SENATE DOCKET, NO. 75 FILED ON: 1/10/2017

SENATE . . . . . No. 565

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:
Michael O. Moore	*Second Worcester*

SENATE DOCKET, NO. 75 FILED ON: 1/10/2017

SENATE . . . . . No. 565

By Mr. Moore, a petition (accompanied by bill, Senate, No. 565) of Michael O. Moore for legislation to alleviate health care burdens for Massachusetts employers. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *535* OF 2015-2016.]

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

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:

SECTION 1. Section 1 of chapter 176J of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by striking out the definition of “Eligible individual”.

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

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

issued by a nonprofit medical service corporation under chapter 176B; and a group health maintenance contract issued by a health maintenance organization under chapter 176G.

SECTION 4. Section 2 of said chapter l76J, as so appearing, is hereby amended by striking out the words “and all health benefit plans issued, made effective, delivered or renewed to any eligible individual on or after July 1, 2007,”.

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

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

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

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

(iii) may offer any rate basis types, but rate basis types that are offered to any eligible small group shall be offered to every eligible small group for all coverage issued or renewed;

provided, however, that if an eligible small group does not meet a carrier's minimum or participation contribution requirements, the carrier may separately rate each employee as an eligible individual, as set forth in section 1 of chapter 176M;

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

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

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

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

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

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

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

(c) For the purposes of this section, no eligible employee or eligible dependent shall be considered to be enrolled in a health benefit plan issued pursuant to a carrier's authority under

chapter 175, 176A or 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under chapter 176G.

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

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

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

Except under the conditions set forth in paragraph (2) of subsection (b), each carrier shall enroll any eligible small business which seeks to enroll in a health benefit plan. Each carrier shall permit each eligible small business group to enroll all eligible employees and all eligible dependents; provided, however, that the commissioner shall promulgate regulations which limit the circumstances under which coverage shall be required to be made available to an eligible employee who seeks to enroll in a health benefit plan significantly later than when such eligible

employee was initially eligible to enroll in a group plan. Notwithstanding the foregoing, this section shall not apply to health benefit plans sold exclusively as child-only plans or catastrophic plans.

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

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

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

(2) A carrier shall not be required to issue a health benefit plan to an eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible small business has repeatedly failed to pay on a timely basis the

required health premiums; or, (b) the eligible small business has committed fraud, misrepresented whether or not a person is an eligible employee, or misrepresented other information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or (c) the eligible small business has failed to comply in a material manner with a health benefit plan provision, including for an eligible small business, compliance with carrier requirements regarding employer contributions to group premiums. A carrier shall not be required to issue a health benefit plan to an eligible small business if the small business fails to comply with the carrier's requests for information which the carrier deems necessary to verify the application for coverage under the health benefit plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued,

delivered, made effective or renewed to qualified small businesses, shall offer to all small businesses in at least 1 geographic area at least 1 plan with either:

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

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

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

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

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

(2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible individuals, as defined in section 2741 of the Health Insurance Portability and Accountability

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

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

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

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

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

(b) Notwithstanding paragraph (2) of subsection (a), a carrier shall only enroll an eligible individual who does not meet the requirements of said paragraph (2) into a health plan during the

annual open enrollment period for eligible individuals and their dependents. The open enrollment period shall be from October 15 to December 7, inclusive, unless otherwise designated by the commissioner and coverage shall begin on January 1 of the following year.

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

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

(2) A carrier shall not be required to issue a health benefit plan to an eligible individual if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible individual has repeatedly failed to pay on a timely basis the required health premiums; or, (b) the eligible individual has committed fraud, misrepresented whether or

not a person is an eligible individual; or (c) the eligible individual has failed to comply in a material manner with a health benefit plan provision; or (d) the eligible individual voluntarily ceases coverage under a health benefit plan; provided that the carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible individual if the individual fails to comply with the carrier's requests for information which the carrier deems necessary to verify the application for coverage under the health benefit plan.

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

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

(5) Notwithstanding any other provision in this section, with respect to a health benefit plan offered only through a public exchange that pursuant to federal law and regulation does not include pediatric dental benefits, a carrier may deny an eligible individual enrollment in such health benefit plan unless the eligible individual enrolls through the connector. If an eligible

individual elects to enroll through the connector, a carrier may not deny that eligible individual or enrollment. The carrier shall implement such requirements consistently, treating all eligible individuals in a similar manner.

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

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

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

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

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

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

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

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

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

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

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

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

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