Chapter 58 of the Acts of 2006

AN ACT PROVIDING ACCESS TO AFFORDABLE, QUALITY, ACCOUNTABLE HEALTH CARE.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is forthwith to expand 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. To provide for supplementing certain items in the general appropriation act and other appropriation acts for fiscal year 2006 for the purpose of funding certain costs associated with health care reform, the sums set forth in section 2 are hereby appropriated from the General Fund unless specifically designated otherwise in this act or in those other appropriation acts, for the several purposes and subject to the conditions specified in this act or in these other appropriation acts and subject to laws regulating the disbursement of public funds for the fiscal year ending June 30, 2006. The sums in said section 2 shall be in addition to any amounts previously appropriated and made available for the purposes of those items, provided further, that all funds appropriated in this section shall not revert and shall be available for expenditure until June 30, 2007.

SECTION 2.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Office of the Secretary

4000-0352 .... $3,000,000

Department of Public Health

4513-1026 .... $750,000

4513-1112 .... $1,000,000

4513-1114 .... $750,000

4513-1115 .... $250,000

4513-1121 .... $200,000

4530-9000 .... $1,000,000

4570-1500 .... $4,000,000

4590-0300 .... $4,000,000

EXECUTIVE OFFICE OF ECONOMIC DEVELOPMENT

Division of Insurance

7006-0020 For costs related to the special commission to examine and study the impact of merging the non-group insurance market as defined in chapter 176M of the General Laws and small-group health insurance market as defined in chapter 176J of the General Laws, established pursuant to section 114 of this act $500,000

SECTION 2A. To provide for certain unanticipated obligations of the commonwealth, to provide for an alteration of purpose for current appropriations, and to meet certain requirements of law, the sums set forth in this section are hereby appropriated from the General Fund unless specifically designated otherwise, for the several purposes and subject to the conditions specified in this section, and subject to laws regulating the disbursement of public funds for the fiscal year ending June 30, 2006. The sums shall be in addition to any amounts previously appropriated and made available for the purposes of these items, provided further, that all funds appropriated in this section shall not revert and shall be available for expenditure until June 30, 2007.

EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE

Reserves

1599-2006 For a reserve to fund the additional administrative costs associated with the implementation of this act, including, but not limited to, costs of commonwealth personnel and overtime, contracts, and the purchase of new information technologies as necessary; provided further, that the secretary may transfer from the sum appropriated herein to other items of appropriation and allocations for fiscal years 2006 and 2007 such amounts as are necessary to meet said costs where the amounts otherwise available are insufficient for the purpose, in accordance with a transfer plan which shall be filed in advance with the house and senate committees on ways and means; and provided further, that the secretary may only transfer such amounts to other items of appropriation and allocations within the executive office for administration and finance, the executive office of health and human services, and the division of insurance; and provided further that the secretary shall transfer funds from the sum appropriated herein for the cost of the health care quality and cost council in fiscal year 2007.......................... $10,000,000

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Office of the Secretary

4000-0140 For the operation of the Betsy Lehman center for patient safety and medical error reduction established in section 16E of chapter 6A of the General Laws...................................... $500,000

4000-0301 For the costs of MassHealth provider and member audit and utilization review activities including, but not limited to, eligibility verification, disability evaluations, provider financial and clinical audits and other initiatives intended to enhance program integrity; provided, that $150,000 shall be expended for the operation of the Medicaid fraud control unit within the office of the attorney general; and provided further, that $150,000 shall be expended for MassHealth auditing within the office of the state auditor $1,500,000

Department of Public Health

4513-1111 For an osteoporosis education and prevention program; provided, that the program shall include, but not be limited to: (1) development or identification of educational materials to promote public awareness of the cause of osteoporosis, options for prevention and the value of early detection and possible treatments, including their benefits and risks, to be made available to consumers, particularly targeted to high risk groups; (2) development or identification of professional education programs for health care providers; (3) development and maintenance of a list of current providers of specialized

services for the prevention and treatment of osteoporosis; and (4) a program for awareness, prevention and treatment of hip fractures $100,000

4513-1122 For an ovarian cancer screening, education and treatment program; provided, that no funds shall be expended in the AA object class for any personnel-related costs............................ $200,000

4513-1116 For a renal disease program; provided, that not less than $100,000 shall be expended for renal disease programs administered by the National Kidney Foundation of Massachusetts, Rhode Island, Vermont and New Hampshire, including organ donor awareness, nutritional supplements and early intervention services for those affected with renal disease and those at risk of renal disease.. $100,000

4516-0264 For a diabetes screening and outreach program to raise public awareness and provide outreach and education for high risk individuals, including, but not limited to, targeted populations of adolescents and the elderly.. $350,000

4570-1502 For the purposes of implementing a proactive statewide infection prevention and control program; provided, that notwithstanding any general or special law to the contrary, the department of public health shall, through its division of health care quality, develop a proactive statewide infection prevention and control program in licensed health care facilities following protocols of the Centers for Disease Control for the purposes of implementation and adherence to infection control practices that are the keys to preventing the transmission of infectious diseases, including respiratory diseases spread by droplet or airborne routes; provided further, that recommended infection control practices shall include, but not be limited to, hand hygiene; standard precautions and transmission-based precautions, including contact, droplet and airborne, and respiratory hygiene; and provided further, that the infection prevention and control program shall include mandatory education in the recommended infection control practices for licensed health care personnel and employees of licensed health care facilities and penalties for individual and institutional noncompliance with Centers for Disease Control protocols................................... $1,000,000

4590-1503 For the pediatric palliative care program established in section 24K of chapter 111 of the General Laws.................... $800,000

SECTION 3. Chapter 6A of the General Laws is hereby amended by inserting after section 16I the following 6 sections:—

Section 16J. As used in this section and in sections 16K and 16L, the following words shall, unless the context clearly requires otherwise, have the following meanings:—

“Clinician”, a health care professional licensed under chapter 112.

“Council”, the health care quality and cost council, established by section 16K.

“Facility”, a hospital, clinic or nursing home licensed under chapter 111 or a home health agency.

“Health care provider”, a clinician, a facility or a physician group practice.

“Insurer”, a carrier authorized to transact accident and health insurance under chapter 175, a nonprofit

hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F and a health maintenance organization licensed under chapter 176G.

“Physician group practice”, 2 or more physicians who deliver patient care, make joint use of equipment and personnel and divide income by a prearranged formula.

Section 16K. There shall be a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall establish health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely, efficient, equitable and patient-centered health care. The council shall receive staff assistance from the executive office of health and human services and may, subject to appropriation, employ such additional staff or consultants as it may deem necessary. The council shall consist of the secretary of health and human services, the auditor of the commonwealth or his designee, the inspector general or his designee, the attorney general or his designee, the commissioner of insurance, the executive director of the group insurance commission, and 7 persons to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid services, 1 of whom shall be a representative of the Institute for Healthcare Improvement, Inc. recommended by the organization’s board of directors, 1 of whom shall be a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, 1 of whom shall be an expert in health care policy from a foundation or academic institution and 1 of whom shall represent a non-governmental purchaser of health insurance. The representatives of nongovernmental organizations shall serve staggered 3-year terms. The council shall be chaired by the secretary of health and human services.

Section 16L. (a) The council shall develop and coordinate the implementation of health care quality improvement goals that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities. For each such goal, the council shall identify the steps needed to achieve the goal; estimate the cost of implementation; project the anticipated short-term or long-term financial savings achievable to the health care industry and the commonwealth, and estimate the expected improvements in the health status of health care consumers in the commonwealth.

(b) The council may, subject to chapter 30B, contract with an independent health care organization to provide the council with technical assistance related to its duties including, but not limited to, the development of health care quality goals, cost containment goals, performance measurement benchmarks, the design and implementation of health quality interventions, the construction of a consumer health information website and the preparation of reports, including any reports as required by this section. The independent health care organization shall have a history of demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to costs and quality across the health care continuum; (ii) identify, through data analysis quality improvement areas; (iii) work with Medicare, MassHealth, other payers’ data and clinical performance measures; (iv) collaborate in the design and implementation of quality improvement measures; (v) establish and maintain security measures necessary to maintain confidentiality and preserve the integrity of the data; (vi) design and implement health care quality improvement interventions with health care service providers; and (vii) identify and, when necessary, develop appropriate measures of cost and quality for inclusion in the website. To the extent possible, the independent organization shall collaborate with other organizations that develop, collect and publicly report health care cost and quality measures.

(c) Any independent organization under contract with the council shall develop and update on an annual basis a reporting plan specifying the cost and quality measures to be included on the internet site. The reporting plan shall be consistent with the requirements of subsections (a) and (b). The organization shall give consideration to those measures that are already available in the public domain and to whether it is cost effective for the council to license commercially available comparative data and consumer decision support tools. If the organization determines that making available through the internet site only those measures already available in the public domain would not fully comply with subsection (b) or would not provide consumers with sufficient information to make informed health care choices, the organization shall develop appropriate measures for inclusion on the internet site and shall specify in the reporting plan the sources from which it proposes to obtain the data necessary to construct those measures and any specifications for reporting of that data by insurers and health care providers. As part of the reporting plan, the organization shall determine for each service that comparative information is to be included on the internet site whether it is more practical and useful to: (1) list that service separately or as part of a group of related services; and (2) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately. The independent organization shall submit the reporting plan and any periodic revisions to the council. The council shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the council shall state its reasons therefor. The reporting plan and any revisions adopted by the council shall be promulgated by the council.

(d) Insurers and health care providers shall submit data to the council or to the independent organization on behalf of the council, as required by regulations promulgated under subsection (e). If any insurer or health care provider fails to submit required data to the council on a timely basis, the council shall provide written notice to the insurer or provider. If the insurer or health care provider fails, without just cause, to provide the required information within 2 weeks following receipt of said written notice, the insurer or provider may be required to pay a penalty of $1,000 for each week of delay; provided, however, that the maximum penalty under this section shall be $50,000.

(e) The council may promulgate additional rules and regulations relative to the type of information that reasonably may be required and the format in which it should be provided for the implementation the quality improvement and cost containment goals.

(f) The council may adopt by-laws for itself and for its advisory committee for the efficient operation of both organizations, and may recommend that public or private health care organizations be responsible for overseeing implementation of a goal and may assist these organizations in developing implementation plans.

(g) The council shall develop performance measurement benchmarks for its goals and publish such benchmarks annually, after consultation with lead agencies and organizations and the council's advisory committee. Such benchmarks shall be developed in a way that advances a common national framework for quality measurement and reporting including, but not limited to measures that are approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality. Performance benchmarks shall be clinically important and include both process and outcome data, shall be standardized, timely, and allow and encourage physicians, hospitals and other health care professionals to improve their quality of care. Any data reported by the council should be accurate and evidence-based, and not imply distinctions where comparisons are not statistically significant. Members of the advisory committee established by this section shall have reasonable opportunity to review and comment on all reports before public release.

(h) The council shall establish and maintain a consumer health information website. The website shall contain information comparing the cost and quality of health care services and may also contain general

information related to health care as the council determines to be appropriate. The website shall be designed to assist consumers in making informed decisions regarding the medical care and informed choices between health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website and make available written documentation available upon request and as necessary.

(i) The internet site shall provide updated information on a regular basis, at least annually, and additional comparative cost and quality information shall be posted as determined by the council. To the extent possible, the internet site shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided, (ii) general information related to each service or category of service for which comparative information is provided; and (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction.

(j) The council shall conduct annual public hearings to obtain input from health care industry stakeholders, health care consumers and the general public regarding the goals and the performance measurement benchmarks. The council shall invite the stakeholders involved in implementing or achieving each goal to assist with the implementation and evaluation of progress for each goal.

(k) The council shall review and file a report, not less than annually, with the joint committee on health care financing and the clerks of the house and senate on its progress in achieving the goals of improving quality and containing or reducing health care costs. Reports of the council shall be made available electronically through an internet site.

(l) The council shall establish an advisory committee to allow the broadest possible involvement of health care industry and other stakeholders in the establishment of its goals and the review of its progress. The advisory committee shall include 1 member representing the Massachusetts Medical Society, 1 member representing the Massachusetts Hospital Association, 1 member representing the Massachusetts Association of Health Plans, 1 member representing Blue Cross Blue Shield of Massachusetts, 1 member representing the Massachusetts AFL-CIO, 1 member representing the Massachusetts League of Community Health Centers, 1 member representing Health Care For All, Inc., 1 member representing the Massachusetts Public Health Association, 1 member representing the Massachusetts Association of Behavioral Health Systems, 1 member representing the Massachusetts Extended Care Federation, 1 member representing the Massachusetts Council of Human Service Providers, 1 member representing the Home Care Alliance of Massachusetts, 1 member representing Associated Industries of Massachusetts, 1 member of the Massachusetts Business Roundtable, 1 member of the Massachusetts Taxpayers Foundation, 1 member of the Massachusetts chapter of the National Federation of Independent Business, 1 member of the Massachusetts Biotechnology Council, 1 member representing the Blue Cross Blue Shield Foundation, 1 member representing the Massachusetts chapter of the American Association of Retired Persons, 1 member representing the Massachusetts Coalition of Taft Hartley Trust Funds, and additional members to be appointed by the governor which shall include, but not be limited to, a representative of the mental health field, a representative of pediatric health care, a representative of primary care, a representative of medical education, a representative of racial or ethnic minority groups concerned with health care, a representative of hospice care, a representative of the nursing profession and a representative of the pharmaceutical field.

(m) The council may recommend legislation or regulatory changes, including recommendations for the commonwealth's health care payment methodologies to promote the health care quality and cost containment goals set by the council, and the council may promulgate regulations under this section.

(n) Subject to appropriation, the council may disburse funds in the form of grants or loans to assist

members of the health care industry in implementing the goals of the council.

(o) All meetings of the council shall conform to chapter 30A, except that the council, through its bylaws, may provide for executive sessions of the council. No action of the council shall be taken in an executive session.

(p) The members of the council shall not receive a salary or per diem allowance for serving as members of the council but shall be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties. The expenses may include reimbursement for reasonable travel and living expenses while engaged in council business.

(q) The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services, including the development and maintenance of the website.

Section 16M. (a) There shall be a MassHealth payment policy advisory board. The board shall consist of the secretary of health and human services or his designee, who shall serve as chair, the commissioner of health care financing and policy, and 12 other members: 1 member appointed by the speaker of the house; 1 member appointed by the president of the senate; 1 member appointed by the Massachusetts Hospital Association; 1 member appointed by the Massachusetts Medical Society; 1 member appointed by the Massachusetts Extended Care Federation; 1 member appointed by Mass Aging Services Association, 1 member appointed by the Home Care Alliance of Massachusetts; 1 member appointed by the Massachusetts League of Community Health Centers; 1 member appointed by Mental Health and Substance Abuse Corporations of Massachusetts; 1 member appointed by the Massachusetts Medicaid Policy Institute; 1 member appointed by the Massachusetts Association of Behavioral Health Systems; 1 member appointed by Planned Parenthood League of Massachusetts; and 2 members appointed by the governor, 1 member representing managed care organizations contracting with MassHealth and 1 member being an expert in medical payment methodologies from a foundation or academic institution.

(b) The board shall have the following powers and duties:—

(1) to obtain from the office of Medicaid all data and analysis required to fully meet its charge under this section and to obtain further data and analysis from the division of health care finance and policy as authorized in chapter 118G of the General Laws;

(2) to conduct public hearings;

(3) to review and evaluate rates and payment systems by the office of Medicaid and recommend Title XIX rates and rate methodologies that provide fair compensation for MassHealth services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care. The board shall specifically review rates and rate methodologies for MassHealth services provided by community health centers. The division shall provide the board with the appropriate information not later than 45 days before the proposals are adopted into regulation; and

(4) to report to the joint committee on health care financing and the house and senate committees on ways and means semi-annually to coincide with the state budget hearings and development.

(c) The executive office of health and human services shall provide the board with staff from the division of health care finance and policy necessary to complete needed research and analysis and enable the committee to make effective recommendations. Not less than 90 days before implementing any of the payment policies established under this section, the division shall provide a detailed plan of implementation of the policies to the joint committee on health care financing and to the house and senate

committees on ways and means.

Section 16N. There shall be a special commission to study the feasibility of reducing or eliminating the contribution made by contributing employers to the Uncompensated Care Trust Fund. The commission shall consist of: the secretary of health and human services or his designee, who shall serve as chair; the commissioner of health care finance and policy or his designee; the commissioner of insurance or his designee; 2 members appointed by the speaker of the house of representatives; 1 member appointed by the minority leader of the house of representatives; 2 members appointed by the president of the senate; and 1 member appointed by the minority leader of the senate.

The study shall evaluate the amount of reimbursements provided from the uncompensated care pool, or any successor fund, for the medical care of the uninsured or underinsured patients in the commonwealth on the first day of each hospital fiscal year and compare it to the amount of reimbursements provided from the uncompensated care pool, or any successor fund, for the medical care of the uninsured or underinsured patients in the commonwealth on the first day of the preceding hospital fiscal year in order to determine whether a decrease or elimination of the contribution by contributing employers is possible based on the amount of reduction, if any, in the amount of reimbursements provided from the uncompensated care pool, or any successor fund, for the medical care of the uninsured or underinsured patients in the commonwealth during a hospital fiscal year.

The commission shall report annually to the senate president, minority leader of the senate, senate committee on ways and means, speaker of the house of representatives, minority leader of the house of representatives and the house committee on ways and means no later than the first day in December.

Section 16O. There shall be a health disparities council, located within, but not subject to the control of, the executive office of health and human services. The council shall make recommendations regarding reduction and elimination of racial and ethnic disparities in health care and health outcomes within the commonwealth. The disparities shall include, but not be limited to, breast, cervical, prostate and colorectal cancers, stroke and heart attack, heart disease, diabetes, infant mortality, lupus, HIV/AIDS, asthma and other respiratory illnesses. The council shall address diversity in the health care workforce, including, but not limited to, doctors, nurses and physician assistants, and shall make recommendations on methods to increase the health care workforce. The council may also make recommendations on other matters impacting upon and relevant to health disparities including but not limited to the environment and housing.

The council shall consist of 34 members: 1 member representing the secretary of health and human services; 1 member representing the commissioner of public health; 1 member representing the director of the office of Medicaid; 3 members of the house of representatives, 1 of whom shall be designated by the speaker of the house as co-chair of the commission; 3 members of the senate, 1 of whom shall be designated by the senate president as co-chair of the commission; 1 member representing the American Cancer Society Massachusetts Division; 1 member representing the American Heart Association New England Division; 1 member representing Massachusetts General Hospital; 1 member representing Brigham and Women's Hospital; 1 member representing the Dana Farber Cancer Center; 1 member representing the Massachusetts League of Community Health Centers; 1 member representing the Massachusetts Medical Society; 1 member representing Boston Public Health Commission; 1 member representing the Office of Multicultural Health in the Department of Public Health; 1 member representing the Springfield Health Department; 1 member representing the Worcester Health Department; 2 members representing the nursing profession, 1 of whom shall be designated by Massachusetts School Nurses Organization and 1 of whom shall be designated by the Massachusetts Association of Public Health Nurses; 1 member representing the Massachusetts Association of Health Plans; 1 member representing the Program to Eliminate Health Disparities at the Harvard School of

Public Health; 1 member representing Boston Medical Center Corporation; 1 member from the Massachusetts Public Health Association; 4 members from communities disproportionately affected by health disparities to be appointed by the speaker of the house; and 4 members from communities disproportionately affected by health disparities to be appointed by the senate president. The council membership shall be re-determined by the speaker of the house of representatives, the president of the senate and the governor on July 1, 2007.

The council shall file an annual report at the end of each fiscal year with the office of the governor, the clerk of the house of representatives and the clerk of the senate. The report shall include, but not be limited to, recommendations for designing, implementing and improving programs and services, proposals for appropriate statutory and regulatory changes to reduce and eliminate disparities in access to health care services and quality care and the disparities in medical outcomes in the commonwealth, and shall address diversity and cultural competency in the health care workforce, including but not limited to, doctors, nurses and physician assistants.

SECTION 4. Section 35M of chapter 10 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in lines 10 and 11, the following words:— "; but, any unexpended balance at the end of the fiscal year shall revert to the General Fund".

Governor disapproved the following section, see H4857
The Legislature overrode the Governor's veto
SECTION 5. Chapter 17 of the General Laws is hereby amended by striking out section 3, as so appearing, and inserting in place thereof the following section:-

Section 3. (a) There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 17 members appointed for terms of 6 years under this section. The commissioner may designate 1 of the members as vice chairperson and may appoint subcommittees or special committees as needed.

(b) Five of the appointed members shall be the chancellor of the University of Massachusetts Medical School or his designee; the dean of the University of Massachusetts Amherst School of Public Health and Health Sciences or his designee; the dean of the Harvard University School of Public Health or his designee; the dean of Public Health Program at Tufts University School of Medicine or his designee, and the dean of the Boston University School of Public Health or his designee.

(c) Six of the appointed members shall be providers of health services: 1 shall be the chief executive officer of an acute care hospital appointed by the Massachusetts Hospital Association; 1 shall be the chief executive officer of a skilled nursing facility appointed by the Massachusetts Extended Care Federation; 2 shall be registered nurses, to be appointed by the board of registration of nurses and shall be the highest vote-getters on a mail ballot sent to the address of record of all registered nurses licensed by the board of registration of nurses, 1 of whom shall be a nurse executive; and 2 shall be physicians appointed by the Massachusetts Medical Society, 1 of whom shall be a primary care physician.

(d) Six of the appointed members shall be non-providers: 1 shall be appointed by the secretary of elder affairs; 1 shall be appointed by the secretary of veterans' services; 1 shall be appointed by Health Care For All, Inc.; 1 shall be appointed by the Coalition for the Prevention of Medical Errors, Inc.; 1 shall be appointed by the Massachusetts Public Health Association; and 1 shall be appointed by the Massachusetts Community Health Worker Network.

(e) For purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he is qualified to act on the council in the public interest; who, and whose spouse, parents, siblings or children, have no financial interest in a health care facility; who, and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established under chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals; and who, and whose spouse, is not licensed to practice medicine.

(f) Upon the expiration of the term of office of an appointive member, his successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his successor. The members shall be appointed not later than 60 days after a vacancy. The council shall meet at least once a month, and at such other times as it shall determine by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 per day that the council meets, and their reasonably necessary traveling expenses while in the performance of their official duties.

SECTION 6. Chapter 26 of the General Laws is hereby amended by inserting after section 7 the following section:—

Section 7A. There shall be in the division of insurance a health care access bureau overseen by a deputy commissioner for health care access, whose duties shall include, subject to the direction of the commissioner of insurance, administration of the division’s statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers about health insurance coverage and access to affordable products. The commissioner shall appoint at least the following employees of the health care access bureau: a deputy commissioner for health access, a health care finance expert, an actuary, and a research analyst. They shall devote their full time to the duties of their office, shall be exempt from chapters 30 and 31, and shall serve at the pleasure of the commissioner. The commissioner may appoint such other employees as the bureau may require.

SECTION 6A. Chapter 26 of the General Laws is hereby amended by inserting after section 7A the following section:—

Section 7B. For the purposes of implementing chapter 111M, the health care access bureau shall maintain a database of members of health benefit plans. Carriers licensed under chapters 175, 176A, 176B, and 176G and the office of Medicaid shall report on the first day of each month to the bureau the names, and any other identifying information as determined by the division of insurance, of each resident of the commonwealth for whom creditable coverage, as defined in said chapter 111M, was provided during the previous month. The division shall enter into an inter-agency agreement with the department of revenue for purposes of implementing said chapter 111M and, in consultation with the department of revenue, shall adopt regulations defining the content of such reports, which shall be limited to the minimum amount of personal information necessary for the purposes of said chapter 111M. These reports shall not contain any information pertaining to previous or current health conditions or treatments. The division of insurance may transfer the content of the database to the department of revenue for the purposes of implementing chapter 111M.

SECTION 7. Section 8H of said chapter 26, as appearing in the 2004 Official Edition, is hereby amended by inserting after the second paragraph the following paragraph:—

The division of insurance, in consultation with the commonwealth health insurance connector established by chapter 176Q, shall establish and publish minimum standards and guidelines at least annually for each type of health benefit plans, except qualified student health insurance plans as set forth in section 18 of chapter 15A, provided by insurers and health maintenance organizations doing business in the

commonwealth.

SECTION 8. Chapter 29 of the General Laws is hereby amended by inserting after section 2NNN the following 4 sections:—

Section 2OOO. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Commonwealth Care Trust Fund, in this section called the trust fund. There shall be credited to the trust fund: (a) all contributions collected under section 188 of chapter 149, (b) all revenue from surcharges imposed under section 18B of chapter 118G, (c) any transfers from the Health Safety Net Trust Fund, established by section 57 of chapter 118E, (d) any funds that may be appropriated or transferred for deposit into the trust fund for the purposes of the demonstration program approved the Secretary of the United States Department of Health and Human Services under section 1115 of the Social Security Act, as extended or renewed from time to time and (e) revenue deposited pursuant to penalties collected under chapter 111M. Amounts credited to the trust fund shall be expended without further appropriation for programs designed to increase health coverage, including a program of subsidized health insurance provided to low-income residents of the commonwealth under chapter 118H and rate increases to certain Medicaid providers and supplemental payments to certain publicly operated or public-service hospital entities, as determined by law. Money from the trust fund may be transferred to the Uncompensated Care Trust Fund, established by section 18 of chapter 118G, or any successor fund, as necessary to provide payments to acute hospitals and community health centers for reimbursable health services. Not later than January 1, the comptroller shall report an update of revenues for the current fiscal year and prepare estimates of revenues to be credited to the trust fund in the subsequent fiscal year. The comptroller shall file this report with the secretary of administration and finance, the office of Medicaid, the joint committee on health care financing, and the house and senate committees on ways and means. If revenues credited to the trust fund are less than the amounts estimated to be credited to the trust fund, the comptroller shall duly notify the secretary, office and committees that this revenue deficiency shall require proportionate reductions in expenditures from the revenues available to support programs appropriated from the trust fund.

Section 2PPP. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Essential Community Provider Trust Fund, in this section called the trust fund. There shall be credited to the trust fund: (a) any funds that may be appropriated or transferred for deposit into the trust fund; and (b) any income derived from investment of amounts credited to the trust fund. In conjunction with the preparation of the commonwealth's annual financial report, the comptroller shall prepare and issue an annual report detailing the revenues and expenditures of the trust fund. The comptroller shall certify payments, including payments during the accounts payable period, in anticipation of revenues, including receivables due and collectibles during the months of July and August, from the trust fund for the purpose of making authorized expenditures. The health safety net office shall administer the trust fund and disburse funds from the trust fund for the purpose of payments to acute hospitals and community health centers under clause (6) of paragraph (b) of section 56 and any further regulations promulgated by the office.

Section 2QQQ. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Medical Assistance Trust Fund, in this section called the trust fund, administered by the secretary of health and human services. There shall be credited to the trust fund: (a) any funds directed to the commonwealth from public entities, and (b) federal reimbursements related to medical assistance payments funded by such funds. All amounts credited to the trust fund shall be available for expenditure by the secretary to be used for medical assistance payments to entities authorized by the general court, and for which a public entity has contractually agreed to direct funds to the trust fund. Any amount in excess of such medical assistance payments may be credited to the General Fund and the amount of all such expenditures shall be subject to annual approval by the general court. The maximum

payments from the trust fund shall not exceed those permissible for federal reimbursement under Title XIX or Title XXI of the Social Security Act or any successor federal law. The comptroller may make payments, including payments during the accounts payable period, in anticipation of revenues, including receivables due and collectibles during the months of July and August, and shall establish procedures for reconciling overpayments or underpayments from the trust fund. Such procedures shall include, but not be limited to, appropriate mechanisms for refunding public funds directed to the trust fund and federal reimbursements upon recoupment of any such overpayments. The secretary of health and human services shall submit to the secretary of administration and finance and the house and senate committees on ways and means a schedule of such payments 10 days before any expenditures, and no funds shall be expended without an enforceable agreement with or legal obligation imposed upon a public entity to make an intergovernmental transfer in an appropriate amount to the trust fund.

Section 2RRR. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Department of Mental Retardation Trust Fund, in this section called the trust fund, administered by the secretary of health and human services. There shall be credited to the trust fund: (a) any receipts from the assessment collected under section 27 of chapter 118G, including transfers by the department of mental retardation of amounts sufficient to pay the assessment for public facilities, (b) any federal financial participation received by the commonwealth as a result of expenditures funded by such assessments, and (c) any interest thereon. The secretary may authorize expenditures of amounts from such trust fund without further appropriation. The comptroller shall transfer to the trust fund no later than the first business day of each quarter, the amounts indicated by the department of mental retardation to provide the appropriate payment adjustments for operating the intermediate care facilities for the mentally retarded and the community residences serving individuals with mental retardation. The comptroller shall establish procedures necessary to effectuate this section, including procedures for the proper transfer, accounting, and expenditures of funds. The comptroller may make payments in anticipation of receipts and shall establish procedures for reconciling overpayments and underpayments from the trust fund. The secretary shall report semi-annually to the house and senate committees on ways and means on the revenue and expenditure activity within the trust fund.

SECTION 9. Section 1 of chapter 32 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting after the word "Authority", in line 211, the first time it appears, the following words:— , commonwealth health insurance connector.

SECTION 10. Section 1 of chapter 62 of the General Laws is hereby amended by striking out the definition "Code", as amended by section 3 of chapter 163 of the acts of 2005, and inserting in place thereof the following definition:—

(c) "Code", the Internal Revenue Code of the United States, as amended on January 1, 2005 and in effect for the taxable year; but Code shall mean the Code as amended and in effect for the taxable year for sections 62(a)(1), 72, 223, 274(m), 274(n), 401 through 420, inclusive, 457, 529, 530, 3401 and 3405 but excluding sections 402A and 408(q).

SECTION 11. Chapter 111 of the General Laws is hereby amended by inserting after section 24J the following section:—

Section 24K. There is hereby established the pediatric palliative care program. Said program shall be administered by the department, subject to appropriation, under this section and regulations promulgated hereunder. The program shall assist eligible children with a life-limiting illness and their families or guardians with services designed to achieve an improved quality of life and to meet the physical, emotional and spiritual needs experienced during the course of illness, death and bereavement.

Children less than 19 years of age shall be eligible for said program if they meet the requirements established by the department, which shall include:—

(a) a diagnosis of a life-limiting illness, including but not limited to, cancer, AIDS, congenital anomalies and other advanced illnesses; provided however, no requirement regarding life expectancy shall be imposed; and

(b) a requirement that the eligible child not be covered by a third-party payer for the services provided by said program.

Services provided by the program shall be determined by the department and shall include, but not be limited to, consultations for pain and symptom management, case management and assessment, social services, counseling, bereavement services, volunteer support services, and respite services, provided by professional or volunteer staff under professional supervision. Services shall be provided by hospice programs licensed under section 57D who meet such other criteria as the department may establish by regulation, including demonstrated expertise in pediatric palliative care. The department may by regulation establish limits on services provided by said program. The program established by this section shall not give rise to enforceable legal rights in any party or an enforceable entitlement to the services described in this section and nothing stated in this section shall be construed as giving rise to such enforceable legal rights or such enforceable entitlement.

SECTION 12. The General Laws are hereby amended by inserting after chapter 111L the following chapter:—

CHAPTER 111M.

INDIVIDUAL HEALTH COVERAGE

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:—

“Creditable coverage”, coverage of an individual under any of the following health plans or as a named beneficiary receiving coverage on another’s plan with no lapse of coverage for more than 63 days: (a) an individual or group health plan which meets the definition of “minimum creditable coverage” as established by the board of the connector; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults under section 10 of chapter 176J; (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as amended, or by regulations promulgated under that act, provided that no plan issued as a supplemental health insurance policy, including but not limited to, accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an

insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set; insurance arising out of a workers compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans shall qualify as creditable coverage.

“Resident”, a person who has:—

(1) obtained an exemption under clause Seventeenth, Seventeenth C, Seventeenth C ½, Seventeenth D, Eighteenth, Twenty-second, Twenty-second A, Twenty-second B, Twenty-second C, Twenty-second D, Twenty-second E, Thirty- seventh, Thirty-seventh A, Forty-first, Forty-first A, Forty-first B, Forty- first C, Forty-second or Forty-third of section 5 of chapter 59;

(2) obtained an exemption under section 5C of said chapter 59;

(3) filed a Massachusetts resident income tax return under chapter 62;

(4) obtained a rental deduction under subparagraph (9) of paragraph (a) of Part B of section 3 of chapter 62;

(5) declared in a home mortgage settlement document that the mortgaged property located in the commonwealth would be occupied as his principal residence;

(6) obtained homeowner's liability insurance coverage on property that was declared to be occupied as a principal residence;

(7) filed a certificate of residency and identified his place of residence in a city or town in the commonwealth in order to comply with a residency ordinance as a prerequisite for employment with a governmental entity;

(8) paid on his own behalf or on behalf of a child or dependent of whom the person has custody, resident in-state tuition rates to attend a state-sponsored college, community college or university;

(9) applied for and received public assistance from the commonwealth for himself or his child or dependent of whom he has custody;

(10) has a child or dependent, of whom he has custody, who is enrolled in a public school in a city or town in the commonwealth, unless the cost of such education is paid for by him, such child or dependent, or by another education jurisdiction;

(11) is registered to vote in the commonwealth;

(12) obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by claiming principal residence in the commonwealth; or

(13) is a resident under any other written criteria under which the commissioner of revenue may determine residency in the commonwealth.

Section 2. (a) As of July 1, 2007, the following individuals age 18 and over shall obtain and maintain creditable coverage so long as it is deemed affordable under the schedule set by the board of the connector, established by chapter 176Q: (1) residents of the commonwealth; or (2) individuals who become residents of the commonwealth within 63 days, in the aggregate. Residents who within 63 days have terminated any prior creditable coverage, shall obtain and maintain creditable coverage within 63 days of such termination.

(b) Every person who files an individual return as a resident of the commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the commissioner of revenue, whether such person, as of the last day of the taxable year for which the return is filed, (i) had creditable coverage in force as required under paragraph (a) whether covered as an individual or as a named beneficiary of a policy covering multiple individuals, (ii) claims an exemption under section 3, or (iii) had a certificate issued under section 3 of chapter 176Q. If the person does not so indicate, or indicates that he did not have such coverage in force, then the tax shall be computed on the return without benefit of the personal exemption set forth in paragraph (b) of Part B of section 3 of chapter 62, or, in the case of a person who files jointly with a spouse, without benefit of one-half of the personal exemption set forth in such paragraph. If the person indicates that he had such coverage in force but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall compute the tax for the taxable year without benefit of the personal exemption set forth in paragraph (b) of Part B of section 3 of chapter 62, or, in the case of a person who files jointly with a spouse, without benefit of one-half of the personal exemption set forth in such paragraph, first giving notice to such person of his intent to do so and an opportunity for a hearing, under rules prescribed by the commissioner. The commonwealth shall have all enforcement and collection procedures available under chapter 62C to collect any penalties assessed under this section.

(c) The commissioner shall deposit all penalties collected into the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.

Section 3. An individual shall be exempt from section 2 if he files a sworn affidavit with his income tax return stating that he did not have creditable coverage and that his sincerely held religious beliefs are the basis of his refusal to obtain and maintain creditable coverage during the 12 months of the taxable year for which the return was filed. Any individual who claimed an exemption but received medical health care during the taxable year for which the return is filed shall be liable for providing or arranging for full payment for the medical health care and be subject to the penalties in subsection (b) of section 2.

Section 4. An individual subject to section 2, who disputes the determination of applicability or affordability, as enforced by the department of revenue, may seek a review of this determination through an appeal established by the board of the commonwealth health insurance connector, under chapter 176Q; provided, however, that no additional penalties shall be enforced against an individual seeking review until the review is complete and any subsequent appeals are exhausted.

Section 5. The commissioner of revenue, in consultation with the board of the commonwealth health insurance connector, established by chapter 176Q, shall promulgate such rules and regulations, as necessary, to carry out this chapter.

SECTION 13. Section 2 of said chapter 111M, inserted by section 12 of this act, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:—

(b) Every person who files an individual income tax return as a resident of the commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the commissioner of revenue, whether such person (i) had creditable coverage in force for each of the 12 months of the taxable year for which the return is filed as required under paragraph (a) whether covered as an individual or as a named beneficiary of a policy covering multiple individuals, (ii) claims an exemption under section 3, or (iii) had a certificate issued under section 3 of chapter 176Q. If the person fails to indicate or indicates that he did not have such coverage in force, then a penalty shall be assessed on the return. If the person indicates that he had such coverage in force but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall assess the penalty. If in any taxable year, in whole or in part, a taxpayer does not comply with the requirement of paragraph (a), the commissioner shall retain any amount overpaid by the taxpayer for purposes of making payments described in paragraph (c); provided, however, that the amount retained shall not exceed 50 per cent of the minimum insurance premium for creditable coverage for which the individual would have qualified during the previous year. The penalty shall be assessed for each of the months the individual did not meet the requirement of paragraph (a); provided, that any lapse in coverage of 63 days or less shall not be counted in calculating the penalty; and, provided further, that nothing in this paragraph shall be considered to authorize the commissioner to retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies as debts described in clauses (i) to (vii), inclusive, of section 13 of chapter 62D. If the amount retained is insufficient to meet the penalty assessed, the commissioner shall notify the taxpayer of the balance due on the penalty and related interest. The commonwealth shall have all enforcement and collection procedures available under chapter 62C to collect any penalties assessed under this section.

SECTION 14. Section 6 of chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by adding the following paragraph:—

The office of Medicaid shall make a report to the committee on health care financing and to house and senate committees on ways and means no later than October 1 of each year on the previous state fiscal year’s activities of the medical care advisory committee. The report shall include, but not be limited to, the names and titles of committee members, dates of committee meetings, agendas and minutes or notes from such meetings, and any correspondence, memorandum, recommendations or other product of the committee’s work.

SECTION 15. Subsection (2) of section 9A of said chapter 118E of the General Laws, as so appearing, is hereby amended by striking out clause (c) and inserting in place thereof the following clause:—

(c) children and adolescents, from birth to 18 years, inclusive, whose financial eligibility as determined by the division exceeds 133 per cent but is not more than 300 per cent of the federal poverty level, including such children and adolescents made eligible for medical benefits under this chapter by Title XXI of the Social Security Act.

SECTION 16. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by inserting after the word “eligibility”, in line 112, the following words:— ; provided, however, that the division shall not establish disability criteria for applicants or recipients which are more restrictive than the criteria authorized by Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

SECTION 17. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out, in line 115, the figure “133” and inserting in place thereof the following figure:— 200.

SECTION 18. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by adding the following subsection:—

(15) The office of Medicaid shall report monthly to the health care access bureau, established by section 7A of chapter 26, a listing of all individuals for whom creditable coverage is provided as of the first day of the month.

SECTION 19. Section 9C of said chapter 118E is hereby amended by striking out the definition "Eligible employee" and inserting in place thereof the following definition:—

"Eligible employee", an employee: (i) who is employed by an eligible employer; (ii) who resides in the commonwealth; (iii) who has not attained age 65; (iv) whose employer or family member's employer has not in the last 6 months provided insurance coverage for which the individual is eligible; and (v) who meets the financial and other eligibility standards set forth in regulations promulgated by the division, if the gross family income standard does not exceed 300 per cent of the federal poverty level; provided further that clause (iv) shall not apply to employees participating in the program established under this chapter as of June 30, 2006.

SECTION 20. Section 9C of said chapter 118E, as so appearing, is hereby amended by inserting after the word "employees", in line 56, the following words:— ; and, provided further, that the amount of the subsidy shall not be greater than that of the subsidy the employee would have received if enrolled in the subsidized insurance program under chapter 118H.

SECTION 21. Subsection (2) of said section 9C of said chapter 118E, as so appearing, is hereby amended by striking out paragraph (B) and inserting in place thereof the following paragraph:—

(B) a subsidy program to assist the self-employed single individual and the self-employed husband and wife with reducing the cost of premiums or other costs of purchasing qualified medical insurance; provided, however, that the amount of said subsidies may vary with the income or insurance costs of said persons and their families under 1 or more sliding fee schedules set forth in regulations promulgated by the division and may be paid directly to or on behalf of said persons; and provided further, that the amount of the subsidy shall not be greater than that of the subsidy the employee would have received if enrolled in the subsidized insurance program under chapter 118H.

SECTION 22. Paragraph (C) of said subsection (2) of said section 9C of said chapter 118E, as so appearing, is hereby amended by adding the following sentence:— No payments authorized under this paragraph shall be made to a self-employed individual or a self-employed husband and wife.

SECTION 23. Said section 9C of said chapter 118E, as so appearing, is hereby further amended by striking out subsection (5).

SECTION 24. The fourth paragraph of section 12 of said chapter 118E, as so appearing, is hereby amended by adding the following sentence:— Rules and regulations which restrict eligibility or covered services require a public hearing under section 2 of chapter 30A.

SECTION 25. Said chapter 118E is hereby further amended by inserting after section 13A the following section:—

Section 13B. Hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care. Such benchmarks shall be developed or adopted by the executive office of health and human services so as to advance a common national framework for quality measurement and reporting, drawing on measures that are approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality, in addition

to the Boston Public Health Commission Disparities Project Hospital Working Group Report Guidelines. The office of Medicaid shall consult with the Massachusetts health care quality and cost council, established under section 16K of chapter 6A and the MassHealth payment policy advisory board established under section 16M of said chapter 6A, during the process of developing these quality standards and performance benchmarks.

SECTION 26. Section 16C of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 4 and 20, the figure “200” and inserting in place thereof, in each instance, the following figure:— 300.

Governor disapproved the following section, see H4857
The Legislature overrode the Governor's veto
SECTION 27. Section 16D of said chapter 118E, as so appearing, is hereby amended by adding the following subsection:—

(7) Notwithstanding subsection (3), a person who is not a citizen of the United States but who is either a qualified alien within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or is otherwise permanently residing in the United States under color of law shall be eligible to receive benefits under MassHealth Essential if such individual meets the categorical and financial eligibility requirements under MassHealth; provided further that such individual is either age 65 or older, or between age 19 and 64, inclusive, and disabled. Such individual shall not be subject to sponsor income deeming or related restrictions.

SECTION 28. The seventh paragraph of section 23 of said chapter 118E, as so appearing, is hereby amended by striking out clause (2) and inserting in place thereof the following clause:—

(2) persons for whom hospitals and community health centers claim reimbursement payments from the Health Safety Net Fund, established by section 57 of chapter 118E.

Governor disapproved the following section, see H4857
The Legislature overrode the Governor's veto
SECTION 29. Said chapter 118E is hereby further amended by adding the following 2 sections:—

Section 53. The division shall include within its covered services for adults all federally optional services that were included in its state plan or demonstration program in effect on January 1, 2002. Covered services for adults in the MassHealth Essential program shall include dental services to the same extent as such services were covered for adults in the MassHealth Basic program as of January 1, 2002.

Section 54. The executive office of health and human services shall implement, in cooperation with the department of public health, a wellness program for MassHealth enrollees to encourage activities that lead to desired health outcomes, including smoking cessation, diabetes screening for early detection, teen pregnancy prevention, cancer screening for early detection and stroke education for enrolled individuals. To the extent enrollees comply with the goals of the wellness program, the executive office shall reduce MassHealth premiums and/or copayments proportionally. The executive office shall report annually on the number of enrollees who meet at least 1 wellness goal, the premiums collected from the enrollees, and the reduction of premiums due to enrollees meeting wellness goals to the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 30. Said chapter 118E is hereby further amended by adding the following 6 sections:—

Section 55. As used in this section and sections 56 to 60, inclusive, the following words shall, unless the

context clearly requires otherwise, have the following meanings:—

"Acute hospital", the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under section 51 of chapter 111 and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

"Allowable reimbursement", payment to acute hospitals and community health centers for health services provided to uninsured patients of the commonwealth under section 60 and any further regulations promulgated by the office.

“Ambulatory surgical center”, a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Financing Administration for participation in the Medicare program.

“Ambulatory surgical center services”, services described for purposes of the Medicare program under 42 U.S.C. 1395k(a)(2)(F)(I). These services include facility services only and do not include surgical procedures.

“Bad debt”, an account receivable based on services furnished to a patient which: (i) is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office, which regulations shall allow third party payers to negotiate with hospitals to collect the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a governmental unit or the federal government or any agency thereof; and (iv) is not a reimbursable health care service.

“Community health center”, a health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626, including all community health centers which file cost reports as requested by the division of health care finance and policy.

“Critical access services”, those health services which are generally provided only by acute hospitals, as further defined in regulations promulgated by the division.

“Director”, the director of the health safety net office.

“DRG”, a patient classification scheme known as diagnosis related grouping, which provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost incurred by the hospital.

“Emergency bad debt”, bad debt resulting from emergency services provided by an acute hospital to an uninsured or underinsured patient or other individual who has an emergency medical condition that is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office.

“Emergency medical condition”, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1295dd(e)(1)(B).

“Emergency services”, medically necessary health care services provided to an individual with an emergency medical condition.

"Financial requirements", a hospital's requirement for revenue which shall include, but not be limited to, reasonable operating, capital and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

"Fund", the Health Safety Net Trust Fund, established by section 57 of chapter 118E.

"Fund fiscal year", the 12-month period starting in October and ending in September.

"Gross patient service revenue", the total dollar amount of a hospital's charges for services rendered in a fiscal year.

"Health services", medically necessary inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Health services shall not include: (1) nonmedical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-surgery hormone therapy; and (7) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

"Office", the health safety net office, established by section 56.

"Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health services and ambulatory surgical centers for ambulatory surgical center services; provided, however, that "payments subject to surcharge" shall not include: (i) payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies; (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter 176K or similar policies issued on a group basis; and provided further, that "payments subject to surcharge" may exclude amounts established by regulations promulgated by the division for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

"Pediatric hospital", an acute care hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment system regulations.

"Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20. In calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds, and the total of all licensed hospital beds shall include the total of all licensed acute care hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

"Private sector charges", gross patient service revenue attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients, reimbursable health services and bad debt.

"Reimbursable health services", health services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or part, under applicable regulations of the office; provided that the health services are emergency, urgent and critical access services provided by acute hospitals or services provided by community health centers; and provided further, that such services shall not be eligible for reimbursement by any other public or private third-party payer.

“Resident”, a person living in the commonwealth, as defined by the office by regulation; provided, however, that such regulation shall not define as a resident a person who moved into the commonwealth for the sole purpose of securing health insurance under this chapter. Confinement of a person in a nursing home, hospital or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

“Surcharge payor”, an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers, as defined in this section; provided, however, that the term “surcharge payor” shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients and the workers’ compensation program established by chapter 152.

“Underinsured patient”, a patient whose health insurance plan or self-insurance health plan does not pay, in whole or in part, for health services that are eligible for reimbursement from the health safety net trust fund, provided that such patient meets income eligibility standards set by the office.

“Uninsured patient”, a patient who is a resident of the commonwealth, who is not covered by a health insurance plan or a self-insurance health plan and who is not eligible for a medical assistance program.

Section 56. (a) There is hereby established a health safety net office within the office of Medicaid. The director of Medicaid shall, in consultation with the secretary of health and human services, appoint the director of the health safety net office. The director shall have such educational qualifications and administrative and other experience as the commissioner and secretary determine to be necessary for the performance of the duties of director including, but not limited to, experience in the field of health care financial administration.

(b) The office shall have the following powers and duties:—

(1) to administer the Health Safety Net Trust Fund, established by section 57 of chapter 118E, and to require payments to the fund consistent with acute hospitals' and surcharge payors’ liability to the fund, as determined under sections 58 and 59, and any further regulations promulgated by the office;

(2) to set, after consultation with the division of health care finance and policy established by section 2 of chapter 118G, reimbursement rates for payments from the fund to acute hospitals and community health centers for reimbursable health services provided to uninsured and underinsured patients and to disburse monies from the fund consistent with such rates; provided that the office shall implement a fee-for-service reimbursement system for acute hospitals;

(3) to promulgate regulations further defining: (a) eligibility criteria for reimbursable health services; (b) the scope of health services that are eligible for reimbursement by the Health Safety Net Trust Fund; (c) standards for medical hardship; and (d) standards for reasonable efforts to collect payments for the costs of emergency care. The office shall implement procedures for verification of eligibility using the eligibility system of the office of Medicaid and other appropriate sources to determine the eligibility of uninsured and underinsured patients for reimbursable health services and shall establish other procedures to ensure that payments from the fund are made for health services for which there is no other public or private third party payer, including disallowance of payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources; and

(4) to develop programs and guidelines to encourage maximum enrollment of uninsured individuals who

receive health services reimbursed by the fund into health care plans and programs of health insurance offered by public and private sources and to promote the delivery of care in the most appropriate setting, provided that the programs and guidelines are developed in consultation with the commonwealth health insurance connector, established by chapter 176Q. Such programs shall not deny payments from the fund because services should have been provided in a more appropriate setting if the hospital was required to provided such services under 42 U.S.C. 1395 (dd);

(5) to conduct a utilization review program designed to monitor the appropriateness of services for which payments were made by the fund and to promote the delivery of care in the most appropriate setting; and to administer demonstration programs that reduce health safety net trust fund liability to acute hospitals, including a demonstration program to enable disease management for patients with chronic diseases, substance abuse and psychiatric disorders through enrollment of patients in community health centers and community mental health centers and through coordination between these centers and acute hospitals, provided, that the office shall report the results of such reviews annually to the joint committee on health care financing and the house and senate committees on ways and means;

(6) to administer the Essential Community Provider Trust Fund, established by section 2PPP of chapter 29, and to make expenditures from that fund without further appropriation for the purpose of improving and enhancing the ability of acute hospitals and community health centers to serve populations in need more efficiently and effectively, including, but not limited to, the ability to provide community-based care, clinical support, care coordination services, disease management services, primary care services, and pharmacy management services through a grant program. The office shall consider applications from acute hospitals and community health centers in awarding the grants. The criteria for selection shall include, but not be limited to, the following criteria:—

(i) the financial performance of the provider as determined, in the case of applications from acute hospitals, quarterly by the division of health care finance and policy and by consulting other appropriate measurements of financial performance;

(ii) the percentage of patients with mental or substance abuse disorders served by a provider;

(iii) the numbers of patients served by a provider who are chronically ill, elderly, or disabled;

(iv) the payer mix of the provider, with preference given to acute hospitals where a minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act or other governmental payors, including reimbursements from the Health Safety Net Fund;

(v) the percentage of total annual operating revenue that funding received in fiscal years 2005 and 2006 from the Distressed Provider Expendable Trust Fund comprised for the provider; and

(vi) the cultural and linguistic challenges presented by the populations served by the provider.

(7) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with a private individual, partnership, firm, corporation, association or other entity, and to make contracts and execute all instruments necessary or convenient for the carrying on of its business;

(8) to secure payment, without imposing undue hardship upon any individual, for unpaid bills owed to acute hospitals by individuals for health services that are ineligible for reimbursement from the Health Safety Net Trust Fund which have been accounted for as bad debt by the hospital and which are voluntarily referred by a hospital to the department for collection; provided, however that such unpaid

charges shall be considered debts owed to the commonwealth and all payments received shall be credited to the fund; and provided, further, that all actions to secure such payments shall be conducted in compliance with a protocol previously submitted by the office to the joint committee on health care financing;

(9) to require hospitals and community health centers to submit to the office such data as it reasonably deems necessary; and

(10) to make, amend and repeal rules and regulations to effectuate the efficient use of monies from the Health Safety Net Trust Fund; provided, however, that the regulations shall be adopted only after notice and hearing and only upon consultation with the board of the commonwealth health insurance connector, the secretary of health and human services, the director of the office of Medicaid and representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts Safety Net Hospitals and the Massachusetts League of Community Health Centers.

(11) to provide an annual report at the close of each fund fiscal year, in consultation with the office of Medicaid, to the joint committee on health care financing and the house and senate committees on ways and means, evaluating the processes used to determine eligibility for reimbursable health services, including the Virtual Gateway, so-called. The report shall include (i) an analysis of the effectiveness of these processes in enforcing eligibility requirements for publicly funded health programs and in enrolling uninsured residents into programs of health insurance offered by public and private sources; (ii) an assessment of the impact of these processes on the level of reimbursable health services by providers; and (iii) recommendations for ongoing improvements that will enhance the performance of eligibility determination systems and reduce hospital administrative costs.

Section 57. (a) There is hereby established a Health Safety Net Trust Fund, in this section and sections 58 to 60, inclusive, called the fund, which shall be administered by the health safety net office. Expenditures from the fund shall not be subject to appropriation unless otherwise required by law. The purpose of the fund shall be to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents of the commonwealth. The office shall administer the fund using such methods, policies, procedures, standards and criteria that it deems necessary for the proper and efficient operation of the fund and programs funded thereby in a manner designed to distribute the fund resources as equitably as possible.

(b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors under sections 58 and 59; all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured and underinsured residents; any transfers from the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29; and all property and securities acquired by and through the use of monies belonging to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to hospitals and community health centers for reimbursable health services provided to uninsured and underinsured residents of the commonwealth, consistent with the requirements of this section and section 60 and the regulations promulgated by the office; provided, that $6,000,000 shall be expended annually from the fund for demonstration projects that use case management and other methods to reduce the liability of the fund to acute hospitals. Any annual balance remaining in the fund after such payments have been made shall be transferred to the Commonwealth Care Trust Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund. The director shall from time to time requisition from the fund such amounts as he deems necessary to meet the current obligations of the office for the purposes of the fund and estimated obligations for a reasonable future period.

Section 58. (a) An acute hospital's liability to the fund shall equal the product of (1) the ratio of its private sector charges to all acute hospitals' private sector charges; and (2) $160,000,000. Before October 1 of each year, the office, in consultation with the division of health care finance and policy, shall establish each acute hospital's liability to the fund using the best data available, as determined by the division, and shall update each acute hospital's liability to the fund as updated information becomes available. The office shall specify by regulation an appropriate mechanism for interim determination and payment of an acute hospital's liability to the fund.

(b) An acute hospital's liability to the fund shall in the case of a transfer of ownership be assumed by the successor in interest to the acute hospital.

(c) The office shall establish by regulation an appropriate mechanism for enforcing an acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled payment to the fund. These enforcement mechanisms may include (1) notification to the office of Medicaid requiring an offset of payments on the Title XIX claims of any such acute hospital or any health care provider under common ownership with the acute care hospital or any successor in interest to the acute hospital, and (2) the withholding by the office of Medicaid of the amount of payment owed to the fund, including any interest and late fees, and the transfer of the withheld funds into the fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be considered to be in breach of contract or any other obligation for the payment of noncontracted services, and providers whose payment is offset under order of the division shall serve all Title XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a noncontracting or disproportionate share hospital, under its obligation for providing services to Title XIX recipients under this chapter. In no event shall the office direct the office of Medicaid to offset claims unless an acute hospital has maintained an outstanding obligation to the health safety net fund for a period longer than 45 days and has received proper notice that the division intends to initiate enforcement actions under the regulations of the office.

Section 59. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge on all payments subject to surcharge as defined in section 1. The surcharge shall be distinct from any other amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge percentage and (ii) amounts paid for these services by a surcharge payor. The office shall calculate the surcharge percentage by dividing $160,000,000 by the projected annual aggregate payments subject to the surcharge. The office shall determine the surcharge percentage before the start of each fund fiscal year and may redetermine the surcharge percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge established the previous October will produce less than $150,000,000 or more than $170,000,000. Before each succeeding October 1, the office shall redetermine the surcharge percentage incorporating any adjustments from earlier years. In each determination or redetermination of the surcharge percentage, the office shall use the best data available as determined by the division and may consider the effect on projected surcharge payments of any modified or waived enforcement under subsection (e). The office shall incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

(b) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an amount equal to the surcharge described in subsection (a) as a separate and identifiable amount distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical center services. Each surcharge payor shall pay the surcharge amount to the office for deposit in the Health Safety Net Trust Fund on behalf of said acute hospital or ambulatory surgical center. Upon the written request of a surcharge payor, the office may implement another billing or collection method for the surcharge payor; provided, however, that the office has received all information that it requests which is necessary to implement such billing or collection method; and provided further, that the office shall specify by regulation the criteria for

reviewing and approving such requests and the elements of such alternative method or methods.

(c) The office shall specify by regulation appropriate mechanisms that provide for determination and payment of a surcharge payor's liability, including requirements for data to be submitted by surcharge payors, acute hospitals and ambulatory surgical centers.

(d) A surcharge payor's liability to said Health Safety Net Trust Fund shall in the case of a transfer of ownership be assumed by the successor in interest to the surcharge payor.

(e) The office shall establish by regulation an appropriate mechanism for enforcing a surcharge payor's liability to said Health Safety Net Trust Fund in the event that a surcharge payor does not make a scheduled payment to said Health Safety Net Trust Fund; provided, however, that the office may, for the purpose of administrative simplicity, establish threshold liability amounts below which enforcement may be modified or waived. Such enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement mechanism may also include notification to the division of medical assistance requiring an offset of payments on the claims of the surcharge payor, any entity under common ownership or any successor in interest to the surcharge payor, from the division of medical assistance in the amount of payment owed to the Health Safety Net Trust Fund including any interest and penalties, and to transfer the withheld funds into said fund. If the division of medical assistance offsets claims payments as ordered by the office, said division of medical assistance shall be deemed not to be in breach of contract or any other obligation for payment of noncontracted services, and a surcharge payor whose payment is offset under order of the division shall serve all Title XIX recipients under the contract then in effect with the division of medical assistance. In no event shall the office direct the division of medical assistance to offset claims unless the surcharge payor has maintained an outstanding liability to the Health Safety Net Trust Fund for a period longer than 45 days and has received proper notice that said office intends to initiate enforcement actions under the regulations of the office.

(f) If a surcharge payor fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the office, the office shall provide written notice to the payor. If a surcharge payor fails to provide required information within 2 weeks after the receipt of written notice, or falsifies the same, he shall be subject to a civil penalty of not more than $5,000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this chapter.

Section 60. (a) Reimbursements from the fund to hospitals and community health centers for health services provided to uninsured individuals shall be made in the following manner, and shall be subject to further rules and regulations promulgated by the office.

(1) Reimbursements made to acute hospitals shall be based on actual claims for health services provided to uninsured and underinsured patients that are submitted to the office, and shall be made only after determination that the claim is eligible for reimbursement under this chapter and any additional regulations promulgated by the office. Reimbursements for health services provided to residents of other states and foreign countries shall be prohibited, and the office shall make payments to acute hospitals using fee-for-service rates calculated as provided in paragraphs (4) and (5).

(2) The office shall, in consultation with the office of Medicaid, develop and implement procedures to verify the eligibility of individuals for whom health services are billed to the fund and to ensure that other coverage options are used fully before services are billed to the fund, including procedures adopted under

section 35. The office shall review all claims billed to the fund to determine whether the patient is eligible for medical assistance under this chapter and whether any third party is financially responsible for the costs of care provided to the patient. In making these determinations, the office shall verify the insurance status of each individual for whom a claim is made using all sources of data available to the office. The office shall refuse to allow payments or shall disallow payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources, provided that payments shall not be denied from the fund because services should have been provided in a more appropriate setting if the hospital was required to provide these services under 42 U.S.C. 1395(dd).

(3) The office shall require acute hospitals and community health centers to screen each applicant for reimbursed care for other sources of coverage and for potential eligibility for government programs, and to document the results of that screening. If an acute hospital or community health center determines that an applicant is potentially eligible for Medicaid or for the commonwealth care health insurance program, established by chapter 118H, or another assistance program, the acute hospital or community health center shall assist the applicant in applying for benefits under that program. The office shall audit the accounts of acute hospitals and community health centers to determine compliance with this section and shall deny payments from the fund for any acute hospital or community health center that fails to document compliance with this section.

(4) The office shall reimburse acute hospitals for health services provided to individuals based on the payment systems in effect for acute hospitals used by the United States Department of Health and Human Services Centers for Medicare & Medicaid Services to administer the Medicare Program under Title XVIII of the Social Security Act, including all of Medicare's adjustments for direct and indirect graduate medical education, disproportionate share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of the annual increase in the Medicare hospital market basket index. The division shall, in consultation with the division of health care finance and policy and the Massachusetts Hospital Association, promulgate regulations necessary to modify these payment systems to account for:—

(i) the differences between the program administered by the office and the Title XVIII Medicare program, including the services and benefits covered;

(ii) grouper and DRG relative weights for purposes of calculating the payment rates to reimburse acute hospitals at rates no less than the rates they are reimbursed by Medicare;

(iii) the extent and duration of covered services;

(iv) the populations served;

(v) and any other adjustments to the payment methodology under this section as deemed necessary by the office, based upon circumstances of individual hospitals.

Following implementation of this section, the office shall ensure that the allowable reimbursement rates under this section for health services provided to uninsured individuals shall not thereafter be less than rates of payment for comparable services under the Medicare program, taking into account the adjustments required by this section.

(5) For the purposes of paying community health centers for health services provided to uninsured individuals under this section, the office shall pay community health centers a base rate that shall be no less than the then-current Medicare Federally Qualified Health Center rate as required under 42 U.S.C.

13951 (a)(3), and the office shall add payments for additional services not included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent care, and emergency room diversion services.

(6) Reimbursements to acute hospitals and community health centers for bad debt shall be made upon submission of evidence, in a form to be determined by the office, that reasonable efforts to collect the debt have been made.

(b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after consultation with the division of health care finance and policy, and using the best data available, provide an estimate of the projected total reimbursable health services provided by acute hospitals and community health centers and emergency bad debt costs, the total funding available, and any projected shortfall after adjusting for reimbursement payments to community health centers. In the event that a shortfall in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health services, the office shall allocate that shortfall in a manner that reflects each hospital's proportional financial requirement for reimbursements from the fund, including, but not limited to, the establishment of a graduated reimbursement system and under any additional regulations promulgated by the office.

(c) The division shall enter into interagency agreements with the department of revenue to verify income data for patients whose health care services are reimbursed by the Health Safety Net Trust Fund and to recover payments made by the fund for services provided to individuals who are ineligible to receive reimbursable health services or on whose behalf the fund has paid for emergency bad debt. The division shall promulgate regulations requiring acute hospitals to submit data that will enable the department of revenue to pursue recoveries from individuals who are ineligible for reimbursed health services and on whose behalf the fund has made payments to acute hospitals for emergency bad debt. Any amounts recovered shall be deposited in the Health Safety Net Trust Fund, established by section 57 of chapter 118E.

(d) The office shall not at any time make payments from the fund for any period in excess of amounts that have been paid into or are available in the fund for that period, but the office may temporarily prorate payments from the fund for cash flow purposes.

SECTION 31. Section 1 of chapter 118G of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out the definition of “Pool”.

SECTION 32. Section 1 of said chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Non-acute hospital" the following definition:—

"Non-providing employer", an employer of a state-funded employee, as defined in this section; provided, however, that the term "non-providing employer" shall not include:—

(i) an employer that offers to contribute toward, or arrange for the purchase of health insurance, including coverage through the connector, under chapter 176Q for such employee;

(ii) an employer that is signatory to or obligated under a negotiated, bona fide collective bargaining agreement between such employer and bona fide employee representative which agreement governs the employment conditions of such person receiving free care;

(iii) an employer who participates in the Insurance Partnership Program; or

(iv) an employer that employs not more than 10. For the purposes of this definition, an employer shall

not be considered to pay for or arrange for the purchase of health care services provided by acute hospitals and ambulatory surgical centers by making or arranging for any payments to the uncompensated care pool.

SECTION 33. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of “Payments subject to surcharge” and inserting in place thereof the following definition:—

“Payments from non-providing employers”, all amounts paid to the Uncompensated Care Trust Fund or the General Fund by non-providing employers.

SECTION 34. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of “Private sector charges”.

SECTION 35. Said section 1 of said chapter 118G is hereby further amended by inserting after the definition of “specialty hospital”, as so appearing, the following definition:—

“State-funded employee”, any employed person, or dependent of such person, who receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free care; or any employed persons, or dependents of such persons, of a company that has 5 or more occurrences of health services paid for as free care by all employees in aggregate during any fiscal year. An occurrence shall include all healthcare related services incurred during a single visit to a health care professional.

SECTION 36. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of “Surcharge payor”.

SECTION 37. Section 2 of said chapter 118G, as so appearing, is hereby amended by inserting after the word “services”, in line 19, the following word:— and.

SECTION 38. Said section 2 of said chapter 118G, as so appearing, is hereby further amended by striking out clause (c) of the second paragraph.

SECTION 39. Section 3 of said chapter 118G, as so appearing, is hereby amended by striking out clause (g).

SECTION 40. Section 5 of said chapter 118G is hereby amended by striking out the first 2 sentences and inserting in place thereof the following 2 sentences:— Each acute hospital shall pay to the commonwealth an amount for the estimated expenses of the division and of the health safety net office, established by section 56 of chapter 118E. This amount shall be equal to the amount appropriated by the general court for the expenses of the division of health care finance and policy and of the health safety net office minus amounts collected from (1) filing fees, (2) fees and charges generated by the division’s publication or dissemination of reports and information, (3) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies.

SECTION 41. Section 6 of said chapter 118G, as so appearing, is hereby amended by inserting after the first paragraph the following paragraph:—

In addition, such uniform reporting shall provide the name and address and such other identifying information as may be needed relative to the employer of any patient for whom health care services were rendered under this chapter and for whom reimbursement from the uncompensated care pool has been requested.

SECTION 42. Said chapter 118G is hereby further amended by inserting after section 6A the following 2 sections:—

Section 6B. Notwithstanding any general or special law to the contrary, an applicant for uncompensated care pool assistance shall, if eligible, be enrolled in MassHealth under section 9A, chapter 118E or in the Insurance Partnership Program, as provided in section 9C of said chapter 118E. An applicant deemed ineligible for either program and who is unable to make all or part of the payment for health services, shall provide the name and address of his employer, if any, and his name, address, social security number and date of birth. The director of labor, in collaboration with the division, shall collaborate with the division of insurance and the department of revenue to implement this section and sections 6C and 18 and section 41 of chapter 268.

Section 6C. The division shall promulgate a form labeled “Health Insurance Responsibility Disclosure” to be completed and signed, under oath, by every employer and employee doing business in the commonwealth. The form shall indicate whether the employer has offered to pay for or arrange for the purchase of health care insurance, whether the employee has accepted or declined such coverage and whether the employee has an alternative source of health insurance coverage. The form shall contain a statement that an employee who chooses to decline health insurance coverage offered by an employer shall be legally responsible for that employee’s health care costs, if any, and may be subject to sanctions under chapter 111M. The division may make arrangements with other agencies of the commonwealth, including the department of revenue, to distribute and collect forms to all employers and employees in the commonwealth.

SECTION 43. Sections 18 and 18A of said chapter 118G are hereby repealed.

SECTION 44. Said chapter 118G is hereby further amended by inserting after section 18A the following section:—

Section 18B. (a) The division shall, upon verification of the provision of services and costs to a state-funded employee, assess a free rider surcharge on the non-providing employer under regulations promulgated by the division.

(b) The amount of the free rider surcharge on non-providing employers shall be determined by the division under regulations promulgated by the division, and assessed by the division not later than 3 months after the end of each hospital fiscal year, with payment by non-providing employers not later than 90 days after the assessment. The amount charged by the division shall be greater than 10 per cent but no greater than 100 per cent of the cost to the state of the services provided to the state-funded employee, considering all payments received by the state from other financing sources for free care; provided that the “cost to the state” for services provided to any state-funded employee may be determined by the division as a percentage of the state’s share of aggregate costs for health services. The free rider surcharge shall only be triggered upon incurring $50,000 or more, in any hospital fiscal year, in free care services for any employer’s employees, or dependents of such persons, in aggregate, regardless of how many state-funded employees are employed by that employer.

(c) The formula for assessing free rider surcharges on non-providing employers shall be set forth in regulations promulgated by the division that shall be based on factors including, but not limited to: (i) the number of incidents during the past year in which employees of the non-providing employer received services from the uncompensated care pool, under chapter 118E; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of employees for whom the non-providing employer provides health insurance.

(d) If a state-funded employee is employed by more than one non-providing employer at the time he or she receives services, the division shall assess a free rider surcharge on each said employer consistent with the formula established by the division under this section.

(e) The division shall specify by regulation appropriate mechanisms for implementing free rider surcharges on non-providing employers. Said regulations shall include, but not be limited to, the following provisions:—

(i) Appropriate mechanisms that provide for determination and payment of surcharge by a non-providing employer including requirements for data to be submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and

(ii) Penalties for nonpayment or late payment by the non-providing employer, including assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

(f) All surcharge payments made under this Section shall be deposited into the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.

(g) A non-providing employer's liability to that fund shall in the case of a transfer of ownership be assumed by the successor in interest to the non-providing employer's.

(h) If a non-providing employer fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the division, the division shall provide written notice of the required information. If the employer fails to provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction.

(i) The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this chapter.

(j) No employer shall discriminate against any employee on the basis of the employee’s receipt of free care, the employee’s reporting or disclosure of his employer’s identity and other information about the employer, the employee’s completion of a Health Insurance Responsibility Disclosure form, or any facts or circumstances relating to “free rider” surcharges assessed against the employer in relation to the employee. Violation of this subsection shall constitute a per se violation of chapter 93A.

(k) A hospital, surgical center, health center or other entity that provides uncompensated care pool services shall provide any uninsured patient with written notice of the criminal penalties for committing fraud in connection with the receipt of uncompensated care pool services, as provided in section 41 of chapter 268. The division shall promulgate a standard written notice form to be made available to health care providers in English and foreign languages. The form shall further include written notice of every employee’s protection from employment discrimination under this section.

SECTION 45. The General Laws are hereby amended by inserting after chapter 118G the following chapter:—

CHAPTER 118H

COMMONWEALTH CARE HEALTH INSURANCE PROGRAM

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise have the following meanings:—

“Board”, the board of the commonwealth health insurance connector, established by subsection (b) of section 2 of chapter 176Q.

“Connector”, the commonwealth health insurance connector, established by subsection (a) of section 2 of chapter 176Q.

“Eligible health insurance plan”, a health insurance plan that meets the criteria, established by the board, for receiving premium assistance payments; provided, that no eligible health insurance plan may require an annual deductible.

“Eligible individual”, an individual, including a sole proprietor, who meets the eligibility requirements in section 3.

“Fund”, the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.

“Premium contribution payment”, a payment made by an enrollee in the program towards an eligible health insurance plan, under a fee schedule established by the board.

“Premium assistance payment”, a payment of health insurance premiums made by the connector to an eligible health insurance plan on behalf of an enrollee in the program, under a schedule established by the board.

“Program”, the commonwealth care health insurance program, established by section 2.

“Resident”, a person living in the commonwealth, as defined by the office by regulation, including a qualified alien, as defined by section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, or a person who is not a citizen of the United States but who is otherwise permanently residing in the United States under color of law; provided, however, that the person has not moved into the commonwealth for the sole purpose of securing health insurance under this chapter; provided, further, that confinement of a person in a nursing home, hospital or other medical institution in the commonwealth shall not, in and of itself, suffice to qualify a person as a resident.

Section 2. For the purpose of reducing uninsurance in the commonwealth, there shall be a commonwealth care health insurance program within the commonwealth health insurance connector, established by chapter 176Q. The program shall be administered by the board of the connector, in consultation with the office of Medicaid and the health safety net office. The program shall provide subsidies to assist eligible individuals in purchasing health insurance, provided that subsidies shall only be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured by the commonwealth health insurance connector under said chapter 176Q, and shall be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by the board of the connector. Eligibility for premium assistance payments under this section shall be determined in coordination with and using the procedures of the office of Medicaid. After consultation with the director of the office of Medicaid, representatives of any carrier eligible to receive premium subsidy payments under this chapter, representatives of hospitals that serve a high number of uninsured individuals, and representatives of low-income health care advocacy organizations, the board shall develop a plan for outreach and education that is designed to reach low-income uninsured residents and maximize their enrollment in the program.

Section 3. (a) An uninsured individual shall be eligible to participate in the program if:—

(1) an individual's or family's household income does not exceed 300 per cent of the federal poverty level;

(2) the individual has been a resident of the commonwealth for the previous 6 months;

(3) the individual is not eligible for any MassHealth program, for Medicare, or for the child health insurance program established by section 16C of chapter 118E;

(4) the individual's or family member's employer has not provided health insurance coverage in the last 6 months for which the individual is eligible and for which the employer covers at least 20 per cent of the annual premium cost of a family health insurance plan or at least 33 per cent of an individual health insurance plan; and

(5) the individual has not accepted a financial incentive from his employer to decline his employer's subsidized health insurance plan.

(b) The board may waive section 4, provided that the individual's employer complies with section 110 of chapter 175, section 8½ of chapter 176, section 3B of chapter 176B or section 7A of chapter 176G; provided, further, that the employer's health insurance premium contribution for the applying individual, which shall be the median health insurance premium contribution made by the employer to all of its full-time employees participating in the employer-sponsored health plan, must be paid to the connector. The connector shall use the employer's health insurance premium contribution payment for the individual to first offset the commonwealth's premium assistance payment for the individual with any residual amount offsetting the individual.

Section 4. All residents shall have the right to apply for the program established by this chapter, the right to receive written determination detailing denial of eligibility, and the right to appeal any eligibility decision, provided such appeal is conducted pursuant to the process established by the board of the commonwealth health insurance connector, established by chapter 176Q. Applicants for said program shall be eligible for subsequent appeals subject to chapter 30A. Notwithstanding any general or special law to the contrary, all eligible individuals on whose behalf premium assistance payments are made, including those enrolled in plans offered by Medicaid managed care organizations referenced in section 28 of chapter 47 of the acts of 1997 shall under this section be entitled to consumer protections as described in chapter 176O.

Section 5. Premium assistance payments shall be made under a schedule set annually by the board, in consultation with the office of Medicaid and the health safety net office; provided that this schedule shall be published on or before September 30, starting in 2006. Premium assistance payments shall not be subject to appropriation from the fund, established by section 2OOO of chapter 29, and shall be made directly by the connector to eligible health insurance plans, under chapter 176Q. If the director determines that amounts in the fund are insufficient to meet the projected costs of enrolling new eligible individuals, the director shall impose a cap on enrollment in the program.

Section 6. (a) There shall be established a program for any resident with a household income that does not exceed 100 percent of the federal poverty level, in which the board of the connector shall procure health insurance plans that include, but are not limited to: (1) inpatient services; (2) outpatient services and preventative care by participating providers; (3) prescription drugs as provided under the MassHealth formulary; (4) medically necessary inpatient and outpatient mental health services and substance abuse services; and (5) medically necessary dental services, including preventative and restorative procedures.

(b) Enrollees with a household income that does not exceed 100 percent of the federal poverty level shall only be responsible for a copayment toward the purchase of each pharmaceutical product and for use of emergency room services in acute care hospitals for nonemergency conditions equal to that required of enrollees in the MassHealth program, as described in clause (5) of section 25 of chapter 118E. The board may waive copayments upon a finding of substantial financial or medical hardship. No other premium, deductible, or other cost sharing shall apply to enrollees under this program.

SECTION 46. Chapter 149 of the General Laws is hereby amended by inserting after section 6D the following section:—

Section 6D ½. No employee shall be penalized by an employer as a result of such employee's filing of an application to the uncompensated care pool or otherwise providing notice to the division of health care finance and policy or to a health care provider in regard to the need for health care services for that employee that results in the employer being required to reimburse the pool in whole or in part.

Governor disapproved the following section, see H4857

The Legislature overrode the Governor's veto

SECTION 47. Said chapter 149 is hereby further amended by inserting after section 187 the following section:—

Section 188. (a) As used in this section, the following words, unless the context clearly requires otherwise, shall have the following meanings:—

"Commissioner", the commissioner of health care finance and policy.

"Contributing employer", an employer that offers a group health plan, as defined in 26 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as defined in regulation by the division of health care finance and policy.

"Department", the department of labor, established by chapter 23.

"Director", the director of the department of labor.

"Division", the division of health care finance and policy, established by chapter 118G.

"Employer", an employing unit as defined in section 1 of chapter 151A.

"Employee", any individual employed by an employer subject to this chapter for at least 1 month, provided that for the purpose of this section self-employed individuals shall not be considered employees.

(b) For the purpose of more equitably distributing the costs of health care provided to uninsured residents of the commonwealth, each employer that (i) employs 11 or more full-time equivalent employees in the commonwealth and (ii) is not a contributing employer shall pay a per-employee contribution at a time and in a manner prescribed by the director of the department of labor, in this section called the fair share employer contribution. Said contribution shall be pro-rated by a fraction which shall not exceed one, the numerator of which is the number of hours worked in a year by all of the employer's employees who worked for the employer for at least 1 month and the denominator of which is the product of the number of employees employed by an employer during that year for at least 1 month multiplied by 2,000 hours.

(c) The director shall, in consultation with the division of health care finance and policy, annually determine the fair share employer contribution rate based on the best available data and under the

following provisions:—

(1) The per-user share of private sector liability shall be calculated annually by dividing the sum of hospital liability and third-party payor liability for uncompensated care, as defined by law, by the total number of individuals in the most recently completed fiscal year whose care was reimbursed in whole or in part by the uncompensated care pool, or any successor thereto.

(2) The total number of employees in the most recent fiscal year on whose behalf health care services were reimbursed in whole or in part by the uncompensated care pool, or any successor thereto, shall be calculated. In calculating this number, the division shall use all resources available to enable it to determine the employment status of individuals for whom reimbursements were made, including quarterly wage reports maintained by the department of revenue.

(3) The total number of employees as calculated in paragraph (2) shall be adjusted by multiplying that number by the percentage of employers in the commonwealth that are not contributing employers, as determined by the division.

(4) The total cost of liability associated with employees of non-contributing employers shall be determined by multiplying the number of employees, as calculated in paragraph (3) by the per-user share of private sector liability as calculated in paragraph (1).

(5) The fair share employer contribution shall be calculated by dividing the total cost of liability as calculated in paragraph (4) by the total number of employees of employers that are not contributing employers, as determined by the division.

(6) The fair share employer contribution, as determined in paragraph (5) shall be adjusted annually to reflect medical inflation, using an appropriate index as determined by the division.

(7) The total dollar amount of health care services provided by physicians to non-elderly, uninsured residents of the commonwealth for which no reimbursement is made from the Health Safety Net Trust Fund shall be calculated using a survey of physicians or other data source that the division determines is most accurate.

(8) The per-employee cost of uncompensated physician care shall be calculated by dividing the dollar amount of such services, as calculated in paragraph (7) by the total number of employees of contributing employers in the commonwealth, as estimated by the division using the most accurate data source available, as determined by the division.

(9) The annual fair share employer contribution shall be calculated by adding the fair share employer contribution as calculated in paragraph (6) and the per-employee cost of unreimbursed physician care, as calculated in paragraph (8).

(10) Notwithstanding this section, the total annual fair share employer contribution shall not exceed $295 per employee; and provided further, that the director shall allow employers to make the annual fair share employer contribution either annually, or in equal amounts semi-annually or quarterly, at the employer's sole discretion.

(d) The director of labor shall determine and collect the contribution under subsections (b) and (c), and shall implement penalties for employers that fail to make contributions as required by this section, provided that in order to reduce the administrative costs of collection of contributions the director shall, to the extent possible, use any existing procedures that have been implemented by the department to

make similar collections. All amounts collected shall be deposited in the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.

(e) In promulgating regulations defining the term “contribution” under this section, no proposed regulation by the division of health care finance and policy, except an emergency regulation, shall take effect until 60 days after the proposed regulations have been transmitted to the joint committees on health care financing and financial services.

SECTION 48. The General Laws are hereby amended by inserting after chapter 151E the following chapter:—

CHAPTER 151F

EMPLOYER-SPONSORED HEALTH INSURANCE ACCESS

Section 1. As used in this chapter, the following words shall, unless the context clearly requires otherwise, have the following meanings:—

“Employee”, any individual employed by any employer subject to this chapter and in employment subject thereto.

“Employer”, an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association, corporation or other legal entity, employing employees subject to this chapter; provided, however, that the owner of a dwelling house having not more than 3 apartments and who resides therein, or the occupant of a dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or buildings appurtenant thereto shall not because of such employment be deemed to be an employer. The word “employer” shall not include nonprofit entities, as defined by the Internal Revenue Code, that are exclusively staffed by volunteers nor shall the word employer include sole proprietors.

“Connector”, the commonwealth health insurance connector, established under chapter 176Q, acting through its board.

Section 2. Each employer with more than 10 employees in the commonwealth shall adopt and maintain a cafeteria plan that satisfies 26 U.S.C. 125 and the rules and regulations promulgated by the connector. A copy of such cafeteria plan shall be filed with the connector.

Section 3. The attorney general shall enforce this chapter and shall have the authority to seek and obtain injunctive relief in a court of appropriate jurisdiction.

SECTION 49. Paragraph (a) of subdivision (2) of section 108 of chapter 175 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out clause (3) and inserting in place thereof the following clause:—

(3) It purports to insure only 1 person, except that a policy must insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, 2 or more eligible members of that family, including husband, wife, dependent children or any children under a specified age not to exceed 25 years of age or 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first, and any other person dependent upon the

policyholder. If a policy provides for termination of a dependent child's coverage at a specified age and if such a child is mentally or physically incapable of earning his own living on the termination date, the policy shall continue to insure such child while the policy is in force and so long as such incapacity continues, if due proof of such incapacity is received by the insurer within 31 days of such termination date. The term "dependent children" as used in this provision shall include children of adopting parents during pendency of adoption procedures under chapter 210; and.

SECTION 50. Section 110 of said chapter 175, as so appearing, is hereby amended by adding the following subdivision:—

(O) An insurer authorized to issue or deliver within the commonwealth any general or blanket policy of insurance under this section may only contract to sell any general or blanket policy of insurance with an employer if said insurance is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees. Notwithstanding the foregoing, a carrier may enter into a general or blanket policy of insurance with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

SECTION 51. Said chapter 175 is hereby further amended by inserting after section 110L the following section:—

Section 110M. On the first day of each month, carriers shall report to the health care access bureau, established by section 7A of chapter 26, a listing of all individuals for whom creditable coverage as established by chapter 111M was provided for the previous month.

SECTION 52. Chapter 176A of the General Laws is hereby amended by inserting after section 8 the following section:—

Section 8½. A corporation organized under this chapter may only contract to sell a group non-profit hospital service contract to an employer if the group non-profit hospital service contract is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees. Notwithstanding the foregoing, a carrier may enter into a contract to sell a group non-profit hospital service contract with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

SECTION 53. Said chapter 176A is hereby further amended by inserting after section 8Y the following section:—

Section 8Z. Any subscription certificate under a group nonprofit hospital service agreement, except certificates which provide supplemental 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 principal place of employment within the commonwealth, coverage to persons who are age 25 and under or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first.

SECTION 54. Said chapter 176A is hereby further amended by adding the following section:—

Section 34. On the first day of each month, any corporation subject to this chapter shall report to the health care access bureau, established by section 7A of chapter 26, a listing of all individuals for whom creditable coverage as established by chapter 111M was provided for the previous month.

SECTION 55. Chapter 176B of the General Laws is hereby amended by inserting after section 3A the following section:—

Section 3B. A medical service corporation organized under this chapter may only enter into a group medical service agreement with an employer if the group medical service agreement is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees. Notwithstanding the foregoing, a carrier may enter into a group medical service agreement with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

SECTION 56. Said chapter 176B is hereby further amended by inserting after section 4Y the following section:—

Section 4Z. Any subscription certificate under an individual or group medical service agreement which shall be delivered or issued or renewed in this 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 persons who are age 25 and under or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first.

SECTION 57. Said chapter 176B is hereby further amended by adding the following section:—

Section 22. On the first day of each month, carriers shall report to the health care access bureau, established by section 7A of chapter 26, a listing of all individuals for whom creditable coverage as established by chapter 111M was provided for the previous month.

SECTION 58. Chapter 176G of the General Laws is hereby amended by inserting after section 4Q the following section:—

Section 4R. A health maintenance contract shall provide coverage to persons who are age 25 and under or for 2 years following loss of dependent status under the Internal Revenue Code, whichever occurs first.

SECTION 59. Said chapter 176G is hereby further amended by inserting after section 6 the following section:—

Section 6A. A health maintenance organization may only enter into a group health maintenance contract with an employer if the group health maintenance contract is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees. Notwithstanding the foregoing, a health maintenance organization may enter into a group health maintenance contract with an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

SECTION 60. Said chapter 176G is hereby further amended by inserting after section 16 the following section:—

Section 16A. The commissioner shall not disapprove a health maintenance contract on the basis that it includes a deductible that is consistent with the requirements for a high deductible plan as defined in section 223 of the Internal Revenue Code and implementing regulations or guidelines; provided, however, the maximum deductible shall not be greater than the maximum annual contribution to a health savings account permitted under section 223 of the Internal Revenue Code; provided, further that such deductible shall only be approved for products which include a health savings account permitted under said section 223 of the Internal Revenue Code.

SECTION 60A. Said chapter 176G is hereby further amended by inserting after section 16A the following section:—

Section 16B. The commissioner shall not disapprove a health maintenance contract offered as coverage for young adults if the health maintenance contract complies with the minimum standards established under section 10 of chapter 176J.

SECTION 61. Said chapter 176G is hereby further amended by adding the following section:—

Section 30. On the first day of each month, carriers shall report to the health care access bureau, established by section 7A of chapter 26, a listing of all individuals for whom creditable coverage as established by chapter 111M was provided for the previous month.

SECTION 62. Section 1 of chapter 176J of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in line 10, the words "case characteristics" and inserting in place thereof the following words:— rate basis type.

SECTION 63. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Adjusted average market premium price" the following definition:—

"Base premium rate", the midpoint rate within a modified community rate band for each rate basis type of each health benefit plan of a carrier.

SECTION 64. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition "Benefit level" and inserting in place thereof the following definition:—

"Benefit level", the health benefits, including the benefit payment structure or service delivery and network, provided by a health benefit plan.

SECTION 65. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition "Carrier" and inserting in place thereof the following definition:—

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

SECTION 66. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition "Case characteristics".

SECTION 67. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Commissioner" the following 3 definitions:—

“Connector”, the commonwealth health insurance connector, established by chapter 176Q.

“Connector seal of approval”, the approval given by the board of the connector to indicate that a health benefit plan meets certain standards regarding quality and value.

“Creditable coverage”, coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults as offered under section 10 of chapter 176J; or (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

SECTION 68. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of “Eligible dependent” the following definition:—

“Eligible individual”, an individual who is a resident of the commonwealth.

SECTION 69. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out, in lines 48 to 50, inclusive, the words “companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one business” and inserting in place thereof the following words:— a business shall be considered to be 1 eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent.

SECTION 70. The definition of “Eligible small business” in said section 1 of said chapter 176J, as so appearing, is hereby amended by adding the following sentence:— An eligible small business that exists within a MEWA shall be subject to this chapter.

SECTION 71. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition “Emergency services” and inserting in place thereof the following definition:—

“Emergency services”, services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(l)(B).

SECTION 72. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out, in lines 70 and 71, the words “employee and eligible dependents” and inserting in place thereof the following words:— employees and eligible dependents or eligible individuals and their dependents.

SECTION 73. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by

inserting, after the word "rate", the first time it appears, in line 76, the following words:— , tobacco usage.

SECTION 74. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Group base premium rates" the following definition:—

"Group health plan", an employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002, to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement or otherwise. For the purposes of this chapter, medical care means amounts paid for (i) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (ii) amounts paid for transportation primarily for and essential to medical care referred to in clause (i); and (iii) amounts paid for insurance covering medical care referred to in clauses (i) and (ii). Any plan, fund or program which would not be, but for section 2721(e) of the federal Public Health Service Act, an employee welfare benefit plan, and which is established or maintained by a partnership, to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to clause (a), as an employee welfare benefit plan which is a group health plan. In a group health plan, (a) the term "employer" also includes the partnership in relation to any partner; and (b) the term "participant" also includes:—

(1) in connection with a group health plan maintained by a partnership, an individual who is a partner of the partnership; or

(2) in connection with a group health plan maintained by a self-employed individual, under which 1 or more employees are participants, the self-employed individual if that individual is, or may become, eligible to receive a benefit under the plan or that individual's beneficiaries may be eligible to receive any benefit.

SECTION 75. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of "Health benefit plan" and inserting in place thereof the following definition:—

"Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; an individual or group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; an individual or group medical service plan issued by a nonprofit medical service corporation under chapter 176B; and an individual or group health maintenance contract issued by a health maintenance organization under chapter 176G. Health benefit plans shall not include: accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately;

coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

SECTION 76. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Mandated benefit" the following 2 definitions:—

"Member", any person enrolled in a health benefit plan.

"Modified community rate", a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a health benefit plan is the same without regard to health status, but premiums may vary due to factors such as age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level for each rate basis type as permitted by this chapter.

SECTION 77. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of "Pre-existing conditions provision" and inserting in place thereof the following definition:—

"Pre-existing conditions provision", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to that information.

SECTION 78. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Rate basis type" the following definition:—

"Rating factor", characteristics including, but not limited to, age, industry, rate basis type, geography, wellness program usage or tobacco usage.

SECTION 79. Said section 1 of said chapter 176J, as so appearing, is further amended by inserting after the definition "Rating period" the following 2 definitions:—

"Resident", a natural person living in the commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a resident.

"Trade Act/HCTC-eligible persons", any eligible trade adjustment assistance recipient or any eligible alternative trade adjustment assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient who is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, under Public Law 107-210.

SECTION 80. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the word "expenses", in line 192, the following words:— , but in all cases pays for emergency services.

SECTION 81. Said chapter l76J is hereby further amended by striking out section 2, as so appearing, and inserting in place thereof the following section:—

Section 2. Except as otherwise provided, this chapter applies to all health benefit plans issued, made effective, delivered or renewed to any eligible small business after April 1, 1992, and all health benefit plans issued, made effective, delivered or renewed to any eligible individual on or after July 1, 2007, whether issued directly by a carrier, through the connector, or through an intermediary. Nothing in this chapter shall be construed to require a carrier that does not issue health benefit plans subject to the chapter to issue health benefit plans subject to this chapter.

SECTION 82. Said chapter 176J is hereby further amended by striking out section 3, as so appearing, and inserting in place thereof the following section:—

Section 3. (a) Premiums charged to every eligible small business for a health benefit plan issued or renewed on or after April 1, 1992, or eligible individuals for a health benefit plan issued or renewed on or after July 1, 2007, shall satisfy the following requirements:—

(1) For every health benefit plan issued or renewed to eligible small groups on or after April 1, 1992 and to eligible individuals on or after July 1, 2007, including a certificate issued to an eligible small group or eligible individual 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 for a class of business. The group base premium rates charged by a carrier to each eligible group or eligible individual during a rating period shall not exceed 2 times the group base premium rate which could be charged by that carrier to the eligible group or eligible individual with the lowest group base premium rate for that rate basis type within that class of business in that group's or individual's geographic area. In calculating the premium to be charged to each eligible small group or eligible individual, a carrier shall develop a group base premium rate for each rate basis type and may develop and use any of the rate adjustment factors identified in paragraphs (2) to (6), inclusive, provided that after multiplying any of the used rate adjustment factors by the group base premium, the resulting product for all adjusted group base premium rate combinations fall within rate bands ranging between 0.66 and 1.32 that is required of all products offered to eligible small groups and eligible individuals. In addition, carriers may apply additional factors, identified in subsection (b) that would apply outside the 0.66 to 1.32 rate band. All other rating adjustments are prohibited. Carriers may offer any rate basis types, but rate basis types that are offered to any eligible small employer or eligible individual shall be offered to every eligible small employer or eligible individual for all coverage issued or renewed on and after July 1, 2007. If an eligible small business does not meet a carrier's minimum participation or contribution requirements, the carrier may separately rate each employee as an eligible individual.

(2) A carrier may establish an age rate adjustment that applies to both eligible individuals and eligible small groups.

(3) A carrier may establish an industry rate adjustment. If a carrier chooses to establish industry rate adjustments, every eligible small group in an industry shall be subject to the applicable industry rate adjustment. The industry rate adjustment applicable to an eligible individual shall be based on the industry of the eligible individual's primary employer and shall be the same adjustment applied to eligible small groups in the same industry. A carrier may not apply an industry rate to an eligible individual who is not employed.

(4) A carrier may establish participation-rate rate adjustments that apply only to eligible small groups for any health benefit plan or plans for any ranges of participation rates below the minimum participation requirements established under the definition of participation requirement in section 1, the value of which

shall be expressed as a number. Alternatively, a carrier may separately rate each employee enrolling through such a group as an eligible individual. The participation-rate rate adjustments must be based upon actuarially sound analysis of the differences in the experience of groups with different participation rates. If a carrier chooses to establish participation-rate rate adjustments, every eligible small group with a participation rate within the ranges defined by the carrier shall be subject to the applicable participation-rate rate adjustment.

(5) A carrier may apply a wellness program rate discount that applies to both eligible individuals and eligible small groups who follow those wellness programs that have been approved by the commissioner. If a carrier establishes a wellness program rate discount every eligible insured following the wellness program shall be subject to the applicable wellness program rate discount.

(6) A carrier may apply a tobacco use rate discount that applies to both eligible small groups and eligible individuals who can certify, in a method approved by the commissioner, 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.

(b)(1) 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 small group or eligible individual 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 small group and every eligible individual shall be subject to the applicable benefit level rate adjustment.

(2) The commissioner shall establish not less than 5 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 one-fifth. If a carrier chooses to establish area rate adjustments, every eligible small group and every eligible individual within each area shall be subject to the applicable area rate adjustment.

(3) A carrier shall establish a rate basis type adjustment factor for eligible individuals which shall be expressed as a number. The number shall represent the relative actuarial value of the rate basis type, which shall include at least the following 4 categories:— single, 2 adults, 1 adult and children, and family.

(4) A carrier may establish a group size rate adjustment that applies to both eligible individuals and eligible small groups, the value of which shall range from 0.95 to 1.10. If a carrier chooses to establish group size rate adjustments, every eligible individual and eligible small group shall be subject to the applicable group size rate adjustment. If an eligible small business does not meet a carrier’s participation or contribution requirements, the carrier may apply the group size adjustment that applies to eligible individuals to each employee who enrolls through the eligible small business.

(c)(1) A carrier that, as of the close of the calendar year 2005, had a combined total of 5,000 or more eligible employees and eligible dependents as defined by this chapter who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its license under chapter 176G, shall be required to file a plan with the connector, for its consideration, which could attain the connector seal of approval.

(2) As of January 1, 2007, 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.

(d)(1) A carrier that, as of the close of the calendar year 2005 had a combined total of 5,000 or more eligible employees and eligible dependents as defined by this chapter who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its authority under chapter 175, chapter 176A or chapter 176B shall be required to file a plan with the connector for its consideration, which could attain the connector seal of approval.

(2) As of January 1, 2007, 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.

(e) 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.

SECTION 83. Said chapter 176J is hereby further amended by striking out section 4, as so appearing, and inserting in place thereof the following section:—

Section 4. (a)(1) Every carrier shall make available to every eligible individual and every small business, including an eligible small group or eligible individual a certificate that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, as well as to their eligible dependents, every health benefit plan that it provides to any other eligible individual or eligible small business. No health plan may be offered to an eligible individual or an eligible small business unless it complies with this chapter. Upon the request of an eligible small business or an eligible individual, a carrier must provide that group or individual with a price for every health benefit plan that it provides to any eligible small business or eligible individual. Except under the conditions set forth in paragraph (3) of subsection (a) and paragraph (2) of subsection (b), every carrier shall enroll any eligible small business or eligible individual which seeks to enroll in a health benefit plan. Every carrier shall permit every eligible small business group to enroll all eligible persons and all eligible dependents; provided that the commissioner shall promulgate regulations which limit the circumstances under which coverage must be made available to an eligible employee who seeks to enroll in a health benefit plan significantly later than he was initially eligible to enroll in a group plan.

(2) A carrier shall enroll any person who meets the requirements of an eligible individual into a health plan if such person requests coverage within 63 days of termination of any prior creditable coverage. Coverage shall become effective within 30 days of the date of application, subject to reasonable verification of eligibility.

(3) A carrier shall enroll any eligible individual who does not meet the requirements of subsection (2) into a health benefit plan; provided, however, that a carrier may impose a pre-existing condition exclusion for no more than 6 months or a waiting period, which shall be applied uniformly without regard to any health status-related factors, for no more than 4 months following the individual's effective date of coverage. If a policy includes a waiting period, emergency services shall be covered. In determining

whether a pre-existing condition exclusion or a waiting period applies, all health plans shall credit the time such person was covered under prior creditable coverage if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage and if the previous coverage was reasonably actuarially equivalent to the new coverage. Coverage shall become effective within 30 days of the date of application. The commissioner shall promulgate regulations for pre-existing condition exclusions and waiting periods permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more that 6 months following the individual's effective date of coverage if the Trade Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible for the HCTC; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

(4) As of April 1, 2007, no policy may provide for any waiting period if the eligible individual has not had any creditable coverage for the 18 months prior to the effective date of coverage.

(b)(1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. The commissioner is authorized to promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this chapter.

(2) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months, (a) the eligible individual or eligible small business has repeatedly failed to pay on a timely basis the required health premiums; or, (b) the eligible individual or eligible small business has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented other information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or (c) the eligible individual or eligible small business has failed to comply in a material manner with a health benefit plan provision, including for an eligible small business, compliance with carrier requirements regarding employer contributions to group premiums; or (d) the eligible individual voluntarily ceases coverage under a health benefit plan; provided that the carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the individual or small business fails to comply with the carrier's requests for information which the carrier deems necessary to verify the application for coverage under the health benefit plan.

(3) A carrier shall not be required to issue a health benefit plan to an eligible individual or eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that:—

(i) the small business fails at the time of issuance or renewal to meet a participation requirement established under the definition of participation rate in section 1; or

(ii) acceptance of an application or applications would create for the carrier a condition of financial impairment, and the carrier makes such a demonstration to the same commissioner.

(4) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or an eligible small business with 5 or fewer eligible employees enrollment in a health benefit plan unless the eligible individual or eligible small business enrolls through an intermediary or the connector. If an eligible individual or an eligible small business with 5 or fewer eligible employees elects to enroll

through an intermediary or the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all similarly situated eligible individuals and eligible small businesses in a similar manner.

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

(2) A carrier shall not be required to renew the health benefit plan of an eligible individual or eligible small business if the individual or small business: (i) has not paid the required premiums; (ii) has committed fraud, misrepresented whether or not a person is an eligible individual or eligible employee, or misrepresented information necessary to determine the size of a group, the participation of a group, or the premium rate for a group; (iii) failed to comply in a material manner with health benefit plan provisions including, for employers, carrier requirements regarding employer contributions to group premiums; (iv) fails, at the time of renewal, to meet the participation requirements of the plan; (v) fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or, (vi) in the case of a group, is not actively engaged in business.

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

(d) Nothing in this chapter shall prohibit a carrier from offering coverage in a group to a person, and his dependents, who does not satisfy the hours per week or period employed portions of the definition of eligible employee.

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

SECTION 84. 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. (a) No policy shall exclude any 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 of such person.

(b) Pre-existing conditions provisions shall not exclude coverage for a period beyond 6 months following the individual's effective date of coverage and may only relate to conditions which had, during the 6 months preceding an eligible individual's, eligible employee's or eligible dependent's effective date of coverage and may only relate to a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Pre-existing condition provisions may not apply to a pregnancy existing on the effective date of coverage. A carrier may not impose a pre-existing condition exclusion or waiting period for more than 3 months following the effective date of coverage for Trade Act/Health Coverage Tax Credit Eligible Persons.

(c) No policy may provide for a waiting period of more than 4 months beyond the insured's effective date of coverage under the health benefit plan; but an eligible individual who has not had creditable coverage for the 18 months before the effective date of coverage shall not be subject to a waiting period, and a carrier may not impose any waiting period upon a new employee who had creditable coverage

under a previous qualifying health plan immediately before, or until, employment by the eligible small business. If a policy includes a waiting period, emergency services shall be covered during the waiting period. In determining whether a waiting period applies to an eligible individual, eligible employee or dependent, all health benefit plans shall credit the time such person was covered under a previous qualifying health plan if the insured experiences only a temporary interruption in coverage, and if the previous qualifying coverage was reasonably actuarially equivalent to the new coverage, both as determined by the commissioner. The waiting period may only apply to services which the new plan covers, but which were not covered under the previous plan.

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

SECTION 85. Section 6 of said chapter 176J, as so appearing, is hereby amended by inserting after the word “eligible”, in line 3, the following words:— individuals or eligible.

SECTION 86. Said section 6 of said chapter 176J, as so appearing, is hereby further amended by inserting after the word “benefits”, in line 5, the following words:— and may include networks that differ from those of a health plan’s overall network.

SECTION 87. Said chapter 176J is hereby further amended by striking out section 7, as so appearing, and inserting in place thereof the following section:—

Section 7. (a) Every carrier shall make reasonable disclosure to prospective small business insureds, as part of its solicitation and sales material of:—

(1) the surcharge, if any, which shall be applied to a group’s premium if one or more members are covered in the plan set forth in section 8; and

(2) the participation requirements or participation rate adjustments of the carrier for each health benefit plan.

(b) Every carrier, as a condition of doing business under the jurisdiction of this chapter on and after January 1, 2007, shall electronically file with the commissioner an annual actuarial opinion that the carrier’s rating methodologies and rates to be applied in the upcoming calendar year comply with the requirements of this chapter and any regulations promulgated under the authority of this chapter. In addition, every carrier shall file electronically an annual statement of the number of eligible individuals, eligible employees and eligible dependents, as of the close of the preceding calendar year, enrolled in a health benefit plan offered by the carrier. A carrier that may require eligible individuals or eligible small groups with 5 or fewer eligible employees to obtain coverage through an intermediary or the connector shall file a list of those intermediaries, with associated contact information, before requiring those small groups to go through an intermediary to obtain small group health coverage. Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are under sound actuarial principles, and comply with this chapter. Such information shall be made available to the commissioner upon request, but shall remain confidential.

(c) Every carrier shall notify the commissioner regarding any material changes or additions to the actuarial methodology at least 30 days before the effective date of the change or addition, including amendments to rate basis types, rating factors, intermediary relationships, distribution networks and products offered within this market. If the commissioner determines that a carrier is not complying with this chapter, the commissioner may disapprove the rating methodologies and the rates which the carrier

uses.

SECTION 88. Section 8 of said chapter 176J, as so appearing, is hereby amended by adding the following paragraph:—

By no later than July 1, 2006, the governing committee shall establish a proposal to phase-out the operations of the plan and submit a copy of said proposal to the commissioner for approval. The proposal shall include a method for closing the plan by June 30, 2007. The governing committee shall execute the phase-out of the plan.

SECTION 89. Section 9 of said chapter 176J, as so appearing, is hereby amended by inserting after the word “eligible”, in line 186, the first time it appears, the following words:— individual or eligible.

SECTION 90. Said chapter 176J is hereby further amended by adding the following section:—

Section 10. The division of insurance, with the advice and consent of the director of the connector, shall issue regulations to define coverage for young adult health benefit plans, and to implement this section. Eligibility for enrollment in a qualifying young adult health insurance program will be restricted to individuals between the ages of 19 and 26, inclusive, who do not otherwise have access to health insurance coverage subsidized by an employer. Coverage for young adults shall provide reasonably comprehensive coverage of inpatient and outpatient hospital services and physician services for physical and mental illness and shall provide all services which a carrier is required to include under applicable division of insurance statutes and regulations, including, but not limited to, mental health services, emergency services, and any health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plans. Any carrier offering young adult health plans must offer at least 1 product that includes coverage for outpatient prescription drugs. Coverage for young adults may impose reasonable copayments, coinsurance and deductibles and may use cost control techniques commonly used in the health insurance industry, including tiered provider networks and selective provider contracting.

Such plans shall only be issued through the commonwealth health insurance connector as defined in chapter 176Q. Premium rates for young adult health plans shall be consistent with section 3.

SECTION 91. Section 1 of chapter 176M of the General Laws, as so appearing, is hereby amended by inserting after the definition “Conversion nongroup health plan” the following definition:—

“Closed guaranteed issue health plan”, a nongroup health plan issued by a carrier to an individual, as well as any covered dependents, after November 1, 1997 but before July 1, 2007. A carrier may permit an individual to continue to add new dependents to a policy issued under a closed guaranteed issue health plan.

SECTION 92. Said section 1 of said chapter 176M, as so appearing, is hereby further amended by inserting after the definition of “Subscriber” the following definition:—

“Trade Act/HCTC-Eligible Persons”, any eligible Trade Adjustment Assistance recipient as defined in 35 (c)(2) of section 201 of Title II of Public Law 107-210, eligible alternative Trade Adjustment Assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient that is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, under Public Law 107-210.

SECTION 93. Section 3 of said chapter 176M, as so appearing, is hereby amended by inserting after the word "section", in line 8, the following words:— through June 31, 2007.

SECTION 94. Said section 3 of said chapter 176M, as so appearing, is hereby further amended by striking out subsections (d) and (e) and inserting in place thereof the following 2 subsections:—

(d) As of July 1, 2007, a carrier shall no longer offer, sell, or deliver a health plan to any person to whom it does not have such an obligation pursuant to an individual policy, contract or agreement with an employer or through a trust or association; provided, however, that a closed guaranteed issue plan or a closed health plan shall be subject to all the other requirements of this chapter. A carrier shall be obligated to renew a closed guarantee issue health plan and a closed plan. A carrier may discontinue a closed guarantee issue health plan or a closed plan when the number of subscribers in a closed guaranteed issue plan or a closed plan is less than 25 per cent of the plan's subscriber total as of December 31, 2004.

(e) Carriers shall notify all members, at the direction of the commissioner, at least once annually, of all health benefit plans and pursuant premiums for which the member is eligible under chapter 176J.

SECTION 95. Section 6 of said chapter 176M, as so appearing, is hereby amended by adding the following paragraph:—

By no later than July 1, 2006, the governing committee shall establish a proposal to phase-out the operations of the plan and submit a copy of said proposal to the commissioner for approval. The proposal shall include a method for closing the plan by June 30, 2007. The governing committee shall execute the phase-out of the plan.

SECTION 96. Section 1 of chapter 176N of the General Laws, as so appearing, is hereby amended by striking out the definitions "Emergency services" and "Health plan" and inserting in place thereof the following 2 definitions:—

"Emergency services", services to treat a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(1)(B).

"Health plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a nonprofit hospital service corporation under chapter 176A; a group medical service plan issued by a non profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; provided, however, "health plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which under this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile

medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy, or any policy under chapter 176K. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan under this chapter and shall be governed by said chapter 15A and the regulations promulgated hereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

SECTION 97. Section 2 of said chapter 176N, as so appearing, is hereby amended by striking out, in lines 12 and 13, the words "or (2) a pregnancy existing on the effective date of coverage".

SECTION 98. Said section 2 of said chapter 176N, as so appearing, is hereby further amended by striking out, in line 16, the word "thirty" and inserting in place thereof the following figure:— 63.

SECTION 99. Said section 2 of said chapter 176N, as so appearing, is hereby further amended by striking out, in line 21, the word "six" and inserting in place thereof the following figure:— 4.

SECTION 100. Said section 2 of said chapter 176N, as so appearing, is hereby further amended by inserting after the word "plan", in line 22, the following words:— ; provided that an eligible individual who has not had creditable coverage for the 18 months prior to the effective date of coverage shall not be subject to a waiting period.

SECTION 101. The General Laws are hereby amended by inserting after chapter 176P the following chapter:—

CHAPTER 176Q

COMMONWEALTH HEALTH INSURANCE CONNECTOR

Section 1. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:—

"Authority", the commonwealth health insurance connector authority.

"Board", the board of the commonwealth health insurance connector, established by section 2.

"Business entity", a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G.

"Commissioner", the commissioner of insurance.

"Commonwealth care health insurance program", the program administered under chapter 118H.

"Commonwealth care health insurance program enrollees", individuals and their dependents eligible to enroll in the commonwealth care health insurance program.

"Connector", the commonwealth health insurance connector.

"Connector seal of approval", the approval given by the board of the connector to indicate that a health benefit plan meets certain standards regarding quality and value.

"Division", the division of health care finance and policy.

"Eligible individuals", an individual who is a resident of the commonwealth; provided however, that the individual is not offered subsidized health insurance by an employer with more than 50 employees.

"Eligible small groups", groups, any sole proprietorship, labor union, educational, professional, civic, trade, church, not-for-profit or social organization or firms, corporations, partnerships or associations actively engaged in business that on at least 50 per cent of its working days during the preceding year employed at least one but not more than 50 employees.

"Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; a coverage for young adults health insurance plan under section 10 of chapter 176J. The words "health benefit plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

"Mandated benefits", a health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plan.

"Participating institution", an eligible group that purchases health benefit plans through the connector.

"Premium assistance payment", a payment made to carriers by the connector.

“Rating factor”, characteristics including, but not limited to, age, industry, rate basis type, geography, wellness program usage or tobacco usage.

“Sub-connector”, a locally incorporated and governed organization, with demonstrated experience in the small business health insurance and benefit market and which has been authorized to function in conjunction with the board of the connector.

Section 2. (a) There shall be a body politic and corporate and a public instrumentality to be known as the commonwealth health insurance connector authority, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the authority of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the authority is to implement the commonwealth health insurance connector, the purpose of which is to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups as described in this chapter.

(b) There shall be a board, with duties and powers established by this chapter, that shall govern the connector. The connector board shall consist of 11 members: the secretary for administration and finance, ex officio, who shall serve as chairperson; the director of Medicaid, ex officio; the commissioner of insurance, ex officio; the executive director of the group insurance commission; 3 members appointed by the governor, 1 of whom shall be a member in good standing of the American Academy of Actuaries, 1 of whom shall be a health economist, and 1 of whom shall represent the interests of small businesses; and 3 members appointed by the attorney general, 1 of whom shall be an employee health benefits plan specialist, 1 of whom shall be a representative of a health consumer organization, and 1 of whom shall be a representative of organized labor. No appointee may be an employee of any licensed carrier authorized to do business in the commonwealth. All appointments shall serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30.

(c) Six members of the board shall constitute a quorum, and the affirmative vote of 6 members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the connector. Members shall serve without pay, but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court no less than annually.

(d) Any action of the connector may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the connector shall be subject to section 11A½ of chapter 30A; but, said section 11A½ shall not apply to any meeting of members of the connector serving ex officio in the exercise of their duties as officers of the commonwealth if no matters relating to the official business of the connector are discussed and decided at the meeting. The connector shall be subject to all other provisions of said chapter 30A, and records pertaining to the administration of the connector shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the connector shall be considered to be public funds for purposes of chapter 12A. The operations of the connector shall be subject to chapter 268A and chapter 268B.

(e) The chairperson shall hire an executive director to supervise the administrative affairs and general management and operations of the connector and also serve as secretary of the connector, ex officio. The

executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the connector necessary to the functioning of the connector. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the connector. The executive director shall, with the approval of the board:—

(i) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board;

(ii) employ professional and clerical staff as necessary;

(iii) report to the board on all operations under his control and supervision;

(iv) prepare an annual budget and manage the administrative expenses of the connector; and

(v) undertake any other activities necessary to implement the powers and duties set forth in this chapter.

(f) As of April 1, 2007, the connector shall begin offering health benefit plans under section 5.

Section 3. The purpose of the board of the connector shall be to implement the commonwealth health insurance connector. The goal of the board is to facilitate the purchase of health care insurance products through the connector at an affordable price by eligible individuals, groups and commonwealth care health insurance plan enrollees. For these purposes, the board is authorized and empowered as follows:—

(a) to develop a plan of operation for the connector, this shall include, but not be limited to, the following:—

(1) establish procedures for operations of the connector;

(2) establish procedures for communications with the executive director;

(3) establish procedures for the selection of and the seal of approval certification for health benefit plans to be offered through the connector;

(4) establish procedures for the enrollment of eligible individuals, groups and commonwealth care health insurance program enrollees;

(5) establish procedures for granting an annual certification upon request of a resident who has sought health insurance coverage through the connector, attesting that, for the purposes of enforcing section 2 of chapter 111M, no health benefit plan which meets the definition of creditable coverage was deemed affordable by the connector for said individual. The connector shall maintain a list of individuals for whom such certificates have been granted;

(6) establish procedures for appeals of eligibility decisions for the commonwealth care health insurance program, established by chapter 118H;

(7) establish appeals procedures for enforcement actions taken by the department of revenue under said chapter 111M, including standards to govern appeals based on the assertion that imposition of the penalty under said chapter 111M would create extreme hardship;

(8) establish a plan for operating a health insurance service center to provide eligible individuals, groups and commonwealth care health insurance program enrollees, with information on the connector and manage connector enrollment;

(9) establish and manage a system of collecting all premium payments made by, or on behalf of, individuals obtaining health insurance coverage through the connector, including any premium payments made by enrollees, employees, unions or other organizations;

(10) establish and manage a system of remitting premium assistance payments to the carriers;

(11) establish a plan for publicizing the existence of the connector and the connector's eligibility requirements and enrollment procedures;

(12) develop criteria for determining that certain health benefit plans shall no longer be made available through the connector, and to develop a plan to decertify and remove the seal of approval from certain health benefit plans;

(13) develop a standard application form for eligible individuals, groups seeking to purchase health insurance through the connector, and commonwealth care health insurance program enrollees, seeking a premium assistance payment which shall include information necessary to determine an applicant's eligibility, previous health insurance coverage history and payment method; and

(14) develop criteria for plans eligible for premium assistance payments through the commonwealth care health insurance plan, initially publishing said criteria by July 1, 2006 for plans to be procured and implemented no later than October 1, 2006.

(b) to determine each applicant's eligibility for purchasing insurance offered by the connector, including eligibility for premium assistance payments.

(c) to seek and receive any grant funding from the federal government, departments or agencies of the commonwealth, and private foundations.

(d) to contract with professional service firms as may be necessary in its judgment, and to fix their compensation.

(e) to contract with companies which provide third-party administrative and billing services for insurance products.

(f) to charge and equitably apportion among participating institutions its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter.

(g) to adopt by-laws for the regulation of its affairs and the conduct of its business.

(h) to adopt an official seal and alter the same.

(i) to maintain an office at such place or places in the commonwealth as it may designate.

(j) to sue and be sued in its own name, plead and be impleaded.

(k) to establish lines of credit, and establish one or more cash and investment accounts to receive

payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974.

(l) to approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations.

(m) to enter into interdepartmental agreements with the department of revenue, the executive office of health and human services, the division of insurance and any other state agencies the board deems necessary to implement chapter 111M and chapter 118H.

(n) to create and deliver to the department of revenue a form for the department to distribute to every person to whom it distributes information regarding personal income tax liability, including, without limitation, every person who filed a personal income tax return in the most recent calendar year, informing the recipient of the requirements to establish and maintain health care coverage.

(o) to create for publication, by September 30 of each year, the commonwealth care health insurance program consumer price schedule.

(p) to create for publication by December 1 of each year, a premium schedule, which, accounting for maximum pricing in all rating factors with an exception for age, shall include the lowest premium on the market for which an individual would be eligible for "creditable coverage" as defined in chapter 111M. The schedule shall publish premiums allowing variance for age and rate basis type. The premium schedule shall be delivered to the department of revenue for use in establishing compliance with section 2 of chapter 111M.

(q) to review annually the publication of the income levels for the federal poverty guidelines and devise a schedule of a percentage of income for each 50 per cent increment of the federal poverty level at which an individual could be expected to contribute said percentage of income towards the purchase of health insurance coverage. The director shall consider contribution schedules, such as those set for government benefits programs. The report shall be published annually beginning on June 1, 2007. Prior to publication, the schedule shall be reported to the house and senate committee on ways and means and the joint committee on health care financing.

(r) to establish criteria, accept applications, and approve or reject licenses for certain sub-connectors which shall be authorized to offer health benefit plans offered by the connector. The board shall establish and maintain a procedure for coordination with said sub-connectors.

(s) to define and set by regulation minimum requirements for health plans meeting the requirement of "creditable coverage" as used in section 1 of chapter 111M.

(t) to establish and evaluate requirements for plans issued under section 5 with regard to health care delivery network design.

Section 4. (a) The connector may only offer health benefit plans to eligible individuals, and groups as defined in this chapter. Sub-connectors shall be authorized to offer all health benefit plans that the connector may offer, including all health benefit plans offered through the commonwealth care health insurance program.

(b) An eligible individual or small group's participation in the connector shall cease if coverage is cancelled under section 4 of chapter 176J.

Section 5. (a) Only health insurance plans that have been authorized by the commissioner and underwritten by a carrier may be offered through the connector.

(b) Each health plan offered through the connector shall contain a detailed description of benefits offered, including maximums, limitations, exclusions and other benefit limits.

(c) No health plan shall be offered through the connector that excludes an individual from coverage because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

(d) Plans receiving the connector seal of approval shall meet all requirements of health benefit plans as defined in section 1 of chapter 176J; provided, however, in order to encourage lower cost, high quality health benefit plans, that plans shall not be required to meet health care delivery network design provisions in any other law or regulation, and shall be free to contract on a mutually agreed basis with, or determine not to contract with, any provider for covered services; provided, however, that the contracted network meets the requirements set forth by the board of the connector.

Section 6. Eligible small groups seeking to be a participating institution shall, as a condition of participation in the connector, enter in a binding agreement with the connector which, at a minimum, shall stipulate the following:—

(a) that the employer agrees that, for the term of agreement, the employer will not offer to eligible individuals to participate in the connector any separate or competing group health plan offering the same, or substantially the same, benefits provided through the connector;

(b) that the employer reserves the right to determine, subject to applicable law, the criteria for eligibility, enrollment and participation in the connector and the amounts of the employer contributions, if any, to such health plan, provided that, for the term of the agreement with the connector, the employer agrees not to change or amend any such criteria or contribution amounts at anytime other than during a period designated by the connector for participating employer health plans;

(c) that the employers will participate in a payroll deduction program to facilitate the payment of health benefit plan premium payments by employees to benefit from deductibility of gross income under 26 U.S.C. 104, 105, 106 and 125; and

(d) that the employer agrees to make available, in a timely manner, for confidential review by the executive director, any of the employer’s documents, records or information that the connector reasonably determines is necessary for the executive director to:—

(1) verify that the employer is in compliance with applicable federal and commonwealth laws relating to group health insurance plans, particularly those provisions of such laws relating to non-discrimination in coverage; and

(2) verify the eligibility, under the terms of the health plan, of those individuals enrolled in the employer’s participating health plan.

Section 7. The connector shall administer the commonwealth care health insurance program, as described in chapter 118H, and remit premium assistance payments beginning on October 1, 2006 to those carriers providing health plans to commonwealth care health insurance program enrollees.

Section 8. The connector shall enter into interagency agreements with the department of revenue to

verify income data for participants in the commonwealth care health insurance program. Such written agreements shall include provisions permitting the connector to provide a list of individuals participating in or applying for the commonwealth care health insurance program, including any applicable members of the households of such individuals, which would be counted in determining eligibility, and to furnish relevant information including, but not limited to, name, social security number, if available, and other data required to assure positive identification. Such written agreements shall include provisions permitting the department of revenue to examine 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.

Section 9. The commonwealth, through the group insurance commission, shall enter into an agreement with the connector whereby employees and contractors of the commonwealth who are ineligible for group insurance commission enrollment may elect to purchase a health benefit plan through the connector. The group insurance commission shall develop a protocol for making pro-rated contributions to the chosen plan on behalf of the commonwealth.

Section 10. The connector seal of approval shall be assigned to health benefit plans that the board determines (1) meets the requirements of subsection (d) of section 5; (2) provides good value to consumer; (3) offers high quality; and (4) is offered through the connector.

Section 11. (a) When an eligible individual or group is enrolled in the connector by a producer licensed in the commonwealth, the health plan chosen by each eligible individual or group shall pay the producer a commission that shall be determined by the board. In setting the commission, the board of the connector shall consider rates of commissions paid to producers for health plans issued under chapter 176J as of January 1, 2006.

Section 12. (a) The connector shall be authorized to apply a surcharge to all health benefit plans which shall be used only to pay for administrative and operational expenses of the connector; provided, however, that such a surcharge shall be applied uniformly to all health benefit plans offered through the connector and sub-connectors; provided further that a sub-connector may charge an additional fee to be used only to pay for additional administrative and operational expenses of the sub-connector. These surcharges shall not be used to pay any premium assistance payments under the commonwealth care health insurance program, as described in chapter 118H.

(b) Each carrier participating in the connector shall be required to furnish such reasonable reports as the board determines necessary to enable the executive director to carry out his duties under this chapter.

(c) The board may withdraw a health plan from the connector only after notice to the carrier.

Section 13. (a) All expenses incurred in carrying out this chapter shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the connector hereunder beyond the extent to which monies shall have been provided under this chapter.

(b) The connector shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer, or employee of the connector acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances; provided, however, that the connector shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.

(c) No person shall be liable to the commonwealth, to the connector or to any other person as a result of his activities, whether ministerial or discretionary, as a member, officer or employee of the connector except for willful dishonesty or intentional violation of the law; provided, however, that such person shall provide reasonable cooperation to the connector in the defense of any claim. Failure of such person to provide reasonable cooperation shall cause him to be jointly liable with the connector, to the extent that such failure prejudiced the defense of the action.

(d) The connector may indemnify or reimburse any person, or his personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from such person's activities, whether ministerial or discretionary, as a member, officer or employee of the connector; provided that the defense of settlement thereof shall have been made by counsel approved by the connector. The connector may procure insurance for itself and for its members, officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

(e) No civil action hereunder shall be brought more than 3 years after the date upon which the cause thereof accrued.

(f) Upon dissolution, liquidation or other termination of the connector, all rights and properties of the connector shall pass to and be vested in the commonwealth, subject to the rights of lien holders and other creditors. In addition, any net earnings of the connector, beyond that necessary for retirement of any indebtedness or to implement the public purpose or purposes or program of the commonwealth, shall not inure to the benefit of any person other than the commonwealth.

Section 14. The connector shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its board, to the governor, to the general court, and to the state auditor, such reports to be in a form prescribed by the board, with the written approval of the auditor. The board or the auditor may investigate the affairs of the connector, may severally examine the properties and records of the connector, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the connector. The connector shall be subject to biennial audit by the state auditor.

Section 15. No later than 2 years after the connector begins operation and every year thereafter, the connector shall conduct a study of the connector and the persons enrolled in the connector and shall submit a written report to the governor, the president of the senate, the speaker of the house of representatives, the chairs of the joint committee on health care financing, and the house and senate committees on ways and means on status and activities of the connector based on data collected in the study. The report shall also be available to the general public upon request. The study shall review:—

(1) the operation and administration of the connector, including surveys and reports of health benefits plans available to eligible individuals and on the experience of the plans. The experience on the plans shall include data on enrollees in the connector and enrollees purchasing health benefit plans as defined by chapter 176J outside of the connector, the operation and administration of the commonwealth care health insurance program described in chapter 118H, expenses, claims statistics, complaints data, how the connector met its goals, and other information deemed pertinent by the connector; and

(2) any significant observations regarding utilization and adoption of the connector.

Section 16. The connector may adopt regulations to implement this chapter.

SECTION 102. Section 22 of chapter 47 of the acts of 1997 is hereby amended by striking out, in line 2,

the figure "2007", inserted by section 156 of chapter 184 of the acts of 2002, and inserting in place thereof the following figure:— 2012.

SECTION 103. Chapter 241 of the acts of 2004 is hereby repealed.

SECTION 104. Item 4000-0352 of section 2 of chapter 45 of the acts of 2005 is hereby amended by inserting after the words "administered by the executive office" the following words:— ; provided, that grants shall be awarded to groups statewide, including areas in which the United States Census deems a high percentage of uninsured individuals and areas in which there are limited health care providers; provided further, that funds shall be awarded as grants to community and consumer-focused public and private nonprofit groups to provide enrollment assistance, education and outreach activities directly to consumers who may be eligible for MassHealth or subsidized health care coverage, and who may require individualized support due to geography, ethnicity, race, culture, immigration or disease status and representative of communities throughout the commonwealth; provided further, that funds shall be allocated to provide informational support and technical assistance to recipient organizations and to promote appropriate and effective enrollment activities through the statewide health access network; provided further, that the cost of information support and technical assistance shall not exceed 10 per cent of the appropriation and shall not be used to defray current state obligations to provide this assistance.

SECTION 105. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 1,600 people, for a maximum total of 15,600 enrollees, in the CommonHealth program, funded in item 4000-0430 in section 2 of chapter 45 of the acts of 2005.

SECTION 106. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 250 people, for a maximum total of 1,300 enrollees, in the Family Assistance HIV positive program, funded in item 4000-1400 in section 2 of chapter 45 of the acts of 2005.

SECTION 107. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval effective July 1, 2006 to enroll an additional 16,000 people, for a maximum total of 60,000 enrollees, in the MassHealth Essential program, funded in item 4000-1405 in section 2 of chapter 45 of the acts of 2005.

SECTION 108. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall create a 2-year pilot program for smoking and tobacco use cessation treatment and information to include within its MassHealth-covered services. Smoking and tobacco use cessation treatment and information benefits shall include nicotine replacement therapy, other evidence-based pharmacologic aids to quitting smoking, and accompanying counseling by a physician, certified tobacco use cessation counselor, or other qualified clinician. The executive office shall report annually on the number of enrollees who participate in smoking cessation services, number of enrollees who quit smoking, and Medicaid expenditures tied to tobacco use by Medicaid enrollees. The comptroller shall transfer $7 million from the Health Care Security Trust, established by section 1 of chapter 29D of the General Laws, to the General Fund in each fiscal year 2007 and fiscal year 2008 to fund this program.

SECTION 109. The executive office of health and human services shall investigate and study the creation of selective provider networks. The study shall consider geography and cultural competence of providers. The executive office shall report the results of the study to the joint committee on health care financing and the house and senate committees on ways and means no later than January 1, 2007.

SECTION 110. The department of public health shall make an investigation and study relative to (a)

using and funding of community health workers by public and private entities in the commonwealth, (b) increasing access to health care, particularly Medicaid-funded health and public health services, and (c) eliminating health disparities among vulnerable populations. The department shall convene a statewide advisory council to assist in developing said investigation, interpreting its results, and developing recommendations for a sustainable community health worker program involving: public and private partnerships to improve access to health care, elimination of health disparities, increased use of primary care and a reduction in inappropriate use of hospital emergency rooms, and stronger workforce development in the commonwealth, including a training curriculum and community health worker certification program to insure high standards, cultural competency and quality of services. The advisory council shall be chaired by the commissioner of public health or his designee and shall include 14 additional members, including the chief executives or their designees of the following agencies or organizations:— office of Medicaid, department of labor, Massachusetts Community Health Workers Network, Outreach Worker Training Institute of Central Massachusetts Area Health Education Center, Community Partners' Health Access Network, the Massachusetts Public Health Association, Massachusetts Center for Nursing, Boston Public Health Commission, Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, Massachusetts Medical Society, Massachusetts Hospital Association, the Massachusetts League of Community Health Centers and the MassHealth Technical Forum.

The department shall report to the general court the results of its study and its recommendations by filing them with the clerks of the house and senate, who shall forward them to the joint committee on health care financing and to the house and senate committees on ways and means on or before January 1, 2007.

SECTION 111. The secretary of health and human services shall seek to obtain federal SCHIP reimbursement, under Title XXI, for all persons eligible. To the extent SCHIP funds are not available for all eligible programs, the secretary shall first seek SCHIP reimbursement for Title XXI eligible programs prior to claiming SCHIP reimbursement for Title XIX eligible programs. The secretary shall report quarterly to the joint committee on health care financing and the house and senate committees on ways and means on the status of federal SCHIP reimbursement.

Governor disapproved the following section, see H4857
The Legislature overrode the Governor's veto

SECTION 112. The secretary of health and human services shall seek an amendment to the MassHealth demonstration waiver granted by the United States Department of Health and Human Services under section 1115(a) of the Social Security Act, as authorized by chapter 203 of the acts of 1996, to implement this act. All negotiations with the federal Centers for Medicare and Medicaid Services or the federal Office of Management and Budget concerning this amendment shall be conducted in consultation with the secretary or his designee, a member of the house of representatives as appointed by the speaker of the house or his designee, and a member of the senate as appointed by the senate president or his designee. Any terms and conditions negotiated with the federal Centers for Medicare and Medicaid Services, including all correspondence related to the waiver, shall be submitted to the appointed member of the house of representatives and the appointed member of the senate, no fewer than 7 business days prior to submission to the federal Centers for Medicare and Medicaid Services. The secretary shall seek to obtain maximum federal reimbursement for all expenditures made under provisions of this act for which federal financial participation is available. The secretary shall report quarterly to the joint committee on health care financing and the house and senate committees on ways and means on the status of the waiver amendment sought under this section.

Governor disapproved the following section, see H4857
The Legislature overrode the Governor's veto

SECTION 113. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall not make any change to the financing, operation or regulation of, or contracts pertaining to, the provision of behavioral health services to persons receiving services administered, provided, paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI SCHIP, and any MassHealth expansion population served under Section 1115 waivers, nor shall it recommend or procure, by request for response or otherwise, any such changes, nor shall it seek approval from the federal Centers for Medicare and Medicaid Services for any such changes, until it has submitted a report outlining the proposed changes, together with its reasons and an explanation of the benefits of such changes, to the joint committees on mental health and substance abuse and health care financing; and further, all managed care organizations contracting or delivering behavioral health services to persons receiving services administered, provided, paid for or procured by the executive office of health and human services, office of Medicaid, including, but not limited to services under Title XIX of the Social Security Act, and Title XXI SCHIP, and any MassHealth expansion population served under Section 1115 waivers, and youth in the care and custody of the department of social services or the department of youth services, including any specialty behavioral health managed care organization contracted to administer said behavioral health services, shall obtain the approval of the commissioner of mental health for all of the behavioral health benefits, including but not limited to policies, protocols, standards, contract specifications, utilization review and utilization management criteria and outcome measurements. For purposes of this section, "specialty behavioral health managed care organization" shall mean a managed care organization whose primary line of business is the management of mental health and substance abuse services.

SECTION 114. (a) Notwithstanding any general or special laws to the contrary, there shall be a special commission to examine and study the impact of merging the non-group insurance market as defined in chapter 176M of the General Laws and small-group health insurance market as defined in chapter 176J of the General Laws.

(b) The commission shall consist of the commissioner of insurance, who shall serve as chair; the secretary of administration and finance; the commissioner of the division of health care finance and policy; 3 members appointed by the president of the senate, including an actuary in good standing with the American Society of Actuaries, a health economist, and a member of the senate; and 3 members appointed by the speaker of the house of representatives, including an actuary in good standing with the American Society of Actuaries, a health economist, and a member of the house of representatives.

(c) The commission shall conduct a study, which shall include examining the impact of merging the non-group and small-group health insurance markets on premiums charged to individuals and small groups. The report shall take into account the following factors:—

(1) the individual mandate, established by chapter 111M of the General Laws;

(2) the commonwealth care health insurance program, established by chapter 118H of the General Laws;

(3) health benefit plans authorized to be sold through the commonwealth health insurance connector, established by chapter 176Q of the General Laws, and the operation of the connector;

(4) the requirement in chapter 151F of the General Laws for employers to establish plans under 26 U.S.C. 125;

(5) the fair share employer assessment, established by section 188 of chapter 149 of the General Laws;

(6) the free rider surcharge, established by section 18B of chapter 118E of the General Laws; and

(7) appropriate use by insurance plans of standardized industry codes as used as a rating factor in section 1 of chapter 176J of the General Laws.

(d) The commission shall then direct that the results of the study shall be further studied to analyze the potential impact of reinsurance on the new merged market.

(e) For the purpose of conducting these studies, the commission may contract with an outside organization with expertise in fiscal analysis of the private insurance market. The commission shall establish appropriate guidelines and assumptions regarding the health reforms authorized in this act before engaging an outside organization. In conducting its examination, the organization shall, to the extent possible, obtain and use actual health plan data; but such data shall be confidential and shall not be a public record.

(f) The commission shall meet no later than May 1, 2006 and shall file a report with the clerks of the senate and house of representatives no later than December 31, 2006.

SECTION 115. There shall be an open enrollment period for eligible individuals and their dependents as defined in section 1 of chapter 176J of the General Laws. The open enrollment period shall begin on March 1, 2007, and end on May 31, 2007. No carrier shall impose a pre-existing condition provision or waiting period provision for any eligible individual who enrolls during the open enrollment period.

SECTION 116. Notwithstanding any general or special law to the contrary, the comptroller shall transfer $5,000,000, upon passage of this act, from the General Fund to the Massachusetts Technology Park Corporation established in section 3 of chapter 40J of the General Laws, to support the initial implementation of its computerized physician order entry system initiative and other activities designed to save lives, reduce health care costs and increase economic competitiveness for the citizens of the commonwealth.

SECTION 117. Notwithstanding any general or special law to the contrary, on September 30, 2007, the comptroller shall transfer any balance remaining in the Uncompensated Care Trust Fund to the Health Safety Net Trust Fund, established by section 57 of chapter 118E of the General Laws.

SECTION 118. Notwithstanding any general or special law to the contrary, as of September 30, 2006, the comptroller shall transfer all monies remaining in the Distressed Provider Expendable Trust Fund, established by chapter 241 of the acts of 2004, to the Essential Community Provider Trust Fund, established by section 2PPP of chapter 29 of the General Laws.

SECTION 119. Notwithstanding any general or special law to the contrary, the comptroller shall, in consultation with the state treasurer, the secretary of administration and finance and the secretary of health and human services, develop a schedule for transferring not less than $125,000,000 from the General Fund to the Commonwealth Care Trust Fund. This schedule shall make the transfers in increments considered appropriate to meet the cash flow needs of the commonwealth and the Commonwealth Care Trust Fund. The transfers shall not begin before July 1, 2005, and shall be completed on or before June 30, 2006.

SECTION 120. Notwithstanding any general or special law to the contrary, the comptroller shall, in consultation with the state treasurer, the secretary of administration and finance and the secretary of health and human services, develop a schedule for transferring not less than $290,000,000 from the Commonwealth Care Trust Fund to the Uncompensated Care Trust Fund for the purpose of making

revenues available for the uncompensated care pool during hospital fiscal year 2007. This schedule shall make the transfers in increments considered appropriate to meet the cash flow needs of the commonwealth and said uncompensated care pool. The transfers shall not begin before October 1, 2005, and shall be completed on or before June 30, 2006.

SECTION 121. Notwithstanding any general or special law to the contrary, the state comptroller shall transfer $25,000,000 from the General Fund to the commonwealth health insurance connector, established under chapter 176Q of the General Laws, for administrative and operating expenses of the connector, including, but not limited to, marketing efforts associated with educating and increasing the awareness of uninsured residents of the commonwealth as to their options for becoming insured through the connector.

SECTION 122. Notwithstanding any general or special law to the contrary, during fiscal years 2007, 2008, and 2009, the executive office of health and human services shall reimburse certain publicly operated or public-service hospital entities operated by the Cambridge public health commission and the Boston Medical Center Corporation, respectively, providing Title XIX reimbursable services, directly, or through contracts with hospitals under an agreement with the executive office, at levels consistent with their net supplemental payments of $287,000,000 in fiscal year 2006. For fiscal year 2007, the executive office shall hold harmless this amount of $287,000,000 in funding by allocating $200,000,000 in net supplemental payments from the Commonwealth Care Trust Fund and by increasing actuarially sound rates by not less than an additional $87,000,000 for certain publicly operated or public-service hospital entities operated by the Cambridge public health commission and the Boston Medical Center Corporation. For fiscal year 2008, subject to appropriation, the executive office shall hold harmless said amount of $287,000,000 in funding by allocating $180,000,000 in net supplemental payments from the Commonwealth Care Trust Fund and by increasing actuarially sound rates to the maximum extent allowable and eligible for financial participation, including the balance from other financing mechanisms, such as direct supplemental payments for certain publicly operated or public-service hospital entities operated by the Cambridge public health commission and the Boston Medical Center Corporation. For fiscal year 2009, subject to appropriation, the executive office shall hold harmless said amount of $287,000,000 in funding by allocating $160,000,000 in net supplemental payments from the Commonwealth Care Trust Fund and by increasing actuarially sound rates to the maximum extent allowable and eligible for financial participation, including the balance from other financing mechanisms, such as direct supplemental payments for certain publicly operated or public-service hospital entities operated by the Cambridge public health commission and the Boston Medical Center Corporation. Twenty-five per cent of the payments in fiscal years 2008 and 2009 shall be made in accordance with criteria established before each fiscal year by the secretary, in collaboration with said entities, based on the following 3 criteria: (a) the success of each entity in enrolling uninsured patients into said plans, including the commonwealth care health insurance program, other publicly funded health programs, or private insurance plans offered through the commonwealth health insurance connector; (b) reasonable progress made in minimizing the number of individuals utilizing the uncompensated care pool, or any successor thereto, and recognizing that some individuals will be ineligible for the new coverage options under this act; and (c) the submission of a written plan detailing the use of the supplemental funds. The criteria in clauses (a), (b), and (c) shall be established in collaboration with the entities and will be contingent on the administration's execution of the health care reform implementation plan established in section 132 of this act. Payments for fiscal year 2007 shall be made in full in equal monthly payments. In fiscal years 2008 and 2009, payments for 75 per cent of the supplemental funding amount shall be made to the entities on an equal monthly basis, and payments for the remaining 25 per cent shall be paid on a quarterly basis within 30 days after the entities submit data that reflects these requirements of each entity or hospital.

SECTION 123. Notwithstanding any general or special law to the contrary, from July 1, 2006 through

June 20, 2009, the executive director of the commonwealth health insurance connector shall collaborate with the secretary of health and human services and the commissioner of insurance to ensure that only Medicaid managed care organizations, that have contracted with the commonwealth as of July 1, 2006 to deliver such managed care services, receive premium assistance payments from the commonwealth care health insurance program, under chapter 118H of the General Laws, for the purposes of enrolling low-income individuals, but any organization referenced in section 28 of chapter 47 of the acts of 1997 may offer health benefit plans through the commonwealth care health insurance program, through the connector. Such organizations shall be considered carriers and the contracts offered by such organizations shall be considered health benefit plans. If the total enrollment among all Medicaid managed care organizations does not total 40,000 enrollees as of June 30, 2007, or 12 months after enrollment in that program is implemented, whichever is later, and 80,000 enrollees as of June 30, 2008, or 24 months after enrollment in that program is implemented, whichever is later, as defined in section 1 of chapter 118H of the General Laws, the director may allow non-Medicaid managed care organizations to apply to the commonwealth health insurance connector in order to receive premium assistance for the purposes of maximizing health insurance coverage in the commonwealth. The director shall collaborate with the secretary of health and human services and the group insurance commission to implement a methodology for the purposes of adjusting for variations in clinical risk among populations served by each of the commonwealth health insurance connector contractors. Adjustments to final payments to each of the contractors for a contract year shall be made in accordance with the risk adjustment methodology.

SECTION 124. Notwithstanding any general or special law to the contrary, in hospital fiscal year 2007, the division of health care finance and policy may administer, as provided in this section, the Uncompensated Care Trust Fund, established by section 18 of chapter 118G of the General Laws, to collect assessments as specified in this section for deposit to the fund, and to make certain payments to acute hospitals and community health centers from the uncompensated care pool to offset the costs of services provided to uninsured or low income residents. The division and the executive office of health and human services may promulgate regulations to implement this section.

The division, in consultation with the executive office, shall ensure that assessment liability to the fund and payments from the uncompensated care pool are structured in a manner to secure for the General Fund the maximum allowable federal reimbursement under Title XIX, XXI, or any successor federal law.

In hospital fiscal year 2007, the total liability of all acute care hospitals to the fund shall be $160,000,000. The division shall calculate an assessment percentage rate by dividing $160,000,000 by the projected annual aggregate private sector charges in the fiscal year for all acute care hospitals. Each acute care hospital's liability to the fund shall be equal to the product of the percentage rate and its private sector charges.

In hospital fiscal year 2007, the total surcharge liability of surcharge payers to the Uncompensated Care Trust Fund shall be $160,000,000. The surcharge amount for each surcharge payer shall be equal to the product of: (a) the surcharge percentage, and (b) the amounts paid for services of an acute hospital or ambulatory surgical center by each surcharge payer. The division shall calculate the surcharge percentage by dividing $160,000,000 by the projected annual aggregate payments subject to surcharge, as the term "payment subject to surcharge" is defined in said section 1 of said chapter 118G.

All Title XIX federal financial participation revenue generated by hospital payments funded by the Uncompensated Care Trust Fund, whether the payments are made by the division or the executive office, shall be credited to the General Fund.

All hospital payments made under this section shall be subject to federal approval and conditioned on the

receipt of full federal financial participation. All such payments shall be established under Title XIX of the Social Security Act, or any successor federal law, any regulations promulgated thereunder and the commonwealth's Title XIX state plan.

The division shall calculate an annual payment liability from the uncompensated care pool to each acute care hospital for fiscal year 2007. In determining the liability amount, the division shall:—

(a)(1) calculate the projected allowable uncompensated care charges for each hospital using the best and latest available data on allowable uncompensated care reported by the hospital times its ratio of costs to charges for pool fiscal year 2006; and

(2) take into account such factors as the financial burden of hospitals that provide proportionately the largest volume of free care and the situation of any free-standing pediatric hospital with a disproportionately low volume of Title XVIII payments; and

(b) allocate the available funds in a manner that pays to each hospital the highest possible fixed percentage of its projected free care costs for hospital fiscal year 2007, as determined by the division using prior year data and considering the total funds available for the purpose. This fixed percentage shall not be less than 85 per cent of free care costs, as defined in said section 1 of said chapter 118G, for the 2 disproportionate share hospitals with the highest relative volume of free care costs in hospital fiscal year 2004, and not less than 88 per cent of free care costs, as defined in said section 1 of said chapter 118G, for the 14 acute hospitals with the next-highest relative volume of free care costs in that year. In order to identify these 16 hospitals, the division shall rank all hospitals based on the percentage of each hospital's free care costs divided by the total free care costs of all hospitals in the commonwealth. All other acute care hospitals shall receive the highest possible percentage of free care costs given available remaining funds. The hospital fiscal year 2007 annual liability amount to each hospital shall be funded by the trust fund. This liability may be satisfied through either a disproportionate share payment or an adjustment to Title XIX service rate adjustment payment, or a combination thereof, under the terms provided for in an agreement entered into by an acute care hospital and the executive office. The comptroller, in consultation with the division and the executive office, shall transfer funds from the trust fund to the executive office for the purpose of the Title XIX service rate adjustment payments.

The executive office may use other federally permissible funding mechanisms available for publicly operated hospitals and hospitals with an affiliation with a publicly operated health care entity to reimburse up to $70,000,000 of uncompensated care costs at the hospitals using sources distinct from the funding made available to the trust fund under this section.

The executive office shall make payments from the uncompensated care pool for services provided by community health centers to low income residents. The executive office shall structure such payments to maximize allowable federal reimbursement under Title XIX. Under section 117 of chapter 140 of the acts of 2003, all Title XIX federal financial participation revenue generated by community health center payments funded by the Uncompensated Care Trust Fund, whether the payments are made by the division or the executive office, shall be deposited into the General Fund.

In hospital fiscal year 2007, $550,000,000 from the trust fund shall be credited to the uncompensated care pool for payments to acute hospitals provided for in this section, provided that, of this amount, $70,000,000 shall be used to reimburse uncompensated care costs at the 2 disproportionate share hospitals, as defined by section 1 of chapter 118G of the General Laws, with the highest relative volume of free care costs for hospital year 2007, as determined by the division of health care finance and policy. In addition, $56,000,000 from the trust fund shall be credited to the pool for payments to community health centers provided for in this section and $4,000,000 shall be credited for administrative

expenses, including demonstration projects under sections 21 and 22 of chapter 47 of the acts of 1997, as amended by sections 156, 157, and 158 of chapter 184 of the acts of 2002.

Not later than April 1, 2007, the division of health care finance and policy, in consultation with the secretary of health and human services, shall submit to the house and senate committees on ways and means a report on a new methodology for equitably allocating free care reimbursements from the Uncompensated Care Trust Fund to hospitals and community health centers beginning in hospital fiscal year 2008.

SECTION 125. Notwithstanding any general or special law to the contrary, the division of health care finance and policy shall continue in effect and enforce 114.6 C.M.R. 12.00 regarding services eligible for payment from the Uncompensated Care Trust Fund in effect on September 15, 2005, and promulgated under chapter 118G of the General Laws.

SECTION 126. Section 125 of this act is hereby repealed.

SECTION 127. It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until the latter of either January 1, 2008, or until the division of health care finance and policy has concluded review of, and published results from, a comprehensive review of mandated health benefits in effect on January 1, 2006.

SECTION 128. Notwithstanding any general or special law to the contrary, in fiscal year 2007, $90,000,000 shall be made available from the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29 of the General Laws, to pay for an increase in the Medicaid rates paid to acute hospitals, as defined in section 1 of chapter 118G of the General Laws, and physicians, provided that not less than 15 per cent of the increase be allocated to rate increases for physicians; provided further, that in fiscal year 2008, an additional $90,000,000, for a total of $180,000,000, shall be made available from the Commonwealth Care Trust Fund to pay for an increase in the Medicaid rates paid to acute hospitals, as defined in section 1 of chapter 118G of the General Laws, and physicians, provided that not less than 15 per cent of the increase be allocated to rate increases for physicians; and provided further, that in fiscal year 2009, an additional $90,000,000, for a total of $270,000,000, shall be made available from the Commonwealth Care Trust Fund to pay for an increase in the Medicaid rates paid to acute hospitals, as defined in said section 1 of said chapter 118G, and physicians, provided that not less than 15 per cent of the increase be allocated to rate increases for physicians.

SECTION 129. The secretary of health and human services shall conduct a study to determine the costs of allowing primary care givers to obtain MassHealth benefits if they care for, on a full-time basis, elderly parents or immediate family members who are disabled. The secretary shall submit the report to the joint committee on health care financing and the house and senate committees on ways and means no later than July 1, 2007.

SECTION 130. Notwithstanding any general or special law to the contrary, the president of the university of Massachusetts, upon the recommendation of the chancellor of the Worcester campus that resources are available from the unrestricted non-appropriated revenues received by said campus from the license agreements and services it provides to third parties, may make a payment to the General Fund of an amount representing all or part of the support provided by the commonwealth for the fringe benefits of university employees paid from state appropriated funds as such were determined for the Worcester campus for the fiscal years 1993 and 1994 under the September 22, 1992 memorandum of understanding between the secretary of administration and finance and said chancellor. These amounts may include support of the benefits provided by the state retirement system and/or the group insurance commission. The president shall notify the comptroller of the university's commitment to make such

payments and these payments shall become obligations of the university upon notification.

SECTION 131. Notwithstanding any general or special law to the contrary, the president of the university of Massachusetts, upon the recommendation of the chancellor of the Worcester campus that resources are available from the unrestricted non-appropriated revenues received by said campus for the services it provides to third parties, may make a payment to the General Fund of an amount representing all or part of the capital appropriations made available to the university by the commonwealth in the prior fiscal year. The president shall notify the comptroller of the university's commitment to make such payments and such payments shall become obligations of the university upon such notification.

SECTION 132. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall develop, in coordination with other appropriate state agencies, an implementation plan and corresponding timeline detailing monthly action steps toward implementing the health care reform legislation and progress projected and made toward reducing the uninsured in the commonwealth. Said implementation plan shall be developed in concert with stakeholders, including consumers, health care providers, health insurers including the Medicaid managed care organizations, and advocacy and business organizations, and shall be reported to the speaker of the house, the senate president, the joint committee on health care financing and the house and senate committees on ways and means within 60 days of the effective date of this act. Said report shall be updated bi-monthly thereafter. Said plan shall include all regulatory and operational aspects delineated in this act, including but not limited to:—

(a) the projected and actual monthly health insurance enrollment targets by coverage type including Medicaid coverage, newly available subsidized private insurance products for individuals up to 300 per cent of the federal poverty level, private insurance products for individuals available for individuals over 300 per cent of the federal poverty level and how such progress reduces the uninsured in the commonwealth;

(b) health insurance market reforms, including the availability of affordable insurance products;

(c) the implementation and timetable for Medicaid expansions, including the uncapping of current Medicaid enrollment caps;

(d) the development and approval of new subsidized private insurance products for the uninsured up to 300 per cent of the federal poverty level;

(e) the establishment of the connector;

(f) the development of a collaborative marketing and outreach plan, that includes an emphasis on consumer and business education and linguistic diversity of target populations, with accompanying budget and implementation timeline;

(g) the development of the program of sliding-scale premium assistance and collection processes;

(h) detailed implementation plan on how current uncompensated care pool eligible individuals, as determined by the Virtual Gateway process, can be considered eligible for automatic enrollment in new subsidized private insurance products;

(i) the timeline and public process regarding any proposed regulations on the uncompensated care pool;

(j) an electronic connection and other collaborative processes between the executive office of health and

humans services' Virtual Gateway public health care eligibility system and the connector to facilitate enrollment in new health insurance products available for premium assistance;

(k) a collaborative planning and implementation process with the Medicaid managed care organizations, including those operated by Cambridge public health commission and Boston Medical Center Corporation, to facilitate any enrollment targets into the new subsidized private insurance products;

(l) collaborative planning and procedures including safety net systems developed in concert with health care providers, including Cambridge public health commission, Boston Medical Center Corporation and other disproportionate share hospitals, community and teaching hospitals and community health centers to undertake analyses of their respective current uncompensated care pool-approved members within their health systems and health plan networks and devise implementation plans to foster expeditious enrollment in new subsidized private insurance products for the uninsured up to 300 per cent of the federal poverty level; and

(m) a detailed implementation schedule of the rate payments authorized in this act for acute care hospitals, community health centers and physicians participating in the Medicaid program in fiscal years, 2007, 2008, and 2009, respectively.

SECTION 133. On or before August 1, 2006, the executive director of the commonwealth health insurance connector shall submit to the board of the connector a plan of operation and any recommendations for amendments to chapter 176Q of the General Laws or other general laws to assure the fair, reasonable and equitable administration and the effective operation of the connector that is consistent with said chapter 176Q and any other applicable laws and regulations.

Governor disapproved the following section, see H4857

The Legislature overrode the Governor's veto

SECTION 134. The department of labor and the division of health care finance and policy shall jointly report, on or before July 1, 2007, on the implementation and impact of the fair share employer assessment, established by section 188 of chapter 149 of the General Laws, including, but not limited to, the number of employers in the commonwealth subject to the assessment, the impact of the assessment on the number of uninsured workers and the impact of the assessment on using services reimbursed from the health safety net fund. The report shall be filed with the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 135. Notwithstanding any general or special law to the contrary, only for the hospital rate year commencing October 1, 2007, hospitals may appeal to the division of health care finance and policy to receive Medicaid hospital rate increases without meeting the quality standards and achieving performance benchmarks established by the executive office of health and human services under section 13B of chapter 118E.

SECTION 136. The website to be established pursuant to section 16L of chapter 6A of the General Laws shall be operational not later than July 1, 2006 and shall include, at a minimum, links to other internet sites that display comparative cost and quality information. Not later than January 1, 2007, the internet site shall, at a minimum, include comparative cost information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, high-volume elective surgical procedures, high-volume diagnostic tests and high-volume therapeutic procedures. Cost information shall include, at a minimum, the average payment for each service or category or service received by each facility, clinician or physician practice on behalf of insured patients. Cost information shall be aggregated for all insurers and the council shall not publicly release the payment rates of any individual insurer which shall not be deemed to be public record.

Governor disapproved the following section, see H4857

The Legislature overrode the Governor's veto

SECTION 137. Notwithstanding any general or special law to the contrary, the terms of the initial members of the public health council, established by section 3 of chapter 17 of the General Laws, to be appointed on February 1, 2007, shall be as follows: 3 providers and 3 non-providers shall serve initial terms of 3 years, and the remaining providers and non-providers shall serve initial terms of 6 years, as designated by the commissioner of public health.

SECTION 138. Notwithstanding any special or general law to the contrary, the terms of the initial appointed members of the board of the commonwealth health insurance connector, established by section 2 of chapter 176Q, to be appointed by July 1, 2006, shall be as follows: the governor shall designate 3 appointed members for a term of 3 years; 3 appointed members for a term of 4 years; and 2 appointed members for a term of 5 years.

SECTION 139. Notwithstanding any general or special law to the contrary, no eligible individual shall be eligible for a health benefit plan offered in chapter 176J on any date prior to July 1, 2007.

SECTION 140. Sections 15, 17, 26, 27, 29, and 103 shall take effect on July 1, 2006.

SECTION 141. Sections 19, 20, 45, and 47 shall take effect on October 1, 2006.

SECTION 142. Sections 48, 49, 50, 52, 55, 59, 62, 63, 66, 69, 70, 76, 78, 82, 84, and 87 shall take effect on January 1, 2007.

SECTION 143. Section 5 shall take effect on February 1, 2007.

SECTION 144. Sections 60A, 64, 65, 76, 86, and 90 shall take effect on April 1, 2007.

SECTION 145. Sections 12, 21, 23, 68, 72, 74, 85, 88, 89, 127, and 128 shall take effect on July 1, 2007.

SECTION 146. Sections 25, 28, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 43, and 126 shall take effect on October 1, 2007.

SECTION 147. Sections 6A, 13, 18, 51, 54, 57, and 61 shall take effect on January 1, 2008.

Approved (in part) April 12, 2006.

Disapproved sections 5, 27, 29, 47, 112, 113, 134 and 137

Sections 5, 29, 47, 113, 134 and 137 overidden on May 4, 2006

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