

Section-by-Section Summary: House Small Business Health Care Bill

Section 1: Studying Mandated Benefits

Requires the Division of Health Care Finance and Policy (DHCFP) to periodically review all mandated benefits to ensure they conform to existing standards of care in terms of clinical appropriateness or evidence-based medicine.

Sections 2, 3: Adding Representation to the Health Care Quality and Cost Council

Increases small business representation on the Council by adding a representative from a small business with fewer than fifty employees. The Council is required to develop annual cost containment goals to promote affordable, high quality, patient-centered health care.

Section 4: Establishing a Disproportionate Share Hospital Trust Fund

Fifty percent of savings from provider rate convergence will be deposited to help Disproportionate Share Hospitals (DSH) reach statewide averages (as established in Section 34).

Sections 5, 6: Overseeing Determination of Need

Gives the Attorney General oversight to protect against needless and/or duplicative capital expenditures contributing to escalating health care costs over time. Also gives the Attorney General authority to review applications to determine adverse impact on competition and any inappropriate increase in utilization of health care services.

Section 7: Tracking and Reporting Quality Information

Increases transparency by requiring the Department of Public Health (DPH) to track and report provider quality metrics.

Section 8: Granting Open Enrollment Waivers

Allows the Office of Patient Protection (OPP) to grant open enrollment waivers to allow, in certain cases, individuals to purchase insurance outside the open enrollment periods.

Sections 9, 10: Defining Transparency/Measurement

Defines “total medical expenses” as the total cost of care for patient population for provider, group per member/per month. Defines “relative prices” as the negotiated payments between carriers and providers adjusted by statewide average. Provides uniformity for comparative cost analysis.

Sections 11, 12: Requiring Data Disclosure

Requires the DHCFP to collect certain data from health care payers and providers including prices paid to providers in a uniform manner. The data from health care payers will be publicly reported on the DHCFP’s website.

Section 13: Protecting Employee Privacy

Further protects information exchanged among the Department of Revenue (DOR), the Commonwealth Health Insurance Connector Authority (Connector), and the Division of Insurance (DOI). Results in penalties for employers who knowingly falsify information.

Sections 14, 15, 16: Allowing Prescription Drug Discounts

Allows patients access to prescription drug discounts to decrease trend in health care costs. Increased cost of co-payments causes patients to fill prescriptions less often, skip doses, and not take medication.

Sections 17, 18: Protecting Against Unfair/Deceptive Business Practices

Protects against “most favored” contract provisions, i.e. cannot contract based on price paid to other provider/carrier. Prevents contracting for the purpose of separating employee from group coverage to reduce employer costs.

Section 19: Preventing Fraud and Abuse Related to Emergency Medical Services

Encourages prompt, direct reimbursement from insurance companies to EMS providers and prevents consumers from being unfairly caught up in complex paperwork when they expect that payment for service go directly to the provider.

Sections 20, 21, 22: Adding Definitions to the Small Group Statute

Defines “direct claims incurred” or “direct premiums earned” for the purpose of calculating medical loss ratios. Redefines “eligible individual” as an individual who is not seeking to replace an employer sponsored plan. Helps protect against jumping in and out of health insurance coverage. Adds definition of “medical loss ratio” to improve disclosure requirements.

Sections 23, 24: Reducing Drastic Consumer Rate Increases

Allows the Commissioner of Insurance to address rate fluctuation as a result of changes in the demographics of a group. The Commissioner can annually smooth rate adjustments to prevent drastic increases in rates for individuals and employers.

Sections 25, 26: Limiting Open Enrollment

Limits open enrollment to twice annually in 2011, once in 2012, and once thereafter. Encourages individuals to buy and keep health insurance and prevents individuals from “gaming the system,” obtaining/dropping coverage for isolated cases.

Sections 27, 32: Simplifying Plans

Carriers may cancel plans that are closed to new individuals and small groups upon approval from the DOI in order to save administrative costs.

Section 28: Strengthening the Commonwealth’s Rate Review Authority

Requires carriers to submit rate filings to the DOI at least ninety days before the effective date with sufficient detail for the DOI to determine if the rates should be disapproved because they are inadequate, excessive or unreasonable in relation to the benefits provided. For a period of two years, if a carrier submits a rate filing requesting an increase over 150 per cent of the prior calendar year’s percentage increase in the consumer price index for medical care services, or if a carrier files a base rate whose administrative expense loading component increases by more than the most recent calendar year’s percentage increase in the employment cost index for the private industry health care and social assistance industry group, as reported by the United States Bureau of Labor Statistics, or if a carrier files an initial base rate request that is greater than the average base rate for actuarially equivalent policies offered by other small group carriers by more than 150 per cent of the prior calendar year’s base premium rate, such carrier’s rate will be presumptively disapproved.

Section 29: Creating Affordable Insurance Choices

Requires every carrier to offer selective network products that are at least 20% cheaper than that carrier's full network product.

Section 30: Establishing Small Business Employee Wellness Initiatives

Establishes employee wellness incentive program under the DPH to improve employee health, decrease employer health costs, and increase productivity. Small businesses that implement programs are eligible for a 5% subsidy.

Section 31: Technical Change

Confirms participation in the Connector if policy is renewed through Connector.

Section 33: Standardizing Accreditation of Carriers

The Bureau of Managed Care with the DOI will adopt national standards for the accreditation of carriers.

Section 34: Enhancing Oversight of Provider Rates

Allows the DHCFP to review contracts for medical services between insurers and hospitals, physician group practices, and imaging service providers to determine if payment increases are appropriate. Beginning in January of 2011, insurance carriers will only be permitted to enter into or renew contracts with health care providers if the provider's increased rate of reimbursement falls within specific parameters based on that provider's rates relative to the carrier's statewide average provider rates. This section also authorizes DHCFP to assess fifty percent of the savings in provider rates of reimbursement for deposit in a Disproportionate Share Hospital Trust Fund. The remaining fifty percent of the savings in provider rates of reimbursement will be incorporated in premium savings to employers.

Section 35: Limiting Period of Oversight of Provider Rates

Sets period of provider oversight as established in Section 34 to four years, until December 31, 2014.

Section 36: Prohibiting Anti-Competitive Practices

Prohibits certain provider/carrier contracting processes. Prevents carriers from forcing all members of a provider group to be in the same tier. Carriers cannot be forced to include all members of a provider group in a select network on an all-or-nothing basis.

Section 37: Adding Definition to the Connector Statute

Redefines "eligible individual" as an individual who is not seeking to replace an employer sponsored plan. Helps protect against jumping in and out of health insurance coverage.

Section 38: Adding Agent Representation to the Connector Board

Adds Massachusetts Association of Health Underwriters (MAHU) member to the Connector Board.

Section 39: Requiring Notice for Changes to Minimum Creditable Coverage

Establishes a ninety day notification window, filed with relevant legislative committees, for changes to regulations defining minimum creditable coverage.

Section 40: Allowing Carrier Flexibility to Participate in Small Group Plans

Allows carriers flexibility to participate in either the small group or individual markets through the Connector.

Section 41: Further Protecting Consumer Information

Prohibits use of data from Department of Revenue for soliciting and advertising.

Section 42: Requiring DOI Reporting

Requires the DOI to notify the legislature of any applications for federal funding under the federal Patient Protection and Affordable Care Act (PPACA) as well as any funding received under such Act.

Section 43: Calculating Medical Loss Ratios

Requires the DOI, in consultation with the DHCFP, to promulgate regulations establishing a uniform method for calculating medical loss ratios.

Section 44: Establishing Uniform Reporting Standards

The DHCFP, in consultation with the DOI, will promulgate regulations to establish uniform reporting health status adjusted total medical expenses.

Section 45: Establishing Uniform Methodology for Reporting Provider Prices

The DHCFP, in consultation with the DOI, will promulgate regulations to establish uniform reporting of methods of calculating and reporting relative prices paid to providers.

Section 46: Establishing New Disclosure Requirements

The DHCFP, in consultation with the DOI, will promulgate regulations for reporting inpatient and outpatients costs under new disclosure requirements.

Section 47: Establishing Health Care Provider Quality Metrics

The DPH will promulgate regulations for a uniform reporting of health care provider quality metrics.

Section 48: Ensuring Open Enrollment Eligibility

Allows individuals to renew coverage in 2010 until the beginning of the 2011 open enrollment period.

Section 49: Establishing an Administrative Simplification Working Group

Establishes an Administrative Simplification Working Group to including both public and private market representatives to report on ways to reduce administrative filing requirements for health care carriers and providers.

Section 50: Studying Health Benefit Plans

Establishes a commission to study the reduction of the number of health plans offered.

Section 51: Considering the Special Needs of Children and Pediatric Patients

Requires differentiation between pediatric and adult patients in comparative data requirements.

Section 52: Studying Carrier Reporting Deadlines

The DOI will study the appropriateness of carrier reporting deadlines.

Section 53: Studying Determination of Need

Establishes a special commission to study the capital needs of community hospitals.

Section 54: Studying Community Hospitals

The DPH will conduct a study of community hospitals, focusing on outmigration of patients.

Section 55: Studying a Uniform Claims Administration System

Establishes a special commission to study the value of a uniform claims administration system for all payers in the Commonwealth.

Section 56: Establishing a Bundled Payments Pilot Program

The DHCFP will institute a pilot program intended to foster the adoption by providers and payers in the commonwealth of arrangements by which providers will contract to accept payment on a bundled, rather than a fee-for-service, basis.

Section 57: Imposing a Moratorium on New Mandated Benefits

Imposes a moratorium on mandated benefits to exclude those that have been subject to DHCFP review.