospital shall submit a revised plan within thirty (30) days. If the revised plan continues to be disapproved, or if a hospital fails to submit a plan, the commissioner may issue an order that such a plan be submitted immediately. If such an order is issued, health insurance carriers may deny payment for any duplicate services furnished unless the hospital can establish that the duplicate service was medically necessary and appropriate. In the event that a carrier denies payment for duplicate services, the hospital may not bill the insured for those services.

SECTION 6. Section 51 of Chapter 111 of the General Laws is hereby amended by inserting at the end thereof the following:

Each hospital in the Commonwealth that operates an Emergency Room shall annually file with the Department, within thirty (30) days of the start of the hospital fiscal year, a written operating plan designed to eliminate emergency room overcrowding and diversions. The plan shall include the following:

1) A comprehensive assessment of emergency room wait times for the prior fiscal year, including the average wait time and the number of complaints submitted to the hospital regarding wait times in the emergency room, and a review of steps taken to reduce the wait time. The assessment shall also include the number of hours the emergency room was on diversion status, broken down by day of the week, and the actual number of emergency diversions for the prior fiscal year;

2) A summary of the specific measures that the hospital will take in the current fiscal year to eliminate overcrowding in the emergency room, such as adjusting elective surgery schedules to reduce variability;

3) The anticipated impact the plan will have on staffing ratios and, after the first year, the actual impact the plan has had for the previous year;

4) A defined set of measures by which to assess the plan's success, such as the number of emergency room diversions, the average wait time to receive emergency services, and/or the percentage of patients in a bed within one hour of arriving in the emergency room;

The Department shall notify the hospital that the plan has been approved or disapproved within twenty (20) days after filing, based on a determination as to whether the plan adequately addresses the needs of emergency room patients. If such plan has not been acted upon by the Department within twenty (20) days, the plan shall be deemed approved. If the Department disapproves of such plan, the hospital shall submit a revised plan within twenty (20) days. If the revised plan continues to be disapproved, or if a hospital fails to submit a plan, the commissioner may take any action deemed appropriate.

SECTION 7. Section 12 of Chapter 118E of the General Laws is hereby amended by inserting at the beginning of the section the following new definitions:

“Managed Care Organization”, any entity with which the Commonwealth contracts to provide managed care services to eligible MassHealth enrollees on a capitated basis.

"Network", a grouping of health care providers who contract with a managed care organization to provide services to MassHealth enrollees covered by the managed care organization’s plans, policies, contracts or other arrangements.

“Non-network provider”, a health care provider who has not entered into a contract with a managed care organization to provide services to MassHealth enrollees.

SECTION 8. Section 12 of Chapter 118E of the General Laws is further amended by inserting at the end of the section the following new language:

For emergency, post-stabilization, and certain other services that have received a prior approval by a managed care organization contracting with the Commonwealth to provide managed care services to MassHealth enrollees, health care providers not included in a managed care organization’s network, must accept a rate equal to the rate paid by Medicaid for the same or similar services. Nothing in this section shall prohibit a managed care organization from denying payment for unapproved services conducted by a non-network provider.

SECTION 9. Chapter 118H of the General Laws is hereby amended by the addition of a new Section 7, as follows:

Section 7. For emergency, post-stabilization, and certain other services that have received a prior approval by a carrier or managed care organization contracting with the Connector to

provide managed care services to Commonwealth Care Health Insurance Program enrollees, health care providers not included in a managed care organization's network, must accept a rate equal to the rate paid by Medicaid for the same or similar services. Nothing in this section shall prohibit a carrier or managed care organization from denying payment for unapproved services conducted by a non-network provider.

SECTION 10. Chapter 118G is hereby amended by adding the following new Section:

As used in this section, the following words shall have the following meanings:

"Payor", carrier, as defined by M.G.L. Chapter 176O, the group insurance commission established under chapter 32A; and to the extent legally feasible and otherwise not prohibited by any applicable provision of the Employee Retirement Income Security Act of 1974, other employee welfare benefit plans.

Every acute care hospital, health care facility, ambulatory surgical center, or outpatient facility licensed in the commonwealth that does not agree to participate in a payor's network must accept a rate equal 110% of the rate paid by Medicare for the same or similar services. Nothing in this section shall prohibit a payor from denying payment for unapproved services conducted by a non-network provider. Every acute care hospital, health care facility, ambulatory surgical center, or outpatient facility licensed in the commonwealth shall be prohibited from attempting to charge or to collect from the enrollee, or persons acting on the enrollee's behalf, any amount in excess of the amount paid by the payor for that service pursuant to the requirements of this section, other than applicable co-payments, co-insurance and deductibles.

SECTION 11. Chapter 118G of the General Laws is hereby amended by inserting after section 4 the following new section:

4A. Reporting of Hospital Margins

If in any fiscal year, an Acute Hospital, as defined in this chapter, reports to the division an operating margin that exceeds 5 percent, the division shall hold a public hearing within 60 days. The Acute Hospital shall submit testimony on its overall financial condition and the continued need to sustain an operating margin that exceeds 5 percent. The Acute Hospital shall also submit testimony on efforts the Acute Hospital is making to advance health care cost containment and health care quality improvement; and whether, and in what proportion to the total operating margin, the Acute Hospital will dedicate any funds to reducing health care costs. The division shall review such testimony and issue a final report on the results of the hearing. In implementing the requirements of this Section, the Division shall utilize data collected by hospitals pursuant to the requirements of Section 53 of Chapter 288 of the Acts of 2010.

SECTION 12. Chapter 118G of the General Laws is hereby amended by after section 15 inserting the following new section:

15A: Contracting Rights of Private Payors- Unfair Methods of Competition and Unfair or Deceptive Acts or Practices in the Conduct of Health Care Providers

It shall be an unfair business trade practice for any health care provider to attempt to recoup any unreimbursed amounts paid by government payors by increasing charges to other

nongovernmental payors. Violations of this section shall be subject to enforcement by the office of the attorney general.

The division shall monitor health care provider charges to ensure compliance with this section and shall report any non-compliance to the attorney general. The division of health care finance and policy in cooperation with the office of the attorney general shall promulgate regulations enforcing this subsection, which shall include penalties for noncompliance.

SECTION 13. Chapter 118G of the General Laws is hereby amended by inserting the following new section:

Section 40 - Review and evaluation of regulatory changes on health insurance

Section 40 (a) For the purposes of this section, a mandated health benefit is a statutory or regulatory requirement that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part 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 organized under chapter 32A , individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized 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 , or an organization entering into a preferred provider arrangement under chapter 176I , any health plan issued, renewed, or delivered within or without the commonwealth to a natural person who is a resident of the

commonwealth, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association for said natural person and his dependent, including said person's spouse organized under chapter 176M.

(b) Joint committees of the general court and the house and senate committees on ways and means when reporting favorably on mandated health benefits bills referred to them shall include a review and evaluation conducted by the division of health care finance and policy pursuant to this section.

(c) Upon request of a joint standing committee of the general court having jurisdiction or the committee on ways and means of either branch, the division of health care finance and policy shall conduct a review and evaluation of the mandated health benefit proposal, in consultation with other relevant state agencies, and shall report to the committee within 90 days of the request. If the division of health care finance and policy fails to report to the appropriate committee within 45 days, said committee may report favorably on the mandated health benefit bill without including a review and evaluation from the division.

(d) Any state agency or any board created by statute, including but not limited to the Board of the Commonwealth Connector, the Department of Health, the Division of Medical Assistance or the Division of Insurance that proposes to add a mandated health benefit by rule, bulletin or other guidance must request that a review and evaluation of that proposed mandated health benefit be conducted by the division of health care finance and policy pursuant to this section. The report on the mandated health benefit by the division of health care finance and policy must be received by the agency or board and available to the public at least 30 days prior to any public hearing on the proposal. If the division of health care finance and policy fails to

report to the agency or board within 45 days of the request, said agency or board may proceed with a public hearing on the mandated health benefit proposal without including a review and evaluation from the division.

(e) Any party or organization on whose behalf the mandated health benefit was proposed shall provide the division of health care finance and policy with any cost or utilization data that they have. All interested parties supporting or opposing the proposal shall provide the division of health care finance and policy with any information relevant to the division's review. The division shall enter into interagency agreements as necessary with the division of medical assistance, the group insurance commission, the department of public health, the division of insurance, and other state agencies holding utilization and cost data relevant to the division's review under this section. Such interagency agreements shall ensure that the data shared under the agreements is used solely in connection with the division's review under this section, and that the confidentiality of any personal data is protected. The division of health care finance and policy may also request data from insurers licensed or otherwise authorized to transact accident or health insurance under chapter 175 , nonprofit hospital service corporations organized under chapter 176A , nonprofit medical service corporations organized under chapter 176B , health maintenance organizations organized under chapter 176G , and their industry organizations to complete its analyses. The division of health care finance and policy may contract with an actuary, or economist as necessary to complete its analysis.

The report shall include, at a minimum and to the extent that information is available, the following: (1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years, the extent to which the proposed coverage might increase the appropriate or

inappropriate use of the treatment or service over the next 5 years, the extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of municipalities, large employers, small employers, employees and nongroup purchasers, the potential benefits and savings to municipalities, large employers, small employers, employees and nongroup purchasers, the effect of the proposed mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment and the effect on the overall cost of the health care delivery system in the commonwealth; (2) the medical efficacy of mandating the benefit, including the impact of the benefit to the quality of patient care and the health status of the population and the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services or not providing the treatment or service; and (3) if the proposal seeks to mandate coverage of an additional class of practitioners, the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered and the methods of the appropriate professional organization that assures clinical proficiency.

SECTION 14. Chapter 118G: Section 19. Reduction of Preventable Hospital Readmissions

As used in this section, the following words shall have the following meanings:

“Potentially Preventable Readmission” (PPR) shall mean a readmission to a hospital that follows a prior discharge from a hospital within 14 days, and that is clinically-related to the prior hospital admission.

“Observed rate of Readmission” shall meant the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

“Expected Rate of Readmission” shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, and age of patients at the time of discharge preceding the readmission.

”Excess Rate of Readmission” shall mean the difference between the observed rates of potentially preventable readmissions and the expected rate of potentially preventable readmissions for each hospital.

(a) Potentially Preventable Readmission criteria.

1) A hospital readmission is a return hospitalization following a prior discharge that meets all of the following criteria:

a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.

b. The readmission is for a condition or procedure related to the care during the prior hospitalization or the care during the period immediately following the prior discharge and including, but not limited to:

i. The same or closely related condition or procedure as the prior discharge.

ii. An infection or other complication of care.

iii. A condition or procedure indicative of a failed surgical intervention.

iv. An acute decompensation of a coexisting chronic disease.

c. The readmission is back to the same or to any other hospital.

2) Readmissions, for the purposes of determining potentially preventable readmissions, excludes the following circumstances:

a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.

b. The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions.

c. The readmission was a planned readmission or one that occurred on or after 15 days following an initial admission.

(b) The division shall develop a methodology to calculate the expected rate of potentially preventable readmissions for each hospital, and calculate the excess rate of readmission.

(c) The division shall measure the observed rate of readmission, and on a regular and ongoing basis; publish on its website the rates of potentially preventable hospital readmission rates for each hospital licensed in the commonwealth using the definitions and criteria set for in this section. The division shall calculate and publish, both by individual hospital and statewide, the observed rate of readmission, the expected rate of readmission and the excess rate of

readmission for each hospital. In compiling the data necessary for the calculation, the division shall, to the maximum extent feasible, utilize existing data collected from hospitals and carriers.

(d) The division shall convene an advisory committee to develop a standardized methodology to be applied to payments to hospitals that report excess readmissions and make recommendations for a consistent methodology to be adopted across all payers to reduce hospital payments for those hospitals with excess readmissions. The advisory committee shall consist of the commissioner of the division of health care finance and policy, who shall serve as chair; the commissioner of the group insurance commission, or designee; the director of the office of Medicaid, or designee; the commissioner of the department of public health, or designee; the executive director of the commonwealth connector, or designee; one member representing the Massachusetts association of health plans, one member representing the Massachusetts hospital association, one member representing the Massachusetts medical society, one members with expertise in hospital billing and payment, and one member with expertise in hospital reimbursement.

The advisory committee shall convene no later than January 1, 2012 and shall develop its recommendation by no later than April 1, 2012, which shall include a plan to implement the recommended methodologies in all state programs including the state Medicaid program, the health safety net care pool, and the commonwealth care program.

SECTION 15. Chapter 6A of the General Laws, as appearing in the 2008 official edition, is hereby amended by adding after section 16, the following new section:

16A. The division of health care finance and policy shall be the sole repository for health care data collected pursuant to Section 6 of Chapter 118G. The division shall collect, store and

maintain such data in a payer and provider claims database created under said section 6. All other agencies, authorities, councils, boards, and commissions of the commonwealth seeking health care data that is collected under said section 6 shall utilize such data prior to requesting any data from health care providers and payers. The division may enter into interagency services agreements for transfer and use of the data.

SECTION 16. Section 6 of chapter 118G of the General Laws as amended by chapters 131 and 288 of the acts of 2010 is hereby amended by adding at the beginning thereof the following:

"(a). The division shall establish an all payer and provider health care claims database to record and maintain all information collected by the division under subsection (b). The division shall be the sole administrator and operator of said database and shall be responsible for safeguarding the privacy of information collected, recorded and maintained.

There shall be established a reviewing committee to advise the commissioner on the administration of the data base. The reviewing committee shall be comprised of representatives from the hospital, health plan and provider communities, and shall include, but not be limited to the following: a representative of the Massachusetts Hospital Association, a representative of Blue Cross and Blue Shield of Massachusetts, a representative of the Massachusetts Association of Health Plans, and a representative of the Massachusetts Medical Society. The reviewing committee shall be responsible for advising the division on the standards for release and use of the information submitted and shall ensure that such standards protect patient privacy and guard against utilization of the data for the purpose of anti-competitive behavior.

SECTION 17. Said section 6 is hereby further amended by adding at the end thereof the following:

(c) The division shall provide access to information recorded and maintained in the database only in accordance with the division's requirements for protecting patient privacy and shall guard against utilization of the data for the purpose of anti-competitive behavior. Health care providers and payers that supply the data under this section may only be charged reasonable administrative fees for access to information in the database

SECTION 18. Chapter 176O of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting after section 20, the following new section:

Section 21. Beginning January 1, 2010, all hospitals, physician practices and carriers shall conduct the following transactions electronically:

1. Eligibility for a health plan transaction, as described under Code of Federal Regulations, title 45, part 162, subpart L;

2. Health care payment and remittance advice transaction, as described under Code of Federal Regulations, title 45, part 162, subpart P;

3. Health care claims or equivalent encounter information transaction, as described under Code of Federal Regulations, title 45, part 162, subpart K;

SECTION 19. Section 108 of Chapter 175 of the General Laws, as appearing in the Official Edition, is hereby amended by striking out subsection 4(c) and inserting in place thereof the following:

4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or provider under a policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2006, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 20. Section 110 of Chapter 175 of the General Laws, as appearing in the Official Edition, is hereby amended by striking out subsection (G) and inserting in place thereof the following:

(G) For purposes of this section the term ""notice of a claim" shall mean any notification whether in writing or otherwise, to an insurer or its authorized agent, by any person, firm, association, or corporation asserting right to payment under a policy of insurance which reasonably apprises the insurer of the existence of a claim.

Within fifteen days after an insurer's receipt of notice of claim by a claimant under a general or blanket policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 21. Chapter 176G of the General Laws, as appearing in the Official Edition, is hereby amended by striking out section 6 and inserting in place thereof the following:

Section 6. A health maintenance organization may enter into contractual arrangements with any other person or company for the provision, to the health maintenance organization, of health services, insurance, reinsurance and administrative, marketing, underwriting or other services on a nondiscriminatory basis. A health maintenance organization shall not refuse to contract with or compensate for covered services an otherwise eligible provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's

products as they relate to the needs of such provider's patients. No contract between a participating provider of health care services and a health maintenance organization shall be issued or delivered in the commonwealth unless it contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the provider of health care services, the health maintenance organization shall (i) make payments for such services provided, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the health maintenance organization fails to comply with this paragraph for any claims related to the provision of health care services, said health maintenance organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the health maintenance organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the health maintenance organization is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 22. Chapter 176I of the General Laws, as appearing in the Official Edition, is hereby amended by striking section 2 and inserting in place thereof the following:

Section 2. An organization may enter into a preferred provider arrangement with one or more health care providers upon a determination by the commissioner that the organization and the arrangement comply with the requirements of this chapter and the regulations hereunder. An organization shall not condition its willingness to allow any health care provider to participate in a preferred provider arrangement on such health care provider's agreeing to enter into other

contracts or arrangements with the organization that are not part of or related to such preferred provider arrangements. An organization shall not refuse to contract with or compensate for covered services an otherwise eligible participating or nonparticipating provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients. An organization shall submit information concerning any proposed preferred provider arrangements to the commissioner for approval in accordance with regulations promulgated by the commissioner. Said regulations shall comply with the applicable provisions of chapter thirty A of the General Laws. Said information shall include at least the following: (a) a description of the health services and any other benefits to which the covered person is entitled; (b) a description of the locations where and the manner in which health services and other benefits may be obtained; (c) a copy of the evidence of coverage; (d) copies of any contracts with preferred providers; (e) a description of the rating methodology and rates. The arrangement shall meet the following standards: (a) Standards for maintaining quality health care, including satisfying any quality assurance regulations promulgated by any state agency; (b) Standards for controlling health care costs; (c) Standards for assuring reasonable levels of access of health care services and an adequate number and geographical distribution of preferred providers to render those services; (d) Standards for assuring appropriate utilization of health care service; and (e) Other standards deemed appropriate by the commissioner.

No organization may enter into a preferred provider arrangement with one or more health care providers unless said written arrangement contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the health care

provider, the organization shall (i) make payments for the provision of such services, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the organization fails to comply with the provisions of this paragraph for any claims related to the provision of health care services, said organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the organization is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 23. Section one of Chapter 175 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new definitions:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

“State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an

insured is entitled to receive care.

"Policy of Accident and Sickness Insurance," any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of this chapter.

SECTION 24. Section 108 of chapter 175 of the General Laws, as so appearing, is hereby further amended by adding the following new paragraph at the end thereof:—

A carrier authorized to transact individual policies of accident or sickness insurance under this section may offer a flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION 25. Section 110 of chapter 175, as so appearing, is hereby amended by inserting the following new paragraph at the end thereof:—

A carrier authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on

health insurance policy that provides all state mandated benefits. The carrier shall provide each subscriber under a group policy upon enrollment with written notice stating that this is a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 26. Chapter 176A of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new section:—

Section 1D. Definitions

The following words, as used in this chapter, unless the text otherwise requires or a different meaning is specifically required, shall mean-

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

"Policy of Accident and Sickness Insurance," any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

SECTION 27. Section 8 of chapter 176A of the General Laws, as so appearing, is hereby further amended by adding the following paragraphs at the end thereof:—

(h) A non-profit hospital service corporation authorized to transact individual policies of accident or sickness insurance under this section may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

(i) A non-profit hospital service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The non-profit hospital service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this is a

flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 28. Section one of Chapter 176B of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new definitions:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

SECTION 29. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby further amended by adding the following paragraphs at the end thereof:—

A medical service corporation authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

A medical service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits.

The medical service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this is a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 30. Section one of Chapter 176G of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new definitions:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

SECTION 31. Section 4 of chapter 176G of the General Laws, as so appearing, is hereby further amended by adding the following paragraph at the end thereof:—

A health maintenance organization authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective

individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION 32. Chapter 176G, as so appearing, is hereby further amended by inserting the following new section:

Section 4A. A health maintenance organization authorized to transact group policies of accident or sickness insurance under this chapter may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The health maintenance organization shall provide each subscriber under a group policy upon enrollment with written notice stating that this is a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 33. Chapter 176M of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting in section one the following new definitions:—

"Flexible health benefit policy" means a health insurance that, in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required to be offered any general or special law that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION 34. Section 2 of said chapter 176M is hereby amended by striking out the first sentence of paragraph (d) and inserting in place thereof the following:

A carrier that participates in the nongroup health insurance market shall make available to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c) and may additionally make available to eligible individuals no more than two alternative guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits and cost sharing requirements, including deductibles, that differ from the standard guaranteed issue health plan.

SECTION 35. Chapter 175 of the General Laws 175 is hereby amended by inserting after section 111H, the following section:--

Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and

surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include coverage for at least one mandated benefit unless the carrier continues to offer at least one policy that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.

SECTION 36. Chapter 176A of the General Laws is hereby amended by inserting after section 1D the following section:

Section 1E. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a contract that does not include coverage for at least one mandated benefit unless the corporation continues to offer at least one contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months.

SECTION 37. Chapter 176B of the General Laws is hereby further amended by inserting after section 6B, the following section:-- Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least one subscription certificate that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section. (f) Notwithstanding any special or general law to the contrary, no plan approved by

the commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.

SECTION 38. Chapter 176G of the General Laws is hereby amended by inserting after Section 16 the following new section:

Section 16A. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a health maintenance contract unless it provides coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least one mandated benefit unless the health maintenance organization continues to offer at least one health maintenance contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a health maintenance contract, to any employee within 12 months.

SECTION 39. It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until the later of July 31, 2012, or until the rate of increase in the Consumer Price Index (CPI) for medical care services as reported by the United States Bureau of Labor Statistics remains at zero or below zero for two consecutive years.

SECTION 40. Chapter 118E of the General Laws is hereby amended by adding the following new section:

Section 62 - The Executive Office of Health and Human Services shall discontinue membership in the MassHealth fee-for-service program and primary care clinician plan, and shall begin to enroll all members meeting eligibility requirements, as established pursuant to

applicable federal and state law and regulation, into a Medicaid managed care organization that has contracted with the commonwealth to deliver such managed care services, in accordance with the enrollment and assignment process for other eligible categories and at the appropriate levels of premium.

SECTION 41.

Section 40 of this act shall take effect on January 1, 2012.