An Act Providing Access to Affordable, Quality, Accountable Health Care

Conference Committee Report

Section-by-Section Summary

Bill Section	MGL Chp	MGL Sec	Description
0			Emergency Preamble
1			Appropriation language
2			Contains FY06 supplemental spending of $15.45 million related to bill.
2A			Contains FY06 supplemental spending of $14.55 million related to bill.
3	6A	16J-L	Creates a Health Care Quality and Cost Council that will promote health care quality improvement and cost containment.
	6A	16M	Creates a MassHealth Payment Policy Advisory Board to review and evaluate Medicaid rates and rate methodologies, especially rates paid to Community Health Centers.
	6A	16N	Creates a special commission to study the feasibility of reducing or eliminating the surcharge payor assessment paid by insurers and self-insured employers into the Free Care Pool.
	6A	16*O*	Creates a Health Disparities Council within EOHHS to make recommendations to reduce racial and ethnic health disparities in the Commonwealth
4	10	35M	Allows Board of Registration in Medicine Trust funds to carry over into the next fiscal year.
5	17	3	Changes composition of Public Health Council to include members from public health schools, providers, and health advocates, none of whom will be appointed by the Governor.
6	26	7A	Creates a new Health Access Bureau within the Division of Insurance with responsibility for oversight of the small group and individual health insurance market and affordable health plans.
6A	26	7B	Establishes a database within the Bureau to track insurance coverage for purposes of complying with the individual mandate. All insurers must report monthly coverage to the Bureau for this database and the information will be shared with DOR.
7	26	8H	Directs the Division of Insurance, in consultation with the Connector, to establish and publish annually minimum standards for health insurance products.
8	29	2*OOO*	Creates a Commonwealth Care Trust Fund that will receive revenue generated from the Fair Share Contribution, the Free Rider Surcharge, and other revenue that will be used to pay for subsidized health insurance and Medicaid rate increases.
	29	2PPP	Creates an Essential Community Provider Trust Fund that will replace the current Distressed Provider Fund. Funds will be used to make grant payments to hospitals and community health centers in accordance with criteria established by the new Health Safety Net Office.
	29	2QQQ	Technical change that reestablishes an existing fund used to maximize federal reimbursements.
	29	2RRR	Technical change that reestablishes an existing fund used to make payments to DMR facilities.
9	32	1	Allows board members of the Connector to receive pension benefits

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10	62	1	Changes current tax law definition of "Code" so that it includes section 223 of the Internal Revenue Code, which creates a deduction for health savings accounts.
11	111	24K	Establishes a pediatric palliative care program, administered by Public Health, to serve children with life-threatening illness, and their families.
12	111M*		Individual Mandate. Adds a new chapter 111M, establishing a requirement that residents for whom an affordable health insurance product is available must have "creditable coverage."
		1	Defines "creditable coverage" as a qualifying health plan type as listed in section and to be further defined by the board of the Connector. Also defines "resident" for purposes of the individual mandate.
		2	Establishes the procedure for implementation of the individual mandate. Effective July 1, 2007, qualifying individuals for whom "creditable coverage" is deemed affordable must have "creditable coverage" in place. Individuals must include information about health insurance status on their tax forms. Failure to meet the insurance requirement will result in a penalty, assessed by the department of revenue, which will be the loss of the personal exemption for tax year 2007. All penalties will be deposited in the Commonwealth Care Trust Fund.
		3	Establishes an exemption for individuals whose religious beliefs prevent them from using medical health care.
		4	Establishes a hardship exemption process.
		5	Authorizes the commissioner of revenue to promulgate regulations to carry out the individual mandate.
13	111M	2b	Creates a penalty for non-compliance with the individual mandate as equal to 50% of an available premium cost for each month the individual was not adequately covered beginning January 1, 2008.
14	118E	6	Requires Office of Medicaid to report on the previous year's activities of the Medical Care Advisory Committee.
15	118E	9A	Raises eligibility for children receiving MassHealth from 200% FPL to 300% FPL. Effective July 1, 2006
16	118E	9A	Prevents MassHealth from establishing disability criteria for determining eligibility that is more restrictive than the federal Social Security standard
17	118E	9A	Places in statute MassHealth eligibility standards for people with HIV at 200% FPL
18	118E	9A	Adds a new clause to require the Office of Medicaid to provide a monthly list of MassHealth-enrolled individuals for whom they provided "creditable coverage" to the DOI
19	118E	9C	Expands employee eligiblity for participation in Insurance Partnership Program to 300% FPL.
20	118E	9C	Ensures that Insurance Partnership subsidies are consistent with those provided under Commonwealth Care subsidy program.
21	118E	9C	Ensures that Insurance Partnership subsidies are consistent with those provided under Commonwealth Care subsidy program.
22	118E	9C	Specifies that self-employed individuals enrolled in the Insurance Partnership Program are eligible for employee subsidy only.

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23	118E	9C	Specifies that self-employed individuals enrolled in the Insurance Partnership Program are eligible for employee subsidy only.
24	118E	12	States that MassHealth must provide public hearing and notice before restricting eligibility or benefits.
25	118E	13B	Makes Medicaid rate increases for hospitals contingent on hospitals' meeting certain quality standards and performance benchmarks.
26	118E	16C	Expands S-CHIP eligibility for children from 200% FPL to 300% FPL.
27	118E	16D	Places in statute MassHealth Essential eligibility for elderly and disabled special status immigrants, and prohibits sponsor deeming.
28	118E	23	Technical language change.
29	118E	53	Restores all MassHealth benefits cut in 2002, including dental, vision, chiropractic, and prosthetics, effective July 1, 2006.
	118E	54	Creates a Wellness Program for MassHealth recipients to encourage healthy outcomes by reducing premiums as goals are met
30	118E	55	Health Safety Net Office definitions
	118E	56	Creates Health Safety Net Office to replace current Uncompensated Care Pool administration.
	118E	57	Creates a Health Safety Net Trust Fund, to replace the current Uncompensated Care Trust Fund and Pool.
	118E	58	Sets out provisions concerning hospital liability to fund (similar to current provisions in MGL 118G:18).
	118E	59	Sets out provisions concerning surcharge payor liablity to fund (similar to current MGL 118G:18A).
	118E	60	Sets out provisions concerning remibursements to hospitals and community health centers from Health Safety Net Trust Fund.
31	118G	1	Technical language change.
32	118G	1	Adds definition of "non-providing employer" for purpose of Free Rider surcharge.
33	118G	1	Adds definition of "payments from non-providing employers" for purpose of Free Rider surcharge.
34	118G	1	Technical language change.
35	118G	1	Adds definition of "state-funded employee" for purpose of Free Rider surcharge.
36	118G	1	Technical language change.
37	118G	2	Technical language change.
38	118G	2	Technical language change.
39	118G	3	Technical language change.
40	118G	5	Technical language change.
41	118G	6	Requires hospitals' uniform reporting to Division of Health Care Finance and Policy to include names and addresses of employers whose employees receive free care.
42	118G	6B	Requires applicants for free care to be enrolled in other publicly-funded health programs, if eligible; applicants deemed ineligible for such programs are required to provide the name and address of their employer and their own identifying information, including social security number.

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		6C	Requires every employer and employee doing business in Massachusetts to sign, under oath, a Health Insurance Responsibility Disclosure form indicating whether the employer has offered insurance and whether the employee has accepted or declined it.
43	118G	18-18A	Technical language change.
44	118G	18B	Sets out provisions governing assessment of Free Rider surcharge on non-providing employers.
45	118H		Creates the Commonwealth Care Health Insurance program, which will provide subsidized insurance to people with incomes under 300% FPL who are not eligible for other publicly-funded programs. Subsidies will be paid based on a sliding scale for eligible plans that are procured by the Commonwealth Health Insurance Connector. The new chapter provides that enrolles with incomes under 100% FPL will not pay premiums or deductibles, and also contains other language protections for all enrollees.
46	149	6D 1/2	Prohibits employers from penalizing employees who use free care.
47	149	188	Creates the Fair Share Contribution, to be paid by employers who do not provide or make a reasonable contribution to health insurance for their employees. The contribution requirement will apply to employers with 11 or more employees, will be pro-rated for part-time employees, and will be capped at $295 per employee.
48	151F		Establishes the requirement that all employers with more than 10 employees must maintain a Section 125 plan to give employees access to pre-tax health insurance payments. Employers who do not comply will be faced with a fine.
49	175	108	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
50	175	110	Insurers offering blanket or group insurance policies may only sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
51	175	110M	Requires commercial insurers to provide a monthly list to DOI of residents for whom they provided "creditable coverage" for the previous month.
52	176A	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 to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.

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53	176A	8Z	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
54	176A	34	Requires non-profit hospital services to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
55	176B	3B	A medical service corp can offer a group medical service agreement sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
56	176B	4Z	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
57	176B	22	Requires medical service corps to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
58	176G	4R	Require family policies to maintain children up to age 25 or for 2 years past "loss of dependent status", whichever occurs first.
59	176G	6A	An HMO may only sell to employers if the insurance is offered to all full-time employees and the employer must offer to cover the same premium contribution percentage for each employee, allowing, however greater contribution percentages to lower paid employees and separate percentages for employees with collective bargaining agreements. This policy is intended to prevent employers from offering different health plans to different classes of workers or dropping coverage for certain workers.
60	176G	16A	An HMO can include a maximum deductible consistent with the maximum contribution requirements allowed for a federally-established Health Savings Account (HSA)
60A		16B	Allows HMOs to offer Coverage for Young Adult plans as long as the provisions are consistent with those established for those plans.
61	176G	30	Requires HMOs to provide a monthly list to the Group Insurance Commission of residents for whom they provided "creditable coverage" for the previous month.
62	176J	1	Eliminates "case characteristics" from the determination of "Adjusted average market premium rates" and uses "rate basis type" in its place. (In compliance with HIPAA)
63	176J	1	Establishes a "Base premium rate" as a midpoint rate for each rate basis type for each health benefit plan offered by a carrier.
64	176J	1	Modifies "benefit level" to include the service delivery and network of a health benefit plan
65	176J	1	Eliminates preferred provider arrangements (176I) from being considered carriers for the non-group and small group market.

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66	176J	1	Eliminates "case characteristics" from being used in determination of pricing of health benefit plans leaving "rate basis type" as the primary price differentiation method.
67	176J	1	Adds definitions for "Connector Seal of Approval" regarding approval of the value of benefit plans by the Connector. Also defines "creditable coverage" for individuals as any one of eleven types of health coverage including group health plans, federal employee and military plans, Medicare and Medicaid plans, and any other plans that meet HIPAA requirements.
68	176J	1	Defines an "eligible individual" for health insurance as a resident of the Commonwealth
69	176J	1	Extends the definition of "eligible small business" to include as one affiliated companies with the "same corporate parent".
70	176J	1	Includes small businesses within a MEWA (multiple employer welfare agreement) in the definition of "eligible small business"
71	176J	1	Clarifies "emergency services" to include mental medical conditions and assistance to pregnant women.
72	176J	1	Adds consideration for rates of "eligible individuals and their dependents" (residents of MA) in setting "Group average premium rates"
73	176J	1	Adds tobacco usage as a factor for consideration in setting group base premium rates.
74	176J	1	Defines "group health plan" as "an employee welfare benefit plan" with specification given to defining medical care.
75	176J	1	Redefines "health benefit plan" to exclude MEWA (multiple employer welfare agreements) from being included in this definition. The definition further excludes hospital indemnity insurance polities if offered separately from a coordinated benefit plan, specific disease insurance purchased to supplement a health plan, and also excludes student health plans from this definition. The commissioner is given the authority to modify this definition.
76	176J	1	Adds a definition for "modified community rate" defining how carriers must offer the same premiums to members within a particular rate basis type and can only vary premiums on age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level. Specifically, this section adds wellness program usage and tobacco usage as rating categories.
77	176J	1	Specifies that genetic information in the absence of a related condition cannot be used against an individual as a preexisting condition. Eliminates prototype plans as it pertains to HMOs.
78	176J	1	Adds tobacco usage as insurance "rating factors"
79	176J	1	Provides a definition for "resident" as a "natural person living in the commonwealth" but providing exclusions for individuals to qualify as residents based upon their confinement to a MA nursing home or hospital. Also defines "Trade Act/Health Coverage Tax Credit" to allow affected individuals to qualify for federal funds.
80	176J	1	Requires providers to pay for emergency services during an insured's "waiting period" if a waiting period exists within the health benefit plan.

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81	176J	2	Opens the small group market to accept nongroup members as "eligible individuals" as of July 1, 2007.
82	176J	3	Changes requirements health benefit plans must meet with regard to premium setting and rate basis types. This section establishes a maximum rate band range from .66 to 1.32 for the following factors: age, industry, participation-rate, wellness program rate, and tobacco use rate. Additionally, carriers can apply only the following factors outside of the rating band in establishing premiums: benefit level, geographic region, adjustment for eligible individual rather than small group, and group size adjustment. Additionally, requirements are laid out for which carriers with 5,000 or more members will be required to file a plan with the Connector to be considered for the "Connector Seal of Approval."
83	176J	4	Modifies the current requirement of carriers to make health benefit plans available in the following ways: Requires carriers to offer coverage effective within 30 days to any eligible individuals if they request coverage within 63 days of prior creditable coverage. If the 63 day period has lapsed, carriers must offer coverage to eligible individuals but may impose a 6 month exclusion of coverage for pre-existing conditions and a 4 month waiting period for receipt of services with the exception of emergency services which must be covered. However, plans offered to individuals without coverage for 18 months prior to application may not be subjected to a waiting period. Additionally, a carrier can deny enrollment in any plan if the carrier files proof of intent to stop selling that plan with the Commissioner. Carriers can require individuals or groups of 1-5 to enroll in plans via the Connector or an intermediary.
84	176J	5	Specifies that plans offered to Trade Act/ Health Coverage Tax Credit eligible persons may not include a waiting period of more than 3 months or a pre-existing condition exclusion. This brings these plans in line with federal regulations for federal reimbursement for qualifying individuals. Increases the period in which an eligible individual, employee, or dependent may go without coverage from thirty days to 63 days before a pre-existing condition may be excluded from coverage. Decreases the waiting period in which a newly insured member must wait for coverage from six months to four months. Eliminates waiting periods entirely for eligible individuals who have had no creditable coverage for the past 18 months. Specifies defined "creditable coverage" rather than general "coverage".
85	176J	6	Incorporates "eligible individuals" into those eligible for plans in the merged market
86	176J	6	Allows plans to offer restricted networks that differ from the overall carrier's network.
87	176J	7	Requires electronic filing of rates and notification to DOI of actuarial methodology and any relevant changes prior to filing.
88	176J	8	Requires the governing committee of the carrier-funded small-group reinsurance plan to establish a plan to phase out the program by June 2007.

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89	176J	9	Adds "eligible individuals" to those who do not qualify for "continuous coverage"
90	176J	10	Establishes "Coverage for Young Adults" as a health plan with exact specifications to be set by DOI. Only individuals between 19 & 26 who do not have employer -sponsored coverage are eligible for these products.
91	176M	1	Ends enrollment opportunities for non-group.
92	176M	1	Provides a definition for "Trade Act/Health Coverage Tax Credit Eligible Persons" to allow those who qualify to receive the federal benefit.
93	176M	3	Ends enrollment opportunities for non-group.
94	176M	3	Ends enrollment in non-group products aside from dependents of current enrollees. Requires nongroup insurers to notify members at least annually of all products and premiums for which they are eligible in the merged market.
95	176M	6	Phase-out proposal for non-group health reinsurance plan
96	176N	1	Defines "emergency services" and "health plan"
97	176N	2	Excludes pregnancy as a pre-existing condition.
98	176N	2	Extends the time an individual can be without coverage from 30 days to 63 days.
99	176N	2	Changes the maximum waiting period on an individual from 6 to 4 months.
100	176N	2	Allows an individual who has been without coverage for 18 months to have no waiting period or pre-existing conditions exclusionary period.
101	176Q		Establishes the Commonwealth Health Insurance Connector Authority (the Connector)
		1	Definitions.
		2	Establishes the Connector as an Authority within the Exec Office of Administration and Finance. Establishes the governance of the Connector with the Secretary of A&F as the director of the 11 member Connector board.
		3	Authorizes actions of the Board including taking actions necessary to offer insurance products to individuals and small businesses, publishing a schedule for premiums at which individuals of varying ages are eligible, establishing a schedule for affordability to be used in enforcing the individual mandate (ch 111M) based upon percentage of income eligible to be spent on health care.
		4	Specifies that the Connector will offer products to eligible individuals and small groups
		5	Establishes the criteria products must meet to receive the Seal of Approval and be offered through the Connector.
		6	Outlines requirements of small businesses who participate in the Connector
		7	Authorizes the Connector to administer Commonwealth Care health insurance program beginning October 1, 2006.
		8	Directs an interagency agreement with the department of revenue for purposes of determining eligibility for commonwealth care.
		9	Allows the GIC to allow employees and contractors into the Connector mechanism.

Bill Section	MGL Chp	MGL Sec	Description
		10	Establishes further criteria for Connector Seal of Approval product specifications
		11	Allows for intermediaries and producers to earn commission on individuals enrolled through the Connector
		12	Connector operations will be financed through surcharge on all Connector health plans
		13	Establishes financial liability of Connector
		14	Reporting requirements for Connector.
		15	Establishes requirements for a study to report on the operations of the Connector
		16	Implementation language
102	Ch 47, Acts of 1997		Extends Fisherman Health Care Demonstration program through 2012.
103	Ch 241 of the Acts of 2004		Repeals Distressed Provider Expendable Trust Fund
104	Acts of 2005	45	Adds language to 4000-0352 item in FY06 budget, regarding MassHealth outreach, to ensure community organizations receive the majority of funds
105			Raises enrollment cap on MassHealth CommonHealth program by 1,600 people
106			Raises enrollment cap on MassHealth HIV+ program by 250 people
107			Raises enrollment cap on MassHealth Essential by 16,000 people, effective July 1, 2006
108			Directs EOHHS to create a 2-year pilot program for smoking cessation benefits for MassHealth enrollees. This program will be funded by the Tobacco Trust Fund.
109			Directs EOHHS to study the creation of selective provider networks
110			Directs DPH to study the role of Community Health Workers, and to develop a sustainable Community Health Worker program
111			Directs EOHHS to seek maximum federal match of State Children's Health Insurance (S-CHIP) funds
112			Directs EOHHS to seek an amendment to the Medicaid 1115 federal wavier, and to seek maximum federal matching funds. Mandates that all negotiations with CMS would necessarily involve members of the House and Senate.
113			Establishes a moratorium on changes to Medicaid behavioral health services, pending a report outlining and justifying proposed changes.
114			Creates a commission to study the merger of the non-group and small-group insurance markets. Report will be filed with legislature by December 2006 with any legislative recommendations which would be useful in implementing the merger.

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115			Provides for an open enrollment period for purchase of health insurance through the Connector.
116			Authorizes transfer of funds to the Massachusetts Technology Park Corporation for implementation of a computerized physician order entry system initiative.
117			Authorizes transfer of balance in Uncompensated Care Trust Fund to Health Safety Net Trust Fund.
118			Authorizes transfer of funds remaining in Distressed Provider Expendable Trust Fund to the Essential Community Provider Trust Fund.
119			Authorizes funding transfer for partial funding reform implementation.
120			Authorizes transfer of funds from Commonwealth Care Fund to Uncompensated Care Trust Fund in FY07.
121			Authorizes transfer of funds for start-up costs for Commonwealth Health Insurance Connector.
122			Authorized continued payments of supplemental funding to Medicaid Managed Care Organizations operated by Cambridge Health Alliance and Boston Medical Center.
123			Provides exclusive rights to Medicaid Managed Care Organizations that are contracting with the state as of July 1, 2006 to offer plans under the Commonwealth Care subsidized insurance program, provided that they meet certain enrollment targets.
124			Sets out hospital and surcharge payor liability; Uncompensated Care Pool distributions for FY07.
125			Continues a moratorium on changes to Uncompensated Care Pool regulations.
126			Repeals above moratorium on Pool regulations, effective October 2007.
127			Establishes a legislative moratorium on new mandated health benefit legislation until the Division of Health Care Finance and Policy completes a comprehensive review of such benefits or until January 1, 2008, whichever is later.
128			Authorized funding for rate increases of $90 million in each of the fiscal years 2007-2009.
129			Directs Secretary of the Executive Office of Health and Human Services to conduct a study determining the cost of allowing primary care family caregivers to obtain MassHealth benefits.
130			Authorizes transfer of revenues from the University of Massachusetts to the state, related to hospital funding.
131			Authorizes transfer of revenues from the University of Massachusetts to the state, related to hospital funding.
132			Directs EOHHS to develop a plan and timeline for implementing health care reform legislation.
133			Directs the Executive Director of the Connector to submit a plan of operation and recommendations for amendments to Chapter 176Q to the Board of the Connector by August, 2006.
134			Directs the Department of Labor and the Division of Health Care Finance and Policy to report on the implementation and impact of the Fair Share Contribution.

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135			Allows hospitals to appeal to receive rate increases before meeting quality standards.
136			Requires website with cost and quality information to be operational by July, 2006.
137			Includes provisions governing the length of terms for the initial members of the Public Health Council.
138			Includes provisions governing the terms of the initial members of the Board of the Commonwealth Health Insurance Connector.
139			Allows individuals to enter into the merged insurance market on and after July 1, 2007.
140			Effective Dates
141			Effective Dates
142			Effective Dates
143			Effective Dates
144			Effective Dates
145			Effective Dates
146			Effective Dates
147			Effective Dates