Joint Committee on Health Care Financing
Section by Section Summary

Bill Number: Report of Conference on House, No. 4653 & Senate, No. 2881

Title: An Act enhancing the market review process

Sponsors: Representative John J. Lawn, Jr.& Senator Cindy F. Friedman

Bill Section	MGL Chp	MGL Sec	Agency & Function	Description of §
1	6A	16	EOHHS - Agencies within EOHHS	• Tech amendment related to the 2012 transfer of the Betsy Lehman Center from EOHHS to CHIA
2	6A	16D	EOHHS - Managed care oversight board	• Tech amendment related to the 2012 transfer of the Office of Patient Protection from EOHHS to HPC
3	6A	16N	EOHHS - Special Commission on Uncompensated Care Pool	• Repeals outdated special commission.
4	6A	16T	EOHHS - Health Planning Council / State Health Resource Plan	• Repeals current statute establishing the Health Planning Council as an entity within EOHHS
5 **6** **7** **8** **9** **10** **11**	6D	1	HPC - Definitions	• Defines "Health care real estate investment trust" • Defines "Health care resource" • Defines "Health disparities" • Defines "Health equity" • Defines "Management services organization" • Technical Amendment to existing definition of "Payer" • Defines “Pharmaceutical manufacturing company” • Defines “Pharmacy benefit manager” • Defines "Private equity company" • Defines "Significant equity investor"
12	6D	2	HPC - Governing Board; Members	• Amends composition of the Health Policy Commission. Total remains set at 11, as follows: o Secretary of EOHHS; o Commissioner of Insurance o 6 members appointed by the Governor ▪ A chairperson with expertise in health care administration, finance, and management at a senior level ▪ 1 member with expertise representing hospitals or hospital health systems ▪ 1 member with expertise in health plan administration and finance ▪ 1 registered nurse with expertise in the delivery of care and development and utilization of innovative treatments in the practice of patient care ▪ 1 member from a list of nominees submitted by the president of the senate, with expertise in representing the health care workforce as a leader in a labor organization ▪ 1 member from a list of nominees submitted by the speaker of the house of representatives, with expertise in health care innovation, including pharmaceuticals, biotechnology, or medical devices o 3 members appointed by the Attorney General ▪ 1 health economist ▪ 1 member with expertise in health care consumer advocacy ▪ 1 member with expertise in behavioral health, substance use disorder, mental health services and mental health reimbursement systems

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				• Appointed members shall receive a stipend in an amount not greater than 10% of the salary of the secretary of A&F, except the chairperson shall receive a stipend in an amount not greater than 12% of the salary of the secretary
13	6D	5	HPC - Monitoring of Health Care Delivery and Payment System	• Adds "monitor the location and distribution of health care services and health care resources" to current subjects within the scope & purpose of HPC to account for the transfer of the Health Planning Council & duty to produce the State Health Resource Plan from EOHHS to HPC
14	6D	6	HPC – Operations Assessment	• Expands categories of entities subject to the HPC's operating assessment to "non-hospital provider organization", defined to include to a provider organization required to register under section 11 that is a (i) non-hospital-based physician practice with not less than $500,000,000 in annual gross patient service revenue, (ii) clinical laboratory, (iii) imaging facility, or (iv) network of affiliated urgent care centers • Requires the assessment on hospitals, ambulatory surgical cents, and non-hospital provider organizations to be set at an amount between 30% and 40% of the HPC's appropriation o Limits the portion of this assessment levied against non-hospital provider organizations to an amount between 3% and 8% of the total assessment collected from hospitals, ambulatory surgical cents, and non-hospital provider organizations • Expands categories of entities subject to the HPC's operating assessment to include pharmaceutical manufacturing companies and requires to be set at an amount between 5% and 10% of the HPC's appropriation • Expands categories of entities subject to the HPC's operating assessment to include pharmacy benefit managers and requires to be set at an amount between 5% and 10% of the HPC's appropriation
15	6D	7	HPC - Healthcare Payment Reform Fund	• Adds "advance health equity" to list of approved uses of HPC grants provided from the Health Care Payment Reform Trust Fund

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	6D	8	HPC - Cost Trends Hearings & Annual Report	• Expands the scope of the HPC cost trends hearings to include an examination of pharmaceutical manufacturing companies, pharmacy benefit managers, and any relevant impact of significant equity investors, health care real estate investment trusts, management services organizations
				• Adds the following to the list of stakeholders required to testify at the HPC's annual cost trends hearing:
				  o (xi) significant equity investors, health care real estate investment trusts or management services organizations associated with a provider or provider organization;
				  o (xii) a representative from the division of insurance
				  o (xiii) the executive director of the commonwealth health insurance connector authority
				  o (xiv) the assistant secretary for MassHealth
				  o (xv) not less than 2 representatives of the pharmacy benefit management industry
				  o (xvi) not less than 3 representatives of pharmaceutical manufacturing companies, 1 of whom shall be a representative of a publicly traded company that manufactures specialty drugs, 1 of whom shall be a representative of a company that manufacturers generic drugs and 1 of whom shall be a representative of a company that has been in existence for fewer than 10 years
				• Outlines scope of testimony required from MassHealth, pharmacy benefit managers, pharmaceutical manufacturing companies, and significant equity investors, health care real estate investment trusts or management services organization associated with a provider or provider organization
				• Directs HPC to request testimony from officials representing CMS
				• Amends the directive that the HPC produce an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system as follows:
				  o Expands the scope of spending trends examined to include primary care spending

				○ Expands scope of HPC's examination to include new data collected through the registered provider organization process, amended by the Act to require submissions from significant equity investors, health care real estate investment trusts, management services organizations ○ Expands scope of HPC's examination to include new data collected by CHIA from pharmacy benefit managers pursuant to MGL chapter 12C § 10A [Note: new MGL chapter 12C § 10A included in S2520-H4910 conference report]
22	6D	11	HPC - Registered Provider Organizations; Division of Insurance Risk Certificate	• Expands scope of ownership, governance and organizational information HPC collects from Registered Provider Organization to include significant equity investors, health care real estate investment trusts, and management services organizations"
23	6D	12		• Expands the Registered Provider Organization reporting threshold to include revenue generated from all payers, not just commercial payer revenue.
24	6D	13	HPC - Notice of Material Changes; Cost and Market Impact Review	• Adds the following new transactions to the HPC's material change notice process: (i) significant expansions in a provider or provider organization's capacity; (v) transactions involving a significant equity investor which result in a change of ownership or control of a provider, provider organization or a carrier; (vi) significant acquisitions, sales or transfers of assets including, but not limited to, real estate sale lease-back arrangements; and (vii) conversion of a provider or provider organization from a non-profit entity to a for-profit entity • Amends existing transaction subject to the HPC material change notice process involving mergers or acquisitions of provider organizations which will result in a provider organization having a "near-majority" market share in a given service or region to such transactions that result in a "dominant" market share. • Clarifies that provider and provider organization material change notices submitted to the HPC must be deemed to be complete prior to the initiation of the deadlines in this section • Authorizes HPC to initiate a cost and market impact review (CMIR) for any material change involving providers or provider organizations whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark, as identified by CHIA under chapter 12C § 18 • Expands HPC authority to require the submission of documents and information as part of a notice of material change or a cost and market impact to include such materials from any significant equity investor or "other party" involved • Authorizes HPC to require additional information to be submitted as part of a material change notice involving a significant equity investor, including information regarding the significant equity investor's capital structure, general financial condition, ownership and management structure, and audited financial statements • Authorizes HPC to require additional information to be submitted for a period of 5 years after the completion of a material change to assess post-transaction impacts • Adds the following factors HPC may examine as part of a CMIR to include (xii) the size and market share of any corporate affiliates or significant equity investors of the provider or provider organization; (xiii) the inventory of health care resources maintained by the DPH; (xiv) any related data or reports from the office of health resource planning • Any final CMIR report issued by the HPC must be referred to DPH for consideration during any pending determinations of need or other departmental action involving the provider or provider organization

25	6D	22	HPC - Health Planning Council / State Health Resource Plan	• Transfers responsibility for the Health Planning Council from EOHHS to HPC and reconstitutes the entity as a new Office of Health Resource Planning within the commission • New Office of Health Resource Planning charged with developing a State Health Plan as a forecast of anticipated demand, production, supply and distribution of health care resources on a state-wide and regional basis during a 5-year planning period to identify: (i) the anticipated needs for health care services, providers, programs, and facilities; (ii) the existing health care resources, providers, programs, and facilities available to meet those needs; (iii) the projected resources, including the health care workforce, necessary to meet those anticipated needs; (iv) recommendations for the appropriate supply and distribution of resources, workforce, programs, capacities, technologies and services on a statewide and regional basis; (v) the priorities for addressing those needs; and (vi) recommendations for any further legislative, regulatory, or other state action • Directs the Office of Health Resource Planning to conduct at least 1 public hearing seeking input on the state health plan • Directs the Office of Health Resource Planning to provide direction to DPH to establish and maintain a health care resources inventory • Authorizes the Office of Health Resource Planning in consultation with other state agencies, to conduct focused assessments of supply, distribution and capacity in relation to projected need of health care services, and to make recommendations to address the drivers of disparities and areas of misalignment of need, supply, distribution and capacity • Directs the Office of Health Resource Planning to publish analyses and report and to file a report with the Joint Committee on Health Care Financing annually by January 1 • Clarifies that nothing in this section shall impose caps on health care resources in the Commonwealth
26 **27**	12	5A	AGO - False Claims; Definitions	• Amends the AGO false claims statute to hold private equity and other owners liable under the false claims act if they are or become aware of any violation of the false claims act and fail to appropriately address the violation in a timely manner, regardless of whether the owner/investor caused the violation • Inserts new definition of "Ownership or investment interest" defined any: (1) direct or indirect possession of equity in the capital, stock, or profits totaling more than 10 per cent of an entity; (2) interest held by an investor or group of investors who engages in the raising or returning of capital and who invests, develops, or disposes of specified assets; or (3) interest held by a pool of funds by investors, including a pool of funds managed or controlled by private limited partnerships, if those investors or the management of that pool or private limited partnership employ investment strategies of any kind to earn a return on that pool of funds.
28 **29**	12	5B	AGO - False Claims Liability	• Extends liability for False Claim Act (FCA) violations to anyone with (i) an "ownership or investment interest" in a person who violates the FCA, (ii) knows of the FCA violation, and (iii) fails to report the violation within 60 days of identifying the FCA violation.
30	12	11N	AGO - Monitoring Health Care Market Trends; Investigation of Unfair Methods of Competition or Anti-Competitive Behavior	• Expands the AGO's civil investigative demand authority for health care entity oversight to include significant equity investors, health care real estate investment trusts and management services organizations.
31 **32** **33** **34** **35** **36**	12C	1	CHIA - Definitions	• Defines "Health care real estate investment trust" • Defines "Health disparities" • Defines "Health equity" • Defines "Management services organization" • Technical Amendment to existing definition of "Payer" • Defines "Pharmaceutical manufacturing company" • Defines "Pharmacy benefit manager"

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				• Defines "Private equity company" • Defines "Significant equity investor"
37	12C	2A	Health Equity	• Adds health equity advocacy experience to the CHIA Oversight Council
38	12C	7	CHIA – Operations Assessment	• Expands categories of entities subject to the CHIA's operating assessment to "non-hospital provider organization", defined to include to a provider organization required to register under section 11 that is a (i) non-hospital-based physician practice with not less than $500,000,000 in annual gross patient service revenue, (ii) clinical laboratory, (iii) imaging facility, or (iv) network of affiliated urgent care centers • Requires the assessment on hospitals, ambulatory surgical cents, and non-hospital provider organizations to be set at an amount between 30% and 40% of the HPC's appropriation o Limits the portion of this assessment levied against non-hospital provider organizations to an amount between 3% and 8% of the total assessment collected from hospitals, ambulatory surgical cents, and non-hospital provider organizations • Expands categories of entities subject to the HPC's operating assessment to include pharmaceutical manufacturing companies and requires to be set at an amount between 5% and 10% of the HPC's appropriation • Expands categories of entities subject to the HPC's operating assessment to include pharmacy benefit managers and requires to be set at an amount between 5% and 10% of the HPC's appropriation

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	12C	8	CHIA - Reporting Requirements for Institutional Providers and Their Parent Organization and Other Affiliates	• Enhances acute and non-acute hospital reporting to CHIA as follows:
				  o Expands the entities subject to CHIA reporting authority over institutional providers and their parent organizations to include affiliated significant equity investors, health care real estate investment trusts and management services organizations
				  o Directs CHIA to promulgate regulations to require acute and non-acute hospitals to file the audited financial statements of the out-of-state operations of a hospital's parent organization and of significant equity investors, health care real estate investment trusts and management services organizations.
				  o Expands CHIA's data collection and analysis related to its duty to monitor the financial conditions of acute hospitals by requiring acute hospitals to file the following additional data:
				    ▪ Margins, including margins by payer type,
				    ▪ investments, and
				    ▪ information on any relationships with significant equity investors, health care real estate investment trusts and management services organizations.

42	12C	9	CHIA - Reporting Requirements for Registered Provider Organizations	• Enhances registered provider organization [RPO] reporting to CHIA as follows:
				  o Directs CHIA to consult with the HPC in determining data collections elements for registered provider organizations
				  o Shortens reporting requirement period from every 2 years to annual reporting
				  o Expands scope of data CHIA shall collect to include data necessary for the center to monitor clinical services of RPOs
				  o Expands the information RPOs must annually report to CHIA to include the name, address and capacity of all other locations where the provider organization, or any of its affiliates, delivers health care services, health care resources listed in subsection (a) of section 22 of chapter 6D
				  o Expands the information RPOs must annually report to CHIA as part of a comprehensive financial statements to include, for information on RPO parent entities, information on their out-of-state operation and information on their corporate affiliates, including significant equity investors, health care real estate investment trusts and management services organizations, with details regarding annual costs, annual

				receipts, realized capital gains and losses, accumulated surplus and accumulated reserves o Expands the list of information RPOs must annually report to CHIA by requiring the submission of information regarding other assets and liabilities that may affect the financial condition of the provider organization or the provider organization's facilities, including, but not limited to, real estate sale-leaseback arrangements with health care real estate investment trusts o Directs CHIA to consider the administrative burden of reporting when developing RPO reporting requirements o Expands CHIA authority to require additional data from RPOs that is reasonable and necessary to achieve the goals of this section to include information related to RPO total adjusted debt and total adjusted earnings o Authorizes CHIA to modify reporting requirements, require RPOs with private equity investment to report necessary information on a quarterly basis, or require disclosure of relevant information from any significant equity investor associated with a RPO
43	12C	11	CHIA - Timely Reporting of Information Required Under Secs. 8, 9, 10 and 10A	• Increases penalties levied against payers, providers, registered provider organizations and pharmacy benefit managers for failure to timely report required data from $1,000 to $25,000 per violation, strikes the cap on financial penalties and requires CHIA to notify HPC and DPH of failure to report to be considered by the HPC in the CMIR process and by DPH when considering a determination of need application or when reviewing licensure and suitability.
44	12C	14	CHIA - Standard Quality Measure Set	• Updates the Standard Quality Measure Set; CHIA, consultation with statewide advisory committee, shall by March 1 in even-numbered years, shall establish the Standard Quality Measure Set for use in the following: (i) public and private contracts between payers & providers, provider organizations and ACOs which incorporate quality measures into payment terms, including the designation of a set of core measures & a set of non-core measures; (ii) provider tiering assignments in any health plan design; (iii) consumer transparency websites & other methods of providing consumer information; (iv) monitoring system-wide performance • Mandates the use of the Standard Quality Measure Set "core measures" and allows for the use of optional "non-core measures" in contracts that incorporate quality measures into payment terms; applies to contracts entered into by the GIC, MassHealth, and commercial health plans, Blue Cross / Blue Shield plans, HMO plans, PPO plans; & for use in the assignment of provider tiering in tiered network plans offered in the merged market under MGL c176J § 11 • Requires the Standard Quality Measure Set to allow for innovation in the development of measures for both quality and safety • Directs CHIA to develop uniform reporting requirements for the Standard Quality Measure Set for each health care provider facility, medical group or provider group in the commonwealth • Establishes the Statewide Advisory Committee to make recommendations on the Standard Quality Measure Set • Directs the advisory committee to incorporate recognized quality measures in its recommendations for the Standard Quality Measure Set • Directs the advisory committee to submit its recommendations to CHIA not later than January 1 in each even-numbered year •
45 **46** **47** **48**	12C	15	Betsy Lehman Center for Patient Safety and Medical Error Reduction	• Amends the enabling statute of the Betsy Lehman Center as follows: o Amends definition of "Adverse event" in Betsy Lehman Center statute to capture incidents of harm, as opposed to just injury o Adds definitions of "Agency", "Healthcare-associated infections", and "Patient safety information" to clarify the purview of the Betsy Lehman Center statute and to clarify the duty of other state agencies to share relevant patient safety data with the Center on request

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				○ Authorizes the Betsy Lehman Center to share information with other agencies that collect patient safety information through an interagency service agreement. ○ Authorizes the Betsy Lehman Center to adopt rules and regulations necessary for its operation and to contract with another entity to manage its affairs or carry out the purpose of the section
49	12C	17	CHIA - Attorney General Review and Analysis of Information Submitted Under Secs. 8, 9 and 10 and Under SEC. 8 of Chapter 6D	• Expands the AGO's civil investigative demand authority for information reported to CHIA and the HPC include information submitted by significant equity investors, health care real estate investment trusts and management services organizations
50	13	10	Board of Registration in Medicine - Membership; Officers	• Grants the Commissioner of DPH approval authority over BORM regulatory actions, appointment of executive director and legal counsel.
51	13	10A	Board of Registration in Medicine - Review and Approval of Rules and Regulations	• BORIM regulatory actions deemed disapproved if Commissioner of DPH does not approve within 30 days
52	106	9-609	Uniform Commercial Code - Secured Party's Right to Take Possession After Default	• Amends the Uniform Commercial Code related to secured transactions to require 60 days notice to DPH in any case where a secured party is looking to possess collateral in the form of a medical device. Defines "medical device" as the term is used in Chapter 111N, the Pharmaceutical and Medical Device Manufacturer Code of Conduct
53 **54** **55**	111	25A	DPH - Inventory of Health Care Resources and Inventory of Health Care Resources and Related Information	• Directs DPH to take direction from the Office of Health Planning on the health care resources inventory • Removes the requirement for DPH to publish analyses and reports of information collected under the health care resources inventory to prevent conflicts and overlap with responsibilities and authorities granted to the new Office of Health Resource Planning established in section 11 of chapter 6D
56	111	25B	DPH - Determination of Need Definitions applicable to Secs. 25B to 25G	• Defines "Party of record"
57 **58** **59** **60** **61**	111	25C	DPH - Determination of Need for Construction of Health Care Facility or Change in Service of Facility	• Expands the list of factors DPH shall consider in its review of an application for a Determination of Need certificate to include the following new factors: ○ in addition to comments, any relevant data from CHIA ○ in addition to comments, relevant data from the HPC, including any final Cost and Market Impact Review report related to a provider or provider organization submitted to it by pursuant to section 13 of chapter 6D, which shall be included as part of the written record of a DON application in applicable ○ the Commonwealth's cost containment goals ○ the impact on the applicant's patients, including considerations of health equity ○ the impact on the workforce of surrounding health care providers ○ the impact on other residents of the Commonwealth • In the event DPH requires an applicant to provide an independent cost analyses (ICAs) to demonstrate that a proposed DON project is consistent with the Commonwealth's efforts to meet health care cost containment goals established by the HPC, the bill authorizes DPH to choose the entity conducting the ICA from a list of 3 entities submitted by the applicant. • Codifies DPH regulation to toll the DON timeline for an independent cost analysis, cost and market impact review, and performance improvement plan. • Allows any party of record to review a DON application and any associated independent cost analysis and provide written comments and specific recommendations for DPH's consideration. • Requires DPH to share materials submitted by a party of record on a DON with all other parties of record.

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62	111	25F	DPH - Determination of Need; submission or proposed rules and regulations to legislative committees	• Technical correction to the DON legislative reporting requirement section to reference the Joint Committee on Health Care Financing.
63 **64**	111	51G	DPH - Acute-Care Hospitals; Original Licensure Process; Determination of Suitability and Responsibility; Factors	• Requires DPH to hold a public hearing prior to the closure of a hospital or any essential health service • Authorizes DPH to seek an impact analysis of a closure of a hospital or any essential health service from HPC • Prohibits DPH from issuing a license to establish or maintain an acute care hospital if the main campus of the acute hospital is leased from a health care real estate investment trust. Any acute hospital leasing its main campus from such an entity as of 4/1/2024 will be exempt for this section and that exempt status will be maintained to any subsequent transfer Prohibits DPH from issuing a license to establish or maintain an acute care hospital unless the applicant discloses, as part of its application, all documents related to any lease, master lease, sublease, license or any other agreement for the use, occupancy or utilization of the premises to be occupied by the acute care hospital. • Prohibits DPH from issuing a license to establish or maintain an acute care hospital unless the applicant is in compliance with CHIA reporting requirements.
65 **66** **67**	111	51H	DPH - Reporting About Healthcare-Associated Infections and Serious Reportable Events, and Serious Adverse Drug Events; Charges or Reimbursement for Resulting Services Prohibited	• Expands the list of health care facilities required to report health care associated infections, serious reportable events, and serious adverse drug events to include limited-service clinics, office-based surgical centers, and urgent care centers. • Defines "Operational impairment event" as any action, or notice of impending action, including a notice of financial delinquency, concerning the repossession of medical equipment or supplies necessary for the provision of patient care • Requires hospitals, free standing ambulatory surgical centers, limited-service clinics, office-based surgical centers, and urgent care center to notify DPH of any operation impairment event within 1 calendar day • Bans contract terms between vendors and hospitals, free standing ambulatory surgical centers, limited-service clinics, office-based surgical centers, and urgent care centers, that allow for repossession of medical or surgical equipment without 60-day prior notice to DPH and makes such terms void as against public policy of the commonwealth.
68	111	51N 51O	DPH - License Office-Based Surgical Centers DPH – License Urgent Care Centers	• Directs DPH to establish regulations & practice standards for licensing office-based surgical centers and may, at its discretion, determine which regulations applicable to an ambulatory surgical center shall apply; 2 year renewal cycle; license to list the specific locations on the premises where surgical services are provided; 1-time provisional licensed for accredited applicants; No limitation on DPH authority to require a fee, impose a fine, conduct surveys & investigations or to suspend, revoke or refuse to renew • Directs DPH to establish regulations & practice standards for licensing urgent care centers and may, at its discretion, determine which regulations applicable to an ambulatory surgical center shall apply; 2 year renewal cycle; 1-time provisional licensed for accredited applicants; No limitation on DPH authority to require a fee, impose a fine, conduct surveys & investigations or to suspend, revoke or refuse to renew
69	111	218	DPH - Guidelines for Human Leukocyte or Histocompatibility Locus Antigen Testing	• Tech amendment to update a reference to Massachusetts Association of Health Plans
70	111D	7	DPH - Licensing & Regulation of Clinical Laboratories; Clinical Laboratory Director; Qualifications; DPH Conditions of Employment	• Increases the cap on the number of clinical labs for which one individual may serve as clinical director from 3 to 5

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71	112	2	BORM - Registration of Physicians – Submission of Information with License Renewal Application	• Tech change to remove reference to "his or her" specialties in the information required upon physician licensure.
72	118E	9C	Division of Medical Assistance / MassHealth - Reimbursement Programs	• Technical correction to insert reference the Joint Committee on Health Care Financing
73	176A	5	Non–Profit Hospital Service Corporations - Joint Administration with Certain Corporations	• In the examination of rates of payments submitted for approval under this section to determine whether a contract is not excessive, requires the DOI to consider affordability to consumers and affordability to purchasers of health insurance products • Requires rate reviews under this section to adhere to principles of solvency and actuarial soundness
74	176A	6	Non–Profit Hospital Service Corporations - Approval of Nongroup Contracts	• In the examination of rates of payments submitted for approval under this section to determine whether a contract is not excessive, requires the DOI to consider affordability to consumers and affordability to purchasers of health insurance products • Requires rate reviews under this section to adhere to principles of solvency and actuarial soundness
75	176A	10	Non–Profit Hospital Service Corporations - Group Hospital Service Plan; Approval or Disapproval of Contracts and Rates	• In the examination of rates of payments submitted for approval under this section to determine whether a contract is not excessive, requires the DOI to consider affordability to consumers and affordability to purchasers of health insurance products • Requires rate reviews under this section to adhere to principles of solvency and actuarial soundness
76	176B	4	Medical Service Corporations -Contracts for Medical, Chiropractic, Visual, Surgical, and Other Health Services; Approval, Subscription Certificates; Classification of Risks	• In the examination of rates of payments submitted for approval under this section to determine whether a contract is not excessive, requires the DOI to consider affordability to consumers and affordability to purchasers of health insurance products • Requires rate reviews under this section to adhere to principles of solvency and actuarial soundness
77	176G	16	Health Maintenance Organizations - Contracts, Rates, Evidence of Coverage; Disapproval of Commissioner	• In the examination of rates of payments submitted for approval under this section to determine whether a contract is not excessive, requires the DOI to consider affordability to consumers and affordability to purchasers of health insurance products • Requires rate reviews under this section to adhere to principles of solvency and actuarial soundness
78	176J	6	Small Group Health Insurance - Approval of Health Insurance Policies; Eligibility Criteria; Submission of Information; Approval of Changes to Small Group Product Base Rates or Rating Factors	• In the examination of rates of payments submitted for approval under this section to determine whether a contract is not excessive, requires the DOI to consider affordability to consumers and affordability to purchasers of health insurance products • Requires rate reviews under this section to adhere to principles of solvency and actuarial soundness
79	176K	7	Medicare Supplement Insurance Plans - Compliance; Withdrawal from Market	• In the examination of rates of payments submitted for approval under this section to determine whether a contract is not excessive, requires the DOI to consider affordability to consumers and affordability to purchasers of health insurance products • Requires rate reviews under this section to adhere to principles of solvency and actuarial soundness
80	Task Force		Primary Care Payment and Delivery Task Force	• Creates a task force to study and make recommendations to improve primary care access, delivery and financial stability. • The Task Force comprised of 23 members and chaired by EOHHS and HPC • The task force's recommendations will include: definitions of service, create standardized data reporting, establish a primary care spending target for public and private payers, assess impacts on health equity, and devise ways to increase the workforce supply and improve employment conditions

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			• The state will publish relevant data on a Primary Care Dashboard maintained by CHIA and Massachusetts Health Quality Partners • Recommendations related to definitions and standardized data collections and reporting are due by 9/15/2025 • Recommendations related to the spending target is due by 12/15/2025 • Recommendations related to payment models and plan design are due on 3/15/2026 • Recommendations on service delivery are due on 5/15/2026
81	Effective Date	HPC & CHIA – Operations Assessment	• Creates an effective date of beginning of Fiscal Year 2026 for SECTIONS 14 and 38 of the bill relating to changes in HPC and CHIA assessments.
82	Reporting Deadline	Health Resource Plan – Initial Report	• Directs the Office of Health Resource Planning to submit a state health plan to the governor and the general court on or before January 1, 2027.
83	Regulation Deadline	DPH - License Office-Based Surgical Centers	• Directs DPH, in consultation with BORM, to promulgate regulations for the licensing office-based surgical centers by October 1, 2025
84	Regulation Deadline	DPH – License Urgent Care Centers	• Directs DPH, in consultation with BORM, to promulgate regulations for the licensing urgent care centers by October 1, 2025
85	Notwithstanding	DPH - License Office-Based Surgical Centers	• Directs DPH, to grant a 1-time provisional license for a period of not more than 1 year to office-based surgical center license which is deemed to be in substantial compliance with initial DPH regulations and demonstrates potential for achieving full compliance within the provisional licensure period
86	Notwithstanding	DPH – License Urgent Care Centers	• Directs DPH, to grant a 1-time provisional license for a period of not more than 1 year to an urgent care center license which is deemed to be in substantial compliance with initial DPH regulations and demonstrates potential for achieving full compliance within the provisional licensure period
87	Notwithstanding	HPC - Governing Board; Members	• Technical language related to the implementation of changes to the membership of the board governing the Health Policy Commission
88	Effective Date	HPC - Governing Board; Members	• Effective date for the changes to the membership of the board governing the Health Policy Commission set as July 1, 2025

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