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HOUSE . . . . . No. 3452

The Commonwealth of Massachusetts

EXECUTIVE DEPARTMENT
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DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

May 3, 2013

To the Honorable Senate and House of Representatives,

I am filing for your consideration a bill entitled, "An Act Implementing the Affordable Care Act and Providing Further Access to Affordable Health Care." This legislation will allow Massachusetts to realize the full benefits of the Affordable Care Act, including expanded federal funding to support coverage for low and middle-income families and federal insurance reforms that will secure additional protections for Massachusetts residents.

The legislative package includes a number of changes that will allow Massachusetts to align with the Affordable Care Act, such as:

- Implementing a transition period in the merged individual/small group market to allow Massachusetts to conform to federal rating factor requirements;

- Implementing the ACA requirement that health insurance rates for individuals be filed on a calendar year basis, but allowing small group rates to be filed on a quarterly basis until 2016;

- Aligning the Commonwealth's definition of who is eligible to purchase non-group insurance with the federal definition;

- Conforming the state's insurance laws to align with ACA requirements;

- Aligning MassHealth and Connector eligibility definitions with ACA definitions; and

- Allowing for data to be shared with EOHHS and the Connector so that eligibility for MassHealth or subsidized coverage through the Exchange can be verified in real-time through the new on-line integrated eligibility system.

Enacting these provisions builds on the progress we have already made to improve health care coverage in our state. I urge your prompt and favorable consideration of this legislation.

Respectfully submitted

Deval L. Patrick,
Governor

HOUSE . . . . . No. 3452

Message from His Excellency the Governor recommending legislation relative to implementing the Affordable Care Act and providing further access to affordable health care. Ways and Means.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

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 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 appearing in the 2010 Official Edition, is hereby 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, and other public or quasi-public entity in the commonwealth, and such agencies and entities shall provide, any information, including personal data as defined in 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, in its judgment, as being reasonably necessary to make available, determine eligibility for, enroll individuals in, and otherwise administer various public benefit programs authorized under 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, Pub. L. 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

under chapter 176Q, provided 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 is reasonably necessary for the commonwealth health insurance connector authority to perform its duties pursuant to chapter 176Q.

SECTION 2. Section 1 of chapter 6D, as inserted by section 15 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition "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, including prepaid health plans subject to section 28 of chapter 47 of the acts of 1997; the group insurance commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 3. Subsection (d) of section 8 of said chapter 6D, as inserted by section 15 of chapter 224 of the acts of 2012, is hereby amended by striking out, in clause (vii), the words "or under the commonwealth care health insurance program".

SECTION 4. Section 1 of chapter 12C, as inserted by section 19 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition "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, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

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 under chapters 175, 176A, 176B, 176E, 176F, and 176G, the commissioner of insurance may implement and enforce applicable provisions of the federal Patient Protection and Affordable Care Act, Public Law 111–148, as amended from time to time and of the Women's Health and Cancer Rights Act, 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 the federal Patient

Protection and Affordable Care Act and 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 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time.

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 chapter 111 of the General Laws 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 appearing in the 2010 Official Edition, is hereby amended by striking out the definition “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 “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, as so appearing, is hereby amended by inserting after the word “A,” in line 11, the following words:- , and such other persons as may be required under Title XIX and regulations adopted thereunder

SECTION 12. Said section 9 of said chapter 118E, as so appearing, is hereby further amended by inserting after the third sentence 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 so appearing, 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 up to 300 per cent of poverty 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 so appearing, is hereby amended by inserting after the word “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 “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 “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 eighteen or benefits authorized by 42 USC 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 “Traditional beneficiaries.”

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

(b) infants to age one 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 one 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 subdivision (d) and inserting in place thereof the following subdivision:-

(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 subdivision:-

(j) premium assistance for employer sponsored health insurance for adults up to 300 per cent of the poverty level who are uninsured at the time of application, are not eligible for any other program under this chapter and cannot purchase a qualified health plan through the health connector because they have access to employer sponsored minimum essential coverage as defined in section 1401 of the federal Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time.

SECTION 21. Said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out, in line 130, the word “the” where it appears before the word “demonstration”, and inserting in place thereof the 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 two sentences.

SECTION 23. Said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 157, 164, 174, 179, 211, and 212 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 of the General Laws is hereby repealed.

SECTION 26. Section 10 of said chapter 118E of the General Laws, as so appearing, 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 27. Section 12 of said chapter 118E, as so appearing, is hereby amended by inserting after the words “Title XIX,” in line 21, the 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 as 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. Section 64 of chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out, in the definition “Payments subject to surcharge”, the words “(2) enrollees in the commonwealth care health insurance program”.

SECTION 32. Paragraph (ii) of subsection (a) of section 66 of said chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, 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 chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, is hereby further amended by striking out the words “and the commonwealth care health insurance programs” and inserting in place thereof the following word:- program

SECTION 34. Subsection (a) of section 69 of said chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out, in paragraph (3), 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, as appearing in the 2010 Official Edition, is hereby amended by striking out paragraph (7) and inserting in place thereof the following paragraph:-

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

administration of the fair share employer contribution requirement under section 188 of chapter 149.

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

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

(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 subsection (P) and inserting in place thereof the following subsection:-

(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 appearing in the 2010 Official Edition, 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 appearing in the 2010 Official Edition, 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 appearing in the 2010 Official Edition, 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, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition “Eligible dependent” 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 26th year of age.

SECTION 44. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition “Eligible individual” 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, as so appearing, is hereby further amended by inserting after the definition of “Financial impairment”, the following definition”:-

“Grandfathered health plan”, any group health plan or health insurance coverage to which 42 USC 18011 applies.

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

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

SECTION 48. Chapter 176J is amended by striking out Section 3, as appearing in the 2010 Official Edition, 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 are to do as follows:

(i) With respect to the group base premium rate developed for eligible individuals and eligible small groups, a carrier must 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) Carriers 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. 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 paragraph (i), above;

(iv) Carriers 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 the provisions of this section, all carriers offering any coverage to any eligible individual or eligible small group is required to make that coverage available to every eligible individual and eligible small group.

(2) The commissioner shall annually file with the federal 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 two-to-one. A carrier that elects to apply standard age rate adjustment factors must apply them based upon the covered person's age when the coverage period begins.

(3) The commissioner shall annually file with the federal department of health and human services to establish no 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 eight-tenths to one and two-tenths. 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 rate basis type 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 no more than the three oldest covered children must be taken into account in determining the total family premium.

(5) The commissioner shall annually file with the federal 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 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 may not apply any rate factor adjustment 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 could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year.

(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 could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year.

(c) For the purposes of this section, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its 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 so appearing, is hereby amended by striking out clause (2), and inserting in place thereof the following clause:-

(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. 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 federal Patient Protection and Affordable Care Act, 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 the federal 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, then 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 50. Said chapter 176J is hereby amended by striking out section 5, as appearing in the 2010 Official Edition, 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, as so appearing, is hereby amended by striking out subsection (c) 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, as amended by section 179 of chapter 224 of the acts of 2012, is amended by striking out subsection (h) 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 so appearing, 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 appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 2. No health plan shall:

(a) 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.

(b) exclude late enrollees from coverage for more than twelve months from the date of the application for coverage of any late enrollee.

(c) In any circumstance in which more extensive coverage than that provided by clauses (a) and (b) is required by any other provision of the General Laws or any law of the United States, 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, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition “Grievance” 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, in accordance with the requirements of this chapter.

SECTION 57. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by striking out the definition “Office of patient protection” 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 58. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by striking out the definition “adverse determination” 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 59. Section 2 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 22 and 23, the words “division of health care finance and policy” and inserting in place thereof the following words:- center for health information and analysis

SECTION 60. Said section 2 of said chapter 176O, as so appearing is hereby amended by striking out, in lines 28 and 29, 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, as so appearing, is hereby amended by striking out, in line 54, the words “section 217 of chapter 111” and inserting in place thereof the following words:- section 16 of chapter 6D

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

SECTION 63. Section 7 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 23 and 24, 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, as so appearing, is hereby further amended by striking out, in lines 45 and 55, 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 federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time as with as well as 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 adding after clause (iii), the following clause:-

(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:-

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, notwithstanding the requirement in section 14 that the insured must complete the internal review process.

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 three unrelated and objective review agencies through a bidding process, and refer grievances to one of the review agencies on a random selection basis. The review agencies must 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 herein, 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 two sentences:-

There shall be a process for the expedited review of grievances. The external review panel 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 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. 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:- designated state consumer assistance program

SECTION 74. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition "Commonwealth care health insurance program".

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

SECTION 76. Said section 1 of said chapter 176Q, as so appearing, is hereby further amended by striking out the definition "Eligible individual" 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. § 18032(f).

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

“Federal advanced premium tax credits”, a payment made pursuant to 26 U.S.C. § 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 26 U.S.C. § 36B 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. Said Section 1 of said chapter 176Q is hereby further amended by striking out the word “offset” in the definition “Point-of-service cost-sharing subsidy”, as inserted by section 38 of chapter 118 of the Acts of 2012, 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 “Premium assistance payment”, as inserted by section 38 of chapter 118 of the Acts of 2012, 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, as appearing in the 2010 Official Edition, is hereby further amended by striking out the definition of “Rating factor” 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, as so appearing, is hereby amended by striking out, in line 5, the words “groups and commonwealth care health insurance plan enrollees”, and inserting in place thereof the following words:- and eligible small groups

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

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

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

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, as so appearing, is hereby further amended by striking out paragraph (13) 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, as amended by section 132 of chapter 139 of the Acts of 2012, is hereby amended by striking out the words “111M, 118E, 118G 118H” and inserting in place thereof the following words:- 6D, 12C, 15A, 111M, 118E

SECTION 89. Said section 3 of said chapter 176Q is hereby amended by striking out subsection (o).

SECTION 90. Subsection (u) of said section 3 of said chapter 176Q, as inserted by section 7 of chapter 96 of the Acts of 2012, is hereby amended by striking out paragraph (2) and inserting in place thereof the following paragraph:- (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 amended by 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 chapter 176Q is hereby repealed.

SECTION 93. Subsection (a) of section 12 of said chapter 176Q, as amended by section 49 of chapter 118 of the Acts of 2012, is hereby amended by striking out the last sentence.

SECTION 94. 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 such other state agencies, departments, divisions, commissions, authorities or political subdivisions, and the foregoing agencies, departments, divisions, commissions, authorities and political subdivisions are hereby authorized to furnish pursuant to such agreements, 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 is hereby authorized to 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 received and gross income 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 is hereby authorized to 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 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, as inserted by section 216 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition "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, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 97. Section 66 of chapter 288 of the Acts of 2010, as amended by section 234 of chapter 224 of the Acts of 2012, is hereby repealed.

SECTION 98. Section 226 of chapter 224 of the Acts of 2012 is hereby repealed.

SECTION 99. Section 227 of chapter 224 of the Acts of 2012 is hereby repealed.

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

SECTION 101. Section 253 of chapter 224 of the Acts of 2012 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 any provisions of chapter 176J of the Massachusetts General Laws to the contrary, and only for the period from January 1, 2014 through December 31, 2015, carriers will be permitted to develop the group base premium for eligible small employers so that the group base premium will vary by enrollment or renewal month and shall be filed as part of a rate filing for each calendar quarter.

In addition, notwithstanding any provisions of chapter 176J to the contrary, and only for the period from January 1, 2014 through December 31, 2015, in calculating the premium to be charged to each eligible small group or eligible individual, carriers will be permitted to utilize and apply a portion of the following rate adjustment factors, based on the factors a carrier has in place as of July 1, 2013, in addition to those permitted under chapter 176J: (1) an industry rate adjustment factor; (2) a participation rate adjustment factor; (3) a group size rate adjustment factor; (4) an intermediary rate adjustment factor; and (5) a group purchasing cooperative rate adjustment.

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

SECTION 103. Sections 1, 5, and 94 shall take effect 30 days after passage of this act.

SECTION 104. Sections 2 to 4, inclusive, 6 to 50, inclusive, 52 to 93, inclusive, and 95 to 101, inclusive, shall take effect January 1, 2014.