

**HOUSE . . . . . No. 914**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

***F. Jay Barrows***

*To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:*

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act alleviating health care burdens for Massachusetts employers.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>F. Jay Barrows</i>	<i>1st Bristol</i>
<i>Kimberly N. Ferguson</i>	<i>1st Worcester</i>
<i>Steven S. Howitt</i>	<i>4th Bristol</i>
<i>Joseph D. McKenna</i>	<i>18th Worcester</i>
<i>Shaunna L. O'Connell</i>	<i>3rd Bristol</i>
<i>Mathew J. Muratore</i>	<i>1st Plymouth</i>
<i>Michael J. Soter</i>	<i>8th Worcester</i>

**HOUSE . . . . . No. 914**

By Mr. Barrows of Mansfield, a petition (accompanied by bill, House, No. 914) of F. Jay Barrows and others relative to demerging health care markets to alleviating burdens. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION  
SEE HOUSE, NO. 2157 OF 2017-2018.]

**The Commonwealth of Massachusetts**

\_\_\_\_\_  
In the One Hundred and Ninety-First General Court  
(2019-2020)  
\_\_\_\_\_

An Act alleviating health care burdens for Massachusetts employers.

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

1 SECTION 1. Section 1 of said chapter 176J, is hereby amended by striking the following  
2 definition: “Eligible individual”.

3 SECTION 2. Said section 1 of said chapter 176J is further amended by striking from the  
4 definition of “Health Benefit Plan” the phrase: “an individual or group” each time it appears and  
5 inserting in place thereof the words: “a group”. Said definition of “Health Benefit Plan” is further  
6 amended by striking the word “individual” each time it appears.

7 SECTION 3. Section 2 of said chapter 176J is hereby amended by striking the phrase:  
8 “and all health benefit plans issued, made effective, delivered or renewed to any eligible  
9 individual on or after July 1, 2007,”.

10 SECTION 4. Section 3 of said chapter 176J is hereby amended by striking the phrase:  
11 “merged market group base premium rates” and inserting in place thereof the following: “small  
12 group base premium rates”.

13 SECTION 5. Said section 3 of chapter 176J is further amended by striking out the phrase:  
14 “eligible individuals and” each time it appears.

15 SECTION 6. Said section 3 of chapter 176J is further amended by striking out the phrase:  
16 “eligible individual or”.

17 SECTION 7. Said section 3 of chapter 176J is hereby amended in paragraph (1) clause (i)  
18 of subsection (a) by striking the phrase: “a merged individual and”.

19 SECTION 8. Said section 3 of chapter 176J is further amended in paragraph (1) clause  
20 (ii) of subsection (a) by striking the phrase “eligible individuals and eligible small groups,  
21 respectively”.

22 SECTION 9. Said section 3 of chapter 176J is further amended in paragraph (1) of  
23 subsection (a) by striking from clause (iii) the following phrase: “as set forth in clause (i)” and  
24 inserting in place thereof the following: “as set forth in section 1 of chapter 176M”.

25 SECTION 10. Said section 3 of said chapter 176J is hereby amended in paragraph (1) of  
26 subsection (a) by striking clause (iv) in its entirety.

27 SECTION 11. Said section 3 of chapter 176J is hereby amended in paragraph (1) of  
28 subsection (a) by striking clause (v) in its entirety and inserting in place thereof the following:  
29 “(iv) notwithstanding this section, all carriers offering any coverage to any eligible small group  
30 shall make that coverage available to every eligible small group.”

31 SECTION 12. Said section 3 of chapter 176J is hereby amended in paragraph (3) of  
32 subsection (a) by striking the phrase: “eligible individual and”.

33 SECTION 13. Said section 3 of chapter 176J is hereby amended in paragraph (4) of  
34 subsection (a) by striking the phrase: “eligible individuals and”.

35 SECTION 14. Said section 3 of chapter 176J is hereby amended by striking paragraphs  
36 (5) and (6) of subsection (a) in their entirety and inserting in place thereof the following:

37 “(5) The commissioner shall annually file with the United States Department of Health  
38 and Human Services to establish a standard tobacco use factor. A carrier may apply a tobacco  
39 use rate factor in a manner permitted under state and federal law that applies to eligible small  
40 groups; provided, however, that the carrier uses a certification of tobacco use process that has  
41 been approved by the commissioner to determine that eligible small group employees and their  
42 eligible dependents have not used tobacco products within the past year.

43 (6) A carrier may establish a benefit level rate adjustment for all eligible small groups  
44 that shall be expressed as a number. The number shall represent the relative actuarial value of the  
45 benefit level, including the health care delivery network, of the health benefit plan issued to that  
46 eligible small group as compared to the actuarial value of other health benefit plans within that  
47 class of business. If a carrier chooses to establish benefit level rate adjustments, every eligible  
48 small group shall be subject to the applicable benefit level rate adjustment.”.

49 SECTION 15. Said section 3 of chapter 176J is hereby subsection (b) in its entirety, and  
50 inserting in place thereof the following:

51           “(b) (1) A carrier that, as of the close of any preceding calendar year, has a combined  
52 total of 5,000 or more eligible employees and eligible dependents, who are enrolled in health  
53 benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses  
54 pursuant to its license under chapter 176G, shall be required annually to file a plan with the  
55 connector for its consideration, which meets the requirements for the connector seal of approval  
56 pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later  
57 than October 1.

58           (2) A carrier that, as of the close of any preceding calendar year, has a combined total of  
59 5,000 or more eligible employees and eligible dependents, who are enrolled in health benefit  
60 plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to  
61 its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the  
62 connector for its consideration, which meets the requirements for the connector seal of approval  
63 pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later  
64 than October 1.”

65           SECTION 16. Said section 3 of chapter 176J is hereby amended in subsection (c) by  
66 striking the phrase “eligible individual, ”.

67           SECTION 17. Said section 3 of chapter 176J is hereby amended in subsection (d) by  
68 striking the phrase “merged individual and ”.

69           SECTION 18. Section 4 of said chapter 176J is hereby amended by striking paragraph (1)  
70 of subsection (a) in its entirety, and inserting in place thereof the following:

71           “(a)(1) Every carrier shall make available to every small business, including an eligible  
72 small group, a certificate that evidences coverage under a policy or contract issued or renewed to

73 a trust, association or other entity that is not a group health plan, and their eligible dependents,  
74 every health benefit plan that it provides to any other eligible small business. No health plan  
75 shall be offered to an eligible small business unless it complies with this chapter. Upon the  
76 request of an eligible small business, a carrier shall provide that group with a price for every  
77 health benefit plan that it provides to any eligible small business.

78 Except under the conditions set forth in paragraph (2) of subsection (b), each carrier shall  
79 enroll any eligible small business which seeks to enroll in a health benefit plan. Each carrier shall  
80 permit each eligible small business group to enroll all eligible employees and all eligible  
81 dependents; provided, however, that the commissioner shall promulgate regulations which limit  
82 the circumstances under which coverage shall be required to be made available to an eligible  
83 employee who seeks to enroll in a health benefit plan significantly later than when such eligible  
84 employee was initially eligible to enroll in a group plan. Notwithstanding the foregoing, this  
85 section shall not apply to health benefit plans sold exclusively as child-only plans or catastrophic  
86 plans.”

87 SECTION 19. Said section 4 of chapter 176J is hereby amended in paragraph (2) of  
88 subsection (a) by striking the following words: “eligible individuals, as defined by section 1, and  
89 ”.

90 SECTION 20. Said section 4 of chapter 176J is hereby further amended by striking  
91 paragraphs (1) and (2) of subsection (b) in their entirety, and inserting in place thereof the  
92 following:

93 “(1) Notwithstanding any other provision in this section, a carrier may deny an eligible  
94 small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the

95 carrier intends to discontinue selling that health benefit plan to new eligible small businesses. A  
96 health benefit plan closed to new members may be cancelled and discontinued to all members  
97 upon the approval of the commissioner of insurance when such plan has been closed to  
98 enrollment for new small groups and the carrier has complied with the requirements of 42 U.S.C.  
99 Sec. 300gg-12; provided, however, that cancellation of the plan shall be effective on the small  
100 group's next enrollment anniversary after such cancellation is approved by the commissioner of  
101 insurance. The commissioner may promulgate regulations prohibiting a carrier from using this  
102 paragraph to circumvent the intent of this chapter.

103 (2) A carrier shall not be required to issue a health benefit plan to an eligible small  
104 business if the carrier can demonstrate to the satisfaction of the commissioner that within the  
105 prior 12 months, (a) the eligible small business has repeatedly failed to pay on a timely basis the  
106 required health premiums; or, (b) the eligible small business has committed fraud,  
107 misrepresented whether or not a person is an eligible employee, or misrepresented other  
108 information necessary to determine the size of a group, the participation rate of a group, or the  
109 premium rate for a group; or (c) the eligible small business has failed to comply in a material  
110 manner with a health benefit plan provision, including for an eligible small business, compliance  
111 with carrier requirements regarding employer contributions to group premiums. A carrier shall  
112 not be required to issue a health benefit plan to an eligible small business if the small business  
113 fails to comply with the carrier's requests for information which the carrier deems necessary to  
114 verify the application for coverage under the health benefit plan.”

115 SECTION 21. Said section 4 of chapter 176J is hereby amended in paragraph (3) of  
116 subsection (b) by striking the following words: “eligible individual or”.

117 SECTION 22. Said section 4 of chapter 176J is hereby amended by striking paragraph (4)  
118 of subsection (b) in its entirety and inserting in place thereof the following:

119 “(4) Notwithstanding any other provision in this section, a carrier may deny an eligible  
120 small business with 5 or fewer eligible employees enrollment in a health benefit plan unless the  
121 eligible small business enrolls through an intermediary or the connector. If an eligible small  
122 business with 5 or fewer eligible employees elects to enroll through an intermediary or the  
123 connector, a carrier may not deny that eligible small business enrollment. The carrier shall  
124 implement such requirements consistently, treating all similarly situated eligible small businesses  
125 in a similar manner.”

126 SECTION 23. Said section 4 of said chapter 176J is hereby amended by striking  
127 paragraph (4) of subsection (b) in its entirety and inserting in place thereof the following:

128 “(5) Notwithstanding any other provision in this section, with respect to a health benefit  
129 plan offered only through a public exchange that pursuant to federal law and regulation does not  
130 include pediatric dental benefits, a carrier may deny an eligible small business of any size  
131 enrollment in such health benefit plan unless the eligible small business enrolls through the  
132 connector. If an eligible small business elects to enroll through the connector, a carrier may not  
133 deny that eligible small business enrollment. The carrier shall implement such requirements  
134 consistently, treating all eligible small business in a similar manner.”

135 SECTION 24. Said section 4 of chapter 176J is hereby amended in paragraph (2) of  
136 subsection (c) by striking the following: “eligible individual or”.

137 SECTION 25. Said section 4 of chapter 176J is hereby amended in paragraph (3) of  
138 subsection (c) by striking the following: “eligible individual,”.

139 SECTION 26. Section 5 of said chapter 176J is hereby amended by striking the phrase:  
140 “eligible individual.”

141 SECTION 27. Section 6 of said chapter 176J is hereby amended by striking from  
142 subsection (a) the following phrase: “eligible individuals or”.

143 SECTION 28. Said section 6 of chapter 176J is hereby amended by striking from  
144 subsection (b) the following phrase: “and eligible individuals”.

145 SECTION 29. Said section 6 of chapter 176J is hereby amended by striking from  
146 subsection (d) the following phrase: “eligible individuals and”.

147 SECTION 30. Said section 6 of chapter 176J is further amended by striking from  
148 subsection (d) the following phrase: “individuals and”.

149 SECTION 31. Said section 6 of chapter 176J is further amended by striking from  
150 subsection (d) the following phrase: “individual or”.

151 SECTION 32. Said section 6 of chapter 176J is hereby amended by striking from  
152 paragraph (1) of subsection (g) the following phrase: “and individuals”.

153 SECTION 33. Section 7 of said chapter 176J is hereby amended in subsection (b) by  
154 striking the following words each time they appear: “eligible individuals”.

155 SECTION 34. Said section 7 of chapter 176J is further amended in subsection (b) by  
156 striking the following words each time they appear: “eligible individuals or”.

157 SECTION 35. Section 9 of said chapter 176J is hereby amended in clause (iii) of  
158 subsection (k) by striking the following: “eligible individual or”.

159 SECTION 36. Chapter 176J is hereby amended by striking section 10 in its entirety.

160 SECTION 37. Section 11 of said chapter 176J is hereby amended in subsection (a) by  
161 striking the following: “eligible individuals,”.

162 SECTION 38. Said section 11 of chapter 176J is further amended in subsection (a) by  
163 striking the following: “or eligible individuals,”.

164 SECTION 39. Said section 11 of chapter 176J is further amended in subsection (a) by  
165 striking the following: “eligible individuals and”.

166 SECTION 40. Said section 11 of chapter 176J is further amended in subsection (j) by  
167 striking the following: “and eligible individuals”.

168 SECTION 41. Section 12 of said chapter 176J is hereby amended in subsection (h) by  
169 striking the following: “individuals and”.

170 SECTION 42. Section 13 of said chapter 176J is hereby amended in subsection (a) by  
171 striking the following: “eligible individuals,”.

172 SECTION 43. Said section 13 of said chapter 176J is further amended in section (b) by  
173 striking clause (ii) in its entirety.

174 SECTION 44. Chapter 176M is hereby amended by striking section 3 in its entirety and  
175 inserting in place thereof the following:

176 “(a)(1) Every carrier shall make available to every eligible individual a certificate that  
177 evidences coverage under a policy or contract issued or renewed and their eligible dependents,  
178 every health benefit plan that it provides to any other eligible individual. No health plan shall be

179 offered to an eligible individual unless it complies with this chapter. Upon the request of an  
180 eligible individual, a carrier shall provide that individual with a price for every health benefit  
181 plan that it provides to any eligible individual. Except under the conditions set forth in paragraph  
182 (2) of subsection (c), each carrier shall enroll any eligible individual which seeks to enroll in a  
183 health benefit plan. Notwithstanding the foregoing, this section shall not apply to health benefit  
184 plans sold exclusively as child-only plans or catastrophic plans.

185 (2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible  
186 individuals, as defined in section 2741 of the Health Insurance Portability and Accountability  
187 Act of 1996, 42 U.S.C. section 300gg-41(b), into a health plan if those individuals request  
188 coverage within 63 days of termination of any prior creditable coverage. A carrier shall also  
189 enroll eligible individuals, as permitted under the Patient Protection and Affordable Care Act,  
190 Public Law 111-148, and any rules, regulations and guidance's applicable thereto, as amended  
191 from time to time. A carrier shall enable any such eligible individual to renew coverage if that  
192 coverage is available to other eligible individuals. Coverage shall become effective in  
193 accordance with said Patient Protection and Affordable Care Act, and any rules, regulations and  
194 guidance's applicable thereto, as amended from time to time, subject to reasonable verification of  
195 eligibility, and shall be effective through December 31 of that same year. Carriers shall notify  
196 any such eligible individuals that:

197 (i) coverage shall be in effect only through December 31 of the year of enrollment;

198 (ii) if any such eligible individual is in a health plan with a plan-year deductible or out-of-  
199 pocket maximum, an explanation of how that deductible or out-of-pocket maximum and

200 premiums will be impacted for the period between the plan effective date and December 31 of  
201 the enrollment year; and

202 (iii) the next open enrollment period during which any such eligible individual shall have  
203 the opportunity to enroll in a health plan that will begin on January 1 of the following calendar  
204 year.

205 A carrier shall not impose a pre-existing condition exclusion or waiting period of any  
206 duration on a health plan.

207 (b) Notwithstanding paragraph (2) of subsection (a), a carrier shall only enroll an eligible  
208 individual who does not meet the requirements of said paragraph (2) into a health plan during the  
209 annual open enrollment period for eligible individuals and their dependents. The open enrollment  
210 period shall be from October 15 to December 7, inclusive, unless otherwise designated by the  
211 commissioner and coverage shall begin on January 1 of the following year.

212 Notwithstanding this section or any other general or special law to the contrary, the office  
213 of patient protection may administer and grant enrollment waivers to permit enrollment not  
214 during a mandatory open enrollment period to the extent permitted under the federal Patient  
215 Protection and Affordable Care Act, or any rules, regulations or guidance's applicable thereto,  
216 and in accordance with chapter 6D and any other applicable laws.

217 (c)(1) Notwithstanding any other provision in this section, a carrier may deny an eligible  
218 individual enrollment in a health benefit plan if the carrier certifies to the commissioner that the  
219 carrier intends to discontinue selling that health benefit plan to new eligible individuals. A health  
220 benefit plan closed to new members may be cancelled and discontinued to all members upon the  
221 approval of the commissioner of insurance when such plan has been closed to enrollment for

222 new individuals and the carrier has complied with the requirements of 42 U.S.C. Sec. 300gg-12;  
223 provided, however, that cancellation of the plan shall be effective on the individual's next  
224 enrollment anniversary after such cancellation is approved by the commissioner of insurance.  
225 The commissioner may promulgate regulations prohibiting a carrier from using this paragraph to  
226 circumvent the intent of this chapter.

227 (2) A carrier shall not be required to issue a health benefit plan to an eligible individual if  
228 the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12  
229 months, (a) the eligible individual has repeatedly failed to pay on a timely basis the required  
230 health premiums; or, (b) the eligible individual has committed fraud, misrepresented whether or  
231 not a person is an eligible individual; or (c) the eligible individual has failed to comply in a  
232 material manner with a health benefit plan provision; or (d) the eligible individual voluntarily  
233 ceases coverage under a health benefit plan; provided that the carrier shall be required to credit  
234 the time such person was covered under prior creditable coverage provided by a carrier if the  
235 previous coverage was continuous to a date not more than 63 days prior to the date of the request  
236 for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible  
237 individual if the individual fails to comply with the carrier's requests for information which the  
238 carrier deems necessary to verify the application for coverage under the health benefit plan.

239 (3) A carrier shall not be required to issue a health benefit plan to an eligible individual if  
240 the carrier can demonstrate to the satisfaction of the commissioner that acceptance of an  
241 application or applications would create for the carrier a condition of financial impairment, and  
242 the carrier makes such a demonstration to the same commissioner.

243 (4) Notwithstanding any other provision in this section, a carrier may deny an eligible  
244 individual enrollment in a health benefit plan unless the eligible individual enrolls through an  
245 intermediary or the connector. If an eligible individual elects to enroll through an intermediary or  
246 the connector, a carrier may not deny that eligible individual enrollment. The carrier shall  
247 implement such requirements consistently, treating all similarly situated eligible individuals in a  
248 similar manner.

249 (5) Notwithstanding any other provision in this section, with respect to a health benefit  
250 plan offered only through a public exchange that pursuant to federal law and regulation does not  
251 include pediatric dental benefits, a carrier may deny an eligible individual enrollment in such  
252 health benefit plan unless the eligible individual enrolls through the connector. If an eligible  
253 individual elects to enroll through the connector, a carrier may not deny that eligible individual  
254 or enrollment. The carrier shall implement such requirements consistently, treating all eligible  
255 individuals in a similar manner.

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

259 (2) A carrier shall not be required to renew the health benefit plan of an eligible  
260 individual if the individual: (i) has not paid the required premiums; (ii) has committed fraud,  
261 misrepresented whether or not a person is an eligible individual; (iii) failed to comply in a  
262 material manner with health benefit plan provisions; (iv) fails, at the time of renewal, to satisfy  
263 the definition of an eligible individual.

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

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

271 SECTION 45. Section 5 of said chapter 176M is hereby amended at the end of paragraph  
272 (1) by inserting the following:

273 “For every health benefit plan issued or renewed to eligible individuals a carrier shall  
274 develop a base premium rate. In developing these base premium rates, carriers may offer any rate  
275 basis types, but rate basis types that are offered to any eligible individual shall be offered to  
276 every eligible individual for all coverage issued or renewed.”

277 SECTION 46. Chapter 176M is hereby amended by inserting after section 7 the  
278 following:

279 “Section 8. If a medically necessary and covered service is not available to a member  
280 within the carrier’s provider network, the carrier shall cover the services out-of-network, for as  
281 long as the service is unavailable in-network.

282 Section 9. An insurer offering a tiered network plan shall clearly and conspicuously  
283 indicate, in all promotional and agreement materials, the cost-sharing differences for enrollees in  
284 the various tiers. The commissioner shall adopt regulations to carry out this section.

285           Section 10. To the maximum extent possible, carriers shall attribute every member to a  
286 primary care provider. Members may change their primary care provider, provided that the  
287 member gives notice to the carrier.

288           Section 11. To the extent permissible under applicable state and federal privacy laws,  
289 every carrier shall disclose patient-level data to providers in their network solely for the purpose  
290 of carrying out treatment, coordinating care among providers and managing the care of their own  
291 patient panel; provided, that an individual provider shall only receive patient-level data related to  
292 patients treated by said provider. Patient-level data shall include, but not be limited to, health  
293 care service utilization, medical expenses, and demographics.

294           The division of insurance shall develop procedures and a standard format for disclosing  
295 such patient-level information. The division may require carriers to disclose such information  
296 through the all-payer claims database established under section 12 of chapter 12C if the division  
297 and the center for health information and analysis determine that the all-payer claims database is  
298 an efficient means to provide such information.

299           Carriers shall make available to any provider with whom they have entered into an  
300 alternative payment contract, the contracted prices of individual health care services within such  
301 payer's network for the purpose of referrals.”