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Acts 2013

CHAPTER 35 AN ACT IMPLEMENTING THE AFFORDABLE CARE ACT AND PROVIDING FURTHER ACCESS TO AFFORDABLE HEALTH CARE.

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

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

SECTION 1. Section 16 of chapter 6A of the General Laws, as most recently amended by section 5 of chapter 224 of the acts of 2012, is hereby further amended by adding the following paragraph:- Notwithstanding any general or special law to the contrary, the executive office of health and human services may request from any agency, department, division, commission, board, authority, or other public or quasi-public entity in the commonwealth, and they shall provide, any information, including personal data, as defined in section 1 of chapter 66A and data in the wage reporting system administered by the department of revenue pursuant to chapter 62E, that the executive office of health and human services determines to be necessary to make available, determine eligibility for, enroll individuals in and otherwise administer various public benefit programs authorized pursuant to chapter 118E or other programs that the executive office of health and human services may administer in accord with the Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time, or that the executive office of health and human services determines, in its judgment, as being reasonably necessary to develop and administer a single integrated eligibility system, in conjunction with the commonwealth health insurance connector authority, through which the executive office of health and human services may make available, determine eligibility for, enroll individuals in and otherwise administer such public benefit programs, and through which the commonwealth health insurance connector authority will execute its statutory responsibilities pursuant to chapter 176Q; provided, that the provision of such information to the executive office of health and human services for such purposes is consistent with federal law. Further, notwithstanding any general or special law to the contrary, the executive office of health and human services is authorized to provide to the commonwealth health insurance connector authority any information the executive office of health and human services obtains pursuant to section 23 of chapter 118E as necessary for the commonwealth health insurance connector authority to perform its duties pursuant to chapter 176Q.

SECTION 2. Section 1 of chapter 6D, as appearing in section 15 of said chapter 224, is hereby amended by striking out the definition of “Public health care payer” and inserting in place thereof the following definition:-
“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid to pay for or arrange the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI of the Social Security Act, including prepaid health plans subject to section 28 of chapter 47 of the acts of 1997; the group insurance commission established pursuant to chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

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

SECTION 4. Section 1 of chapter 12C, as appearing in section 19 of said chapter 224, is hereby amended by striking out the definition of “Public health care payer” and inserting in place thereof the following definition:-
“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid to pay for or arrange the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI of the Social Security Act, including prepaid health plans subject to section 28 of chapter 47 of the acts of 1997; the group insurance commission established pursuant to chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 4A. Section 18 of chapter 15A of the General Laws, as amended by section 20 of said chapter 224, is hereby further amended by striking out the first paragraph and inserting in place thereof the following paragraph:-
Every full-time and part-time student enrolled in a public or independent institution of higher learning located in the commonwealth shall participate in a qualifying student health insurance program. For the purposes of this section, “part-time student” shall mean a student participating in at least 75 per cent of the full-time curriculum. Such an institution may allow students to waive participation in its student health insurance program or any part thereof; provided, however, that such an institution shall require students waiving participation to certify in writing prior to any academic year in which the student will not participate in the institution's plan that such student is a participant in a health insurance program providing comparable coverage; and provided further, that such institution shall allow students to waive participation in its student health insurance program if the student is currently enrolled in MassHealth, the student continues to meet all relevant MassHealth eligibility criteria under state and federal law and: (i) the student has been enrolled in MassHealth for at least 1 year prior to becoming eligible for the institution’s student health insurance program or (ii) the

student has been enrolled in MassHealth for at least 6 months and the student provides documentation, as required by the commonwealth health insurance connector in consultation with MassHealth, that participation in the qualifying student health insurance program would be financially prohibitive.

SECTION 5. Chapter 26 of the General Laws is hereby amended by inserting after section 8K the following section:-
Section 8L. In regard to any carrier licensed pursuant to chapters 175, 176A, 176B, 176E, 176F and 176G, the commissioner of insurance may implement and enforce: (i) the Patient Protection and Affordable Care Act, Public Law 111–148, as well as any rules, regulations or guidance applicable thereto, as amended from time to time; and (ii) the Women's Health and Cancer Rights Act of 1998, Public Law 105-277, as well as any rules, regulations or guidance applicable thereto, as amended from time to time, including, but not limited to, the amendments made by: Title X of said Patient Protection and Affordable Care Act; the Health Care and Education Reconciliation Act of 2010, Public Law 111–152; and the Indian Health Care Improvement Reauthorization and Extension Act of 2009, as enacted in amended form by section 10221 said federal Patient Protection and Affordable Care Act.

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

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

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

SECTION 9. Section 8 of chapter 118E of the General Laws, as so appearing, is hereby amended by striking out the definition of "Person" and inserting in place thereof the following definition:-
"Person", any individual who resides in the commonwealth, or any individual residing outside the commonwealth who is deemed to be a resident of the commonwealth under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.

SECTION 10. Said section 8 of said chapter 118E, as so appearing, is hereby further amended by striking out the definition of "Reside" and inserting in place thereof the following definition:-
"Reside", to occupy an established place of abode with no present intention of definite and early removal, but not necessarily with the intention of remaining permanently, but in no event shall the word "reside" be construed more restrictively or less restrictively than as defined by the Secretary

under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.

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

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

SECTION 13. Said section 9 of said chapter 118E, as amended by section 24 of chapter 118 of the acts of 2012, is hereby further amended by adding the following paragraph:-
The secretary of the executive office may establish a program to provide subsidies to assist eligible individuals in purchasing health insurance, provided that such subsidies shall only be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured by the MassHealth program and shall be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by MassHealth. Eligible individuals are residents of the commonwealth whose income is 300 per cent or less of the federal poverty level as calculated pursuant to the regulations of the executive office, who are not eligible for federal advanced premium tax credits, who are ineligible for any other benefits provided pursuant to this chapter, and who are permanently residing in the United States under color of law; provided, that the individual has not moved into the commonwealth for the sole purpose of securing health insurance under this chapter; and provided further, that confinement of an individual in a nursing home, hospital or other medical institution in the commonwealth shall not, in and of itself, suffice to qualify an individual as a resident.

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

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

SECTION 16. Said subsection (1) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out the definition of “Medical benefits” and inserting in place thereof the following definition:-
“Medical benefits”, health care services including managed care programs, provided to beneficiaries pursuant to the terms and conditions of a demonstration project and regulations promulgated by the

division and including, but not limited to, assistance with premiums and costs sharing and medical insurance purchased for beneficiaries pursuant to section 18 or benefits authorized by 42 U.S.C. section 1396e.

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

SECTION 18. Subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out clause (b) and inserting in place thereof the following clause:-
(b) infants to age 1 and pregnant women whose financial eligibility, as determined by the division, does not exceed 200 per cent of the federal poverty level and children and adolescents aged 1 to 20 years, inclusive, whose financial eligibility, as determined by the division, does not exceed 150 per cent of the federal poverty level.

SECTION 19. Said subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out clause (d) and inserting in place thereof the following clause:-
(d) persons aged 21 to 64, inclusive, whose financial eligibility, as determined by the division, does not exceed 133 per cent of the federal poverty level; provided, however, that such persons shall meet such other eligibility criteria that the division and the secretary may establish.

SECTION 20. Said subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by adding the following clause:-
(j) premium assistance for employer sponsored health insurance for adults whose financial eligibility, as determined by the division, does not exceed 300 per cent of the federal poverty level, are uninsured at the time of application, are not eligible for any other program under this chapter and are not eligible for federal advanced premium tax credits through the health connector because they have access to employer sponsored minimum essential coverage as defined in section 1401 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time.

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

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

SECTION 23. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out, in lines 157, 164, 174, the second time it appears, 179, the second time it appears, 211

and in line 212, the second time it appears, the word “the” and inserting in place thereof, in each instance, the following word:- a.

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

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

SECTION 26. Section 10 of said chapter 118E, as appearing in the 2010 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-
The division may, to the extent permitted by Title XIX or other federal authority, provide medical assistance to pregnant women who are presumptively eligible for the period of time prescribed by federal law or other federal authority. The division shall promulgate regulations to implement this section, which shall require health care providers to notify such pregnant women of the need to file an application for Medicaid and which shall set standards to be used by providers in determining presumptive eligibility.

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

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

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

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

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

SECTION 31. The definition of “Payments subject to surcharge” in section 64 of chapter 118E, inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out the words “: (1) Medicaid recipients under age 65; and (2) enrollees in the commonwealth care health

insurance program" and inserting in place thereof the following words:- Medicaid recipients under age 65.

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

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

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

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

SECTION 36. Subsection (c) of section 46 of chapter 151A of the General Laws, as amended by section 145 of chapter 224 of the acts of 2012, is hereby further amended by striking out clause (7) and inserting in place thereof the following clause:-
(7) to the commonwealth health insurance connector authority, information under an interagency agreement for the administration and enforcement of chapter 176Q.

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

SECTION 38. Subsection (a) of subdivision 2 of section 108 of chapter 175 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out paragraph (3) and inserting in place thereof the following paragraph:-
(3) It purports to insure only 1 person, except that a policy, excluding contracts which provide stand-alone dental services, shall insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be considered the policyholder, 2 or more eligible members of that family, including the policyholder, spouse, dependent children and other dependent persons, children during pendency of adoption procedures under chapter 210, children under 26 years of age and children who are mentally or physically incapable of earning their own living, if due proof of the incapacity is received by the insurer within 31 days of the date upon which the coverage would otherwise be terminated; and.

SECTION 39. Section 110 of said chapter 175, as so appearing, is hereby amended by striking out

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

SECTION 40. Chapter 176A of the General Laws is hereby amended by striking out section 8BB, as so appearing, and inserting in place thereof the following section:-
Section 8BB. Any subscription certificate under an individual or group nonprofit hospital service agreement, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered, issued or renewed in the commonwealth, shall provide, as benefits to all individuals or to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 41. Chapter 176B of the General Laws is hereby amended by striking out section 4BB, as so appearing, and inserting in place thereof the following section:-
Section 4BB. Any subscription certificate under an individual or group medical service agreement, except certificates that provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered or issued or renewed in the commonwealth, shall provide, as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 42. Chapter 176G of the General Laws is hereby amended by striking out section 4T, as so appearing, and inserting in place thereof the following section:-
Section 4T. A health maintenance contract, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, shall provide, as benefits to all individuals or to group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 43. Section 1 of chapter 176J of the General Laws, is hereby amended by striking out the definition of “Eligible dependent”, as so appearing, and inserting in place thereof the following definition:-
“Eligible dependent”, the spouse or child of an eligible person, subject to the applicable terms of the health benefit plan covering such employee. The child of an eligible individual or eligible employee shall be considered an eligible dependent until the end of the child’s twenty-sixth year of age.

SECTION 44. Said section 1 of said chapter 176J is hereby further amended by striking out the definition of “Eligible individual”, as most recently amended by section 30 of chapter 118 of the acts of 2012, and inserting in place thereof the following definition:-
“Eligible individual”, an individual who is a resident of the commonwealth.

SECTION 45. Said section 1 of said chapter 176J is hereby further amended by inserting after the definition of “Financial impairment”, as appearing in the 2010 Official Edition, the following definition:-
“Grandfathered health plan”, any group health plan or health insurance coverage to which 42 U.S.C. section 18011 applies.

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

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

SECTION 48. Said chapter 176J is hereby amended by striking out section 3, as amended by section 174 of chapter 224 of the acts of 2012, and inserting in place thereof the following section:-
Section 3. (a) (1) For every health benefit plan issued or renewed to eligible individuals and eligible small groups, including a certificate issued to an eligible individual or eligible small group 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 the same for eligible individuals and eligible small groups. In developing these merged market group base premium rates, carriers:
(i) with respect to the group base premium rate developed for eligible individuals and 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 a merged individual and small group risk pool;
(ii) in calculating the premium to be charged to each eligible individual or 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 individuals and eligible small groups, respectively, with all other rating adjustments being prohibited;
(iii) may offer any rate basis types, but rate basis types that are offered to any eligible individual or eligible small group shall be offered to every eligible individual or 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 clause (i);
(iv) shall apply the same rating factors when calculating premiums for eligible individuals as are used when calculating premiums for eligible small groups; and

(v) notwithstanding this section, all carriers offering any coverage to any eligible individual or eligible small group shall make that coverage available to every eligible individual and 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 individual and 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 individuals and 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 both eligible small groups and eligible individuals; provided, however, that the carrier uses a certification of tobacco use process that has been approved by the commissioner to determine that eligible individuals and their eligible dependents or eligible small group employees and their eligible dependents have not used tobacco products within the past year.
(6) A carrier may establish a benefit level rate adjustment for all eligible individuals and eligible small groups that shall be expressed as a number. The number shall represent the relative actuarial value of the benefit level, including the health care delivery network, of the health benefit plan issued to that eligible individual or eligible small group as compared to the actuarial value of other health benefit plans within that class of business. If a carrier chooses to establish benefit level rate adjustments, every eligible individual and every eligible small group shall be subject to the applicable benefit level rate adjustment.
(7) A carrier shall not apply any rate adjustment factor to the group base premium rate, other than those set forth herein.
(b) (1) A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals 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 individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals 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 individual, 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 merged individual and small group health insurance market.

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

(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.

SECTION 49A. Subsection (b) of section (4) of said chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by adding 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 individual or eligible small business of any size enrollment in such health benefit plan unless the eligible individual or eligible small business enrolls through the connector. If an eligible individual or eligible small business elects to enroll through the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all eligible individuals and eligible small business in a similar manner.

SECTION 50. Said chapter 176J is hereby further amended by striking out section 5, as so appearing, and inserting in place thereof the following section:-
Section 5. No policy shall exclude an eligible individual, eligible employee or eligible dependent on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.

SECTION 51. Section 6 of said chapter 176J is hereby amended by striking out subsection (c), as so appearing, and inserting in place thereof the following subsection:-
(c) Notwithstanding any general or special law to the contrary, carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, shall file small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rates of reimbursement or rating factors included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

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

SECTION 53. Section 12 of said chapter 176J is hereby amended by striking out subsection (h), as appearing in section 179 of chapter 224 of the acts of 2012, and inserting in place thereof the following subsection:-
(h) Any rates offered by a carrier to a certified group purchasing cooperative under this section shall be based on those group base premium rates that apply to individuals and small employer groups enrolling outside the group purchasing cooperative.

SECTION 54. Section 13 of said chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-
(b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i) include all state-mandated benefits; (ii) apply open enrollment periods for individuals in the same manner as the carrier applies them for individuals outside the group purchasing cooperative, provided, however, that small business group purchasing cooperatives shall establish rules and open enrollment periods for qualified association members to enter or exit group purchasing cooperatives; (iii) apply continuation of coverage provisions in the same manner as the carrier applies those provisions to small group products offered outside the group purchasing cooperative; (iv) apply managed care practices in the same manner as the carrier applies those practices to small group products offered outside the group purchasing cooperative; and (v) apply rating rules, including rating bands, rating factors and the value of rating factors, in the same manner as the carrier applies those rules to small group products offered outside the group purchasing cooperative.

SECTION 55. Chapter 176N of the General Laws is hereby amended by striking out section 2, as so appearing, and inserting in place thereof the following section:-
Section 2. (a) No health plan shall:
(i) exclude any eligible insured on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition of such person; and
(ii) exclude late enrollees from coverage for more than 12 months from the date of the application for coverage of any late enrollee.
(b) In any circumstance in which more extensive coverage than that provided by clauses (i) and (ii) of subsection (a) is required by any other state or federal law, the health benefit plan shall satisfy such other provision insofar as it requires more extensive coverage.

SECTION 56. Section 1 of chapter 176O of the General Laws is hereby amended by striking out the definition of “Adverse determination”, as so appearing, and inserting in place thereof the following definition:-
“Adverse determination”, based upon a review of information provided by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and

level of care, or effectiveness, including a determination that a requested or recommended health care service or treatment is experimental or investigational.

SECTION 57. Said section 1 of said chapter 176O is hereby further amended by striking out the definition of “Grievance”, as so appearing, and inserting in place thereof the following definition:-
“Grievance”, any oral or written complaint submitted to the carrier which has been initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, under the requirements of this chapter.

SECTION 58. Said section 1 of said chapter 176O is hereby further amended by striking out the definition of “Office of patient protection”, as so appearing, and inserting in place thereof the following definition:-
“Office of patient protection”, the office in the health policy commission established by section 16 of chapter 6D, responsible for the administration and enforcement of sections 13, 14, 15 and 16.

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

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

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

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

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

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

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

SECTION 66. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is hereby amended by striking out clause (iii) and inserting in place thereof the following 2 clauses:-
(iii) a resolution within 5 days from the receipt of such grievance if submitted by an insured with a terminal illness; and
(iv) a resolution of a claim involving urgently needed services within 72 hours.

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

SECTION 68. Said section 13 of said chapter 176O, as so appearing, is hereby further amended by adding the following subsection:-
(d) An insured may request an expedited review of a grievance and at the same time may request an expedited external review of the grievance pursuant to section 14.

SECTION 69. Section 14 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-
(a) An insured who remains aggrieved by an adverse determination and has exhausted all remedies available from the formal internal grievance process required pursuant to section 13, may seek further review of the grievance by a review panel established by the office of patient protection pursuant to paragraph (5) of subsection (a) of section 16 of chapter 6D. The insured shall pay the first $25 of the cost of the review to said office, which may waive the fee in cases of extreme financial hardship and which shall refund the fee to the insured if the adverse determination is reversed in its entirety. No insured shall be required to pay more than $75 per plan year, regardless of the number of external review requests submitted. The carrier shall be responsible for the remainder of the cost of the review pursuant to regulations promulgated by the executive director of the health policy commission in consultation with the commissioner of insurance. The office of

patient protection shall contract with at least 3 unrelated and objective review agencies through a bidding process and refer grievances to 1 of the review agencies on a random selection basis. The review agencies shall be accredited by a national accrediting organization and shall develop review panels appropriate for the given grievance, which shall include qualified clinical decision-makers experienced in the determination of medical necessity, utilization management protocols and grievance resolution, and shall not have any financial relationship with the carrier making the initial determination. The standard for review of a grievance by such a panel shall be the determination of whether the requested treatment or service is medically necessary, as defined in section 1, and a covered benefit under the policy or contract. The panel shall consider, but not be limited to considering: (i) written documents submitted by the insured, (ii) additional information from the involved parties or outside sources that the review panel deems necessary or relevant, and (iii) information obtained from any informal meeting held by the panel with the parties. The panel shall send final written disposition of the grievance and the reasons therefore, to the insured and the carrier within 45 days of receipt of the request for review. Notwithstanding the requirements of this section, an insured may request an external review of an adverse determination without exhausting the carrier's internal appeals process if the insured is seeking an expedited review or if the carrier failed to meet the time limits specified in section 13.

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

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

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

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

SECTION 74. Section 1 of chapter 176Q of the General Laws is hereby amended by striking out the definition of "Commonwealth care health insurance program", as so appearing.

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

SECTION 76. Said section 1 of said chapter 176Q is hereby further amended by striking out the definition of “Eligible individual”, as so appearing, and inserting in place thereof the following definition:-
“Eligible individual”, an individual who is a resident of the commonwealth and who is qualified to purchase coverage through the connector pursuant to 42 U.S.C. section 18032(f).

SECTION 77. Said section 1 of said chapter 176Q is hereby further amended by inserting after the definition of “Eligible small group”, as so appearing, the following 2 definitions:-
“Federal advanced premium tax credits”, a payment made pursuant to 26 U.S.C. section 36B on behalf of an eligible individual or eligible child to reduce the value of a health benefit plan premium.
“Federal point-of-service cost-sharing reductions”, a payment made pursuant to 42 U.S.C. section 18071 on behalf of an eligible individual or eligible child to reduce point-of-service cost-sharing expenses which shall include, but not be limited to, copayments, coinsurance and deductibles.

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

SECTION 79. Said section 1 of said chapter 176Q is hereby further amended by striking out the definition of “Premium assistance payment”, as so inserted, and inserting in place thereof the following definition:-
“Premium assistance payment”, a payment made to a carrier or an individual by the connector to reduce the value of a health benefit plan premium paid by the individual.

SECTION 80. Said section 1 of said chapter 176Q is hereby further amended by striking out the definition of “Rating factor”, as appearing in the 2010 Official Edition, and inserting in place thereof the following definition:-
“Rating factor”, characteristics including, but not limited to, age, rate basis type and geography.

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

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

words:- and eligible small groups.

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

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

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

SECTION 86. Subsection (a) of said section 3 of said chapter 176Q is hereby amended by striking out paragraph (13), as so appearing, and inserting in place thereof the following paragraph:-
(13) develop a standard application form for eligible individuals and eligible small groups seeking to purchase health insurance through the connector; and.

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

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

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

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

through the Exchange, as provided by federal law; and

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

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

SECTION 93. Said chapter 176Q is hereby further amended by striking out section 8, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-
Section 8. (a) The connector shall enter into interagency agreements with the department of revenue, the executive office of health and human services, the department of public health, the executive office of labor and workforce development, the registry of motor vehicles, the department of correction, the center for health information and analysis and any other state agencies, departments, divisions, commissions, authorities or political subdivisions. The agreements shall authorize foregoing agencies, departments, divisions, commissions, authorities and political subdivisions to furnish information, including personal data as defined in chapter 66A, that is necessary for the connector to perform its duties under this chapter, including the determination of an individual's eligibility for federal advanced premium tax credits and federal point-of-service cost-sharing reductions and adjudication of appeals arising from such determinations. Such written agreements shall include provisions permitting the department of revenue to furnish the data available under the wage reporting system established under section 3 of chapter 62E. The department of revenue may furnish the connector with information on the cases of persons so identified, including, but not limited to, name, social security number and other data to ensure positive identification, name and identification number of employer, and amount of wages and gross income received from all sources. The connector shall not utilize any of the data received from the department of revenue for any solicitations or advertising.
(b) The connector may receive and use any information provided pursuant to section 23 of chapter 118E as necessary for the connector to perform the duties under this chapter, including the determination of an individual's eligibility for federal advanced premium tax credits and federal point-of-service cost-sharing reductions and adjudication of appeals arising from such determinations.

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

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

SECTION 96. Section 1 of chapter 176T of the General Laws, as inserted by section 216 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition of “Public health care payer” and inserting in place thereof the following definition:-
“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid to pay for or arrange the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI of the Social Security Act, including prepaid health plans subject to section 28 of chapter 47 of the acts of 1997; the group insurance commission established pursuant to chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

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

SECTION 98. Said first paragraph of said section 271 of said chapter 127 is hereby further amended by striking out clause (i), as amended by section 227 of said chapter 224 of the acts of 2012, and inserting in place thereof the following clause:-
(i) participants in the Senior Pharmacy program, so-called, pursuant to section 16B of chapter 118E of the General Laws.

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

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

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

SECTION 102. Notwithstanding chapter 176J of the General Laws, for the period from January 1, 2014 through December 31, 2015, carriers may develop the group base premium for eligible small employers in order to vary the group base premium by enrollment or renewal month and shall file the group base premium as part of a rate filing for each calendar quarter.
In calculating the premium to be charged to each eligible small group or eligible individual, carriers may utilize and apply a portion of the following rate adjustment factors, provided, that the carrier has such factor in place as of July 1, 2013, in addition to those rate adjustment factors permitted under said chapter 176J: (i) an industry rate adjustment factor; (ii) a participation rate adjustment factor; (iii) a group size rate adjustment factor; (iv) an intermediary rate adjustment factor; or (v) a group purchasing cooperative rate adjustment factor.

The commissioner of insurance shall promulgate regulations to implement this section, including, but not limited to, regulations setting forth the manner in which carriers may utilize and apply the rate adjustment factors set forth in this section during the period from January 1, 2014 through December 31, 2015, to the extent required by federal law.

SECTION 102A. The commonwealth, by and through the governor or the governor's designee, shall formally request a federal waiver to avoid the adverse effects of rating and rule changes to the Massachusetts merged market, to protect consumers and businesses in the commonwealth and in an effort to maintain current Massachusetts rating and rule requirements including, but not limited to, the number of ratings factors and the number of annual rate settings. All negotiations with any federal agency concerning this waiver shall be conducted in consultation with a member of the house of representatives as appointed by the speaker of the house and a member of the senate as appointed by the senate president. The governor, or the governor's designee shall file a detailed report describing the waiver application and waivers received, along with all documentation, including, but not limited to, all related written and verbal responses from the department of health and human services, with the clerks of the senate and house not later than October 1, 2014. The governor shall report monthly to the joint committee on health care financing and the house and senate committees on ways and means on the status of the waiver request under this section.

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

SECTION 104. Sections 2 to 4, inclusive, 6 to 49, inclusive, section 50, sections 52 to 92, inclusive, and sections 94 to 101, inclusive, shall take effect on January 1, 2014.

SECTION 105. Section 4A shall take effect on July 1, 2014.

Approved, July 5 , 2013.
