

HOUSE No. 3452

The Commonwealth of Massachusetts



OFFICE OF THE GOVERNOR
COMMONWEALTH OF MASSACHUSETTS
· , MA
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May 3, 2013

To the Honorable Senate and House of Representatives,

I am filing for your consideration a bill entitled, “An Act Implementing the Affordable Care Act and Providing Further Access to Affordable Health Care.” This legislation will allow Massachusetts to realize the full benefits of the Affordable Care Act, including expanded federal funding to support coverage for low and middle-income families and federal insurance reforms that will secure additional protections for Massachusetts residents.

The legislative package includes a number of changes that will allow Massachusetts to align with the Affordable Care Act, such as:

- Implementing a transition period in the merged individual/small group market to allow Massachusetts to conform to federal rating factor requirements;
- Implementing the ACA requirement that health insurance rates for individuals be filed on a calendar year basis, but allowing small group rates to be filed on a quarterly basis until 2016;
- Aligning the Commonwealth’s definition of who is eligible to purchase non-group insurance with the federal definition;
- Conforming the state’s insurance laws to align with ACA requirements;

- Aligning MassHealth and Connector eligibility definitions with ACA definitions;
- and
- Allowing for data to be shared with EOHHS and the Connector so that eligibility for MassHealth or subsidized coverage through the Exchange can be verified in real-time through the new on-line integrated eligibility system.

Enacting these provisions builds on the progress we have already made to improve health care coverage in our state. I urge your prompt and favorable consideration of this legislation.

Respectfully submitted

Deval L. Patrick,
Governor

HOUSE No. 3452

Message from His Excellency the Governor recommending legislation relative to implementing the Affordable Care Act and providing further access to affordable health care. Ways and Means.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act implementing the Affordable Care Act and providing further access to affordable health care.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to which is to expand forthwith access to health care for Massachusetts residents, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section 16 of chapter 6A of the General Laws, as appearing in the 2010
2 Official Edition, is hereby amended by adding the following paragraph:-

3 Notwithstanding any general or special law to the contrary, the executive office of health
4 and human services may request from any agency, department, division, commission, board,
5 authority, and other public or quasi-public entity in the commonwealth, and such agencies and
6 entities shall provide, any information, including personal data as defined in chapter 66A and
7 data in the wage reporting system administered by the department of revenue pursuant to chapter
8 62E, that the executive office of health and human services determines, in its judgment, as being
9 reasonably necessary to make available, determine eligibility for, enroll individuals in, and
10 otherwise administer various public benefit programs authorized under chapter 118E or other
11 programs that the executive office of health and human services may administer in accord with
12 the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time,
13 or that the executive office of health and human services determines, in its judgment, as being
14 reasonably necessary to develop and administer a single integrated eligibility system, in
15 conjunction with the commonwealth health insurance connector authority, through which the
16 executive office of health and human services may make available, determine eligibility for,

17 enroll individuals in, and otherwise administer such public benefit programs, and through which
18 the commonwealth health insurance connector authority will execute its statutory responsibilities
19 under chapter 176Q, provided the provision of such information to the executive office of health
20 and human services for such purposes is consistent with federal law. Further, notwithstanding
21 any general or special law to the contrary, the executive office of health and human services is
22 authorized to provide to the commonwealth health insurance connector authority any information
23 the executive office of health and human services obtains pursuant to section 23 of chapter 118E
24 as is reasonably necessary for the commonwealth health insurance connector authority to
25 perform its duties pursuant to chapter 176Q.

26 SECTION 2. Section 1 of chapter 6D, as inserted by section 15 of chapter 224 of the acts
27 of 2012, is hereby amended by striking out the definition “Public health care payer” and inserting
28 in place thereof the following definition:-

29 “Public health care payer”, the Medicaid program established in chapter 118E; any
30 carrier or other entity that contracts with the office of Medicaid to pay for or arrange the
31 purchase of health care services on behalf of individuals enrolled in health coverage programs
32 under Titles XIX or XXI, including prepaid health plans subject to section 28 of chapter 47 of
33 the acts of 1997; the group insurance commission established under chapter 32A; and any city or
34 town with a population of more than 60,000 that has adopted chapter 32B.

35 SECTION 3. Subsection (d) of section 8 of said chapter 6D, as inserted by section 15 of
36 chapter 224 of the acts of 2012, is hereby amended by striking out, in clause (vii), the words “or
37 under the commonwealth care health insurance program”.

38 SECTION 4. Section 1 of chapter 12C, as inserted by section 19 of chapter 224 of the
39 acts of 2012, is hereby amended by striking out the definition “Public health care payer” and
40 inserting in place thereof the following definition:-

41 “Public health care payer”, the Medicaid program established in chapter 118E; any
42 carrier or other entity that contracts with the office of Medicaid to pay for or arrange the
43 purchase of health care services on behalf of individuals enrolled in health coverage programs
44 under Titles XIX or XXI, including prepaid health plans subject to the provisions of section 28
45 of chapter 47 of the acts of 1997; the group insurance commission established under chapter
46 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

47 SECTION 5. Chapter 26 of the General Laws is hereby amended by inserting after
48 section 8K the following section:-

49 Section 8L. In regard to any carrier licensed under chapters 175, 176A, 176B, 176E,
50 176F, and 176G, the commissioner of insurance may implement and enforce applicable
51 provisions of the federal Patient Protection and Affordable Care Act, Public Law 111–148, as
52 amended from time to time and of the Women’s Health and Cancer Rights Act, Public Law:

53 105-277, as well as any rules, regulations, or guidance applicable thereto, as amended from time
54 to time, including but not limited to the amendments made by title X of the federal Patient
55 Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of
56 2010, Public Law 111–152 and the Indian Health Care Improvement Reauthorization and
57 Extension Act of 2009, as enacted in amended form by section 10221 of the federal Patient
58 Protection and Affordable Care Act, Public Law 111-148, as amended from time to time.

59 SECTION 6. Section 4N of chapter 111 of the General Laws, as appearing in the 2010
60 Official Edition, is hereby amended by striking out, in line 23, the words “or the commonwealth
61 care health insurance program”.

62 SECTION 7. Section 217 of chapter 111 of the General Laws is hereby repealed.

63 SECTION 8. Section 51 of chapter 112 of the General Laws, as appearing in the 2010
64 Official Edition, is hereby amended by striking out, in lines 60 and 61, the words “or the
65 commonwealth care health insurance program”.

66 SECTION 9. Section 8 of chapter 118E of the General Laws, as appearing in the 2010
67 Official Edition, is hereby amended by striking out the definition “Person” and inserting in place
68 thereof the following definition:-

69 “Person”, any individual who resides in the commonwealth, or any individual residing
70 outside the commonwealth who is deemed to be a resident of the commonwealth under Title
71 XIX, Title XXI or other state or federal programs established or administered pursuant to this
72 chapter.

73 SECTION 10. Said section 8 of said chapter 118E, as so appearing, is hereby further
74 amended by striking out the definition “Reside” and inserting in place thereof the following
75 definition:-

76 “Reside” to occupy an established place of abode with no present intention of definite
77 and early removal, but not necessarily with the intention of remaining permanently, but in no
78 event shall the word “reside” be construed more restrictively or less restrictively than as defined
79 by the Secretary under Title XIX, Title XXI or other state or federal programs established or
80 administered pursuant to this chapter.

81 SECTION 11. Section 9 of said chapter 118E, as so appearing, is hereby amended by
82 inserting after the word “A,” in line 11, the following words:- , and such other persons as may be
83 required under Title XIX and regulations adopted thereunder

84 SECTION 12. Said section 9 of said chapter 118E, as so appearing, is hereby further
85 amended by inserting after the third sentence the following sentence:-

86 In addition to the foregoing, medical assistance under this chapter may be made available
87 to such other persons as may be permitted under Title XIX or Title XXI and regulations adopted
88 thereunder.

89 SECTION 13. Said section 9 of said chapter 118E, as so appearing, is hereby further
90 amended by adding the following paragraph:-

91 The secretary of the executive office may establish a program to provide subsidies to
92 assist eligible individuals in purchasing health insurance, provided that such subsidies shall only
93 be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured
94 by the MassHealth program and shall be made under a sliding-scale premium contribution
95 payment schedule for enrollees, as determined by MassHealth. Eligible individuals are residents
96 of the Commonwealth up to 300 per cent of poverty who are not eligible for Federal advanced
97 premium tax credits, who are ineligible for any other benefits provided pursuant to this chapter,
98 and who are permanently residing in the United States under color of law, provided that the
99 individual has not moved into the commonwealth for the sole purpose of securing health
100 insurance under this chapter and provided further that confinement of an individual in a nursing
101 home, hospital or other medical institution in the commonwealth shall not, in and of itself,
102 suffice to qualify an individual as a resident.

103 SECTION 14. Section 9A of said chapter 118E, as so appearing, is hereby amended by
104 inserting after the word “1315a,” in line 9, the following words:- or any other federal waiver or
105 demonstration authority

106 SECTION 15. Subsection (1) of said section 9A of said chapter 118E, as so appearing, is
107 hereby further amended by striking out the definition “Expansion beneficiaries”.

108 SECTION 16. Said subsection (1) of said section 9A of said chapter 118E, as so
109 appearing, is hereby further amended by striking out the definition “Medical benefits” and
110 inserting in place thereof the following definition:-

111 “Medical benefits” health care services including managed care programs, provided to
112 beneficiaries pursuant to the terms and conditions of a demonstration project and regulations
113 promulgated by the division and including, but not limited to, assistance with premiums and
114 costs sharing and medical insurance purchased for beneficiaries pursuant to section eighteen or
115 benefits authorized by 42 USC 1396e.

116 SECTION 17. Said subsection (1) of said section 9A of said chapter 118E, as so
117 appearing, is hereby further amended by striking out the definition “Traditional beneficiaries.”

118 SECTION 18. Subsection (2) of said section 9A of said chapter 118E, as so appearing, is
119 hereby amended by striking out subdivision (b) and inserting in place thereof the following
120 subdivision:-

121 (b) infants to age one and pregnant women whose financial eligibility as determined by
122 the division does not exceed 200 per cent of the federal poverty level, and children and
123 adolescents aged one to 20 years, inclusive, whose financial eligibility as determined by the
124 division does not exceed 150 per cent of the federal poverty level;

125 SECTION 19. Said subsection (2) of said section 9A of said chapter 118E, as so
126 appearing, is hereby further amended by striking out subdivision (d) and inserting in place
127 thereof the following subdivision:-

128 (d) persons aged 21 to 64, inclusive, whose financial eligibility as determined by the
129 division does not exceed 133 per cent of the federal poverty level, provided however, that such
130 persons shall meet such other eligibility criteria that the division and the secretary may establish;

131 SECTION 20. Said subsection (2) of said section 9A of said chapter 118E, as so
132 appearing, is hereby further amended by adding the following subdivision:-

133 (j) premium assistance for employer sponsored health insurance for adults up to 300 per
134 cent of the poverty level who are uninsured at the time of application, are not eligible for any
135 other program under this chapter and cannot purchase a qualified health plan through the health
136 connector because they have access to employer sponsored minimum essential coverage as
137 defined in section 1401 of the federal Patient Protection and Affordable Care Act, Pub. L. 111-
138 148, as amended from time to time.

139 SECTION 21. Said section 9A of said chapter 118E, as so appearing, is hereby amended
140 by striking out, in line 130, the word “the” where it appears before the word “demonstration”,
141 and inserting in place thereof the word:- a

142 SECTION 22. Subsection (6) of said section 9A of said chapter 118E, as so appearing, is
143 hereby amended by striking out the first two sentences.

144 SECTION 23. Said section 9A of said chapter 118E, as so appearing, is hereby amended
145 by striking out, in lines 157, 164, 174, 179, 211, and 212 the word “the” and inserting in place
146 thereof, in each instance, the following word:- a

147 SECTION 24. Said section 9A of said chapter 118E, as so appearing, is hereby further
148 amended by striking out, in line 182, the words “for expansion beneficiaries”.

149 SECTION 25. Section 9B of said chapter 118E of the General Laws is hereby repealed.

150 SECTION 26. Section 10 of said chapter 118E of the General Laws, as so appearing, is
151 hereby amended by striking out the second paragraph and inserting in place thereof the following
152 paragraph:-

153 The division may, to the extent permitted by Title XIX or other federal authority, provide
154 medical assistance to pregnant women who are presumptively eligible for the period of time

155 prescribed by federal law or other federal authority. The division shall promulgate regulations to
156 implement this section, which shall require health care providers to notify such pregnant women
157 of the need to file an application for Medicaid and which shall set standards to be used by
158 providers in determining presumptive eligibility.

159 SECTION 27. Section 12 of said chapter 118E, as so appearing, is hereby amended by
160 inserting after the words "Title XIX," in line 21, the words:- and Title XXI

161 SECTION 28. Section 16D of said chapter 118E, as so appearing, is hereby amended by
162 striking out, in line 40, the words "MassHealth Essential" and inserting in place thereof the
163 following words:- MassHealth Family Assistance.

164 SECTION 29. Section 27 of said chapter 118E, as so appearing, is hereby amended by
165 striking out subsection (c) and inserting in place thereof the following subsection:-

166 (c) Periodically in accordance with federal law.

167 SECTION 30. Said section 27 of said chapter 118E, as so as appearing, is hereby further
168 amended by inserting after the word "shall," in line 12, the following words:- to the extent
169 required by federal law

170 SECTION 31. Section 64 of chapter 118E, as inserted by section 131 of chapter 224 of
171 the acts of 2012, is hereby amended by striking out, in the definition "Payments subject to
172 surcharge", the words "(2) enrollees in the commonwealth care health insurance program".

173 SECTION 32. Paragraph (ii) of subsection (a) of section 66 of said chapter 118E, as
174 inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out the
175 words "this chapter and the commonwealth care health insurance program under chapter 118H".

176 SECTION 33. Subsection (b) of said section 66 of chapter 118E, as inserted by section
177 131 of chapter 224 of the acts of 2012, is hereby further amended by striking out the words "and
178 the commonwealth care health insurance programs" and inserting in place thereof the following
179 word:- program

180 SECTION 34. Subsection (a) of section 69 of said chapter 118E, as inserted by section
181 131 of chapter 224 of the acts of 2012, is hereby amended by striking out, in paragraph (3), the
182 words "or for the commonwealth care health insurance program, established under chapter
183 118H,".

184 SECTION 35. Chapter 118H of the General Laws is hereby repealed.

185 SECTION 36. Subsection (c) of section 46 of chapter 151A, as appearing in the 2010
186 Official Edition, is hereby amended by striking out paragraph (7) and inserting in place thereof
187 the following paragraph:-

188 (7) to the commonwealth health insurance connector authority, information under an
189 interagency agreement for the administration and enforcement of chapter 176Q and for the
190 administration of the fair share employer contribution requirement under section 188 of chapter
191 149.

192 SECTION 37. Said subsection (c) of said section 46 of said chapter 151A, as so
193 appearing, is hereby amended by striking out Paragraph (8).

194 SECTION 38. Subsection 2. of section 108 of chapter 175 of the General Laws, as
195 appearing in the 2010 Official Edition, is hereby amended by striking out, in paragraph (a),
196 subparagraph (3) and inserting in place thereof the following subparagraph:-

197 (3) It purports to insure only 1 person, except that a policy, excluding contracts which
198 provide stand-alone dental services, shall insure, originally or by subsequent amendment, upon
199 the application of an adult member of a family who shall be considered the policyholder, 2 or
200 more eligible members of that family, including the policyholder, spouse, dependent children
201 and other dependent persons, children during pendency of adoption procedures under chapter
202 210, children under 26 years of age, and children who are mentally or physically incapable of
203 earning their own living, if due proof of the incapacity is received by the insurer within 31 days
204 of the date upon which the coverage would otherwise be terminated; and

205 SECTION 39. Section 110 of said chapter 175, as so appearing, is hereby amended by
206 striking out subsection (P) and inserting in place thereof the following subsection:-

207 (P) A blanket or general policy of insurance described in subdivision (A), (C) or (D),
208 except policies or certificates which provide stand-alone dental services or coverage to Medicare
209 or other governmental programs which shall be delivered, issued or renewed in the
210 commonwealth, shall provide, as benefits to all group members having a place of employment in
211 the commonwealth, coverage to dependent persons under 26 years of age.

212 SECTION 40. Chapter 176A of the General Laws is hereby amended by striking out
213 section 8BB, as appearing in the 2010 Official Edition, and inserting in place thereof the
214 following section:-

215 Section 8BB Any subscription certificate under an individual or group nonprofit hospital
216 service agreement, except certificates which provide stand-alone dental services, supplemental
217 coverage to Medicare or other governmental programs, that is delivered, issued or renewed in the
218 commonwealth, shall provide, as benefits to all individuals or to all group members having a
219 principal place of employment within the commonwealth, coverage to eligible dependents under
220 26 years of age.

221 SECTION 41. Chapter 176B of the General Laws is hereby amended by striking out
222 section 4BB, as appearing in the 2010 Official Edition, and inserting in place thereof the
223 following section:-

224 Section 4BB. Any subscription certificate under an individual or group medical service
225 agreement, except certificates that provide stand-alone dental services, supplemental coverage to
226 Medicare or other governmental programs, that is delivered or issued or renewed in the
227 commonwealth, shall provide, as benefits to all individual subscribers and members within the
228 commonwealth and to all group members having a principal place of employment within the
229 commonwealth, coverage to eligible dependents under 26 years of age.

230 SECTION 42. Chapter 176G of the General Laws is hereby amended by striking out
231 section 4T, as appearing in the 2010 Official Edition, and inserting in place thereof the following
232 section:-

233 Section 4T. A health maintenance contract, except certificates which provide stand-alone
234 dental services, supplemental coverage to Medicare or other governmental programs, shall
235 provide, as benefits to all individuals or to group members having a principal place of
236 employment within the commonwealth, coverage to eligible dependents under 26 years of age.

237 SECTION 43. Section 1 of chapter 176J of the General Laws, as appearing in the 2010
238 Official Edition, is hereby amended by striking out the definition “Eligible dependent” and
239 inserting in place thereof the following definition:-

240 “Eligible dependent,” the spouse or child of an eligible person, subject to the applicable
241 terms of the health benefit plan covering such employee. The child of an eligible individual or
242 eligible employee shall be considered an eligible dependent until the end of the child’s 26th year
243 of age.

244 SECTION 44. Said section 1 of said chapter 176J, as so appearing, is hereby further
245 amended by striking out the definition “Eligible individual” and inserting in place thereof the
246 following definition:-

247 “Eligible individual”, an individual who is a resident of the commonwealth.

248 SECTION 45. Said section 1 of said chapter 176J, as so appearing, is hereby further
249 amended by inserting after the definition of “Financial impairment”, the following definition”:-

250 “Grandfathered health plan”, any group health plan or health insurance coverage to which
251 42 USC 18011 applies.

252 SECTION 46. Said section 1 of said chapter 176J, as so appearing, is hereby further
253 amended by striking out the definition “Pre-existing conditions provision”.

254 SECTION 47. Said section 1 of said chapter 176J, as so appearing, is hereby further
255 amended by striking out the definition “Waiting period”.

256 SECTION 48. Chapter 176J is amended by striking out Section 3, as appearing in the
257 2010 Official Edition, and inserting in place thereof the following section:-

258 Section 3. (a)(1) For every health benefit plan issued or renewed to eligible individuals
259 and eligible small groups, including a certificate issued to an eligible individual or eligible small
260 group that evidences coverage under a policy or contract issued or renewed to a trust, association
261 or other entity that is not a group health plan, a carrier shall develop a group base premium rate
262 that is the same for eligible individuals and eligible small groups. In developing these merged
263 market group base premium rates, carriers are to do as follows:

264 (i) With respect to the group base premium rate developed for eligible individuals
265 and eligible small groups, a carrier must consider all enrollees in those health plans, other than
266 grandfathered health plans, offered by such carrier to be members of a merged individual and
267 small group risk pool;

268 (ii) In calculating the premium to be charged to each eligible individual or eligible
269 small group, a carrier shall develop a base premium and use only those rate adjustment factors
270 identified in this section, inclusive, for all insured health benefit plans offered to eligible
271 individuals and eligible small groups, respectively, with all other rating adjustments being
272 prohibited;

273 (iii) Carriers may offer any rate basis types, but rate basis types that are offered to any
274 eligible individual or eligible small group shall be offered to every eligible individual or eligible
275 small group for all coverage issued or renewed. If an eligible small group does not meet a
276 carrier’s minimum or participation contribution requirements, the carrier may separately rate
277 each employee as an eligible individual, as set forth in paragraph (i), above;

278 (iv) Carriers shall apply the same rating factors when calculating premiums for
279 eligible individuals as are used when calculating premiums for eligible small groups; and

280 (v) Notwithstanding the provisions of this section, all carriers offering any coverage
281 to any eligible individual or eligible small group is required to make that coverage available to
282 every eligible individual and eligible small group.

283 (2) The commissioner shall annually file with the federal department of health and human
284 services to establish a standard age rate adjustment factor table so that the ratio of the highest
285 factor for adults over age 20 compared to the lowest factor for adults over age 20 shall not
286 exceed a ratio of two-to-one. A carrier that elects to apply standard age rate adjustment factors
287 must apply them based upon the covered person’s age when the coverage period begins.

288 (3) The commissioner shall annually file with the federal department of health and human
289 services to establish no more than 7 distinct regions of the state for the purposes of area rate
290 adjustments. A carrier may establish an area rate adjustment for each distinct region, the value
291 of which shall range from eight-tenths to one and two-tenths. If a carrier chooses to apply area
292 rate adjustments, every eligible individual and eligible small group within each area shall be
293 subject to the applicable area rate adjustment.

294

295 (4) A carrier shall establish a rate basis type adjustment factor for eligible individuals and
296 eligible small groups which shall vary the rate only on the basis of whether the health benefit
297 plan covers an individual or family. For purposes of this section, the total premium for family
298 coverage must be determined by summing the premiums for each individual family member.
299 With respect to family members under the age of 21, the premiums for no more than the three
300 oldest covered children must be taken into account in determining the total family premium.

301 (5) The commissioner shall annually file with the federal department of health and human
302 services to establish a standard tobacco use factor; a carrier may apply a tobacco use rate factor
303 in a manner permitted under state and federal law that applies to both eligible small groups and
304 eligible individuals provided that the carrier uses a certification of tobacco use process that has
305 been approved by the commissioner to determine that eligible individuals and their eligible
306 dependents or eligible small group employees and their eligible dependents have not used
307 tobacco products within the past year.

308 (6) A carrier may establish a benefit level rate adjustment for all eligible individuals and
309 eligible small groups that shall be expressed as a number. The number shall represent the
310 relative actuarial value of the benefit level, including the health care delivery network, of the
311 health benefit plan issued to that eligible individual or eligible small group as compared to the
312 actuarial value of other health benefit plans within that class of business. If a carrier chooses to
313 establish benefit level rate adjustments, every eligible individual and every eligible small group
314 shall be subject to the applicable benefit level rate adjustment.

315 (7) A carrier may not apply any rate factor adjustment to the group base premium rate,
316 other than those set forth herein.

317 (b)(1) A carrier that as of the close of any preceding calendar year, has a combined total
318 of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are
319 enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified
320 small businesses or eligible individuals pursuant to its license under chapter 176G, shall be
321 required annually to file a plan with the connector for its consideration, which could attain the
322 connector seal of approval; provided however, the plan shall be filed no later than October 1 of
323 any calendar year.

324 (2) A carrier that as of the close of any preceding calendar year, has a combined total of
325 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled
326 in health benefit plans sold, issued, delivered, made effective or renewed to qualified small
327 businesses or eligible individuals pursuant to its authority under chapter 175, 176A or 176B,
328 shall be required annually to file a plan with the connector for its consideration, which could
329 attain the connector seal of approval; provided however, the plan shall be filed no later than
330 October 1 of any calendar year.

331 (c) For the purposes of this section, neither an eligible individual or eligible employee,
332 nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued
333 pursuant to its authority under chapter 175, 176A or 176B if the health benefit plan is sold,
334 issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a
335 supplement to a health benefit plan subject to licensure under chapter 176G.

336 (d) The commissioner may conduct an examination with respect to the derivation of
337 group base premium rates used to develop individual group premiums in order to identify
338 whether any expenses inappropriately increase the cost in relation to the risks of the merged
339 individual and small group health insurance market.

340 SECTION 49. Subsection (a) of section 4 of said chapter 176J, as so appearing, is hereby
341 amended by striking out clause (2), and inserting in place thereof the following clause:-

342 (2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible
343 individuals, as defined in section 2741 of the Health Insurance Portability and Accountability
344 Act of 1996, 42 U.S.C. 300gg-41(b), into a health plan if those individuals request coverage
345 within 63 days of termination of any prior creditable coverage. A carrier shall also enroll
346 eligible individuals, as permitted under the federal Patient Protection and Affordable Care Act,
347 and any rules, regulations and guidances applicable thereto, as amended from time to time. A
348 carrier shall enable any such eligible individual to renew coverage if that coverage is available to
349 other eligible individuals. Coverage shall become effective in accordance with the federal Patient
350 Protection and Affordable Care Act, and any rules, regulations and guidances applicable thereto,
351 as amended from time to time, subject to reasonable verification of eligibility, and shall be
352 effective through December 31 of that same year. Carriers shall notify any such eligible
353 individuals that:

354 (i) coverage shall be in effect only through December 31 of the year of
355 enrollment;

356 (ii) if any such eligible individual is in a health plan with a plan-year
357 deductible or out-of-pocket maximum, then an explanation of how that
358 deductible or out-of-pocket maximum and premiums will be impacted
359 for the period between the plan effective date and December 31 of the
360 enrollment year; and

361 (iii) the next open enrollment period during which any such eligible
362 individual shall have the opportunity to enroll in a health plan that will
363 begin on January 1 of the following calendar year.

364 A carrier shall not impose a pre-existing condition exclusion or waiting period of any
365 duration on a health plan.

366 SECTION 50. Said chapter 176J is hereby amended by striking out section 5, as
367 appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

368 Section 5. No policy shall exclude an eligible individual, eligible employee or eligible
369 dependent on the basis of age, occupation, actual or expected health condition, claims
370 experience, duration of coverage or medical condition.

371 SECTION 51. Section 6 of said chapter 176J, as so appearing, is hereby amended by
372 striking out subsection (c) and inserting in place thereof the following subsection:-

373 (c) Notwithstanding any general or special law to the contrary, carriers offering small
374 group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or
375 176G, shall file small group product base rates and any changes to small group rating factors that
376 are to be effective on January 1 of each year, on or before July 1 of the preceding year. The
377 commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate
378 or unreasonable in relation to the benefits charged. The commissioner shall disapprove any
379 change to small group rating factors that is discriminatory or not actuarially sound. Rates of
380 reimbursement or rating factors included in the rate filing materials submitted for review by the
381 division shall be deemed confidential and exempt from the definition of public records in clause
382 Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out
383 this section.

384 SECTION 52. Section 9 of said chapter 176J, as so appearing, is hereby amended by
385 striking out, in lines 64 and 65, the words “which does not contain any exclusion or limitation
386 with respect to any preexisting condition of such beneficiary,”.

387 SECTION 53. Section 12 of said chapter 176J, as amended by section 179 of chapter 224
388 of the acts of 2012, is amended by striking out subsection (h) and inserting in place thereof the
389 following subsection:-

390 (h) Any rates offered by a carrier to a certified group purchasing cooperative under this
391 section shall be based on those group base premium rates that apply to individuals and small
392 employer groups enrolling outside the group purchasing cooperative.

393 SECTION 54. Section 13 of said chapter 176J, as so appearing, is hereby amended by
394 striking out subsection (b) and inserting in place thereof the following subsection:-

395 (b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i)
396 include all state-mandated benefits; (ii) apply open enrollment periods for individuals in the
397 same manner as the carrier applies them for individuals outside the group purchasing
398 cooperative, provided, however that small business group purchasing cooperatives shall establish
399 rules and open enrollment periods for qualified association members to enter or exit group
400 purchasing cooperatives; (iii) apply continuation of coverage provisions in the same manner as
401 the carrier applies those provisions to small group products offered outside the group purchasing
402 cooperative; (iv) apply managed care practices in the same manner as the carrier applies those
403 practices to small group products offered outside the group purchasing cooperative; and (v)
404 apply rating rules, including rating bands, rating factors and the value of rating factors, in the
405 same manner as the carrier applies those rules to small group products offered outside the group
406 purchasing cooperative.

407 SECTION 55. Chapter 176N of the General Laws is hereby amended by striking out
408 section 2, as appearing in the 2010 Official Edition, and inserting in place thereof the following
409 section:-

410 Section 2. No health plan shall:

411 (a) exclude any eligible insured on the basis of age, occupation, actual or expected health
412 condition, claims experience, duration of coverage, or medical condition of such person.

413 (b) exclude late enrollees from coverage for more than twelve months from the date of
414 the application for coverage of any late enrollee.

415 (c) In any circumstance in which more extensive coverage than that provided by clauses
416 (a) and (b) is required by any other provision of the General Laws or any law of the United
417 States, the health benefit plan shall satisfy such other provision insofar as it requires more
418 extensive coverage.

419 SECTION 56. Section 1 of chapter 176O of the General Laws, as appearing in the 2010
420 Official Edition, is hereby amended by striking out the definition “Grievance” and inserting in
421 place thereof the following definition:-

422 “Grievance”, any oral or written complaint submitted to the carrier which has been
423 initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any
424 aspect or action of the carrier relative to the insured, including, but not limited to, review of
425 adverse determinations regarding scope of coverage, denial of services, rescission of coverage,
426 quality of care and administrative operations, in accordance with the requirements of this
427 chapter.

428 SECTION 57. Said section 1 of said chapter 176O, as so appearing, is hereby further
429 amended by striking out the definition “Office of patient protection” and inserting in place
430 thereof the following definition:-

431 “Office of patient protection”, the office in the health policy commission established by
432 section 16 of chapter 6D, responsible for the administration and enforcement of sections 13, 14,
433 15 and 16.

434 SECTION 58. Said section 1 of said chapter 176O, as so appearing, is hereby further
435 amended by striking out the definition “adverse determination” and inserting in place thereof the
436 following definition:-

437 “Adverse determination” based upon a review of information provided by a carrier or its
438 designated utilization review organization, to deny, reduce, modify, or terminate an admission,
439 continued inpatient stay, or the availability of any other health care services, for failure to meet
440 the requirements for coverage based on medical necessity, appropriateness of health care setting
441 and level of care, or effectiveness, including a determination that a requested or recommended
442 health care service or treatment is experimental or investigational.

443 SECTION 59. Section 2 of said chapter 176O, as so appearing, is hereby amended by
444 striking out, in lines 22 and 23, the words “division of health care finance and policy” and
445 inserting in place thereof the following words:- center for health information and analysis

446 SECTION 60. Said section 2 of said chapter 176O, as so appearing is hereby amended by
447 striking out, in lines 28 and 29, the words “department of public health established by section
448 217 of chapter 111” and inserting in place thereof the following words:- health policy
449 commission established by section 16 of chapter 6D

450 SECTION 61. Section 6 of said chapter 176O, as so appearing, is hereby amended by
451 striking out, in line 54, the words “section 217 of chapter 111” and inserting in place thereof the
452 following words:- section 16 of chapter 6D

453 SECTION 62. Said section 6 of said chapter 176O, as so appearing, is hereby further
454 amended by striking out, in line 56, the words “in the department of public health” and inserting
455 in place thereof the following words:- or, where applicable, the designated state consumer
456 assistance program

457 SECTION 63. Section 7 of said chapter 176O, as so appearing, is hereby amended by
458 striking out, in lines 23 and 24, the words “the department of public health under section 25P of
459 chapter 111” and inserting in place thereof the following words:- center for health information
460 analysis

461 SECTION 64. Said section 7 of said chapter 176O, as so appearing, is hereby further
462 amended by striking out, in lines 45 and 55, the words “department of public health” and
463 inserting in place thereof, in each instance, the following words:- health policy commission

464 SECTION 65. Section 13 of said chapter 176O, as so appearing, is hereby amended by
465 striking out, in line 2, the word “provides” and inserting in place thereof the following words:- is
466 compliant with the federal Patient Protection and Affordable Care Act, Public Law 111-148, as
467 amended from time to time as with as well as any rules, regulations, or guidance applicable
468 thereto, and such formal internal grievance process shall provide

469 SECTION 66. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is
470 hereby amended by adding after clause (iii), the following clause:-

471 (iv) a resolution of a claim involving urgently needed services within 72 hours.

472 SECTION 67. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is
473 hereby amended by adding the following sentence:-

474 In the event that an insured claims that a carrier failed to properly act on a grievance that
475 is an adverse determination within the time limits required by this section, such claim is
476 immediately eligible for external review, notwithstanding the requirement in section 14 that the
477 insured must complete the internal review process.

478 SECTION 68. Said section 13 of said chapter 176O, as so appearing, is hereby further
479 amended by adding the following subsection:-

480 (d) An insured may request an expedited review of a grievance and at the same time may
481 request an expedited external review of the grievance pursuant to section 14.

482 SECTION 69. Section 14 of said chapter 176O, as so appearing, is hereby amended by
483 striking out subsection (a), and inserting in place thereof the following subsection:-

484 (a) An insured who remains aggrieved by an adverse determination and has exhausted all
485 remedies available from the formal internal grievance process required pursuant to section 13,
486 may seek further review of the grievance by a review panel established by the office of patient
487 protection pursuant to paragraph (5) of subsection (a) of section 16 of chapter 6D. The insured
488 shall pay the first \$25 of the cost of the review to said office, which may waive the fee in cases
489 of extreme financial hardship and which shall refund the fee to the insured if the adverse
490 determination is reversed in its entirety. No insured shall be required to pay more than \$75 per
491 plan year, regardless of the number of external review requests submitted. The carrier shall be
492 responsible for the remainder of the cost of the review pursuant to regulations promulgated by
493 the executive director of the health policy commission in consultation with the commissioner of
494 insurance. The office of patient protection shall contract with at least three unrelated and
495 objective review agencies through a bidding process, and refer grievances to one of the review

496 agencies on a random selection basis. The review agencies must be accredited by a national
497 accrediting organization and shall develop review panels appropriate for the given grievance,
498 which shall include qualified clinical decision-makers experienced in the determination of
499 medical necessity, utilization management protocols and grievance resolution, and shall not have
500 any financial relationship with the carrier making the initial determination. The standard for
501 review of a grievance by such a panel shall be the determination of whether the requested
502 treatment or service is medically necessary, as defined herein, and a covered benefit under the
503 policy or contract. The panel shall consider, but not be limited to considering: (i) written
504 documents submitted by the insured, (ii) additional information from the involved parties or
505 outside sources that the review panel deems necessary or relevant, and (iii) information obtained
506 from any informal meeting held by the panel with the parties. The panel shall send final written
507 disposition of the grievance, and the reasons therefore, to the insured and the carrier within 45
508 days of receipt of the request for review. Notwithstanding the requirements of this section, an
509 insured may request an external review of an adverse determination without exhausting the
510 carrier's internal appeals process if the insured is seeking an expedited review or if the carrier
511 failed to meet the time limits specified in section 13.

512 SECTION 70. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is
513 hereby amended by adding the following two sentences:-

514 There shall be a process for the expedited review of grievances. The external review
515 panel shall send final written disposition of the grievance, and the reasons therefore, to the
516 insured and the carrier within 72 hours of receipt of the request for review.

517 SECTION 71. Said section 14 of said chapter 176O, as so appearing, is hereby further
518 amended by inserting after the word "binding", in line 40, the following words:- on the insured
519 and on the carrier

520 SECTION 72. Section 17 of said chapter 176O as so appearing, is hereby amended by
521 striking out, in line 2, the words "commissioner of public health" and inserting in place thereof
522 the following words:- health policy commission

523 SECTION 73. Section 20 of said chapter 176O, as so appearing, is hereby amended by
524 striking out, in lines 26 and 27, the words "office of patient protection, established by section
525 217 of chapter 111," and inserting in place thereof the following words:- designated state
526 consumer assistance program

527 SECTION 74. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010
528 Official Edition, is hereby amended by striking out the definition "Commonwealth care health
529 insurance program".

530 SECTION 75. Said section 1 of said chapter 176Q, as so appearing, is hereby further
531 amended by striking out the definition “Commonwealth care health insurance program
532 enrollees”.

533 SECTION 76. Said section 1 of said chapter 176Q, as so appearing, is hereby further
534 amended by striking out the definition “Eligible individual” and inserting in place thereof the
535 following definition:-

536 “Eligible individual”, an individual who is a resident of the commonwealth and who is
537 qualified to purchase coverage through the connector pursuant to 42 U.S.C. § 18032(f).

538 SECTION 77. Said Section 1 of said chapter 176Q, as so appearing, is hereby further
539 amended by inserting after the definition “Eligible small group” the following 2 definitions:-

540 “Federal advanced premium tax credits”, a payment made pursuant to 26 U.S.C. § 36B
541 on behalf of an eligible individual or eligible child to reduce the value of a health benefit plan
542 premium.

543 “Federal point-of-service cost-sharing reductions”, a payment made pursuant to 26
544 U.S.C. § 36B on behalf of an eligible individual or eligible child to reduce point-of-service cost-
545 sharing expenses which shall include, but not be limited to, copayments, coinsurance and
546 deductibles.

547 SECTION 78. Said Section 1 of said chapter 176Q is hereby further amended by striking
548 out the word “offset” in the definition “Point-of-service cost-sharing subsidy”, as inserted by
549 section 38 of chapter 118 of the Acts of 2012, and inserting in place thereof the following word:-
550 reduce.

551 SECTION 79. Said Section 1 of said chapter 176Q is hereby further amended by striking
552 out the definition “Premium assistance payment”, as inserted by section 38 of chapter 118 of the
553 Acts of 2012, and inserting in place thereof the following definition:-

554 “Premium assistance payment”, a payment made to a carrier or an individual by the
555 connector to reduce the value of a health benefit plan premium paid by the individual.

556 SECTION 80. Said section 1 of said chapter 176Q, as appearing in the 2010 Official
557 Edition, is hereby further amended by striking out the definition of “Rating factor” and inserting
558 in place thereof the following definition:-

559 “Rating factor”, characteristics including, but not limited to, age, rate basis type and
560 geography.

561 SECTION 81. Section 3 of said chapter 176Q, as so appearing, is hereby amended by
562 striking out, in line 5, the words “groups and commonwealth care health insurance plan
563 enrollees”, and inserting in place thereof the following words:- and eligible small groups

564 SECTION 82. Said section 3 of said chapter 176Q, as so appearing, is hereby further
565 amended by striking out, in line 15 and lines 30 and 31, the words “groups and commonwealth
566 care health insurance program enrollees” and inserting in place thereof, in each instance, the
567 following words:- and eligible small groups

568 SECTION 83. Said section 3 of said chapter 176Q, as so appearing, is hereby further
569 amended by striking out, in lines 23 and 24, the words “the commonwealth care health insurance
570 program, established by chapter 118H” and inserting in place thereof the following words:-
571 premium assistance payments or cost-sharing subsidies

572 SECTION 84. Said section 3 of said chapter 176Q, as so appearing, is hereby further
573 amended by striking out, in line 33, the word “all”.

574 SECTION 85. Said section 3 of said chapter 176Q, as so appearing, is hereby further
575 amended by inserting after the word “payments”, in line 38, the following words:- and point-of-
576 service cost-sharing subsidies and, if applicable, federal advanced premium tax credits and
577 federal point-of-service cost-sharing reductions

578 SECTION 86. Subsection (a) of said section 3 of said chapter 176Q, as so appearing, is
579 hereby further amended by striking out paragraph (13) and inserting in place thereof the
580 following paragraph:-

581 (13) develop a standard application form for eligible individuals and eligible small groups
582 seeking to purchase health insurance through the connector; and

583 SECTION 87. Subsection (b) of said section 3 of said chapter 176Q, as amended by
584 section 43 of chapter 118 of the Acts of 2012, is hereby amended by inserting after the word “or”
585 the following words:- point-of-service.

586 SECTION 88. Subsection (m) of said section 3 of said chapter 176Q, as amended by
587 section 132 of chapter 139 of the Acts of 2012, is hereby amended by striking out the words
588 “111M, 118E, 118G 118H” and inserting in place thereof the following words:- 6D, 12C, 15A,
589 111M, 118E

590 SECTION 89. Said section 3 of said chapter 176Q is hereby amended by striking out
591 subsection (o).

592 SECTION 90. Subsection (u) of said section 3 of said chapter 176Q, as inserted by
593 section 7 of chapter 96 of the Acts of 2012, is hereby amended by striking out paragraph (2) and
594 inserting in place thereof the following paragraph:- (2) the determination of eligibility of
595 individuals for shopping, receiving federal advanced premium tax credits and qualifying for
596 federal point-of-service cost-sharing reductions through the Exchange, as provided by federal
597 law; and

598 SECTION 91. Subsection (a) of section 4 of said chapter 176Q, as amended by section
599 45 of chapter 118 of the Acts of 2012, is hereby amended by striking out the words “, including
600 all health benefit plans offered through the commonwealth care health insurance program”.

601 SECTION 92. Section 7 of chapter 176Q is hereby repealed.

602 SECTION 93. Subsection (a) of section 12 of said chapter 176Q, as amended by section
603 49 of chapter 118 of the Acts of 2012, is hereby amended by striking out the last sentence.

604 SECTION 94. Said chapter 176Q is hereby further amended by striking out section 8, as
605 appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

606 Section 8. (a) The connector shall enter into interagency agreements with the department
607 of revenue, the executive office of health and human services, the department of public health,
608 the executive office of labor and workforce development, the registry of motor vehicles, the
609 department of correction, the center for health information and analysis and any such other state
610 agencies, departments, divisions, commissions, authorities or political subdivisions, and the
611 foregoing agencies, departments, divisions, commissions, authorities and political subdivisions
612 are hereby authorized to furnish pursuant to such agreements, information, including personal
613 data as defined in chapter 66A, that is necessary for the connector to perform its duties under this
614 chapter, including the determination of an individual’s eligibility for federal advanced premium
615 tax credits and federal point-of-service cost-sharing reductions and adjudication of appeals
616 arising from such determinations. Such written agreements shall include provisions permitting
617 the department of revenue to furnish the data available under the wage reporting system
618 established under section 3 of chapter 62E. The department of revenue is hereby authorized to
619 furnish the connector with information on the cases of persons so identified, including, but not
620 limited to, name, social security number and other data to ensure positive identification, name
621 and identification number of employer, and amount of wages received and gross income from all
622 sources. The connector shall not utilize any of the data received from the department of revenue
623 for any solicitations or advertising.

624 (b) The connector is hereby authorized to receive and use any information provided
625 pursuant to section 23 of chapter 118E as necessary for the connector to perform the duties under
626 this chapter, including the determination of an individual’s eligibility for federal advanced
627 premium tax credits and federal point-of-service cost-sharing reductions and adjudication of
628 appeals arising from such determinations.

629 SECTION 95. Section 15 of said chapter 176Q, as so appearing, is hereby amended by
630 striking out, in lines 14 to 16, inclusive, the words “, the operation and administration of the
631 commonwealth care health insurance program described in chapter 118H”.

632 SECTION 96. Section 1 of chapter 176T, as inserted by section 216 of chapter 224 of the
633 acts of 2012, is hereby amended by striking out the definition “Public health care payer” and
634 inserting in place thereof the following definition:-

635 “Public health care payer”, the Medicaid program established in chapter 118E; any
636 carrier or other entity that contracts with the office of Medicaid to pay for or arrange the
637 purchase of health care services on behalf of individuals enrolled in health coverage programs
638 under Titles XIX or XXI, including prepaid health plans subject to the provisions of section 28
639 of chapter 47 of the acts of 1997; the group insurance commission established under chapter
640 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

641 SECTION 97. Section 66 of chapter 288 of the Acts of 2010, as amended by section 234
642 of chapter 224 of the Acts of 2012, is hereby repealed.

643 SECTION 98. Section 226 of chapter 224 of the Acts of 2012 is hereby repealed.

644 SECTION 99. Section 227 of chapter 224 of the Acts of 2012 is hereby repealed.

645 SECTION 100. Section 246 of chapter 224 of the Acts of 2012 is hereby repealed.

646 SECTION 101. Section 253 of chapter 224 of the Acts of 2012 is hereby amended by
647 striking out the words “, the commonwealth care health insurance program established under
648 chapter 118H of the General Laws, any carrier or other entity which contracts with the
649 commonwealth care health insurance program to pay for or arrange for the purchase of health
650 care services”.

651 SECTION 102. Notwithstanding any provisions of chapter 176J of the Massachusetts
652 General Laws to the contrary, and only for the period from January 1, 2014 through December
653 31, 2015, carriers will be permitted to develop the group base premium for eligible small
654 employers so that the group base premium will vary by enrollment or renewal month and shall be
655 filed as part of a rate filing for each calendar quarter.

656 In addition, notwithstanding any provisions of chapter 176J to the contrary, and only for
657 the period from January 1, 2014 through December 31, 2015, in calculating the premium to be
658 charged to each eligible small group or eligible individual, carriers will be permitted to utilize
659 and apply a portion of the following rate adjustment factors, based on the factors a carrier has in
660 place as of July 1, 2013, in addition to those permitted under chapter 176J: (1) an industry rate
661 adjustment factor; (2) a participation rate adjustment factor; (3) a group size rate adjustment
662 factor; (4) an intermediary rate adjustment factor; and (5) a group purchasing cooperative rate
663 adjustment.

664 The commissioner of insurance shall have the authority to issue regulations to implement
665 this section, including, but not limited to, regulations setting forth the manner in which carriers

666 may utilize and apply the additional rate adjustment factors set forth in this section during the
667 period from January 1, 2014 through December 31, 2015.

668 SECTION 103. Sections 1, 5, and 94 shall take effect 30 days after passage of this act.

669 SECTION 104. Sections 2 to 4, inclusive, 6 to 50, inclusive, 52 to 93, inclusive, and 95 to
670 101, inclusive, shall take effect January 1, 2014.