# SENATE . . . . . . . . . . . . . . No. 1812

Senate, June 26, 2013 -- The committee on Bills in the Third Reading, to whom was referred the House implementing the Affordable Care Act and providing further access to affordable health care (House, No. 3452); reports, recommending that the same ought to pass with an amendment striking out all after the enacting clause and inserting in place thereof the text of Senate document numbered 1812.

## The Commonwealth of Massachusetts

**In the Year Two Thousand Thirteen**

1 SECTION 1. Section 16 of chapter 6A of the General Laws, as most recently amended by
2 section 5 of chapter 224 of the acts of 2012, is hereby further amended by adding the following
3 paragraph:-

4 Notwithstanding any general or special law to the contrary, the executive office of health
5 and human services may request from any agency, department, division, commission, board,
6 authority, or other public or quasi-public entity in the commonwealth, and they shall provide,
7 any information, including personal data, as defined in section 1 of chapter 66A and data in the
8 wage reporting system administered by the department of revenue pursuant to chapter 62E, that
9 the executive office of health and human services determines to be necessary to make available,
10 determine eligibility for, enroll individuals in and otherwise administer various public benefit
11 programs authorized pursuant to chapter 118E or other programs that the executive office of
12 health and human services may administer in accord with the Patient Protection and Affordable
13 Care Act, Public Law 111-148, as amended from time to time, or that the executive office of
14 health and human services determines, in its judgment, as being reasonably necessary to develop
15 and administer a single integrated eligibility system, in conjunction with the commonwealth
16 health insurance connector authority, through which the executive office of health and human
17 services may make available, determine eligibility for, enroll individuals in and otherwise
18 administer such public benefit programs, and through which the commonwealth health insurance
19 connector authority will execute its statutory responsibilities pursuant to chapter 176Q; provided,
20 that the provision of such information to the executive office of health and human services for
21 such purposes is consistent with federal law. Further, notwithstanding any general or special law
22 to the contrary, the executive office of health and human services is authorized to provide to the
23 commonwealth health insurance connector authority any information the executive office of
24 health and human services obtains pursuant to section 23 of chapter 118E as necessary for the

25 commonwealth health insurance connector authority to perform its duties pursuant to chapter
26 176Q.

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

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

37 SECTION 3. Clause (vii) of subsection (d) of section 8 of said chapter 6D, as so inserted,
38 is hereby amended by striking out the words "or under the commonwealth care health insurance
39 program".

40 SECTION 4. Section 1 of chapter 12C, inserted by section 19 of said chapter 224, is
41 hereby amended by striking out the definition of "Public health care payer" and inserting in place
42 thereof the following definition:-

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

50 SECTION 4A. Section 18 of chapter 15A of the General Laws, as appearing in the 2010
51 Official Edition, is hereby amended by striking out the first paragraph and inserting in place
52 thereof the following paragraph:-

53 Every full-time and part-time student enrolled in a public or independent institution of
54 higher learning located in the commonwealth shall participate in a qualifying student health
55 insurance program. For the purposes of this section, "part-time student" shall mean a student
56 participating in at least 75 per cent of the full-time curriculum. Such an institution may allow
57 students to waive participation in its student health insurance program or any part thereof;
58 provided, however, that such an institution shall require students waiving participation to certify
59 in writing prior to any academic year in which the student will not participate in the institution's
60 plan that such student is a participant in a health insurance program providing comparable

61 coverage; and provided further, that such institution shall allow students to waive participation in
62 its student health insurance program if the student is currently enrolled in MassHealth, the
63 student continues to meet all relevant MassHealth eligibility criteria under state and federal law
64 and: (i) the student has been enrolled in MassHealth for at least 1 year prior to becoming eligible
65 for the institution's student health insurance program or (ii) the student has been enrolled in
66 MassHealth for at least 6 months and the student provides documentation, as required by the
67 commonwealth health insurance connector in consultation with MassHealth, that participation in
68 the qualifying student health insurance program would be financially prohibitive.

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

71 Section 8L. In regard to any carrier licensed pursuant to chapters 175, 176A, 176B,
72 176E, 176F and 176G, the commissioner of insurance may implement and enforce: (i) the Patient
73 Protection and Affordable Care Act, Public Law 111–148, as well as any rules, regulations or
74 guidance applicable thereto, as amended from time to time; and (ii) the Women's Health and
75 Cancer Rights Act of 1998, Public Law 105-277, as well as any rules, regulations or guidance
76 applicable thereto, as amended from time to time, including, but not limited to, the amendments
77 made by: Ttitle X of said Patient Protection and Affordable Care Act; the Health Care and
78 Education Reconciliation Act of 2010, Public Law 111–152; and the Indian Health Care
79 Improvement Reauthorization and Extension Act of 2009, as enacted in amended form by
80 section 10221 said federal Patient Protection and Affordable Care Act.

81 SECTION 6. Section 4N of chapter 111 of the General Laws, as appearing in the 2010
82 Official Edition, is hereby amended by striking out, in line 23, the words "or the commonwealth
83 care health insurance program".

84 SECTION 7. Section 217 of said chapter 111 is hereby repealed.

85 SECTION 8. Section 51 of chapter 112 of the General Laws, as appearing in the 2010
86 Official Edition, is hereby amended by striking out, in lines 60 and 61, the words "or the
87 commonwealth care health insurance program".

88 SECTION 9. Section 8 of chapter 118E of the General Laws, as so appearing, is hereby
89 amended by striking out the definition of "Person" and inserting in place thereof the following
90 definition:-

91 "Person", any individual who resides in the commonwealth, or any individual residing
92 outside the commonwealth who is deemed to be a resident of the commonwealth under Title
93 XIX, Title XXI or other state or federal programs established or administered pursuant to this
94 chapter.

95 SECTION 10. Said section 8 of said chapter 118E, as so appearing, is hereby further
96 amended by striking out the definition of "Reside" and inserting in place thereof the following
97 definition:-

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

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

106 SECTION 12. The second paragraph of said section 9 of said chapter 118E is hereby
107 further amended by inserting after the second sentence, as so appearing, the following sentence:-
108 In addition to the foregoing, medical assistance under this chapter may be made available to such
109 other persons as may be permitted under Title XIX or Title XXI and regulations adopted
110 thereunder.

111 SECTION 13. Said section 9 of said chapter 118E, as amended by section 24 of chapter
112 118 of the acts of 2012, is hereby further amended by adding the following paragraph:-

113 The secretary of the executive office may establish a program to provide subsidies to
114 assist eligible individuals in purchasing health insurance, provided that such subsidies shall only
115 be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured
116 by the MassHealth program and shall be made under a sliding-scale premium contribution
117 payment schedule for enrollees, as determined by MassHealth. Eligible individuals are residents
118 of the commonwealth whose income is 300 per cent or less of the federal poverty level as
119 calculated pursuant to the regulations of the executive office, who are not eligible for federal
120 advanced premium tax credits, who are ineligible for any other benefits provided pursuant to
121 this chapter, and who are permanently residing in the United States under color of law; provided,
122 that the individual has not moved into the commonwealth for the sole purpose of securing health
123 insurance under this chapter; and provided further, that confinement of an individual in a nursing
124 home, hospital or other medical institution in the commonwealth shall not, in and of itself,
125 suffice to qualify an individual as a resident.

126 SECTION 14. Section 9A of said chapter 118E, as appearing in the 2010 Official
127 Edition, is hereby amended by inserting after the figure "1315a," in line 9, the following words:-
128 or any other federal waiver or demonstration authority

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

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

134 “Medical benefits”, health care services including managed care programs, provided to
135 beneficiaries pursuant to the terms and conditions of a demonstration project and regulations
136 promulgated by the division and including, but not limited to, assistance with premiums and
137 costs sharing and medical insurance purchased for beneficiaries pursuant to section 18 or
138 benefits authorized by 42 U.S.C. § 1396e.

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

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

143 (b) infants to age 1 and pregnant women whose financial eligibility, as determined by the
144 division, does not exceed 200 per cent of the federal poverty level and children and adolescents
145 aged 1 to 20 years, inclusive, whose financial eligibility, as determined by the division, does not
146 exceed 150 per cent of the federal poverty level.

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

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

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

155 (j) premium assistance for employer sponsored health insurance for adults whose
156 financial eligibility, as determined by the division, does not exceed 300 per cent of the federal
157 poverty level, are uninsured at the time of application, are not eligible for any other program
158 under this chapter and are not eligible for federal advanced premium tax credits through the
159 health connector because they have access to employer sponsored minimum essential coverage
160 as defined in section 1401 of the Patient Protection and Affordable Care Act, Public Law 111-
161 148, as amended from time to time.

162 SECTION 21. Subsection (4) of said section 9A of said chapter 118E, as so appearing, is
163 hereby amended by striking out, in line 130, the word “the”, the second time it appears, and
164 inserting in place thereof the following word:- a.

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

167 SECTION 23. Said section 9A of said chapter 118E, as so appearing, is hereby further
168 amended by striking out, in lines 157, 164, 174, the second time it appears, 179, the second time
169 it appears, 211 and 212, the second time it appears, the word "the" and inserting in place thereof,
170 in each instance, the following word:- a

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

173 SECTION 25. Section 9B of said chapter 118E is hereby repealed.

174 SECTION 26. Section 10 of said chapter 118E, as appearing in the 2010 Official Edition,
175 is hereby amended by striking out the second paragraph and inserting in place thereof the
176 following paragraph:-

177 The division may, to the extent permitted by Title XIX or other federal authority, provide
178 medical assistance to pregnant women who are presumptively eligible for the period of time
179 prescribed by federal law or other federal authority. The division shall promulgate regulations to
180 implement this section, which shall require health care providers to notify such pregnant women
181 of the need to file an application for Medicaid and which shall set standards to be used by
182 providers in determining presumptive eligibility.

183 SECTION 26A. The second paragraph of section 10E of said chapter 118E, as so
184 appearing, is hereby amended by striking out, in line 12, the words, "be limited to" and inserting
185 in place thereof the following words:- include, but shall not be limited to,

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

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

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

193 (c) Periodically in accordance with federal law.

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

197 SECTION 31. The definition of "Payments subject to surcharge" in section 64 of chapter
198 118E, inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking
199 out the words ": (i) Medicaid recipients under age 65; and (2) enrollees in the commonwealth
200 care health insurance program" and inserting in place thereof the following words:- Medicaid
201 recipients under age 65.

202 SECTION 32. Clause (ii) of subsection (a) of section 66 of said chapter 118E, as so
203 inserted, is hereby amended by striking out the words "this chapter and the commonwealth care
204 health insurance program under chapter 118H".

205 SECTION 33. Subsection (b) of said section 66 of said chapter 118E, as so inserted, is
206 hereby amended by striking out the words "and the commonwealth care health insurance
207 programs" and inserting in place thereof the following word:- program.

208 SECTION 34. Paragraph (3) of subsection (a) of section 69 of said chapter 118E, as so
209 inserted, is hereby amended by striking out the words "or for the commonwealth care health
210 insurance program, established under chapter 118H,".

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

212 SECTION 36. Subsection (c) of section 46 of chapter 151A of the General Laws, as
213 amended by section 145 of chapter 224 of the acts of 2012, is hereby further amended by striking
214 out clause (7) and inserting in place thereof the following clause:-

215 (7) to the commonwealth health insurance connector authority, information under an
216 interagency agreement for the administration and enforcement of chapter 176Q.

217 SECTION 37. Said subsection (c) of said section 46 of said chapter 151A, as so
218 amended, is hereby further amended by striking out clause (8).

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

222 (3) It purports to insure only 1 person, except that a policy, excluding contracts which
223 provide stand-alone dental services, shall insure, originally or by subsequent amendment, upon
224 the application of an adult member of a family who shall be considered the policyholder, 2 or
225 more eligible members of that family, including the policyholder, spouse, dependent children
226 and other dependent persons, children during pendency of adoption procedures under chapter
227 210, children under 26 years of age and children who are mentally or physically incapable of
228 earning their own living, if due proof of the incapacity is received by the insurer within 31 days
229 of the date upon which the coverage would otherwise be terminated; and

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

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

237 SECTION 40. Chapter 176A of the General Laws is hereby amended by striking out
238 section 8BB, as so appearing, and inserting in place thereof the following section:-

239 Section 8BB. Any subscription certificate under an individual or group nonprofit hospital
240 service agreement, except certificates which provide stand-alone dental services, supplemental
241 coverage to Medicare or other governmental programs, that is delivered, issued or renewed in the
242 commonwealth, shall provide, as benefits to all individuals or to all group members having a
243 principal place of employment within the commonwealth, coverage to eligible dependents under
244 26 years of age.

245 SECTION 41. Chapter 176B of the General Laws is hereby amended by striking out
246 section 4BB, as so appearing, and inserting in place thereof the following section:-

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

253 SECTION 42. Chapter 176G of the General Laws is hereby amended by striking out
254 section 4T, as so appearing, and inserting in place thereof the following section:-

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

259 SECTION 43. Section 1 of chapter 176J of the General Laws, is hereby amended by
260 striking out the definition of “Eligible dependent”, as so appearing, and inserting in place thereof
261 the following definition:-

262 “Eligible dependent”, the spouse or child of an eligible person, subject to the applicable
263 terms of the health benefit plan covering such employee. The child of an eligible individual or

264 eligible employee shall be considered an eligible dependent until the end of the child's twenty-
265 sixth year of age.

266 SECTION 44. Said section 1 of said chapter 176J is hereby further amended by striking
267 out the definition of "Eligible individual", as most recently amended by section 30 of chapter
268 118 of the acts of 2012, and inserting in place thereof the following definition:-

269 "Eligible individual", an individual who is a resident of the commonwealth.

270 SECTION 45. Said section 1 of said chapter 176J is hereby further amended by inserting
271 after the definition of "Financial impairment", as appearing in the 2010 Official Edition, the
272 following definition:-

273 "Grandfathered health plan", any group health plan or health insurance coverage to which
274 42 U.S.C. § 18011 applies.

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

277 SECTION 47. Said section 1 of said chapter 176J is hereby further amended by striking
278 out the definition of "Waiting period", as so appearing.

279 SECTION 48. Said chapter 176J is hereby amended by striking out section 3, as amended
280 by section 174 of chapter 224 of the acts of 2012, and inserting in place thereof the following
281 section:-

282 Section 3. (a) (1) For every health benefit plan issued or renewed to eligible individuals
283 and eligible small groups, including a certificate issued to an eligible individual or eligible small
284 group that evidences coverage under a policy or contract issued or renewed to a trust, association
285 or other entity that is not a group health plan, a carrier shall develop a group base premium rate
286 that is the same for eligible individuals and eligible small groups. In developing these merged
287 market group base premium rates, carriers :

288 (i) with respect to the group base premium rate developed for eligible
289 individuals and eligible small groups, a carrier shall consider all enrollees in those health plans,
290 other than grandfathered health plans, offered by such carrier to be members of a merged
291 individual and small group risk pool;

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

297 (iii) mayoffer any rate basis types, but rate basis types that are offered
298 to any eligible individual or eligible small group shall be offered to every eligible individual or
299 eligible small group for all coverage issued or renewed; provided, however, that if an eligible
300 small group does not meet a carrier's minimum or participation contribution requirements, the
301 carrier may separately rate each employee as an eligible individual, as set forth in clause (i);

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

304 (v) notwithstanding this section, all carriers offering any coverage to
305 any eligible individual or eligible small group shall make that coverage available to every
306 eligible individual and eligible small group.

307 (2) The commissioner shall annually file with the United States Department of
308 Health and Human Services to establish a standard age rate adjustment factor table so that the
309 ratio of the highest factor for adults over age 20 compared to the lowest factor for adults over age
310 20 shall not exceed a ratio of 2-to-1. A carrier that elects to apply standard age rate adjustment
311 factors shall apply them based upon the covered person's age when the coverage period begins.

312 (3) The commissioner shall annually file with the United States Department of
313 Health and Human Services to establish not more than 7 distinct regions of the state for the
314 purposes of area rate adjustments. A carrier may establish an area rate adjustment for each
315 distinct region, the value of which shall range from .8 to 1.2. If a carrier chooses to apply area
316 rate adjustments, every eligible individual and eligible small group within each area shall be
317 subject to the applicable area rate adjustment.

318 (4) A carrier shall establish a basis type rate adjustment factor for eligible
319 individuals and eligible small groups which shall vary the rate only on the basis of whether the
320 health benefit plan covers an individual or family. For purposes of this section, the total
321 premium for family coverage must be determined by summing the premiums for each individual
322 family member. With respect to family members under the age of 21, the premiums for not more
323 than the 3 oldest covered children must be taken into account in determining the total family
324 premium.

325 (5) The commissioner shall annually file with the United States Department of
326 Health and Human Services to establish a standard tobacco use factor. A carrier may apply a
327 tobacco use rate factor in a manner permitted under state and federal law that applies to both
328 eligible small groups and eligible individuals; provided, however, that the carrier uses a
329 certification of tobacco use process that has been approved by the commissioner to determine
330 that eligible individuals and their eligible dependents or eligible small group employees and their
331 eligible dependents have not used tobacco products within the past year.

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

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

341 (b) (1) A carrier that, as of the close of any preceding calendar year, has a combined
342 total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are
343 enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified
344 small businesses or eligible individuals pursuant to its license under chapter 176G, shall be
345 required annually to file a plan with the connector for its consideration, which meets the
346 requirements for the connector seal of approval pursuant to section 10 of chapter 176Q;
347 provided, however, that the plan shall be filed not later than October 1.

348 (2) A carrier that, as of the close of any preceding calendar year, has a combined
349 total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are
350 enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified
351 small businesses or eligible individuals pursuant to its authority under chapter 175, 176A or
352 176B, shall be required annually to file a plan with the connector for its consideration, which
353 meets the requirements for the connector seal of approval pursuant to section 10 of chapter
354 176Q; provided, however, that the plan shall be filed not later than October 1.

355 (c) For the purposes of this section, no eligible individual, eligible employee, or eligible
356 dependent shall be considered to be enrolled in a health benefit plan issued pursuant to a carrier's
357 authority under chapter 175, 176A or 176B if the health benefit plan is sold, issued, delivered,
358 made effective or renewed to said eligible employee or eligible dependent as a supplement to a
359 health benefit plan subject to licensure under chapter 176G.

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

364 SECTION 49. Subsection (a) of section 4 of said chapter 176J, as most recently
365 amended by section 8 of chapter 3 of the acts of 2013, is hereby further amended by striking out
366 paragraph (2) and inserting in place thereof the following paragraph:-

367 (2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible
368 individuals, as defined in section 2741 of the Health Insurance Portability and Accountability
369 Act of 1996, 42 U.S.C. § 300gg-41(b), into a health plan if those individuals request coverage
370 within 63 days of termination of any prior creditable coverage. A carrier shall also enroll
371 eligible individuals, as permitted under the Patient Protection and Affordable Care Act, Public
372 Law 111-148, and any rules, regulations and guidances applicable thereto, as amended from
373 time to time. A carrier shall enable any such eligible individual to renew coverage if that
374 coverage is available to other eligible individuals. Coverage shall become effective in
375 accordance with said Patient Protection and Affordable Care Act, and any rules, regulations and
376 guidances applicable thereto, as amended from time to time, subject to reasonable verification of
377 eligibility, and shall be effective through December 31 of that same year. Carriers shall notify
378 any such eligible individuals that:

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

381 (ii) if any such eligible individual is in a health plan with a plan-year
382 deductible or out-of- pocket maximum, an explanation of how that
383 deductible or out-of-pocket maximum and premiums will be impacted
384 for the period between the plan effective date and December 31 of the
385 enrollment year; and

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

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

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

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

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

398 (c) Notwithstanding any general or special law to the contrary, carriers offering small
399 group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or
400 176G, shall file small group product base rates and any changes to small group rating factors that
401 are to be effective on January 1 of each year, on or before July 1 of the preceding year. The

402 commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate
403 or unreasonable in relation to the benefits charged. The commissioner shall disapprove any
404 change to small group rating factors that is discriminatory or not actuarially sound. Rates of
405 reimbursement or rating factors included in the rate filing materials submitted for review by the
406 division shall be deemed confidential and exempt from the definition of public records in clause
407 Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out
408 this section.

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

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

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

418 SECTION 54. Section 13 of said chapter 176J, as appearing in the 2010 Official Edition,
419 is hereby amended by striking out subsection (b) and inserting in place thereof the following
420 subsection:-

421 (b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i)
422 include all state-mandated benefits; (ii) apply open enrollment periods for individuals in the
423 same manner as the carrier applies them for individuals outside the group purchasing
424 cooperative, provided, however, that small business group purchasing cooperatives shall
425 establish rules and open enrollment periods for qualified association members to enter or exit
426 group purchasing cooperatives; (iii) apply continuation of coverage provisions in the same
427 manner as the carrier applies those provisions to small group products offered outside the group
428 purchasing cooperative; (iv) apply managed care practices in the same manner as the carrier
429 applies those practices to small group products offered outside the group purchasing cooperative;
430 and (v) apply rating rules, including rating bands, rating factors and the value of rating factors, in
431 the same manner as the carrier applies those rules to small group products offered outside the
432 group purchasing cooperative.

433 SECTION 55. Chapter 176N of the General Laws is hereby amended by striking out
434 section 2, as so appearing, and inserting in place thereof the following section:-

435 Section 2. (a) No health plan shall:

436 (i) exclude any eligible insured on the basis of age, occupation, actual or expected health
437 condition, claims experience, duration of coverage or medical condition of such person; and

438 (ii) exclude late enrollees from coverage for more than 12 months from the date of the
439 application for coverage of any late enrollee.

440 (b) In any circumstance in which more extensive coverage than that provided by clauses
441 (i) and (ii) of subsection (a) is required by any other state or federal law, the health benefit plan
442 shall satisfy such other provision insofar as it requires more extensive coverage.

443 SECTION 57. Section 1 of chapter 176O of the General Laws is hereby further amended
444 by striking out the definition of "Grievance", as so appearing, and inserting in place thereof the
445 following definition:-

446 "Grievance", any oral or written complaint submitted to the carrier which has been
447 initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any
448 aspect or action of the carrier relative to the insured, including, but not limited to, review of
449 adverse determinations regarding scope of coverage, denial of services, rescission of coverage,
450 quality of care and administrative operations, under the requirements of this chapter.

451 SECTION 56. Said section 1 of said chapter 176O is hereby further amended by striking
452 out the definition of "Adverse determination", as so appearing, and inserting in place thereof the
453 following definition:-

454 "Adverse determination", based upon a review of information provided by a carrier or its
455 designated utilization review organization, to deny, reduce, modify, or terminate an admission,
456 continued inpatient stay or the availability of any other health care services, for failure to meet
457 the requirements for coverage based on medical necessity, appropriateness of health care setting
458 and level of care, or effectiveness, including a determination that a requested or recommended
459 health care service or treatment is experimental or investigational.

460 SECTION 58. Said section 1 of said chapter 176O is hereby further amended by striking
461 out the definition of "Office of patient protection", as so appearing, and inserting in place thereof
462 the following definition:-

463 SECTION 59. The fourth sentence of subsection (b) of section 2 of said chapter 176O, as
464 amended by section 189 of chapter 224 of the acts of 2012, is hereby further amended by striking
465 out the words "division of health care finance and policy" and inserting in place thereof the
466 following words:- for health information and analysis.

467 SECTION 60. Said section 2 of said chapter 176O is hereby amended by striking out, in
468 lines 28 and 29, as appearing in the 2010 Official Edition, the words "department of public
469 health established by section 217 of chapter 111" and inserting in place thereof the following
470 words:- health policy commission established by section 16 of chapter 6D.

471 SECTION 61. Section 6 of said chapter 176O is hereby amended by striking out, in line
472 54, as so appearing, the words “paragraph (2) of subsection (a) of section 217 of chapter 111”
473 and inserting in place thereof the following words:- paragraph (3) of subsection (a) of section 16
474 of chapter 6D.

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

479 SECTION 63. Section 7 of said chapter 176O is hereby amended by striking out, in lines
480 23 and 24, as so appearing, the words “the department of public health under section 25P of
481 chapter 111” and inserting in place thereof the following words:- center for health information
482 analysis.

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

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

491 SECTION 66. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is
492 hereby amended by striking out clause (iii) and inserting in place thereof the following 2
493 clauses:-

494 (iii) a resolution within 5 days from the receipt of such grievance if submitted by an
495 insured with a terminal illness; and

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

497 SECTION 67. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is
498 hereby amended by adding the following sentence:- Notwithstanding the exhaustion of formal
499 internal grievance process remedies required by section 14, in the event that an insured claims
500 that a carrier failed to properly act on a grievance that is an adverse determination within the
501 time limits required by this section, such claim is immediately eligible for external review..

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

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

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

508 (a) An insured who remains aggrieved by an adverse determination and has exhausted all
509 remedies available from the formal internal grievance process required pursuant to section 13,
510 may seek further review of the grievance by a review panel established by the office of patient
511 protection pursuant to paragraph (5) of subsection (a) of section 16 of chapter 6D. The insured
512 shall pay the first $25 of the cost of the review to said office, which may waive the fee in cases
513 of extreme financial hardship and which shall refund the fee to the insured if the adverse
514 determination is reversed in its entirety. No insured shall be required to pay more than $75 per
515 plan year, regardless of the number of external review requests submitted. The carrier shall be
516 responsible for the remainder of the cost of the review pursuant to regulations promulgated by
517 the executive director of the health policy commission in consultation with the commissioner of
518 insurance. The office of patient protection shall contract with at least 3 unrelated and objective
519 review agencies through a bidding process and refer grievances to 1 of the review agencies on a
520 random selection basis. The review agencies shall be accredited by a national accrediting
521 organization and shall develop review panels appropriate for the given grievance, which shall
522 include qualified clinical decision-makers experienced in the determination of medical necessity,
523 utilization management protocols and grievance resolution, and shall not have any financial
524 relationship with the carrier making the initial determination. The standard for review of a
525 grievance by such a panel shall be the determination of whether the requested treatment or
526 service is medically necessary, as defined in section 1, and a covered benefit under the policy or
527 contract. The panel shall consider, but not be limited to considering: (i) written documents
528 submitted by the insured, (ii) additional information from the involved parties or outside sources
529 that the review panel deems necessary or relevant, and (iii) information obtained from any
530 informal meeting held by the panel with the parties. The panel shall send final written disposition
531 of the grievance and the reasons therefore, to the insured and the carrier within 45 days of receipt
532 of the request for review. Notwithstanding the requirements of this section, an insured may
533 request an external review of an adverse determination without exhausting the carrier's internal
534 appeals process if the insured is seeking an expedited review or if the carrier failed to meet the
535 time limits specified in section 13.

536 SECTION 70. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is
537 hereby amended by adding the following 2 sentences:- There shall be a process for the expedited
538 review of grievances. The external review panel set forth in section 14 shall send final written
539 disposition of the grievance, and the reasons therefore, to the insured and the carrier within 72
540 hours of receipt of the request for such expedited review.

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

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

547 SECTION 73. Paragraph (3) of subsection (a) of section 20 of said chapter 176O, as so
548 appearing, is hereby amended by striking out, in lines 26 and 27, the words “office of patient
549 protection, established by section 217 of chapter 111,” and inserting in place thereof the
550 following words:- office of patient protection, established by section 16 of chapter 6D or, if
551 applicable, the designated state consumer assistance program.

552 SECTION 74. Section 1 of chapter 176Q of the General Lawsis hereby amended by
553 striking out the definition of “Commonwealth care health insurance program”, as so appearing.

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

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

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

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

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

567 “Federal point-of-service cost-sharing reductions”, a payment made pursuant to 42
568 U.S.C. § 18071 on behalf of an eligible individual or eligible child to reduce point-of-service
569 cost-sharing expenses which shall include, but not be limited to, copayments, coinsurance and
570 deductibles.

571 SECTION 78. The definition of “Point-of-service cost-sharing subsidy” in said section 1
572 of said chapter 176Q, inserted by section 38 of chapter 118 of the acts of 2012, is hereby
573 amended by striking out the word “offset” and inserting in place thereof the following word:-
574 reduce.

575 SECTION 79. Said section 1 of said chapter 176Q is hereby further amended by striking
576 out the definition of "Premium assistance payment", as so inserted, and inserting in place thereof
577 the following definition:-

578 "Premium assistance payment", a payment made to a carrier or an individual by the
579 connector to reduce the value of a health benefit plan premium paid by the individual.

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

583 "Rating factor", characteristics including, but not limited to, age, rate basis type and
584 geography.

585 SECTION 81. Section 3 of said chapter 176Q is hereby amended by striking out, in lines
586 4 and 5, the words "groups and commonwealth care health insurance plan enrollees", as so
587 appearing, and inserting in place thereof the following words:- and eligible small groups.

588 SECTION 82. Said section 3 of said chapter 176Q is hereby further amended by striking
589 out, in lines 14 and 15 and lines 30 and 31, the words ", groups and commonwealth care health
590 insurance program enrollees", as so appearing, and inserting in place thereof, in each instance,
591 the following words:- and eligible small groups.

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

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

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

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

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

607 SECTION 87. Subsection (b) of said section 3 of said chapter 176Q, as amended by
608 section 43 of chapter 118 of the Acts of 2012, is hereby amended by inserting after the word "or"
609 the following words:- point-of-service.

610 SECTION 88. Subsection (m) of said section 3 of said chapter 176Q is hereby further
611 amended by striking out the words ", departments, commissions, authorities or political
612 subdivisions the board considers necessary or appropriate to implement chapters 111M, 118E,
613 118G 118H and this chapter", inserted by section 132 of chapter 139 of the acts of 2012, and
614 inserting in place thereof the following words:- , departments, commissions, authorities or
615 political subdivisions the board considers necessary or appropriate to implement chapters 6D,
616 12C, 15A, 111M, 118E and this chapter.

617 SECTION 89. Said section 3 of said chapter 176Q, as appearing in the 2010 Official
618 Edition, is hereby amended by striking out subsection (o).

619 SECTION 90. Subsection (u) of said section 3 of said chapter 176Q, inserted by section 7
620 of chapter 96 of the acts of 2012, is hereby amended by striking out clause (2) and inserting in
621 place thereof the following clause:- (2) the determination of eligibility of individuals for
622 shopping, receiving federal advanced premium tax credits and qualifying for federal point-of-
623 service cost-sharing reductions through the Exchange, as provided by federal law; and

624 SECTION 91. Subsection (a) of section 4 of said chapter 176Q, as appearing in section
625 45 of chapter 118 of the acts of 2012, is hereby amended by striking out the words ", including
626 all health benefit plans offered through the commonwealth care health insurance program".

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

628 SECTION 94. Subsection (a) of section 12 of said chapter 176Q, as appearing in section
629 49 of chapter 118 of the acts of 2012, is hereby amended by striking out the last sentence.

630 SECTION 93. Said chapter 176Q is hereby further amended by striking out section 8, as
631 appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

632 Section 8. (a) The connector shall enter into interagency agreements with the department
633 of revenue, the executive office of health and human services, the department of public health,
634 the executive office of labor and workforce development, the registry of motor vehicles, the
635 department of correction, the center for health information and analysis and any other state
636 agencies, departments, divisions, commissions, authorities or political subdivisions. The
637 agreements shall authorize foregoing agencies, departments, divisions, commissions, authorities
638 and political subdivisions to furnish information, including personal data as defined in chapter
639 66A, that is necessary for the connector to perform its duties under this chapter, including the
640 determination of an individual's eligibility for federal advanced premium tax credits and federal
641 point-of-service cost-sharing reductions and adjudication of appeals arising from such

642 determinations. Such written agreements shall include provisions permitting the department of
643 revenue to furnish the data available under the wage reporting system established under section 3
644 of chapter 62E. The department of revenue may furnish the connector with information on the
645 cases of persons so identified, including, but not limited to, name, social security number and
646 other data to ensure positive identification, name and identification number of employer, and
647 amount of wages and gross income received from all sources. The connector shall not utilize any
648 of the data received from the department of revenue for any solicitations or advertising.

649 (b) The connector may receive and use any information provided pursuant to section 23
650 of chapter 118E as necessary for the connector to perform the duties under this chapter, including
651 the determination of an individual's eligibility for federal advanced premium tax credits and
652 federal point-of-service cost-sharing reductions and adjudication of appeals arising from such
653 determinations.

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

657 SECTION 96. Section 1 of chapter 176T of the General Laws, as inserted by section 216
658 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition of "Public
659 health care payer" and inserting in place thereof the following definition:-

660 "Public health care payer", the Medicaid program established in chapter 118E; any
661 carrier or other entity that contracts with the office of Medicaid to pay for or arrange the
662 purchase of health care services on behalf of individuals enrolled in health coverage programs
663 under Titles XIX or XXI of the Social Security Act, including prepaid health plans subject to
664 section 28 of chapter 47 of the acts of 1997; the group insurance commission established
665 pursuant to chapter 32A; and any city or town with a population of more than 60,000 that has
666 adopted chapter 32B.

667 SECTION 99. Section 66 of chapter 288 of the acts of 2010 is hereby repealed.

668 SECTION 97. The first paragraph of section 271 of chapter 127 of the acts of 1999 is
669 hereby amended by striking out the words ", the executor director of the commonwealth health
670 insurance connector authority" inserted by section 226 of chapter 224 of the acts of 2012.

671 SECTION 98. Said first paragraph of said section 271 of said chapter 127 is hereby
672 further amended by striking out clause (i), as amended by section 227 of said chapter 224.

673 SECTION 100. Section 246 of chapter 224 of the acts of 2012 is hereby repealed.

674 SECTION 101. Section 253 of chapter 224 of the acts of 2012 is hereby amended by
675 striking out the words ", the commonwealth care health insurance program established under
676 chapter 118H of the General Laws, any carrier or other entity which contracts with the

677 commonwealth care health insurance program to pay for or arrange for the purchase of health
678 care services".

679 SECTION 102. Notwithstanding chapter 176J of the General Laws, for the period from
680 January 1, 2014 through December 31, 2015, carriers may develop the group base premium for
681 eligible small employers in order to vary the group base premium by enrollment or renewal
682 month and shall file the group base premium as part of a rate filing for each calendar quarter.

683 In calculating the premium to be charged to each eligible small group or eligible
684 individual, carriers may utilize and apply a portion of the following rate adjustment factors,
685 provided, that the carrier has such factor in place as of July 1, 2013, in addition to those rate
686 adjustment factors permitted under said chapter 176J: (i) an industry rate adjustment factor; (ii)
687 a participation rate adjustment factor; (iii) a group size rate adjustment factor; (iv) an
688 intermediary rate adjustment factor; or (v) a group purchasing cooperative rate adjustment factor.
689
690 The commissioner of insurance shall promulgate regulations to implement this section,
691 including, but not limited to, regulations setting forth the manner in which carriers may utilize
692 and apply the rate adjustment factors set forth in this section during the period from January 1,
693 2014 through December 31, 2015, to the extent required by federal law.
694
695 SECTION 102A. The commonwealth, by and through the governor or the governor's
696 designee, shall formally request a federal waiver to avoid the adverse effects of rating and rule
697 changes to the Massachusetts merged market, to protect consumers and businesses in the
698 commonwealth and in an effort to maintain current Massachusetts rating and rule requirements
699 including, but not limited to, the number of ratings factors and the number of annual rate
700 settings. All negotiations with any federal agency concerning this waiver shall be conducted in
701 consultation with a member of the house of representatives as appointed by the speaker of the
702 house and a member of the senate as appointed by the senate president. The governor, or the
703 governor's designee shall file a detailed report describing the waiver application and waivers
704 received, along with all documentation, including, but not limited to, all related written and
705 verbal responses from the Department of Health and Human Services, with the clerks of the
706 senate and house not later than October 1, 2014. The governor shall report monthly to the joint
707 committee on health care financing and the house and senate committees on ways and means on
708 the status of the waiver request under this section.

709 SECTION 103. Sections 1, 5 and 93 shall take effect 30 days after the effective date of
710 this act.

711 SECTION 104. Sections 2 to 4, inclusive, 6 to 50, inclusive, 52 to 92, inclusive, and
712 sections 94 to 101, inclusive, shall take effect on January 1, 2014.

713 SECTION 105. Paragraph (4) of subsection (b) of section (4) of Chapter 176J is amended
714 by adding at the end the following:

715 Notwithstanding any other provision in this section, with respect to a health benefit plan
716 offered only through a public exchange that pursuant to federal law and regulation does not
717 include pediatric dental benefits, a carrier may deny an eligible individual or eligible small
718 business of any size enrollment in such health benefit plan unless the eligible individual or
719 eligible small business enrolls through the connector. If an eligible individual or eligible small
720 business elects to enroll through the connector, a carrier may not deny that eligible individual or
721 eligible small business enrollment. The carrier shall implement such requirements consistently,
722 treating all eligible individuals and eligible small business in a similar manner.
723
724 SECTION 106. Section 4A shall take effect on July 1, 2014.