

SENATE No. 535

The Commonwealth of Massachusetts

PRESENTED BY:

Michael O. Moore

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

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

An Act alleviating health care burdens for Massachusetts employers.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Michael O. Moore</i>	<i>Second Worcester</i>
<i>Leah Cole</i>	<i>12th Essex</i>
<i>Brian M. Ashe</i>	<i>2nd Hampden</i>

SENATE No. 535

By Mr. Moore, a petition (accompanied by bill, Senate, No. 535) of Michael O. Moore, Leah Cole and Brian M. Ashe for legislation to alleviate health care burdens for Massachusetts employers. Financial Services.

The Commonwealth of Massachusetts

**In the One Hundred and Eighty-Ninth General Court
(2015-2016)**

An Act alleviating health care burdens for Massachusetts employers.

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 1 of chapter 176J of the General Laws, as appearing in the 2012
2 Official Edition, is hereby amended by striking out the definition of “Eligible individual”.

3 SECTION 2. Said section 1 of said chapter 176J, as so appearing, is hereby further
4 amended by striking out the words “an individual or group”, each time they appear, and inserting
5 in place thereof, in each instance, the following words:- “a group”.

6 SECTION 3. Said section 1 of said chapter 176J, as so appearing, is hereby further
7 amended by striking out the first sentence and inserting in place thereof the following sentence:-
8 "Health benefit plan", any general, blanket or group policy of health, accident and sickness
9 insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued
10 by a non-profit hospital service corporation under chapter 176A; a group medical service plan
11 issued by a nonprofit medical service corporation under chapter 176B; and a group health
12 maintenance contract issued by a health maintenance organization under chapter 176G.

13 SECTION 4. Section 2 of said chapter 176J, as so appearing, is hereby amended by
14 striking out the words “and all health benefit plans issued, made effective, delivered or renewed
15 to any eligible individual on or after July 1, 2007,”.

16 SECTION 5. Said chapter 176J is hereby further amended by striking out section 3, as so
17 appearing, and inserting in place thereof the following section:-

18 Section 3. (a) (1) For every health benefit plan issued or renewed to eligible small groups,
19 including a certificate issued to eligible small groups that evidences coverage under a policy or
20 contract issued or renewed to a trust, association or other entity that is not a group health plan, a
21 carrier shall develop a group base premium rate that is for eligible small groups. In developing
22 these small group base premium rates, carriers:

23 (i) with respect to the group base premium rate developed for eligible small
24 groups, a carrier shall consider all enrollees in those health plans, other than grandfathered health
25 plans, offered by such carrier to be members of the small group risk pool;

26 (ii) in calculating the premium to be charged to each eligible small group, a
27 carrier shall develop a base premium and use only those rate adjustment factors identified in this
28 section, inclusive, for all insured health benefit plans offered to eligible small groups, with all
29 other rating adjustments being prohibited;

30 (iii) may offer any rate basis types, but rate basis types that are offered to any
31 eligible small group shall be offered to every eligible small group for all coverage issued or
32 renewed; provided, however, that if an eligible small group does not meet a carrier's minimum or
33 participation contribution requirements, the carrier may separately rate each employee as an
34 eligible individual, as set forth in section 1 of chapter 176M;

35 (iv) notwithstanding this section, all carriers offering any coverage to any
36 eligible small group shall make that coverage available to every eligible small group.

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

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

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

54 (5) The commissioner shall annually file with the United States Department of Health
55 and Human Services to establish a standard tobacco use factor. A carrier may apply a tobacco
56 use rate factor in a manner permitted under state and federal law that applies to eligible small

57 groups; provided, however, that the carrier uses a certification of tobacco use process that has
58 been approved by the commissioner to determine that eligible small group employees and their
59 eligible dependents have not used tobacco products within the past year.

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

67 (2) A carrier that, as of the close of any preceding calendar year, has a combined total of
68 5,000 or more eligible employees and eligible dependents, who are enrolled in health benefit
69 plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to
70 its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the
71 connector for its consideration, which meets the requirements for the connector seal of approval
72 pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later
73 than October 1.

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

79 (d) The commissioner may conduct an examination with respect to the derivation of
80 group base premium rates used to develop individual group premiums in order to identify
81 whether any expenses inappropriately increase the cost in relation to the risks of the small group
82 health insurance market.

83 SECTION 6. Subsection (a) of section 4 of said chapter 176J, as so appearing, is hereby
84 amended by striking paragraph (1) and inserting in place thereof the following paragraph:-

85 (a) (1) Every carrier shall make available to every small business, including an
86 eligible small group, a certificate that evidences coverage under a policy or contract issued or
87 renewed to a trust, association or other entity that is not a group health plan, and their eligible
88 dependents, every health benefit plan that it provides to any other eligible small business. No
89 health plan shall be offered to an eligible small business unless it complies with this chapter.
90 Upon the request of an eligible small business, a carrier shall provide that group with a price for
91 every health benefit plan that it provides to any eligible small business.

92 Except under the conditions set forth in paragraph (2) of subsection (b), each carrier shall
93 enroll any eligible small business which seeks to enroll in a health benefit plan. Each carrier shall
94 permit each eligible small business group to enroll all eligible employees and all eligible
95 dependents; provided, however, that the commissioner shall promulgate regulations which limit
96 the circumstances under which coverage shall be required to be made available to an eligible
97 employee who seeks to enroll in a health benefit plan significantly later than when such eligible
98 employee was initially eligible to enroll in a group plan. Notwithstanding the foregoing, this
99 section shall not apply to health benefit plans sold exclusively as child-only plans or catastrophic
100 plans.

101 SECTION 7. Paragraph (2) of subsection (a) of section 4 of said chapter 176J, as so
102 appearing, is hereby further amended by striking the following words: “eligible individuals, as
103 defined by section 1, and ”.

104 SECTION 8. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is
105 hereby further amended by striking paragraphs (1) and (2) and inserting in place thereof the
106 following paragraphs:-

107 (1) Notwithstanding any other provision in this section, a carrier may deny an eligible
108 small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the
109 carrier intends to discontinue selling that health benefit plan to new eligible small businesses. A
110 health benefit plan closed to new members may be cancelled and discontinued to all members
111 upon the approval of the commissioner of insurance when such plan has been closed to
112 enrollment for new small groups and the carrier has complied with the requirements of 42 U.S.C.
113 Sec. 300gg-12; provided, however, that cancellation of the plan shall be effective on the small
114 group's next enrollment anniversary after such cancellation is approved by the commissioner of
115 insurance. The commissioner may promulgate regulations prohibiting a carrier from using this
116 paragraph to circumvent the intent of this chapter.

117 (2) A carrier shall not be required to issue a health benefit plan to an eligible small
118 business if the carrier can demonstrate to the satisfaction of the commissioner that within the
119 prior 12 months, (a) the eligible small business has repeatedly failed to pay on a timely basis the
120 required health premiums; or, (b) the eligible small business has committed fraud,
121 misrepresented whether or not a person is an eligible employee, or misrepresented other
122 information necessary to determine the size of a group, the participation rate of a group, or the

123 premium rate for a group; or (c) the eligible small business has failed to comply in a material
124 manner with a health benefit plan provision, including for an eligible small business, compliance
125 with carrier requirements regarding employer contributions to group premiums. A carrier shall
126 not be required to issue a health benefit plan to an eligible small business if the small business
127 fails to comply with the carrier's requests for information which the carrier deems necessary to
128 verify the application for coverage under the health benefit plan.

129 SECTION 9. Paragraph (3) of subsection (b) of said section 4 of said chapter 176J, as so
130 appearing, is hereby further amended by striking out the words “eligible individual or”.

131 SECTION 10. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is
132 hereby further amended by striking out paragraph (4) and inserting in place thereof the following
133 paragraph:-

134 (4) Notwithstanding any other provision in this section, a carrier may deny an eligible
135 small business with 5 or fewer eligible employees enrollment in a health benefit plan unless the
136 eligible small business enrolls through an intermediary or the connector. If an eligible small
137 business with 5 or fewer eligible employees elects to enroll through an intermediary or the
138 connector, a carrier may not deny that eligible small business enrollment. The carrier shall
139 implement such requirements consistently, treating all similarly situated eligible small businesses
140 in a similar manner.

141 SECTION 11. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is
142 hereby further amended by striking out paragraph (5) and inserting in place thereof the following
143 paragraph:-

144 (5) Notwithstanding any other provision in this section, with respect to a health benefit
145 plan offered only through a public exchange that pursuant to federal law and regulation does not
146 include pediatric dental benefits, a carrier may deny an eligible small business of any size
147 enrollment in such health benefit plan unless the eligible small business enrolls through the
148 connector. If an eligible small business elects to enroll through the connector, a carrier may not
149 deny that eligible small business enrollment. The carrier shall implement such requirements
150 consistently, treating all eligible small business in a similar manner.

151 SECTION 12. Paragraph (2) of subsection (c) of said section 4 of said chapter 176J, as so
152 appearing, is hereby further amended by striking out the words “eligible individual or”.

153 SECTION 13. Paragraph (3) of subsection (c) of said section 4 of said chapter 176J, as so
154 appearing, is hereby further amended by striking out the words “eligible individual,”.

155 SECTION 14. Section 5 of said chapter 176J, as so appearing, is hereby amended by
156 striking the words “eligible individuals”.

157 SECTION 15. Section 6 of said chapter 176J, as so appearing, is hereby amended by
158 striking out, in lines 3 and 4, the words “eligible individuals or”.

159 SECTION 16. Said section 6 of chapter 176J, as so appearing, is hereby further amended
160 by striking out, in line 16, the words: “and eligible individuals”.

161 SECTION 17. Said section 6 of chapter 176J, as so appearing, is hereby further amended
162 by striking out, in line 78, the words “eligible individuals and”.

163 SECTION 18. Said section 6 of chapter 176J, as so appearing, is hereby further amended
164 by striking out, in lines 79, 80 and 81, the words “individuals and”.

165 SECTION 19. Said section 6 of chapter 176J, as so appearing, is hereby further amended
166 by striking out, in line 84, the words “individual or”.

167 SECTION 20. Said section 6 of chapter 176J, as so appearing, is hereby further amended
168 by striking out, in line 101, the words “and individuals”.

169 SECTION 21. Subsection (b) of section 7 of said chapter 176J, as so appearing, is hereby
170 amended by striking out, in line 15 and 16, the words “eligible individuals,”.

171 SECTION 22. Subsection (b) of said section 7 of said chapter 176J, as so appearing, is
172 hereby further amended by striking out, in line 18, the words “eligible individuals or”.

173 SECTION 23. Clause (iii) of subsection (k) of section 9 of said chapter 176J, as so
174 appearing, is hereby amended by striking out the words “eligible individual or”.

175 SECTION 24. Section 10 of said chapter 176J is hereby repealed.

176 SECTION 25. Subsection (a) of section 11 of said chapter 176J, as so appearing, is
177 hereby amended by striking out clause (ii) and inserting in place thereof the following clause:-

178 (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more
179 eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued,
180 delivered, made effective or renewed to qualified small businesses, shall offer to all small
181 businesses in at least 1 geographic area at least 1 plan with either:

182 SECTION 26. Subsection (h) of section 12 of said chapter 176J, as so appearing, is
183 hereby amended by striking out the words “individuals and”.

184 SECTION 27. Subsection (a) of section 13 of said chapter 176J, as so appearing, is
185 hereby amended by striking out the words “eligible individuals,”.

186 SECTION 28. Subsection (b) of said section 13 of said chapter 176J, as so appearing, is
187 hereby further amended by striking clause (ii).

188 SECTION 29. Chapter 176M is hereby amended by striking section 3, as appearing in the
189 2012 Official Edition, and inserting in place thereof the following section:-

190 Section 3. (a)(1) Every carrier shall make available to every eligible individual a
191 certificate that evidences coverage under a policy or contract issued or renewed and their eligible
192 dependents, every health benefit plan that it provides to any other eligible individual. No health
193 plan shall be offered to an eligible individual unless it complies with this chapter. Upon the
194 request of an eligible individual, a carrier shall provide that individual with a price for every
195 health benefit plan that it provides to any eligible individual. Except under the conditions set
196 forth in paragraph (2) of subsection (c), each carrier shall enroll any eligible individual which
197 seeks to enroll in a health benefit plan. Notwithstanding the foregoing, this section shall not
198 apply to health benefit plans sold exclusively as child-only plans or catastrophic plans.

199 (2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible
200 individuals, as defined in section 2741 of the Health Insurance Portability and Accountability
201 Act of 1996, 42 U.S.C. section 300gg-41(b), into a health plan if those individuals request
202 coverage within 63 days of termination of any prior creditable coverage. A carrier shall also
203 enroll eligible individuals, as permitted under the Patient Protection and Affordable Care Act,
204 Public Law 111-148, and any rules, regulations and guidances applicable thereto, as amended
205 from time to time. A carrier shall enable any such eligible individual to renew coverage if that

206 coverage is available to other eligible individuals. Coverage shall become effective in
207 accordance with said Patient Protection and Affordable Care Act, and any rules, regulations and
208 guidances applicable thereto, as amended from time to time, subject to reasonable verification of
209 eligibility, and shall be effective through December 31 of that same year. Carriers shall notify
210 any such eligible individuals that:

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

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

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

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

222 (b) Notwithstanding paragraph (2) of subsection (a), a carrier shall only enroll an eligible
223 individual who does not meet the requirements of said paragraph (2) into a health plan during the
224 annual open enrollment period for eligible individuals and their dependents. The open enrollment
225 period shall be from October 15 to December 7, inclusive, unless otherwise designated by the
226 commissioner and coverage shall begin on January 1 of the following year.

227 Notwithstanding this section or any other general or special law to the contrary, the office
228 of patient protection may administer and grant enrollment waivers to permit enrollment not
229 during a mandatory open enrollment period to the extent permitted under the federal Patient
230 Protection and Affordable Care Act, or any rules, regulations or guidances applicable thereto,
231 and in accordance with chapter 6D and any other applicable laws.

232 (c) (1) Notwithstanding any other provision in this section, a carrier may deny an
233 eligible individual enrollment in a health benefit plan if the carrier certifies to the commissioner
234 that the carrier intends to discontinue selling that health benefit plan to new eligible individuals.
235 A health benefit plan closed to new members may be cancelled and discontinued to all members
236 upon the approval of the commissioner of insurance when such plan has been closed to
237 enrollment for new individuals and the carrier has complied with the requirements of 42 U.S.C.
238 Sec. 300gg-12; provided, however, that cancellation of the plan shall be effective on the
239 individual's next enrollment anniversary after such cancellation is approved by the commissioner
240 of insurance. The commissioner may promulgate regulations prohibiting a carrier from using this
241 paragraph to circumvent the intent of this chapter.

242 (2) A carrier shall not be required to issue a health benefit plan to an eligible individual if
243 the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12
244 months, (a) the eligible individual has repeatedly failed to pay on a timely basis the required
245 health premiums; or, (b) the eligible individual has committed fraud, misrepresented whether or
246 not a person is an eligible individual; or (c) the eligible individual has failed to comply in a
247 material manner with a health benefit plan provision; or (d) the eligible individual voluntarily
248 ceases coverage under a health benefit plan; provided that the carrier shall be required to credit
249 the time such person was covered under prior creditable coverage provided by a carrier if the

250 previous coverage was continuous to a date not more than 63 days prior to the date of the request
251 for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible
252 individual if the individual fails to comply with the carrier's requests for information which the
253 carrier deems necessary to verify the application for coverage under the health benefit plan.

254 (3) A carrier shall not be required to issue a health benefit plan to an eligible individual if
255 the carrier can demonstrate to the satisfaction of the commissioner that acceptance of an
256 application or applications would create for the carrier a condition of financial impairment, and
257 the carrier makes such a demonstration to the same commissioner.

258 (4) Notwithstanding any other provision in this section, a carrier may deny an eligible
259 individual enrollment in a health benefit plan unless the eligible individual enrolls through an
260 intermediary or the connector. If an eligible individual elects to enroll through an intermediary or
261 the connector, a carrier may not deny that eligible individual enrollment. The carrier shall
262 implement such requirements consistently, treating all similarly situated eligible individuals in a
263 similar manner.

264 (5) Notwithstanding any other provision in this section, with respect to a health benefit
265 plan offered only through a public exchange that pursuant to federal law and regulation does not
266 include pediatric dental benefits, a carrier may deny an eligible individual enrollment in such
267 health benefit plan unless the eligible individual enrolls through the connector. If an eligible
268 individual elects to enroll through the connector, a carrier may not deny that eligible individual
269 or enrollment. The carrier shall implement such requirements consistently, treating all eligible
270 individuals in a similar manner.

271 (d) (1) Every health benefit plan shall be renewable as required by the Health
272 Insurance Portability and Accountability Act of 1996 as amended, or by regulations promulgated
273 under that act.

274 (2) A carrier shall not be required to renew the health benefit plan of an eligible
275 individual if the individual: (i) has not paid the required premiums; (ii) has committed fraud,
276 misrepresented whether or not a person is an eligible individual; (iii) failed to comply in a
277 material manner with health benefit plan provisions; (iv) fails, at the time of renewal, to satisfy
278 the definition of an eligible individual.

279 (3) A carrier may refuse to renew enrollment for an eligible individual or eligible
280 dependent if: (i) the eligible individual or eligible dependent has committed fraud,
281 misrepresented whether or not he or she is an eligible individual or eligible dependent, or
282 misrepresented information necessary to determine his eligibility for a health benefit plan or for
283 specific health benefits; or (ii) the eligible individual or eligible dependent fails to comply in a
284 material manner with health benefit plan provisions.

285 (e) The commissioner shall adopt regulations to enforce this section.

286 SECTION 30. Section 5 of said chapter 176M is hereby amended by inserting after the
287 first paragraph the following paragraph:-

288 For every health benefit plan issued or renewed to eligible individuals a carrier shall
289 develop a base premium rate. In developing these base premium rates, carriers may offer any rate
290 basis types, but rate basis types that are offered to any eligible individual shall be offered to
291 every eligible individual for all coverage issued or renewed.

292 SECTION 31. Chapter 176M of the General Laws is hereby amended by inserting after
293 section 7 the following 4 sections:-

294 Section 8. If a medically necessary and covered service is not available to a member
295 within the carrier's provider network, the carrier shall cover the services out-of-network, for as
296 long as the service is unavailable in-network.

297 Section 9. An insurer offering a tiered network plan shall clearly and conspicuously
298 indicate, in all promotional and agreement materials, the cost-sharing differences for enrollees in
299 the various tiers. The commissioner shall adopt regulations to carry out this section.

300 Section 10. To the maximum extent possible, carriers shall attribute every member to a
301 primary care provider. Members may change their primary care provider, provided that the
302 member gives notice to the carrier.

303 Section 11. To the extent permissible under applicable state and federal privacy laws,
304 every carrier shall disclose patient-level data to providers in their network solely for the purpose
305 of carrying out treatment, coordinating care among providers and managing the care of their own
306 patient panel; provided, that an individual provider shall only receive patient-level data related to
307 patients treated by said provider. Patient-level data shall include, but not be limited to, health
308 care service utilization, medical expenses, and demographics.

309 The division of insurance shall develop procedures and a standard format for disclosing
310 such patient-level information. The division may require carriers to disclose such information
311 through the all-payer claims database established under section 12 of chapter 12C if the division
312 and the center for health information and analysis determine that the all-payer claims database is
313 an efficient means to provide such information.

314 Carriers shall make available to any provider with whom they have entered into an
315 alternative payment contract, the contracted prices of individual health care services within such
316 payer's network for the purpose of referrals.