The Commonwealth of Massachusetts

IN THE YEAR TWO THOUSAND FIVE

AN ACT Promoting Access To Healthcare

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

"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, it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health."

SECTION 1. Chapter 6A of the General Laws is hereby amended by inserting after section 16G the following new section:-

Section 16H. Massachusetts health care quality and cost council

Section 1. There shall be established a Massachusetts health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall make recommendations regarding health care quality improvement and cost-reduction goals for the commonwealth. The recommendations 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. The council shall consist of the secretary of health and human services, the commissioner of insurance, the executive director of the group insurance commission, the chief of the public protection bureau of the office of the attorney general, and three members appointed by the governor including an expert in health care

policy from a foundation or academic institution, a representative of health care consumers and a non-governmental purchaser of insurance. The representatives of non-governmental organizations shall serve staggered three-year terms. The council shall be chaired by the secretary of health and human services.

Section 2. The duties of the council shall include the following:

(1) The council shall develop health care quality improvement goals for the commonwealth that are intended to lower 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 Massachusetts.

(2) The council 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.

(3) 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, 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. Performance benchmarks should be clinically important and include both process and outcome data; and 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 not imply distinctions where comparisons are not statistically significant. Members of the advisory committee should have the opportunity to review and comment on all reports before public release.

(4) (a)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 their 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 site and make available written documentation available upon request and as necessary.

(b)Not later than July 1, 2006, the internet site shall be operational and, at a minimum, include links to other internet sites that display comparative cost and quality information.

(c) 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 board shall not publicly release the payment rates of any individual insurer.

(d) 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 board. 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.

(5) 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.

(6) The council shall, not less than annually, review and file a report with the clerks of the House and Senate on its progress in achieving the goals of improving quality and reducing health care costs in the Commonwealth. Reports of the council shall be made available electronically through an internet site.

(7) 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 one member representing the Massachusetts Medical Society, one member representing the Massachusetts Hospital Association, one member representing the Massachusetts Association of Health Plans, one member representing Blue Cross Blue Shield of Massachusetts, one member representing the Massachusetts AFL-CIO, one member representing the Massachusetts League of Community Health Centers, one member representing Health Care For All, one member representing the Massachusetts Public Health Association, one member representing the Massachusetts Association of Behavioral Health Systems, one member representing the Massachusetts Extended Care Federation, one member representing the Massachusetts Council of Human Service Providers, one member representing the Home and Health Care Association of Massachusetts, one member representing Associated Industries of Massachusetts, one member representing the Massachusetts chapter of the American Association of Retired Persons, and additional members 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 biomedical or pharmaceutical fields.

(8) The council may recommend any legislation or regulatory changes necessary to carry out its goals, but the council shall not have authority to promulgate regulations under this section.

(9) 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.

(10) All meetings of the council shall be publicly advertised and shall be open to the public, except that the council, through its bylaws, may provide for executive sessions of the council. No act of the council shall be taken in an executive session.

(11) 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 incurred in the performance of their duties. Said expenses may include reimbursement of travel and living expenses while engaged in council business.

SECTION 2. Chapter 17 of the General Laws is hereby amended by striking out section 3, as appearing in the 2004 Official Edition, and inserting in place thereof the following section:–

Section 3. There shall be a public health council to advise the commissioner of public health and to perform such other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 14 members appointed by the Governor for terms of 6 years. The commissioner may designate one of the members as vice chairperson and may appoint such subcommittees or special committees as may be needed.

Three of the appointed members shall be the chancellor of the University of Massachusetts Medical School or his designee; the dean of the Harvard University School of Public Health or his designee; and the dean of the Boston University School of Public Health or his designee. Six of the appointed members shall be providers of health services: 1 shall be the chief executive officer of an acute care hospital nominated by the Massachusetts Hospital Association, 1 shall be the chief executive officer of a skilled nursing facility nominated by the Massachusetts Extended Care Federation, 1 shall be a nurse executive nominated by the Massachusetts Organization of Nurse Executives, 1

shall be a registered nurse nominated by the board of registration of nurses who shall be the highest vote-getter on a mail ballot sent to the address of record of all registered nurses licensed by the board of registration of nurses, and 2 shall be physicians, 1 of whom shall be a primary care physician, nominated by the Massachusetts Medical Society.

Five of the appointed members shall be non-providers: 1 shall be nominated by the secretary of elder affairs, 1 shall be nominated by the secretary of veterans' services, 1 shall be from a consumer health organization, 1 shall be an expert in the prevention of medical errors; and 1 shall be nominated by the Massachusetts Public Health Association. For the purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he or she is qualified to act on the council in the public interest; who has and whose spouse, parents, siblings and children have no financial interest in a health care facility; who has and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established in accordance with chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals; and who is and whose spouse is not licensed to practice medicine.

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 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 four members. The appointive members shall receive $100 a day while in conference, and their necessary traveling expenses while in the performance of their official duties.

SECTION 3. 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 access bureau, 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 relative to health insurance coverage and access to affordable products.

The commissioner shall appoint all employees of the health care access bureau. The bureau may expend for expenses and for such legal, investigative, clerical and other assistance and operation of said bureau, such sums as may be appropriated therefore; provided, however that all costs of administration and operation of said bureau shall be borne by health insurers doing business within the commonwealth. For purposes of this section, the term health insurer shall include an insurer licensed or otherwise authorized to transact health insurance under chapter one hundred and seventy-five; a nonprofit hospital service corporation under chapter one hundred and seventy-six A; a nonprofit hospital service corporation under chapter one hundred and seventy-six B; and a health maintenance organization under chapter one hundred and seventy-six G.

The commissioner shall apportion estimated costs among all such companies and shall assess them for the same on a fair and reasonable basis. Said estimated costs shall be paid to the commissioner within thirty days after the date of the notice from the commissioner of such estimated costs. The commissioner shall subsequently apportion actual costs among all such companies and shall make assessment adjustments for any variation between estimated and actual costs on a fair and reasonable basis. Such estimated and actual costs shall include an amount equal to indirect costs as determined by the commissioner of administration and finance and fringe benefit costs as determined by the commissioner of administration and finance, and to compensate consultants retained by the bureau. The bureau shall consist of at least the following employees who shall devote their full time to the duties of their office and shall be exempt from the provisions of chapters thirty and thirty-one and shall serve at the pleasure of the commissioner: a deputy commissioner for health access; a health care finance expert; an actuary; and a research analyst. The commissioner may appoint such other employees as the bureau may require.

SECTION 4. Chapter 26 of the General Laws is hereby amended by inserting in Section 8H the following paragraph at the end of line 44:-

The division of insurance is directed to establish and publish minimum standards and guidelines at least annually for the use of all types of health insurers and health maintenance organizations doing business in the commonwealth. Health benefit plans established as qualified student health insurance plans and coverage for young adult plans will not be subjected to the same minimum standards and guidelines as set forth in the first sentence. In establishing said guidelines the commissioner shall consult with the commonwealth health insurance connector.

SECTION 5. Chapter 29 of the General Laws is hereby amended by inserting after section 2NNN the following section:-

Section 2*OOO*. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the commonwealth care fund, hereinafter referred

to as the fund. There shall be credited to the fund (a) all health care contributions collected pursuant to section 14N of chapter 151A, (b) any federal reimbursement received for benefits and payments provided pursuant to chapters 118E and 118H, and (d) any other appropriations or monies made available by law for the purposes of the demonstration program approved the Secretary of the United States Department of Health and Human Services pursuant to section 1115 of the Social Security Act, as extended or renewed from time to time. Amounts credited to the fund shall be expended, subject to appropriation, for (a) programs designed to increase health coverage, including a program of subsidized health insurance provided to low-income residents of the commonwealth pursuant to chapter 118H, and (b) a program of health assistance provided to adults pursuant to clause (j) of subsection (2) of section 9A of chapter 118E, provided however that monies from the fund may be transferred to the health safety net trust fund, established by section 57 of chapter 118E. Not later than January first, the comptroller shall report an update of revenues for the current fiscal year and prepare estimates of revenues to be credited to the fund in the subsequent fiscal year. Said report shall be filed with the secretary of administration and finance, the commissioner of medical assistance, the joint committee on health care financing, and the house and senate committees on ways and means. In the event that revenues credited to the fund are less than the amounts

estimated to be credited to the fund, the comptroller shall duly notify said secretary, commissioner and committees that said revenue deficiency shall require proportionate reductions in expenditures from the revenues available to support programs appropriated from the fund.

SECTION 6. Chapter 32A of the General Laws, as so appearing, is amended by adding the following new section:-

Section 3B. The commission shall maintain a database of members of health benefit plans. Carriers licensed under chapters 175, 176A, 176B, and 176G of the General Laws and the office of Medicaid shall report on the first day of each month to the director of the group insurance commission the names of each resident of the commonwealth for whom creditable coverage as defined in chapter 111M was provided during the previous month. The commission shall enter into an inter-agency agreement with the department of revenue for purposes of implementation of chapter 111M and with the executive office of health and human services for use in eligibility determination.

SECTION 7. Section 1 of chapter 62 of the General Laws, as so appearing, is hereby amended by striking out paragraph (c) and inserting in place thereof the following paragraph:-

(c) "Code", the Internal Revenue Code of the United States, as amended on January 1, 1998 and in effect for the taxable year; provided, however, that 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 8. 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 with no lapse of coverage for 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 pursuant to 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 pursuant to 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.

"Health care coverage", coverage under any of the following health plans described herein that does not have an annual hospital deductible that is greater than what is defined in section 223 of the Internal Revenue Code for contributions to health savings accounts and has an annual hospital benefit that is at least equal to or more than $100,000:

(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 pursuant to 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 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.

“Resident”, a person who has

(1) obtained an exemption pursuant to 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 pursuant to section 5C of said chapter 59;

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

(4) obtained a rental deduction pursuant to 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 for 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 January 1, 2007, the following individuals over the age of 18 shall obtain and maintain health care coverage: (1) residents of the commonwealth, (2) individuals who become residents of the commonwealth within 63 days, in the aggregate, and (3) individuals who within 63 days have terminated any prior creditable coverage, provided that creditable coverage is deemed affordable for the individual according to the schedule set by the board of the connector.

(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 had health care coverage in force for each of the twelve months of the taxable year for which the return is filed as required under paragraph (a). 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.

(c) 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 (e); provided, however, that the amount retained shall not exceed 50 per cent of the minimum insurance premium amount which meets the definitions of creditable coverage for which the individual would have qualified for each of the months he did not meet the requirement of paragraph (a); 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 subsections (i) to (vii), inclusive, of section 13 of chapter 62D. In the case of 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.

(d) If the penalty remains unpaid for 60 days following issuance of notification, the commissioner shall notify the registry of motor vehicles of the individual taxpayer's failure to comply. The registrar of motor vehicles shall take such actions as are necessary to prevent the renewal of the taxpayer's driver's license until such time as the penalty has been settled with the department of revenue.

(e) The commissioner shall deposit all penalties collected into the commonwealth care fund, established by section 2*000* of chapter 29.

Section 3. (a) An individual deemed subject to the provisions of Section 2, who disputes the determination of affordability as enforced by the department of revenue, may seek a review of this determination by a review panel established by the department of revenue. The commissioner is authorized to promulgate regulations as needed to carry out the exemption review process.

(b) An individual deemed subject to the provisions of section 2 may seek an exemption from these provisions if imposition of the penalty would create extreme hardship. Criteria for said hardship exemption shall be determined by the commissioner.

Section 4. 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 the purposes of this chapter.

SECTION 9. Section 9A of chapter 118E of the General Laws, as so appearing, is hereby amended by striking out, in line 75, the figure “200” and inserting in place thereof the following figure:- 300.

SECTION 10. Said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out, in line 80, the figure “133” and inserting in place thereof the following figure:- 200.

SECTION 11. Said section 9A of said chapter 118E, as so appearing, is hereby 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 those criteria authorized by Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

SECTION 12. Subsection (2) of said section 9A of said chapter 118E, as so appearing, is further amended in line 115 by striking the figure “133” and inserting in place thereof the following figure:- 200.

SECTION 13. Said subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby amended by adding the following clause:-

(j) adults 19 to 64, inclusive, whose financial eligibility as determined by the division does not exceed 100 per cent of the federal poverty level;

SECTION 14. Section 9A of Chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended after clause (14) by adding the following new clause:-

(15) The office of Medicaid shall report to the director of the group insurance commission monthly a listing of all individuals for whom creditable coverage is provided as of the first day of the month.

SECTION 15. Section 9C of said chapter 118E is hereby repealed.

SECTION 16. 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.

SECTION 17. 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 pursuant to MassHealth; provided further, that such individual is either age 65 or older or age 19 to 64 and disabled; provided further, that any such individual shall not be subject to sponsor income deeming or related restrictions.

SECTION 18. Section 12 of chapter 118E of the General Laws, as amended by section 20 of chapter 65 of the acts of 2004, is hereby amended in the fourth paragraph by adding the following:— The executive office of health and human services shall adopt regulations which restrict eligibility or covered services only after public notice and hearing.

SECTION 19. Chapter 118E of the General Laws, as so appearing, is hereby amended by adding the following section:-

Section 13B. Notwithstanding any general or special law to the contrary, Medicaid hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance measurement benchmarks, including 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 may accept recommendation of such benchmarks from the Massachusetts Health Care Quality and Cost Council as appropriate.

SECTION 20. Section 23 of chapter 118E of the General Laws, as appearing in the 2004 official edition, is hereby amended in line 57 by striking the words "(2) persons for whom hospitals and community health centers claim payments from the uncompensated care pool under chapter 118G;" and inserting in place thereof the words "(2) persons for whom hospitals and community health centers claim payments from the health safety net fund under chapter 118E;"

SECTION 21. Said chapter 118E is hereby amended by adding the following two new sections:-

Section 53. The division shall include within its covered services for adults comprehensive dental benefits which were included in its state plan in effect on January 1, 2002.

Section 54. The executive office of health and human services shall implement a wellness program for MassHealth enrollees to encourage activities that lead to desired health outcomes, including smoking cessation, for enrolled individuals. To the extent enrollees comply with the goals of the wellness program, the executive office shall reduce MassHealth premiums proportionally. The executive office shall report annually on the number of enrollees who participate in the wellness program, 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 22. Said chapter 118E is hereby amended by adding the following five new sections:-

Section 55. As used in sections 54 to 57 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 fifty-one of chapter one hundred and eleven 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, provided that such payments shall be made in accordance with regulations promulgated by the office.

"Community health center", health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626 and shall include all community health centers which file cost reports as requested by the division.

"Director", the director of the health safety net office.

"Emergency bad debt", an account receivable based on services provided by an acute hospital to an uninsured 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).

"Fund", the health safety net fund, established by section 57.

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

"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) non-medical 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; and provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

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

"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, pursuant to applicable regulations of the office, provided that non-emergency and urgent services shall be provided at a community health center unless no community or hospital licensed health center is located within five miles of a hospital campus, as determined by the office. "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.

“Underinsured patient”, a patient whose health insurance plan or self-insurance health plan does not pay for health services that are eligible for reimbursement under this section, provided that such patient meets income eligibility standards set by the office.

"Uninsured patient", a patient who is a resident of the commonwealth and who is not covered by a health insurance plan, a self-insurance health plan, and 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 the office of Medicaid shall, in consultation with the secretary of health and human services, appoint the director of the 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 division shall have the following powers and duties:-

(1) to administer the health safety net trust fund as established by section 57 of this chapter and to require payments to the fund consistent with acute hospitals' liability to the fund, as determined pursuant to section 58, and any further regulations promulgated by the office;

(2) to set, after consultation with the division of health care finance and policy, reimbursement rates for payments from the fund to acute hospitals and community health centers for health services provided to uninsured patients and to disburse monies from the fund consistent with such rates, provided further 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 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 patients for reimbursed 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 disallowal 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) the office shall, in consultation with the commonwealth health insurance connector, 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. Such programs shall not deny payments from the fund on the ground that services should have been provided in a more appropriate setting if the hospital was required to provided such services pursuant to 42 USC 1395 (dd).

(5) the office shall conduct a utilization review program designed to monitor the appropriateness of services paid for by the fund and to promote the delivery of care in the most appropriate setting, and shall administer safety net demonstration programs that reduce safety net 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 coordination between acute hospitals and community health centers.

(6) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with any 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;

(7) without imposing undue hardship upon any individual, to secure payment for unpaid bills owed to acute hospitals by persons 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 that all payments received shall be credited to the health safety net trust 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 committee on health care financing; and

(8) to make, amend, and repeal rules and regulations to effectuate the efficient use of monies from the health safety net fund. Such regulations shall be adopted only after notice and hearing and only upon consultation with the connector, the secretary of the

executive office 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.

Section 57. (a) There is hereby established a health safety net trust fund, which shall be administered by the health safety net office established pursuant to section 56. Expenditures from said trust fund shall not be subject to appropriation unless otherwise required by law. The purpose of the fund is to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of services provided to low-income, uninsured 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 in a manner designed to distribute the costs of providing health care to the uninsured as equitably as possible.

(b) The health safety net trust fund shall consist of all amounts paid by acute hospitals pursuant to section 58; all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured residents; any federal funds made available for payments to hospitals and other providers for health services for the uninsured or other funds received as a result of such payments; any transfers from the commonwealth care fund, established by section 2*OOO* of chapter 29; and all property and securities acquired by and through the use of monies belonging to said fund and all interest thereon. Amounts placed in the health safety net trust fund shall be expended by the office for the purpose of payments to hospitals and community health centers for reimbursable health services provided to uninsured residents of the commonwealth, consistent with the requirements of section 57 and regulations promulgated by the office, except for amounts transferred to the commonwealth care fund, 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. All interest earned on the amounts in the fund shall be deposited or retained in the fund. The director of the health safety net office

shall from time to time requisition from said fund such amounts as the director 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) the acute hospital liability as determined by law. 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. Such enforcement mechanisms may include 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 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 deemed to be in breach of contract or any other obligation for the payment of noncontracted services, and providers to which payment is offset under order of the division shall serve all Title XIX recipients in accordance with the contract then in effect with the office of Medicaid, or, in the case of a noncontracting or disproportionate share hospital, in accordance with its obligation for providing services to Title XIX recipients pursuant to 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 said division intends to initiate enforcement actions in accordance with the regulations of the office.

Section 59. (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 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 patients that are submitted to the office, and shall be made only after determination that the claim is eligible for reimbursement in accordance with this chapter and any additional regulations promulgated by the office, provided that reimbursements for non-urgent and non-emergency health services provided to residents of other states and foreign countries shall be prohibited, and provided further that the office shall, in consultation with the division of health care finance and policy, adopt a fee-for-service payment system.
2) Reimbursements to community health centers shall be based on a fee schedule in accordance with regulations promulgated by the office and upon submission of claims by each center.
3) Reimbursements 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) 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 utilized fully before services are billed to the fund. The office shall review all claims billed to the fund to determine whether the patient is eligible for medical assistance pursuant to this chapter and whether any third party is financially responsible for the costs of care provided to the patient. In making such determinations, the office shall verify the insurance status of each

individual for whom a claim is made using the insurance data base maintained by the group insurance commission. 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. The office shall require acute hospitals and community health centers to screen each applicant for reimbursed care for other source of coverage and for potential eligibility for government programs, and to document the results of such screening. If an acute hospital or community health center determines that an applicant is potentially eligible for Medicaid or for the commonwealth care program established pursuant to chapter 118H or another assistance program, the acute hospital or community health center shall assist the applicant in applying for benefits under such 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.

(c) 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 said shortfall in a manner that reflects each hospital's proportional requirement for reimbursements from the fund, in accordance with regulations promulgated by the office.

(d) The division shall enter into interagency agreements with the department of revenue to verify income data for patients who receive reimbursed health care services and to recover payments made by the fund for services provided to individuals who are ineligible for reimbursed 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.

(e) 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 such period; provided, however, that the office may temporarily prorate payments from the fund for cash flow purposes.

SECTION 23. Section 1 of chapter 118G of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out lines 184-85 and lines 211-213.

SECTION 24. Said chapter 118G is hereby amended in line 19 of section 2 by adding after the word “services” the word “and” and is further amended by striking out clause (c).

SECTION 25. Section 3 of said chapter 118G, as so appearing, is hereby amended by striking out clause (g).

SECTION 26. Said chapter 118G is hereby further amended by inserting after section 11 the following section:-

Section 11A. (a) The division shall monitor and review payments to MassHealth providers as specified in section 13 of chapter 118E. The division, in consultation with the state auditor, shall annually prepare analyses for the advisory board established pursuant to said section 13 on the following:-

(i) a comparison of Title XIX and Title XVIII provider rates for comparable services;

(ii) an analysis comparing Medicare and Medicaid annual inflation updates;

(iii) adequacy of Medicaid payments to providers with particular attention to community hospitals, physicians and other providers located in rural and isolated areas;

(iv). adequacy of Medicaid payment for emergency care rendered as required by 42 USC 1395(dd) and competent interpreter services provided pursuant to section 25J of chapter 111;

(v) adequacy of Medicaid payments to allow providers to cover at least half the cost of employee health care insurance, and

(vi) the extent to which rates charged by providers to health insurance plans are increased due to inadequate payments by commonwealth governmental units under Title XIX.

(b) The division and the auditor shall annually transmit to the governor, the joint committee and health care financing and the house and senate committees on ways and means the results of such analyses. The report shall further estimate the increased costs of health insurance plan premiums due to inadequate payments by commonwealth governmental units under Title XIX. In preparing the report specified in this section, the state auditor shall have access to all information held by the division that are relevant to these analyses.

SECTION 27. Section 18 of said chapter 118G is hereby repealed.

SECTION 28. Sections 18A of said chapter 118G is hereby repealed.

SECTION 29. The General Laws are hereby amended by inserting after chapter 118G the following chapter:-

CHAPTER 118H

THE COMMONWEALTH CARE HEALTH INSURANCE PROGRAM

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

“Board”, the board of the commonwealth health insurance connector, as established in section 3 of chapter 176Q.

“Eligible Health Insurance Plan”, a health insurance plan that meets the criteria for receiving premium assistance payments, as established by the board of the commonwealth health insurance connector.

"Eligible Individual", an individual who meets the eligibility requirements set out in section 3 of this chapter, including an individual who is a sole proprietor.

"Fund", the commonwealth care fund, established in section 2OOO of chapter 29.

"Premium contribution payments", payments made by enrollees in the program according to a fee schedule established by the board of the commonwealth health insurance connector.

"Premium assistance payments", payments on behalf of enrollees in the program for health insurance premiums, according to a schedule established by the board of the commonwealth health insurance connector.

"Resident", a person living in the commonwealth, as defined by the office by regulation; provided, however, that such regulation shall not define a resident as a person who moved into the commonwealth for the sole purpose of securing health insurance under this chapter, and provided further that 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 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.

Section 2. For the purpose of reducing uninsurance in the commonwealth, there shall be a Commonwealth Care Health Insurance program (hereinafter "the program") within the commonwealth health insurance connector established in chapter 176Q. The program shall be administered by the board of the connector, in consultation with the directors of the office of Medicaid and the health safety net office. The board shall determine a sliding-scale premium contribution payment schedule for enrollees, and shall establish procedures for determining eligibility and enrolling residents, in coordination with procedures used by the office of Medicaid. In order to maximize enrollment of low-income uninsured residents, the board of the connector shall develop a plan for outreach and education that is designed to reach these populations. In developing this plan, the board shall consult 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.

Section 3 (a) Uninsured residents of the commonwealth shall be eligible to participate in the Commonwealth Care Program, provided that

1) an individual or family's household income does not exceed 300 percent 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 pursuant to section 16C of chapter 118E;
4) the individual's or family member's employer has not in the last six months provided insurance coverage for which the individual is eligible and for which the employer covers at least 20 percent of the annual premium cost of a family health insurance plan or at least 33 percent of an individual health insurance plan;.

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

(b) The connector may waive the provisions of section (4), provided that the individual's employer is in compliance with section 110 of chapter 175, section 8 ½ 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 for the individual to first offset the commonwealth's premium assistance for individual with any residual amount offsetting the individual.

Section 4. Premium assistance payments shall be made in accordance with a schedule set annually by the board of the connector, in consultation with the directors of the office of Medicaid and the health safety net office, provided that this schedule shall be published on or before May 31, starting in 2006. Premium assistance payments shall be subject to appropriation from the commonwealth care fund established by section 2OOO of chapter 29 and other appropriation of state monies, and shall be made directly by the connector to eligible health insurance plans, in accordance with the provisions of chapter 176Q, provided further that premium assistance payments shall only be made on behalf of enrollees who purchase health plans with no annual deductible. In the event that the secretary determines that amounts in the fund are insufficient to meet the projected costs of enrolling new eligible individuals, the secretary shall impose a cap on enrollment in the program.

SECTION 30. Chapter 151A of the General Laws is hereby amended by inserting after section 14M the following new section:-

Section 14N. (a) Beginning on July 1, 2006, each employer who employs more than 10 employees and is subject to the provisions of 14, 14A, or 14C shall pay, in the same manner and at the same times as the director prescribes for the contribution required

by section fourteen, a commonwealth care contribution for the purpose of expanding health insurance coverage for low-wage workers in the commonwealth. For employers with fewer than 100 employees the contribution shall be computed by multiplying the wages paid its employees by the commonwealth care contribution rate of 3%. For employers with 100 or more employees the contribution shall be computed by multiplying the wages paid its employees by the commonwealth care contribution rate of 5%. The receipts from these contributions shall be paid to the director and shall be credited to the commonwealth care fund established pursuant to section 2*OOO* of chapter 29.

(b) Except where inconsistent with the provisions of this section, the terms and conditions of this chapter that apply to the payment of and the collection of contributions shall apply to the same extent to the payment of and the collection of the commonwealth care contributions required by this section; provided, however, that in order to distribute the costs of funding health care more equitably said contributions shall be reduced by an amount equal to the employer's expense for employee health benefits, including health insurance, and contributions to employee health savings accounts, in the commonwealth that are or would be deductible as medical care under federal tax law, provided further that said contribution shall not be less than zero.

(c) The director, in consultation and cooperation with the commissioner of revenue, shall promulgate regulations to enforce the provisions of this section. The regulations shall include reasonable exemptions, including exemptions for substantial hardship, penalties for late payment and failure to pay, reporting forms and procedures, and other matters as the director may determine.

SECTION 31. Chapter 151A of the General Laws is hereby amended by inserting after section 14M the following new section:-

Section 14N. (a) Beginning on January 1, 2007, each employer who employs more than 10 employees and is subject to the provisions of 14, 14A, or 14C shall pay, in the same manner and at the same times as the director prescribes for the contribution required by section fourteen, a commonwealth care contribution for the purpose of

expanding health insurance coverage for low-wage workers in the commonwealth. For employers with fewer than 100 employees the contribution shall be computed by multiplying the wages paid its employees by the commonwealth care contribution rate of 4%. For employers with 100 or more employees the contribution shall be computed by multiplying the wages paid its employees by the commonwealth care contribution rate of 6%. The receipts from these contributions shall be paid to the director and shall be credited to the commonwealth care fund established pursuant to section 2*OOO* of chapter 29.

(b) Except where inconsistent with the provisions of this section, the terms and conditions of this chapter that apply to the payment of and the collection of contributions shall apply to the same extent to the payment of and the collection of the commonwealth care contributions required by this section; provided, however, that in order to distribute the costs of funding health care more equitably said contributions shall be reduced by an amount equal to the employer's expense for employee health benefits, including health insurance, and contributions to employee health savings accounts, in the commonwealth that are or would be deductible as medical care under federal tax law, provided further that said contribution shall not be less than zero.

(c) The director, in consultation and cooperation with the commissioner of revenue, shall promulgate regulations to enforce the provisions of this section. The regulations shall include reasonable exemptions, including exemptions for substantial hardship, penalties for late payment and failure to pay, reporting forms and procedures, and other matters as the director may determine.

SECTION 32. Chapter 151A of the General Laws is hereby amended by inserting after section 14M the following new section:-

Section 14N. (a) Beginning on July 1, 2007, each employer who employs more than 10 employees and is subject to the provisions of 14, 14A, or 14C shall pay, in the same manner and at the same times as the director prescribes for the contribution required by section fourteen, a commonwealth care contribution for the purpose of expanding health insurance coverage for low-wage workers in the commonwealth. For employers

with fewer than 100 employees the contribution shall be computed by multiplying the wages paid its employees by the commonwealth care contribution rate of 5%. For employers with 100 or more employees the contribution shall be computed by multiplying the wages paid its employees by the commonwealth care contribution rate of 7%. The receipts from these contributions shall be paid to the director and shall be credited to the commonwealth care fund established pursuant to section 2*OOO* of chapter 29.

(b) Except where inconsistent with the provisions of this section, the terms and conditions of this chapter that apply to the payment of and the collection of contributions shall apply to the same extent to the payment of and the collection of the commonwealth care contributions required by this section; provided, however, that in order to distribute the costs of funding health care more equitably said contributions shall be reduced by an amount equal to the employer's expense for employee health benefits, including health insurance, and contributions to employee health savings accounts, in the commonwealth that are or would be deductible as medical care under federal tax law, provided further that said contribution shall not be less than zero.

(c) The director, in consultation and cooperation with the commissioner of revenue, shall promulgate regulations to enforce the provisions of this section. The regulations shall include reasonable exemptions, including exemptions for substantial hardship, penalties for late payment and failure to pay, reporting forms and procedures, and other matters as the director may determine.

SECTION 33. 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 may 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 which shall not exceed 25 years or for 2 years following the loss of dependent status under the Internal

Revenue Code, whichever occurs first, and any other person dependent upon the policyholder; provided, however, that 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.

SECTION 34. Section 110 of said chapter 175 of the General Laws, 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 offer the same health insurance premium contribution percentage amount for each specific or general blanket policy of insurance for all employees.

SECTION 35. Chapter 175 of the MGL is amended by adding the following new section:-

Section 110M. Carriers shall report to the director of the group insurance commission on the first day of each month a listing of all individuals for whom creditable coverage was provided for the previous month.

SECTION 36. Chapter 176A of the General Laws is hereby amended by inserting after section 8 the following section:-

Section 8 1/2. 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 offer the same health insurance premium contribution percentage amount for each specific or general blanket policy of insurance for all employees.

SECTION 37. Chapter 176A of the MGL is amended by adding the following new section:-

Section 34. Any corporation subject to this chapter shall report to the director of the group insurance commission on the first day of each month a listing of all individuals for whom creditable coverage was provided for the previous month.

SECTION 38. 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 offer the same health insurance premium contribution percentage amount for each specific or general blanket policy of insurance for all employees.

SECTION 39. Chapter 176B of the MGL is amended by adding the following new section:-

Section 22. Carriers shall report to the director of the group insurance commission on the first day of each month a listing of all individuals for whom creditable coverage was provided for the previous month.

SECTION 40. Chapter 176G of the General Laws is hereby amended by inserting after section 6 the following section:-

Section 7A. 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 must offer the same health insurance premium contribution percentage amount for each specific or general blanket policy of insurance for all employees.

SECTION 41. Chapter 176G of the MGL is amended by adding the following new section:-

Section 30. Carriers shall report to the director of the group insurance commission monthly a listing of all individuals for whom creditable coverage is provided as of the first day of the month.

SECTION 42. 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 minimum deductible required in section 223 of the Internal Revenue Code and implementing regulations or guidelines.

SECTION 43. Section 1 of chapter 176J of the General Laws, as appearing in the 2004 Official Edition, shall be amended by striking out in line 10, “case characteristics” and replacing it with “rate basis type”.

SECTION 44. Section 1 of chapter 176J, as appearing in the 2004 Official Edition, is hereby 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 45. Said section 1 of said chapter 176J , as so appearing, is hereby further amended by striking out the definition of “Benefit level” and inserting in place thereof the following definition:-

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

SECTION 46. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of “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 non-profit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

SECTION 47. Said section 1 of chapter 176J, as so appearing, is further amended by striking lines 24-25 in its entirety.

SECTION 48. 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 connector’s approval that a health benefit plan which it offers 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 pursuant to 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 49. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition "Eligible dependent" the following definition:-

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

SECTION 50. 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 51. 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 52. 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 53. Said section 1 of chapter 176J, as so appearing, is hereby further amended by inserting in line 70, after the word “employee” the letter “s” and by inserting in line 71, after the letters “dents” the following “or eligible individuals and their dependents”

SECTION 54. Said section 1 of chapter 176J, as so appearing, is hereby further amended by inserting, after the word “rate,”, in line 76," the following words:- "tobacco usage,"

SECTION 55. Said section 1 of 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 such 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; (a) in the case of a group health plan, the term “employer" also includes the partnership in relation to any partner; and (b) in the case of a group health plan, the term “participant" also includes: -

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

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

SECTION 56. 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; 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. 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 pursuant to 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 pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of said chapter 15A and the regulations promulgated thereunder. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

SECTION 57. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition "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; provided, however, that 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 58. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition of “Preexisting conditions provision” and inserting in place thereof the following definition:-

"Preexisting 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 such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information.

SECTION 59. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition "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 60. 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; provided, however, that the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify such 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 that is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, pursuant to Public Law 107-210.

SECTION 61. 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 62. 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 January 1, 2006, 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 63. 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 January 1, 2006, 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 January 1, 2006, 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, of this subsection, 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 sixty-six one-hundredths and one and thirty-two one-hundredths 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 sixty-six one-hundredths to one and thirty-two one-hundredths 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 January 1, 2006. 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 in accordance with 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. The value of the wellness program rate discount shall be up to 5 per cent. 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, two adults, one adult and children, and family.

(4) A carrier may establish a group size rate adjustment that apply to both eligible individuals and eligible small groups, the value of which shall range from ninety-five one-hundredths to one and ten one-hundredths. 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 2004, had a combined total of 5,000 or more eligible employees and eligible dependents as defined by chapter 176J and 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, and 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 2004 had a combined total of 5,000 or more eligible employees and eligible dependents as defined by chapter 176J and 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, and 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 said 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 64. Section 4 of chapter 176J, as appearing in the 2004 Official Edition, shall be amended by striking lines 2 through 107 inclusive and replaced with the following:-

individual and every small business, 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, 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 the requirements of 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 accept for enrollment 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 relative to pre-existing condition exclusions and waiting periods permissible pursuant to this section.

(4) 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, which ensure that a carrier cannot use the provisions of 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: (a) the small business fails at the time of issuance or renewal to meet a participation requirement established in accordance with the definition of participation rate in section one; or, (b) 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.

(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: (a) has not paid the required premiums; or, (b) 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; or, (c) failed to comply in a material manner with health benefit plan provisions including, for employers, carrier requirements regarding employer contributions to group premiums; or, (d) fails, at the time of renewal, to meet the participation requirements of the plan; or, (e) fails, at the time of renewal, to satisfy the definition of an eligible individual or eligible small business; or, (f) 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: (a) 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, (b) 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 be construed to 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.

SECTION 65. Section 5 of said chapter 176J, as so appearing, is hereby amended by striking out section 5 in its entirety and inserting in place thereof the following:-

(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) Preexisting 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. Preexisting condition provisions may not apply to a pregnancy existing on the effective date of coverage. A carrier may not impose a preexisting 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 four months beyond the insured's effective date of coverage under the health benefit plan; 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; provided further, however that a carrier may not impose any waiting period upon a new employee who had creditable coverage under a previous qualifying health plan immediately prior to, or until, employment by the eligible small business. If a policy includes a waiting period, emergency services must 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 old plan.

The commissioner shall promulgate regulations to enforce the provisions of this section.

SECTION 66. Section 6 of chapter 176J, as appearing in the 2004 Official Edition, is hereby amended by adding in line 3 after the word “eligible” the words “individuals or eligible” and is hereby further amended by adding after the word “benefit” the words “or include networks that differ from those of a health plan’s overall network.”

SECTION 67. Said Chapter 176J, as so appearing, is further amended by striking out section 7 in its entirety and inserting the following:-

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

(a) 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 eight of this chapter; and,

(b) the participation requirements or participation rate adjustments of the carrier with regard to each health benefit plan.

(c) Every carrier, as a condition of doing business under the jurisdiction of this chapter on and after January 1, 2006, 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, prior to 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 in accordance with sound actuarial principles, and comply with the provisions of this chapter. Such information shall be made available to the commissioner upon request, but shall remain confidential.

(d) Every carrier shall notify the commissioner regarding any material changes or additions to the actuarial methodology at least 30 days prior to 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 the provisions of this chapter, the commissioner may disapprove the rating methodologies and the rates which the carrier uses.

SECTION 68. Said chapter 176J is hereby further amended by striking out section 8, as so appearing, and inserting in place thereof the following section:-

Section 8. The division of insurance shall monitor the competitiveness of the health insurance market and make an annual determination if a reinsurance program is necessary. If such a program is determined to be necessary, the division shall establish a program in accordance with the following recommendations:

(a) There is hereby established a nonprofit entity to be known as the Massachusetts Health Reinsurance Plan. Any carrier issuing health benefit plans on or after January 1, 2006 shall be a member of the plan.

(b) The plan shall be prepared and administered by a five member governing committee to be appointed by the governor. Such appointees shall represent carriers selling health benefit plans in the commonwealth, of which at least one appointee shall represent a foreign carrier. The initial appointment of two such appointees shall be for a term of three years. The initial appointment of two such appointees shall be for a term of two years. The initial appointment of the remaining appointee shall be for a term of one year. All appointments thereafter shall be for a term of three years. The governing committee shall be responsible for the hiring of any employees or contractors of the plan.

(c) One month following the establishment of the governing committee, the governing committee shall submit to the commissioner a plan of operation. The commissioner shall, after notice and hearing, approve, disapprove or modify the plan of operation. Subsequent amendments to the plan shall be deemed approved by the commissioner if not expressly disapproved in writing by the commissioner within 30 days from the date of the filing. The commissioner shall establish the plan of operation three months following establishment of the governing committee, if the governing committee does not propose such a plan.

(d) Meetings of the governing committee of the plan shall be conducted in accordance with the provisions of section 11A 1/2 of chapter 30A.

(e) The plan shall not reimburse a carrier with respect to the claims of a reinsured individual or dependent in any calendar year until the carrier has paid an amount determined by the governing board and approved by the commissioner for benefits otherwise covered by the plan during the calendar year.

(f) Premium rates charged for coverage reinsured by the plan shall be established by the governing committee and shall be subject to the approval of the commissioner.

(g) Any member of the reinsurance plan may only reinsure the coverage of an eligible individual or any eligible dependent of such an individual or eligible employees or any eligible dependent of such an employee, who enrolls in a health benefit plan on or after three months following approval of the plan of operation. The reinsurance plan shall reinsure the level of coverage provided by the health benefit plan.

(h) Following the close of the fiscal year established in the plan of operation, the governing committee shall determine the premiums charged for reinsurance coverage, the reinsurance plan expenses for administration and the incurred losses, if any, for the fiscal year, taking into account investment income and other appropriate gains and losses. Any net loss for the year shall be recouped by assessment of the members which shall be apportioned in proportion to each such members' respective shares of the total premiums earned in the commonwealth from health plans, but in no event shall such assessments exceed 1 per cent of the premiums earned from such health plans.

(i) If the assessment level is inadequate, the governing committee may adjust reinsurance thresholds, retention levels or consider other forms of reinsurance. The governing committee shall report annually to the commissioner, the joint committee on health care financing, and the joint committee on financial services on its experience, the effect of the reinsurance plan on rates and shall make recommendations, if necessary, relative to sustaining the viability of the reinsurance plan. The committee may enter into negotiations with plan members to resolve any deficit through reductions in future payment levels for reinsurance plans. Any such recommendations shall take into account the findings of an actuarial study to be undertaken after the first three years of the plan's operation to evaluate and measure the relative risks assumed by differing types of carriers. The study shall be conducted by three actuaries appointed by the commissioner,

one of whom shall represent risk assuming carriers, one of whom shall represent reinsuring carriers and one of whom shall represent the commissioner.

SECTION 69. Section 9 of chapter 176J as so appearing, is hereby amended by adding in line 186 after the words “an eligible” the following “individual or eligible.”

SECTION 70. Chapter 176J, as so appearing, is hereby amended by adding a new section:-

Section 10. Coverage for Young Adults

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 the provisions of 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:

a. provide reasonably comprehensive coverage of inpatient and outpatient hospital services and physician services for physical and mental illness;
b. 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 one product that includes coverage for outpatient prescription drugs. Coverage for young adults may:

a. impose reasonable copayments, coinsurance and deductibles;
b. 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. Premiums charged for coverage for young adults must satisfy the following requirements:

a. A carrier must determine premium rates for a coverage for young adults health plan based on the pooled experience of its entire small group and non-group business for all persons within the same rate basis type, provided, however, that premiums may vary due to geographic area and benefit level.
b. A carrier may not vary premium rates for coverage for young adults based on age.
c. The carrier may establish a benefit level rate adjustment for coverage for young adults health plans, in accordance with the requirement of this statute.
d. The carrier may apply the area rate adjustment to coverage for young adults health plans, as otherwise permitted by this statute.

SECTION 71. Section 1 of chapter 176M, as so appearing, is hereby amended by inserting after the definition of "Carrier" the following:-

"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 January 1, 2006. A carrier may permit an individual to continue to add new dependents to a policy issued under a closed guaranteed issue health plan.

SECTION 72. Section 3 of chapter 176M of the General Laws, as so appearing, is amended by adding in line 8 after the word "section" the words "through December 31, 2005" and by striking out subsections (d) and (e) and inserting in place thereof the following subsection:-

(d) As of January 1, 2006, 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 according to Chapter 176J.

SECTION 73. Section 6 of said chapter 176M is hereby amended by inserting the following at the end thereof:-

By no later than July 1, 2006, the governing board for the Massachusetts nongroup health reinsurance plan 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 nongroup health reinsurance plan by June 30, 2007. The governing committee shall be charged with executing the phase-out plan.

SECTION 74. Section 1 of chapter 176N, as so appearing, is hereby amended by striking lines 4 through 39, inclusive and replacing it with the following:-

“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 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; The words “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

for the purposes of this chapter shall mean policies issued pursuant to 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 the provisions of 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 pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of 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 75. Section 2 of chapter 176N ,as so appearing, is hereby amended by striking in lines 12 and 13 the words “or (2) a pregnancy existing on the effective date of coverage” and is further amended by striking in line 16 the word “thirty” and replacing it with the number “63”.

SECTION 76. Said section 2 of chapter 176N, as so appearing, is further amended by striking in line 21 the word “six” and replacing it with the number “4” and is further amended by adding in line 22 after the word “plan” the following:-

;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 77. The General Laws are hereby amended by inserting 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: -

“Board”, board of the commonwealth health insurance connector.

“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 non-profit 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 the division of insurance.

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

“commonwealth care health insurance program”, program administered pursuant to chapter 118H.

“connector”, the Commonwealth Health Insurance connector.

“connector seal of approval”, board approval indicating that the health benefit plan meets certain standards regarding value and quality.

“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

percent 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 pursuant to 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 the provisions of 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 pursuant to section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by the provisions of 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.

“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”, eligible groups that purchase health benefit plans through the connector.

“Premium assistance payments”, payments 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.

Section 2. (a). There shall be established with the executive office of administration and finance, but not under its jurisdiction, an independent public entity to be known as the commonwealth health insurance connector. The purpose of the connector 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 herein, that will govern the connector. The connector board shall consist of 11 members: the director of the office of Medicaid, ex-officio; the secretary for administration and finance, ex-officio; the commissioner of insurance, ex-officio; 7 additional members appointed by the governor including 1 of whom shall be a member in good standing of the American Academy of Actuaries, 1 shall be an employee health benefits plan specialist, 1 shall be a health economist, 1 shall be a representative of a health consumer organization, and 2 shall represent the interests of small businesses; and 1 additional member appointed by the attorney general. No appointee may be an employee of any licensed carrier authorized to do business in the commonwealth. Upon the initial appointments, the governor shall designate three appointed members for a term of 3 years; three appointed members for a term of 4 years; and two appointed members for a term of 5 years. Thereafter, 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 governor shall appoint the chairperson and 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 pursuant to section 6A of chapter 30.

(c) Six members of the board shall constitute a quorum, and the affirmative vote of six 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 11A 1/2 of chapter 30A; but, said section 11A 1/2 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 so long as 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 executive director of the group insurance commission established in section 3 of chapter 32A shall supervise the administrative affairs and general management and operations of the connector and shall 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) Within 120 days of the effective date of this act, the executive director shall submit a plan of operation to the board and any recommended amendments to this chapter or other general laws to assure the fair, reasonable and equitable administration of the connector that is consistent with the provisions of this chapter and any other applicable laws and regulations, which shall provide for the effective operation of the connector.

(g) As of October 1, 2006, the connector shall commence offering health benefit plans pursuant to section 5 of this chapter.

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 insurance plan enrollees. For these purposes, the board is authorized and empowered:-

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

(6) 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;

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

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

(9) 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; and

(10) develop a standard application form for eligible individuals, groups seeking to purchase health insurance through the connector, and commonwealth care 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.

(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 at pleasure.

(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 create and deliver to the department of revenue a form that the department 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 that informs the recipient of the requirements to establish and maintain health care coverage.

(n) To create for publication by the 30th of each September, the Commonwealth Care Insurance Program commonwealth care insurance program consumer price schedule.

(o) To maintain membership lists from carriers in an electronic form that will provide such lists on a monthly basis.

(p) To create for publication by the 1st of each December, 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. Said 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 on December 1 beginning on December 1, 2006. 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.

Section 4. (a) The connector may only offer health benefit plans to eligible individuals, and groups as defined in this chapter.

(b) An eligible individual or small group's participation in the connector shall cease if coverage is cancelled pursuant to 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) The connector may only make available health benefit plans as defined in chapter 176J, which include the following categories of coverage:

(1) preventive and primary care;

(2) emergency services;

(3) surgical benefits;

(4) hospitalization benefits;

(5) ambulatory patient benefits;

(6) mental health benefits; and

(7) maternity benefits.

(e) Plans receiving the connector Seal of Approval shall not be required to meet any other benefit limitations or health care delivery network design in any other law; provided, however, that the carrier must offer a health benefit plan that includes a prescription drug benefit option. Any health benefit plan receiving the connector seal of approval may exclude any new mandated benefit coverage implemented after January 1, 2006.

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 the 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. sections 104, 105, 106 and 125; and

(d) that the employer agrees to make available, in a timely manner, for 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. (a) 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 enrollees.

(b) The connector after an affirmative vote by the board shall from time to time requisition funds from the Commonwealth Care Trust established in section 2*OOO* of chapter 29 by notifying the secretary for administration and finance, in a form prescribed by the secretary, such amounts as the connector deems necessary to meet the current and future obligations and expenses of the commonwealth care health insurance program; provided future obligations do not exceed 30 days.

Section 8. (a) 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 board, 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 will 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 section 5(d); (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.

(b) Any labor union, educational, professional, civic, trade, church, not-for-profit or social organization may enroll its individual eligible members, or the individual members of its member organizations, in health benefit plans offered through the

connector, and shall receive a payment amount determined by the board from each health plan for persons who are enrolled unless the payment is prohibited under any applicable provision of the Employee Retirement Income Security Act of 1974.

(c) Notwithstanding any general law to the contrary, membership organizations that enroll eligible individuals or groups in health benefit plans offered through the connector do not have to be licensed as an insurance producer unless such an arrangement is prohibited under any applicable provision of the Employee Retirement Income Security Act of 1974.

Section 12. (a) The connector shall be authorized to apply a surcharge to all health benefit plans and shall be used only to pay for administrative and operational expenses of the connector; provided that such a surcharge shall be applied uniformly to all health benefit plans offered through the connector. These surcharges shall not be used to pay any premium assistance payments pursuant to the commonwealth care 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 or her 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 1 year 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 promulgate such rules and regulations as necessary to implement this chapter.

Section 17. The chapter, being necessary for the welfare of the commonwealth and its inhabitants, shall be liberally construed to affect the purposes hereof.

SECTION 78. Chapter 241 of the acts of 2004 is hereby repealed.

SECTION 79. Chapter 45 of the Acts of 2005 is hereby amended by inserting in section 2, after item 1108-5500 the following new item:

1108-XXXX For start-up costs and marketing efforts associated with implementation of the Commonwealth Health Insurance Connector and Commonwealth Care Health Insurance Program, so-called…….$25,000,000

SECTION 80. Item 4000-0352 of chapter 45 of the acts of 2005 is hereby amended by inserting after the word “office” the following:-
provided further, that funds shall be awarded in areas in which the United States Census deems a high percentage of uninsured individuals, or in which there are limited health care providers; provided further, that funds shall be awarded as grants to community-oriented, 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 to due 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;

SECTION 81. 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, so-called, funded in item 4000-0430 in section 2 of chapter 45 of the acts of 2005.

SECTION 82. 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, so-called, funded in item 4000-1400 in section 2 of chapter 45 of the acts of 2005.

SECTION 83. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek federal approval within 30 days of the effective date of this act to enroll an additional 16,000 people, for a maximum total

of 60,000 enrollees, in the MassHealth Essential program, so-called, funded in item 4000-1405 in section 2 of chapter 45 of the acts of 2005.

SECTION 84. 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 fiscal year 2007 and fiscal year 2008 to fund said program.

SECTION 85. The executive office of health and human services shall investigate and study the creation of selective provider networks, including geography and cultural competence of providers. The executive office shall report the results of this 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 86. The department of public health shall make an investigation and study relative to (a) utilizing 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. Said 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, eliminate health disparities, and strengthen economic and workforce development in the commonwealth. Said 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, health safety net office, 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, Boston Public Health Commission, Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, Massachusetts Nurses Association, Massachusetts Medical Society, Massachusetts Hospital Association, and the Massachusetts League of Community Health Centers..

Said department shall report to the general court the results of its study and its recommendations to the clerk of the house and senate, who shall forward the same 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 87. The secretary of health and human services shall seek to obtain federal SCHIP reimbursement, pursuant to the provisions of Title XXI, for all persons eligible. To the extent S-CHIP funds are not available for all eligible programs, the secretary shall first seek S-CHIP 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.

SECTION 88. 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 the provisions of this act. The secretary shall seek to obtain maximum federal reimbursement for all 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 application.

SECTION 89. Notwithstanding the provisions of 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 under Title XIX of the Social Security Act, or recommend any such changes, prior to March 31, 2006.

SECTION 90. Notwithstanding the provisions of any general or special law to the contrary, 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, as established in Chapter 118E, section 6. 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 91. There shall be an open enrollment period for eligible individuals and their dependents as defined in section 1 of chapter 176J. The open enrollment period shall begin on September 1, 2006 and end on Nov. 30, 2006. No carrier shall impose a preexisting condition provision or waiting period provision for any eligible individual who enrolls during the open enrollment period.

SECTION 92. Notwithstanding any general or special law to the contrary, in fund fiscal years 2007 and 2008 hospital liability to the health safety net fund, established by section 58 of chapter 118E, shall equal $160,000.

SECTION 93. Notwithstanding the provisions of any general or special law to the contrary, on October 1, 2006 the comptroller shall transfer any balance remaining in the uncompensated care trust fund to the health safety net fund, established in section 58 of chapter 118E of the General Laws.

SECTION 94. Notwithstanding the provisions of any general or special law to the contrary 410 million dollars shall be transferred from the Commonwealth Care Fund to the Health Safety Net Trust Fund in fiscal year 2007, provided further that of this amount 70 million shall be used to reimburse publicly operated hospitals and hospitals with an affiliation with a publicly-operated health care entity for the costs of uncompensated care, separate from any other reimbursements authorized by the health safety net office.

SECTION 95. All monies remaining in the distressed provider expendable trust fund, as established by chapter 241 of the acts of 2004, shall be transferred by the comptroller to the commonwealth care fund, established by section 2*OOO* of the General Laws, on June 30, 2006.

SECTION 96. Notwithstanding the provisions of any general or special law to the contrary, (a) if the attorney general certifies that a court of competent jurisdiction has temporarily or preliminarily restrained any provision relating to the contributions established pursuant to section 14M of chapter 151A of the General Laws pending the results of litigation, including any order that such contribution amounts may or shall be placed in escrow or not actually remitted pending the results of litigation, and a stay of any such orders has not been granted within 30 days of the issuance of any such order, such that the Commonwealth Care Fund established pursuant to section 2*OOO* of chapter 29 of the General Laws will not receive funds from one or more employers pursuant to section 14M, then the provisions of said section 14M shall have no force or effect unless and until such time that said attorney general certifies that such temporary or preliminary order is no longer in effect; (b) if the attorney general certifies that a court of competent jurisdiction has issued a final adjudication on the merits invalidating or otherwise precluding surcharge payments pursuant to section 14M of chapter 151A of the General Laws, then the provisions of said section 14M shall have no force or effect unless and until such time that said attorney general certifies that an appellate court of competent jurisdiction has finally adjudicated that said section 14M is valid and enforceable; (c) if said section 14N is determined not to be in effect pursuant to the operation of this section,

then upon the date of certification by the attorney general section acute hospitals and ambulatory surgical centers shall assess a surcharge on all payments subject to surcharge as defined in section 1 of chapter 118G of the General Laws. 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 said services by a surcharge payor. The health safety net office, established by section xx of 118E, shall calculate the surcharge percentage by dividing $300,000 by the projected annual aggregate payments subject to the surcharge. The office shall determine the surcharge percentage upon certification by the attorney general that section 14M is not in effect, and may redetermine the surcharge percentage before the following April 1 if the office projects the initial surcharge established the previous October will produce less than $280,000 or more than $320,000. Before each succeeding October 1, the office shall redetermine the surcharge percentage, incorporating any adjustments from prior years. In each determination or redetermination of the surcharge percentage, the office shall use the best data available as determined by the office, in consultation with the division of health care finance and policy, and may consider the effect on projected surcharge payments of any modified or waived enforcements, including, but not limited to, updates or corrections or final settlement amounts by prospective adjustment rather than by retrospective payments or assessments. Surcharge payments shall be subject to the following provisions:

(1) 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 hospitals or ambulatory surgical center services. Each surcharge payor shall pay such surcharge amount to the treasurer for deposit in the commonwealth care fund established pursuant to section 2OOO of chapter 29 of the general laws on behalf of said acute hospital or ambulatory surgical center. Upon the written request of a surcharge payor, the health safety net office may implement another billing or collection method for such surcharge payor, provided, however that said office has received all information that it requests which is necessary to implement such billing or collection method, and provided further,

that said office shall specify by regulation the criteria for reviewing and approving such requests and the elements of such alternative method or methods.

(2) The health safety net office shall specify by regulation appropriate mechanism 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.

(3) A surcharge payor's liability to the 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.

(4) The health safety net office shall establish by regulation an appropriate mechanism for enforcing a surcharge payor's liability to the health safety net trust fund in the event that a surcharge payor does not make a scheduled payment to said fund; provided, however, that the said 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 office of Medicaid requiring an offset of payments on the claims of the surcharge payor or any entity under common ownership or any successor in interest to the surcharge payor, and the withholding by the office of Medicaid of the amount of payment owed to said fund including any interest and penalties, and the transfer of the withheld funds into said fund. If the office of Medicaid offsets claims payments as ordered by the health safety net office, said office of Medicaid shall be deemed not to be in breach of contract or any other obligation for payment of noncontracted services, and a surcharge payor to which payment is offset under order of the division shall serve all Title XIX recipients in accordance with the contract then in effect with the office of Medicaid. In no event shall the office of Medicaid offset claims unless the surcharge payor has maintained an outstanding liability to the health safety net fund for a period longer than

45 days and has received proper notice that said division intends to initiate enforcement actions in accordance with the regulations of the division.

(5) Any surcharge payor who fails to file any data, statistics or schedules required under chapter 118G or by any regulations promulgated by the health safety net office or which falsifies the same, 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 the provisions of this chapter.

SECTION 97. Notwithstanding any general or special law or any provisions of this act to the contrary, the division of health care finance and policy shall continue in effect and enforce the following regulations in effect on September 15, 2005, promulgated pursuant to chapter 118G of the General Laws: 114:6 CMR 12.00 regarding services eligible for payment from the uncompensated care trust fund.

SECTION 98. Section 97 of this Act is repealed.

SECTION 99. There shall be a moratorium on all new mandated health benefits.

SECTION 100. The commonwealth health insurance connector shall, in consultation with the executive office of economic development, design and administer a pilot program designed to assist businesses with fifty or fewer employees in purchasing health insurance for their employees, provided that said program may include economic and other incentives for employers who provide health insurance coverage for employees with household incomes below 400 percent of the federal poverty level.

SECTION 101. Notwithstanding any general or special law to the contrary, from July 1, 2006 through June 20, 2009, only carriers that are Medicaid managed care organizations contracted with the commonwealth as of July 1, 2006 to provide Medicaid

managed care services may receive from the Commonwealth Care Program premium assistance payments pursuant to this chapter, provided, that any managed care organization that receives premium assistance payments shall be licensed by the division of insurance, and provided further that if the Medicaid managed care organizations do not have a combined total of 40,000 enrollees as of June 30, 2007, and 80,000 enrollees as of June 30, 2008, as defined as defined in section 1 of chapter 118H, non-Medicaid managed care organizations may receive premium assistance. The group insurance commission shall use a methodology to analyze and adjust for variations in clinical risk among populations served by each of the Commonwealth Care contractors. Adjustments to final payments to each of the contractors for a contract year shall be made in accordance with the risk adjustment methodology, provided further that funds from the commonwealth care fund may be made available for transitional supplemental rate payments for all managed care organizations that meet enrollment goals and other criteria set by the board of the connector and the director of the health safety net office that are designed to maximize the enrollment into health insurance of current users of the uncompensated care pool.

SECTION 102. Sections 5, 9, 10, 13, 16, 21, 28, 29, 30, and 93 shall take effect on July 1, 2006.

SECTION 103. Sections 22, 23, 24, 25, 27, 91, and 96 shall take effect on October 1, 2006.

SECTION 104. Section 8, subsection 2 (c) and section 31shall take effect shall take effect on January 1, 2007.

SECTION 105. Section 15 and 32 shall take effect on July 1, 2007.

SECTION 106. Section 8, subsection 2 (d) shall take effect on January 1, 2009.