

**SENATE . . . . . No. 565**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

***Michael O. Moore***

*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:

*Michael O. Moore*

DISTRICT/ADDRESS:

*Second Worcester*

**SENATE . . . . . No. 565**

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By Mr. Moore, a petition (accompanied by bill, Senate, No. 565) of Michael O. Moore for legislation to alleviate health care burdens for Massachusetts employers. Financial Services.

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[SIMILAR MATTER FILED IN PREVIOUS SESSION  
SEE SENATE, NO. 535 OF 2015-2016.]

**The Commonwealth of Massachusetts**

\_\_\_\_\_  
**In the One Hundred and Ninetieth General Court  
(2017-2018)**  
\_\_\_\_\_

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 chapter 176J of the General Laws, as appearing in the 2014  
2 Official Edition, is hereby amended by striking out the definition of “Eligible individual”.

3 SECTION 2. Said section 1 of said chapter 176J, as so appearing, is hereby further  
4 amended by striking out the words “an individual or group”, each time they appear, and inserting  
5 in place thereof, in each instance, the following words:- “a group”.

6 SECTION 3. Said section 1 of said chapter 176J, as so appearing, is hereby further  
7 amended by striking out the first sentence and inserting in place thereof the following sentence:-  
8 "Health benefit plan", any general, blanket or group policy of health, accident and sickness  
9 insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued  
10 by a non-profit hospital service corporation under chapter 176A; a group medical service plan

11 issued by a nonprofit medical service corporation under chapter 176B; and a group health  
12 maintenance contract issued by a health maintenance organization under chapter 176G.

13 SECTION 4. Section 2 of said chapter 176J, as so appearing, is hereby amended by  
14 striking out the words “and all health benefit plans issued, made effective, delivered or renewed  
15 to any eligible individual on or after July 1, 2007,”.

16 SECTION 5. Said chapter 176J is hereby further amended by striking out section 3, as so  
17 appearing, and inserting in place thereof the following section:-

18 Section 3. (a) (1) For every health benefit plan issued or renewed to eligible small groups,  
19 including a certificate issued to eligible small groups that evidences coverage under a policy or  
20 contract issued or renewed to a trust, association or other entity that is not a group health plan, a  
21 carrier shall develop a group base premium rate that is for eligible small groups. In developing  
22 these small group base premium rates, carriers:

23 (i) with respect to the group base premium rate developed for eligible small groups, a  
24 carrier shall consider all enrollees in those health plans, other than grandfathered health plans,  
25 offered by such carrier to be members of the small group risk pool;

26 (ii) in calculating the premium to be charged to each eligible small group, a carrier shall  
27 develop a base premium and use only those rate adjustment factors identified in this section,  
28 inclusive, for all insured health benefit plans offered to eligible small groups, with all other  
29 rating adjustments being prohibited;

30 (iii) may offer any rate basis types, but rate basis types that are offered to any eligible  
31 small group shall be offered to every eligible small group for all coverage issued or renewed;

32 provided, however, that if an eligible small group does not meet a carrier's minimum or  
33 participation contribution requirements, the carrier may separately rate each employee as an  
34 eligible individual, as set forth in section 1 of chapter 176M;

35 (iv) notwithstanding this section, all carriers offering any coverage to any eligible small  
36 group shall make that coverage available to every eligible small group.

37 (2) The commissioner shall annually file with the United States Department of Health  
38 and Human Services to establish a standard age rate adjustment factor table so that the ratio of  
39 the highest factor for adults over age 20 compared to the lowest factor for adults over age 20  
40 shall not exceed a ratio of 2-to-1. A carrier that elects to apply standard age rate adjustment  
41 factors shall apply them based upon the covered person's age when the coverage period begins.

42 (3) The commissioner shall annually file with the United States Department of Health  
43 and Human Services to establish not more than 7 distinct regions of the state for the purposes of  
44 area rate adjustments. A carrier may establish an area rate adjustment for each distinct region, the  
45 value of which shall range from .8 to 1.2. If a carrier chooses to apply area rate adjustments,  
46 every eligible small group within each area shall be subject to the applicable area rate  
47 adjustment.

48 (4) A carrier shall establish a basis type rate adjustment factor for eligible small groups  
49 which shall vary the rate only on the basis of whether the health benefit plan covers an individual  
50 or family. For purposes of this section, the total premium for family coverage must be  
51 determined by summing the premiums for each individual family member. With respect to  
52 family members under the age of 21, the premiums for not more than the 3 oldest covered  
53 children must be taken into account in determining the total family premium.

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

60 (b) (1) A carrier that, as of the close of any preceding calendar year, has a combined total  
61 of 5,000 or more eligible employees and eligible dependents, who are enrolled in health benefit  
62 plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to  
63 its license under chapter 176G, shall be required annually to file a plan with the connector for its  
64 consideration, which meets the requirements for the connector seal of approval pursuant to  
65 section 10 of chapter 176Q; provided, however, that the plan shall be filed not later than October  
66 1.

67 (2) A carrier that, as of the close of any preceding calendar year, has a combined total of  
68 5,000 or more eligible employees and eligible dependents, who are enrolled in health benefit  
69 plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to  
70 its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the  
71 connector for its consideration, which meets the requirements for the connector seal of approval  
72 pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later  
73 than October 1.

74 (c) For the purposes of this section, no eligible employee or eligible dependent shall be  
75 considered to be enrolled in a health benefit plan issued pursuant to a carrier's authority under

76 chapter 175, 176A or 176B if the health benefit plan is sold, issued, delivered, made effective or  
77 renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan  
78 subject to licensure under chapter 176G.

79 (d) The commissioner may conduct an examination with respect to the derivation of  
80 group base premium rates used to develop individual group premiums in order to identify  
81 whether any expenses inappropriately increase the cost in relation to the risks of the small group  
82 health insurance market.

83 SECTION 6. Subsection (a) of section 4 of said chapter 176J, as so appearing, is hereby  
84 amended by striking paragraph (1) and inserting in place thereof the following paragraph:-

85 (a)(1) Every carrier shall make available to every small business, including an eligible  
86 small group, a certificate that evidences coverage under a policy or contract issued or renewed to  
87 a trust, association or other entity that is not a group health plan, and their eligible dependents,  
88 every health benefit plan that it provides to any other eligible small business. No health plan  
89 shall be offered to an eligible small business unless it complies with this chapter. Upon the  
90 request of an eligible small business, a carrier shall provide that group with a price for every  
91 health benefit plan that it provides to any eligible small business.

92 Except under the conditions set forth in paragraph (2) of subsection (b), each carrier shall  
93 enroll any eligible small business which seeks to enroll in a health benefit plan. Each carrier shall  
94 permit each eligible small business group to enroll all eligible employees and all eligible  
95 dependents; provided, however, that the commissioner shall promulgate regulations which limit  
96 the circumstances under which coverage shall be required to be made available to an eligible  
97 employee who seeks to enroll in a health benefit plan significantly later than when such eligible

98 employee was initially eligible to enroll in a group plan. Notwithstanding the foregoing, this  
99 section shall not apply to health benefit plans sold exclusively as child-only plans or catastrophic  
100 plans.

101 SECTION 7. Paragraph (2) of subsection (a) of section 4 of said chapter 176J, as so  
102 appearing, is hereby further amended by striking the following words: “eligible individuals, as  
103 defined by section 1, and ”.

104 SECTION 8. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is  
105 hereby further amended by striking paragraphs (1) and (2) and inserting in place thereof the  
106 following paragraphs:-

107 (1) Notwithstanding any other provision in this section, a carrier may deny an eligible  
108 small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the  
109 carrier intends to discontinue selling that health benefit plan to new eligible small businesses. A  
110 health benefit plan closed to new members may be cancelled and discontinued to all members  
111 upon the approval of the commissioner of insurance when such plan has been closed to  
112 enrollment for new small groups and the carrier has complied with the requirements of 42 U.S.C.  
113 Sec. 300gg-12; provided, however, that cancellation of the plan shall be effective on the small  
114 group's next enrollment anniversary after such cancellation is approved by the commissioner of  
115 insurance. The commissioner may promulgate regulations prohibiting a carrier from using this  
116 paragraph to circumvent the intent of this chapter.

117 (2) A carrier shall not be required to issue a health benefit plan to an eligible small  
118 business if the carrier can demonstrate to the satisfaction of the commissioner that within the  
119 prior 12 months, (a) the eligible small business has repeatedly failed to pay on a timely basis the

120 required health premiums; or, (b) the eligible small business has committed fraud,  
121 misrepresented whether or not a person is an eligible employee, or misrepresented other  
122 information necessary to determine the size of a group, the participation rate of a group, or the  
123 premium rate for a group; or (c) the eligible small business has failed to comply in a material  
124 manner with a health benefit plan provision, including for an eligible small business, compliance  
125 with carrier requirements regarding employer contributions to group premiums. A carrier shall  
126 not be required to issue a health benefit plan to an eligible small business if the small business  
127 fails to comply with the carrier's requests for information which the carrier deems necessary to  
128 verify the application for coverage under the health benefit plan.

129 SECTION 9. Paragraph (3) of subsection (b) of said section 4 of said chapter 176J, as so  
130 appearing, is hereby further amended by striking out the words “eligible individual or”.

131 SECTION 10. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is  
132 hereby further amended by striking out paragraph (4) and inserting in place thereof the following  
133 paragraph:-

134 (4) Notwithstanding any other provision in this section, a carrier may deny an eligible  
135 small business with 5 or fewer eligible employees enrollment in a health benefit plan unless the  
136 eligible small business enrolls through an intermediary or the connector. If an eligible small  
137 business with 5 or fewer eligible employees elects to enroll through an intermediary or the  
138 connector, a carrier may not deny that eligible small business enrollment. The carrier shall  
139 implement such requirements consistently, treating all similarly situated eligible small businesses  
140 in a similar manner.



141 SECTION 11. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is  
142 hereby further amended by striking out paragraph (5) and inserting in place thereof the following  
143 paragraph:-

144 (5) Notwithstanding any other provision in this section, with respect to a health benefit  
145 plan offered only through a public exchange that pursuant to federal law and regulation does not  
146 include pediatric dental benefits, a carrier may deny an eligible small business of any size  
147 enrollment in such health benefit plan unless the eligible small business enrolls through the  
148 connector. If an eligible small business elects to enroll through the connector, a carrier may not  
149 deny that eligible small business enrollment. The carrier shall implement such requirements  
150 consistently, treating all eligible small business in a similar manner.

151 SECTION 12. Paragraph (2) of subsection (c) of said section 4 of said chapter 176J, as so  
152 appearing, is hereby further amended by striking out the words “eligible individual or”.

153 SECTION 13. Paragraph (3) of subsection (c) of said section 4 of said chapter 176J, as so  
154 appearing, is hereby further amended by striking out the words “eligible individual,”.

155 SECTION 14. Section 5 of said chapter 176J, as so appearing, is hereby amended by  
156 striking the words “eligible individuals”.

157 SECTION 15. Section 6 of said chapter 176J, as so appearing, is hereby amended by  
158 striking out, in lines 3 and 4, the words “eligible individuals or”.

159 SECTION 16. Said section 6 of chapter 176J, as so appearing, is hereby further amended  
160 by striking out, in line 16, the words: “and eligible individuals”.

161 SECTION 17. Said section 6 of chapter 176J, as so appearing, is hereby further amended  
162 by striking out, in line 78, the words “eligible individuals and”.

163 SECTION 18. Said section 6 of chapter 176J, as so appearing, is hereby further amended  
164 by striking out, in lines 79, 80 and 81, the words “individuals and”.

165 SECTION 19. Said section 6 of chapter 176J, as so appearing, is hereby further amended  
166 by striking out, in line 84, the words “individual or”.

167 SECTION 20. Said section 6 of chapter 176J, as so appearing, is hereby further amended  
168 by striking out, in line 101, the words “and individuals”.

169 SECTION 21. Subsection (b) of section 7 of said chapter 176J, as so appearing, is hereby  
170 amended by striking out, in line 15 and 16, the words “eligible individuals,”.

171 SECTION 22. Subsection (b) of said section 7 of said chapter 176J, as so appearing, is  
172 hereby further amended by striking out, in line 18, the words “eligible individuals or”.

173 SECTION 23. Clause (iii) of subsection (k) of section 9 of said chapter 176J, as so  
174 appearing, is hereby amended by striking out the words “eligible individual or”.

175 SECTION 24. Section 10 of said chapter 176J is hereby repealed.

176 SECTION 25. Subsection (a) of section 11 of said chapter 176J, as so appearing, is  
177 hereby amended by striking out clause (ii) and inserting in place thereof the following clause:-

178 (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more  
179 eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued,

180 delivered, made effective or renewed to qualified small businesses, shall offer to all small  
181 businesses in at least 1 geographic area at least 1 plan with either:

182 SECTION 26. Subsection (h) of section 12 of said chapter 176J, as so appearing, is  
183 hereby amended by striking out the words “individuals and”.

184 SECTION 27. Subsection (a) of section 13 of said chapter 176J, as so appearing, is  
185 hereby amended by striking out the words “eligible individuals,”.

186 SECTION 28. Subsection (b) of said section 13 of said chapter 176J, as so appearing, is  
187 hereby further amended by striking clause (ii).

188 SECTION 29. Chapter 176M is hereby amended by striking section 3, as appearing in the  
189 2012 Official Edition, and inserting in place thereof the following section:-

190 Section 3. (a)(1) Every carrier shall make available to every eligible individual a  
191 certificate that evidences coverage under a policy or contract issued or renewed and their eligible  
192 dependents, every health benefit plan that it provides to any other eligible individual. No health  
193 plan shall be offered to an eligible individual unless it complies with this chapter. Upon the  
194 request of an eligible individual, a carrier shall provide that individual with a price for every  
195 health benefit plan that it provides to any eligible individual. Except under the conditions set  
196 forth in paragraph (2) of subsection (c), each carrier shall enroll any eligible individual which  
197 seeks to enroll in a health benefit plan. Notwithstanding the foregoing, this section shall not  
198 apply to health benefit plans sold exclusively as child-only plans or catastrophic plans.

199 (2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible  
200 individuals, as defined in section 2741 of the Health Insurance Portability and Accountability

201 Act of 1996, 42 U.S.C. section 300gg-41(b), into a health plan if those individuals request  
202 coverage within 63 days of termination of any prior creditable coverage. A carrier shall also  
203 enroll eligible individuals, as permitted under the Patient Protection and Affordable Care Act,  
204 Public Law 111-148, and any rules, regulations and guidances applicable thereto, as amended  
205 from time to time. A carrier shall enable any such eligible individual to renew coverage if that  
206 coverage is available to other eligible individuals. Coverage shall become effective in  
207 accordance with said Patient Protection and Affordable Care Act, and any rules, regulations and  
208 guidances applicable thereto, as amended from time to time, subject to reasonable verification of  
209 eligibility, and shall be effective through December 31 of that same year. Carriers shall notify  
210 any such eligible individuals that:

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

212 (ii) if any such eligible individual is in a health plan with a plan-year deductible or out-of-  
213 pocket maximum, an explanation of how that deductible or out-of-pocket maximum and  
214 premiums will be impacted for the period between the plan effective date and December 31 of  
215 the enrollment year; and

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

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

221 (b) Notwithstanding paragraph (2) of subsection (a), a carrier shall only enroll an eligible  
222 individual who does not meet the requirements of said paragraph (2) into a health plan during the

223 annual open enrollment period for eligible individuals and their dependents. The open enrollment  
224 period shall be from October 15 to December 7, inclusive, unless otherwise designated by the  
225 commissioner and coverage shall begin on January 1 of the following year.

226 Notwithstanding this section or any other general or special law to the contrary, the office  
227 of patient protection may administer and grant enrollment waivers to permit enrollment not  
228 during a mandatory open enrollment period to the extent permitted under the federal Patient  
229 Protection and Affordable Care Act, or any rules, regulations or guidances applicable thereto,  
230 and in accordance with chapter 6D and any other applicable laws.

231 (c)(1) Notwithstanding any other provision in this section, a carrier may deny an eligible  
232 individual enrollment in a health benefit plan if the carrier certifies to the commissioner that the  
233 carrier intends to discontinue selling that health benefit plan to new eligible individuals. A health  
234 benefit plan closed to new members may be cancelled and discontinued to all members upon the  
235 approval of the commissioner of insurance when such plan has been closed to enrollment for  
236 new individuals and the carrier has complied with the requirements of 42 U.S.C. Sec. 300gg-12;  
237 provided, however, that cancellation of the plan shall be effective on the individual's next  
238 enrollment anniversary after such cancellation is approved by the commissioner of insurance.  
239 The commissioner may promulgate regulations prohibiting a carrier from using this paragraph to  
240 circumvent the intent of this chapter.

241 (2) A carrier shall not be required to issue a health benefit plan to an eligible individual if  
242 the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12  
243 months, (a) the eligible individual has repeatedly failed to pay on a timely basis the required  
244 health premiums; or, (b) the eligible individual has committed fraud, misrepresented whether or

245 not a person is an eligible individual; or (c) the eligible individual has failed to comply in a  
246 material manner with a health benefit plan provision; or (d) the eligible individual voluntarily  
247 ceases coverage under a health benefit plan; provided that the carrier shall be required to credit  
248 the time such person was covered under prior creditable coverage provided by a carrier if the  
249 previous coverage was continuous to a date not more than 63 days prior to the date of the request  
250 for the new coverage. A carrier shall not be required to issue a health benefit plan to an eligible  
251 individual if the individual fails to comply with the carrier's requests for information which the  
252 carrier deems necessary to verify the application for coverage under the health benefit plan.

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

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

263 (5) Notwithstanding any other provision in this section, with respect to a health benefit  
264 plan offered only through a public exchange that pursuant to federal law and regulation does not  
265 include pediatric dental benefits, a carrier may deny an eligible individual enrollment in such  
266 health benefit plan unless the eligible individual enrolls through the connector. If an eligible

267 individual elects to enroll through the connector, a carrier may not deny that eligible individual  
268 or enrollment. The carrier shall implement such requirements consistently, treating all eligible  
269 individuals in a similar manner.

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

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

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

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

285 SECTION 30. Section 5 of said chapter 176M is hereby amended by inserting after the  
286 first paragraph the following paragraph:-

287 For every health benefit plan issued or renewed to eligible individuals a carrier shall  
288 develop a base premium rate. In developing these base premium rates, carriers may offer any rate  
289 basis types, but rate basis types that are offered to any eligible individual shall be offered to  
290 every eligible individual for all coverage issued or renewed.

291 SECTION 31. Chapter 176M of the General Laws is hereby amended by inserting after  
292 section 7 the following 4 sections:-

293 Section 8. If a medically necessary and covered service is not available to a member  
294 within the carrier's provider network, the carrier shall cover the services out-of-network, for as  
295 long as the service is unavailable in-network.

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

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

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



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

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