HOUSE . . . . . No. 4620

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, May 2, 2024.

The committee on Health Care Financing, to whom were referred the petition (accompanied by bill, Senate, No. 725) of Nick Collins for legislation relative to shared responsibility for health care oversight agencies, the petition (accompanied by bill, Senate, No. 728) of Cynthia Stone Creem for legislation to make a technical changes to the Betsy Lehman Center for Patient Safety and Medical Error Reduction enabling statute, the petition (accompanied by bill, Senate, No. 734) of John J. Cronin and Joanne M. Comerford for legislation to update high-cost hospital and Health Policy Commission system accountability, the petition (accompanied by bill, Senate, No. 736) of Julian Cyr, John C. Velis, Michael D. Brady, Adam Scanlon and other members of the General Court for legislation relative to the closing of hospital essential services, the petition (accompanied by bill, Senate, No. 746) of Barry R. Finegold for legislation relative to the operating budgets of health care oversight agencies, the petition (accompanied by bill, Senate, No. 761) of John F. Keenan for legislation relative to hospital closures and health planning, the petition (accompanied by bill, Senate, No. 777) of Paul W. Mark for legislation relative to hospital billing and licensure, the petition (accompanied by bill, Senate, No. 785) of Mark C. Montigny for legislation to ensure timely health care cost reporting, the petition (accompanied by bill, Senate, No. 788) of Michael O. Moore for legislation to prohibit inappropriate use of the health care cost growth benchmark, the petition (accompanied by bill, Senate, No. 789) of Michael O. Moore for legislation relative to hospital price transparency, the petition (accompanied by bill, Senate, No. 790) of Michael O. Moore, Jack Patrick Lewis, Paul R. Feeney and James B. Eldridge for legislation relative to hospital profit and fairness, the petition (accompanied by bill, Senate, No. 801) of Rebecca L. Rausch for legislation to strengthen health spending accountability processes within the health policy commission and the center for health information and analysis, the petition (accompanied by bill, Senate, No. 802) of Michael F. Rush, Vanna

Howard and Paul McMurtry for legislation to improve health care cost accountability, the petition (accompanied by bill, Senate, No. 810) of Bruce E. Tarr for legislation to ensure temporary nursing service agency quality, the petition (accompanied by bill, House, No. 1165) of Ruth B. Balser for legislation to make technical changes to the Betsy Lehman Center for patient safety and medical error reduction enabling statute, the petition (accompanied by bill, House, No. 1174) of Gerard J. Cassidy and others for legislation to ensure temporary nursing service agency quality and accountability, the petition (accompanied by bill, House, No. 1175) of Edward F. Coppinger and others relative to the closing of hospital essential services, the petition (accompanied by bill, House, No. 1179) of Josh S. Cutler and others relative to hospital profit transparency and fairness and the establishment of a Medicaid reimbursement enhancement fund, the petition (accompanied by bill, House, No. 1181) of Michael S. Day for legislation relative to shared responsibility for funding of health care oversight agencies, the petition (accompanied by bill, House, No. 1185) of Paul J. Donato relative to market oversight in health care, the petition (accompanied by bill, House, No. 1189) of Patricia A. Duffy relative to high-cost hospitals and Health Policy Commission system accountability, the petition (accompanied by bill, House, No. 1203) of Kevin G. Honan and Vanna Howard for legislation to improve health care cost accountability, the petition (accompanied by bill, House, No. 1209) of Hannah Kane relative to the operating budgets of health care oversight agencies, the petition (accompanied by bill, House, No. 1212) of Meghan Kilcoyne relative to determination of need of new health care related technology, the petition (accompanied by bill, House, No. 1219) of John J. Lawn, Jr., and others for legislation to enhance the market review process, and the petition (accompanied by bill, House, No. 1228) of Frank A. Moran and Estela A. Reyes relative to the ability of the healthcare providers to negotiate rate increases with carriers, reports recommending that the accompanying bill (House, No. 4620) ought to pass. [Cost: Greater than $100,000.00].

For the committee,

JOHN J. LAWN, JR..

FILED ON: 4/30/2024

HOUSE . . . . . No. 4620

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act enhancing the market review process.

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

SECTION 1. Section 16 of chapter 6A of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 24 to 26, inclusive, the words ", the division of medical assistance and the Betsy Lehman center for patient safety and medical error reduction" and inserting in place thereof the following words:- and the division of medical assistance.

SECTION 2. Section 16D of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 4 and 5, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 3. Said section 16D of said chapter 6A, as so appearing, is hereby further amended by striking out, in lines 22 and 23, the words "department of public health established by section 217 of chapter 111, and the managed care bureau in the division of insurance" and inserting in place thereof the following words:- health policy commission established by section 2 of chapter 6D, and the managed care bureau in the division of health insurance.

SECTION 4. Section 16G of said chapter 6A, as amended by section 16 of chapter 7 of the acts of 2023, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) The following divisions and agencies shall be within the department of consumer affairs and business regulation: the division of banks, the division of insurance, the division of health insurance, the division of standards, the division of occupational licensure, and the department of telecommunications and cable.

SECTION 5. Section 16N of chapter 6A of the General Laws is hereby repealed.

SECTION 6. Section 16Q of said chapter 6A of the General Laws, as so appearing, is hereby amended by striking out, in line 13, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 7. Section 16T of chapter 6A of the General Laws is hereby repealed.

SECTION 8. Section 16Z of said chapter 6Z, as so appearing, is hereby amended by striking out, in lines 6 and 7, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 9. Section 1 of chapter 6D of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Alternative payment methodologies or methods” the following definition:-

“Benchmark cycle”, a fixed, predetermined period of 3 consecutive calendar years during which the projected average annual percentage change in total health care expenditures in the

commonwealth is calculated pursuant to section 9, and monitored for compliance pursuant to section 10.

SECTION 10. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by striking out the definition of "Health care cost growth benchmark" and inserting in place thereof the following definition:-

"Health care cost growth benchmark", the projected average annual percentage change in total health care expenditures in the commonwealth during a benchmark cycle, as established in section 9.

SECTION 11. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Health care provider" the following definition:-

"Health care real estate investment trust", a real estate investment trust, as defined by 28 U.S.C section 856, whose assets consist of real property held in connection with the use or operations of a provider or provider organization.

SECTION 12. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Health care provider" the following definition:-

"Health care resource", any resource, whether personal or institutional in nature and whether owned or operated by any person, the commonwealth or political subdivision thereof, the principal purpose of which is to provide, or facilitate the provision of, services for the prevention, detection, diagnosis or treatment of those physical and mental conditions experienced by humans which usually are the result of, or result in, disease, injury, deformity or

pain; provided, that the term “treatment” shall include custodial and rehabilitative care incident to infirmity, developmental disability or old age.

SECTION 13. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Health care services” the following 2 definitions:-

“Health disparities”, preventable differences in the opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities, including, but not limited to, preventable differences between groups in health insurance coverage, affordability, and access to quality health care services.

“Health equity”, the state in which a health system offers the infrastructure, facilities, services, geographic coverage, affordability and all other relevant features, conditions and capabilities that will provide all people with the opportunity and reasonable expectation that they can reach their full health potential and well-being and are not disadvantaged in access to health care by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or their socially determined circumstances.

SECTION 14. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Hospital service corporation” the following definition:-

“Management services organization”, any organization that is contracted by a provider or provider organization to perform management or administrative services relating to, supporting, or facilitating the provision of patient care.

SECTION 15. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by striking out, in lines 168 and 169, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 16. Said section 1 of said chapter 6D, as so appearing, is hereby further amended, in line 189, by striking out the word “excludes”.

SECTION 17. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Primary care provider” the following 2 definitions:-

“Priority patient population”, a patient population that is disproportionately impacted by health disparities.

“Private equity company”, a publicly traded or non-publicly traded company that collects capital investments from individuals or entities and purchases a direct or indirect ownership share of a provider or provider organization.

SECTION 18. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Shared decision-making” the following definition:-

“Significant equity investor”, (i) any private equity company with a financial interest in a provider or provider organization, or (ii) an investor, group of investors or other entity with a direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of a provider or provider organization.

SECTION 19. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Surcharge payor” the following definition:-

"Technical advisory committee", the technical advisory committee of the health policy commission established by section 4A.

SECTION 20. Section 2 of said chapter 6D is hereby amended by striking out subsections (b) and (c) and inserting in place thereof the following subsections:-

(b) (1) There shall be a board, with duties and powers established by this chapter, which shall govern the commission. The board shall consist of 9 members: 1 of whom shall be the secretary of health and human services, or a designee; 1 of whom shall be the commissioner of the division of health insurance, or a designee; 5 of whom shall be appointed by the governor, 1 of whom shall serve as chairperson, 1 of whom shall be selected from a list of 3 nominees submitted by the president of the senate and 1 of whom shall be selected from a list of 3 nominees submitted by the speaker of the house or representatives; and 2 of whom shall be appointed by the attorney general. All appointed members shall serve for a term of 5 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment; however, no appointed member shall hold full or part-time employment in the executive branch of state government. The board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board shall be a resident of the commonwealth.

(2) The person appointed by the governor to serve as chairperson shall have demonstrated expertise in health care administration, finance, and management at a senior level. The second person appointed by the governor, shall have demonstrated expertise in health systems or ambulatory care settings. The third person appointed by the governor shall have demonstrated expertise in health plan administration or benefits management. The fourth person appointed by

the governor, from the list of nominees submitted by the president of the senate, shall have demonstrated expertise in representing the health care workforce as a leader in a labor organization. The fifth person appointed by the governor, from the list of nominees submitted by the speaker of the house of representatives, shall have demonstrated expertise in health care innovation, including pharmaceuticals, biotechnology, or medical devices. The first person appointed by the attorney general shall be a health economist. The second person appointed by the attorney general shall have demonstrated expertise in health care consumer advocacy or population health.

(c) Five members of the board shall constitute a quorum, and the affirmative vote of 5 members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the commission. Members of the board shall receive a stipend in an amount not greater than 10 per cent of the salary of the secretary of administration and finance under section 4 of chapter 7; provided, however, that the chairperson shall receive a stipend in an amount not greater than 12 per cent of the salary of the secretary. No member of the board serving ex officio shall receive an additional stipend for their service as a board member.

SECTION 21. Said chapter 6D is hereby further amended by inserting after section 4 the following section:-

Section 4A. (a) There is hereby established a technical advisory committee consisting of appointed members with demonstrated experience in a broad range of provider sectors and public and private health care payers. The technical advisory committee shall: (i) establish the adjustment factor as part of the health care cost growth benchmark setting process pursuant to

subsection (c) of section 9; (ii) provide technical advice to the commission upon request; (iii) provide the commission with operational, policy, regulatory or legislative recommendations for the commission's consideration; and (iv) produce an annual report and other reports pursuant to subsection (c).

(b) The technical advisory committee shall consist of 16 members: 1 of whom shall be the executive director of the commission, who shall serve as non-voting chairperson; 1 of whom shall be the assistant secretary for MassHealth, or a designee; 1 of whom shall be the executive director of the commonwealth health insurance connector authority, or a designee; 1 of whom shall be the commissioner of the group insurance commission, or a designee; and 12 of whom shall be appointed by the executive director of the commission for their technical experience in specific health care sectors, 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Hospital Association, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Senior Care Association, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Medical Society, 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Biotechnology Council, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by the Massachusetts Association of Health Plans, Inc., 1 of whom shall be selected from a list of 3 nominees submitted by Blue Cross Blue Shield of Massachusetts, Inc., and 5 of whom shall be selected by the executive director from applications submitted by candidates with demonstrated experience in health care delivery, health care economics, health care data analysis, clinical research and innovation in health care delivery, or health care benefits management. In selecting members, the executive director shall ensure that

the composition of committee reflects a diversity of expertise in health care providers, purchasers, and consumer advocacy groups. Each member of the committee shall serve without compensation for a term of 3 years, or until a successor is appointed; provided, that no member shall serve more than 2 consecutive terms. The technical advisory committee shall meet at least quarterly or at other times as specified by the commission and shall annually elect 1 of its members to serve as vice-chairperson.

(c) The technical advisory committee shall report technical recommendations and a summary of its activities to the commission at least annually, and shall submit additional reports on its activities and recommendations to the commission, as requested by the commission. In developing any reports or recommendations to the commission, the technical advisory committee shall consider the availability, timeliness, quality, and usefulness of existing data, including the data collected by the center under chapter 12C, and assess the need for additional investments in data collection, data validation, or data analysis capacity to support the committee in performing its duties.

SECTION 22. Section 5 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 10, the words “and (vii)” and inserting in place thereof the following words:- ; (vii) monitor the location and distribution of health care services and health care resources; and (viii).

SECTION 23. Section 6 of said chapter 6D, as so appearing, is hereby amended by striking out the first and second paragraphs and inserting in place thereof the following paragraphs:-

Each acute hospital, ambulatory surgical center, non-hospital provider organization, and surcharge payor shall pay to the commonwealth an amount for the estimated expenses of the commission. For the purposes of this section, "non-hospital provider organization" shall mean a clinical laboratory, imaging facility or affiliated network of urgent care centers required to register under section 11.

The assessed amount for hospitals, ambulatory surgical centers, and non-hospital provider organizations shall be not less than 33 per cent of the amount appropriated by the general court for the expenses of the commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Each acute hospital, ambulatory surgical center, and non-hospital provider organization shall pay such assessed amount multiplied by the ratio of the hospital's, ambulatory surgical center's or non-hospital provider organization's gross patient service revenues to the total gross patient services revenues of all such hospitals, ambulatory surgical centers, and non-hospital provider organizations. Each acute hospital, ambulatory surgical center, and non-hospital provider organization shall make a preliminary payment to the commission on October 1 of each year in an amount equal to 1/2 of the previous year's total assessment. Thereafter, each hospital, ambulatory surgical center, and non-hospital provider organization shall pay, within 30 days notice from the commission, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The commission shall subsequently adjust the assessment for any variation in actual and estimated expenses of the commission and for changes in hospital, ambulatory surgical center, and non-hospital provider organization gross patient service revenue. Such estimated and actual expenses shall include an amount equal to the

cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29. In the event of late payment by any such hospital, ambulatory surgical center or non-hospital provider organization, the treasurer shall advance the amount of due and unpaid funds to the commission prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to such assessments and the commission shall reimburse the treasurer for such advances upon receipt of such revenues. This section shall not apply to any state institution or to any acute hospital which is operated by a city or town.

SECTION 24. Section 7 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 35, the words “and (vi)” and inserting in place thereof the following words:- (vi) advance health equity by reducing disparities in health outcomes that adversely affect priority patient populations; and (vii).

SECTION 25. Section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out the words “for the previous calendar year”, in lines 4 and 5, and inserting in place thereof the following words:- established under section 9.

SECTION 26. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in lines 32 and 33, the words “and (xi) any witness identified by the attorney general or the center” and inserting in place thereof the following words:- (xi) significant equity investors, health care real estate investment trusts, or management services organizations; (xii) a representative from the division of health insurance; (xiii) the executive director of the commonwealth health insurance connector authority; (xiv) the assistant secretary for MassHealth; and (xv) any witness identified by the attorney general or the center. The

commission shall also request testimony from officials representing the federal Centers for Medicare and Medicaid Services.

SECTION 27. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 49, the first time it appears, the word “and”.

SECTION 28. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “commission”, in line 60, the first time it appears, the following words:- ; and (iii) in the case of the assistant secretary for MassHealth, testimony concerning the structure, benefits, eligibility, caseload and financing of MassHealth and other Medicaid programs administered by the office of Medicaid or in partnership with other state and federal agencies and the agency’s activities to align or redesign those programs in order to encourage the development of more integrated and efficient health care delivery systems.

SECTION 29. Subsection (f) of said section 8 of said chapter 6D, as so appearing, is hereby amended, in lines 71 and 72, by striking out the words “exceeded the health care cost benchmark in the previous calendar year” and inserting in place thereof the following words:- in the previous calendar year exceeded the average annual growth established in the health care cost growth benchmark.

SECTION 30. Said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) The commission shall compile an annual health care cost growth progress report concerning spending trends, including primary care and behavioral health expenditures, and the underlying factors influencing said spending trends. The commission’s report on the third year of a benchmark cycle shall be a final benchmark cycle report and shall analyze spending trends for

the entire benchmark cycle. The reports shall be based on the commission's analysis of information provided at the hearings by witnesses, providers, provider organizations and payers, registration data collected pursuant to section 11, data collected or analyzed by the center pursuant to sections 8, 9 and 10 of chapter 12C and any other available information that the commission considers necessary to fulfill its duties in this section, as defined in regulations promulgated by the commission. The reports shall be submitted to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The reports shall include recommendations for strategies to increase the efficiency of the health care system and, in the case of annual progress reports, recommendations on the specific spending trends that threaten the commonwealth's ability to meet the health care cost growth benchmark, along with legislative language necessary to implement said recommendations.

SECTION 31. Said chapter 6D is hereby further amended by striking out sections 9 and 10 and inserting in place thereof the following 3 sections:-

Section 9. (a) The board shall establish a health care cost growth benchmark for the average annual growth in total health care expenditures in the commonwealth during a period of 3 consecutive calendar years. The commission shall establish the health care cost growth benchmark not later than April 15 of the year immediately preceding the first calendar year of a benchmark cycle.

(b) The health care cost growth benchmark shall be equal to the growth rate of potential gross state product established under section 7H½ of chapter 29, plus the adjustment factor adopted by the commission upon the recommendation of the technical advisory committee

pursuant to subsections (d). The commission shall establish procedures to prominently publish the health care cost growth benchmark on the commission's website.

(c) The technical advisory committee shall recommend an adjustment factor to the commission not later than February 15 of the year immediately preceding the first calendar year of the benchmark cycle; provided, that the adjustment factor shall not result in a health care cost growth benchmark that is greater than 1 per cent less than the growth rate of potential gross state product, nor greater than 1 per cent more than the growth rate of potential gross state product. The adjustment factor shall be based on economic and market factors specific to the health care industry including, but not limited to, the following factors: (i) medical inflation as measured by the medical care index within the consumer price index calculated by the United States Bureau of Labor Statistics; (ii) labor and workforce development costs; (iii) the introduction of new pharmaceuticals, medical devices and other health technologies; and (iv) any other factors as determined by the technical advisory committee. The recommended adjustment factor shall be approved by a two-thirds vote of the technical advisory committee; provided, however, that should the technical advisory committee fail to approve a recommended adjustment factor, the adjustment factor shall be 0 per cent. The technical advisory committee shall submit its recommendation to the commission in a public report which shall include an analysis supporting the technical advisory committee's recommended adjustment factor.

(d) The commission shall hold a public hearing prior to accepting or rejecting the technical advisory committee's recommended adjustment factor. The public hearing shall be based on the report submitted by the technical advisory committee pursuant to subsection (c) and by the report submitted by the center under section 16 of chapter 12C monitoring the growth in total health care expenditures in the previous calendar year compared to the health care cost

growth benchmark, any other data provided by the technical advisory committee and the center and such other pertinent information or data as may be available to the commission. The commission shall provide public notice of such hearing at least 45 days prior to the date of the hearing, including notice to the joint committee on health care financing. The joint committee on health care financing may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and such other interested parties as the commission may determine. Any other interested parties may testify at the hearing. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system, and whether, based on the testimony, information and data, it is appropriate to accept the recommended adjustment factor.

(e) The commission shall approve the recommended adjustment factor by a majority vote of the board.

Section 9A. (a) For the purposes of this section, "provider" shall mean an acute hospital or physician organization.

(b) The commission shall establish, concurrently with the health care cost growth benchmark under section 9, a rate equity target for the equitable reimbursement by payers of providers serving priority patient populations.

(1) For the benchmark cycle of calendar years 2026 through 2029, a payer shall not pay any in-network provider a payment rate that is greater than 15 per cent below the average relative price of all providers in the payer's network.

(2) For the benchmark cycle of calendar years 2029 through 2032, a payer shall not pay any in-network provider a payment rate that is greater than 10 per cent below the average relative price of all providers in the payer's network.

(3) For the benchmark cycle of calendar years 2032 through 2035, a payer shall not pay any in-network provider a payment rate that is greater than 5 per cent below the average relative price of all providers in the payer's network.

(4) Beginning in the benchmark cycle of calendar years 2035 through 2038, all payers shall pay all in-network providers an equal rate for the provision of health care services.

Section 10. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Health care entity", a clinic, hospital, ambulatory surgical center, physician organization or accountable care organization.

(b) The commission shall provide notice to all health care entities and payers that have been identified by the center under section 18 of chapter 12C. Such notice shall state that the commission may analyze the cost growth and the health care spending performance of the individual health care entity or payer and the commission may require certain actions, as established in this section, from health care entities and payers so identified.

(c)(1) If the commission finds, based on the center's benchmark cycle report issued under subsection (d) of section 16, that the percentage change in total health care expenditures during the benchmark period exceeded the health care cost growth benchmark, the commission shall

require certain health care entities to file and implement a performance improvement plan, subject to the factors in subsection (f).

(2) In the case of payers, the commission shall only require a payer to file and implement a performance improvement plan if the commission determines that the payer has both exceeded the health care cost growth benchmark and failed to meet the rate equity target established by section 9A.

(d) The commission shall provide written notice to any health care entity or payer it determines must file a performance improvement plan. Within 45 days of receipt of such written notice, the health care entity or payer shall either:

(1) file a performance improvement plan with the commission; or

(2) file an application with the commission to waive or extend the requirement to file a performance improvement plan.

(e) The health care entity or payer may file any documentation or supporting evidence with the commission to support the health care entity or payer's application to waive or extend the requirement to file a performance improvement plan. The commission shall require the health care entity or payer to submit any other relevant information it deems necessary in considering the waiver or extension application; provided, however, that such information shall be made public at the discretion of the commission.

(f) The commission may waive or delay the requirement for a health care entity or payer to file a performance improvement plan in response to a waiver or extension request filed under

subsection (d) in light of all information received from the health care entity or payer, based on a consideration of the following factors:

(1) the baseline spending and trends relative to cost, price, utilization and payer mix of the of the health care entity over time, independently and as compared to similar entities, and any demonstrated improvement to reduce health status adjusted total medical expenses;

(2) any ongoing strategies or investments that the health care entity or payer is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity or payer can reasonably be considered to be unanticipated and outside of the control of the entity. Such factors may include, but shall not be limited to, age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses, medical device expenses and labor costs;

(4) the overall financial condition of the health care entity or payer;

(5) a significant difference between the growth rate of potential gross state product and the growth rate of actual gross state product, as determined under section 7H½ of chapter 29; and

(6) any other factors the commission considers relevant.

(g) If the commission declines to waive or extend the requirement for the health care entity or payer to file a performance improvement plan, the commission shall provide written notice to the health care entity or payer that its application for a waiver or extension was denied and the health care entity or payer shall file a performance improvement plan.

(h) A health care entity or payer shall file a performance improvement plan: (1) within 45 days of receipt of a notice under subsection (d); (2) if the health care entity or payer has

requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (3) if the health care entity or payer is granted an extension, on the date given on such extension. The performance improvement plan shall be generated by the health care entity or payer and shall identify the causes of the entity's cost growth and, in the case of payers, the causes for the payer’s inequitable rates, and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance and rate equity. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 3 years.

(i) The commission shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the health care entity’s or payer’s cost growth and has a reasonable expectation for successful implementation.

(j) If the board determines that the performance improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission; provided, however, that all aspects of the performance improvement plan shall be proposed by the health care entity or payer and the commission shall not require specific elements for approval.

(k) Upon approval of the proposed performance improvement plan, the commission shall notify the health care entity or payer to begin implementation of the performance improvement plan. Public notice shall be provided by the commission on its website, identifying that the health care entity or payer is implementing a performance improvement plan. All health care entities and payers implementing an approved performance improvement plan shall be subject to

additional reporting requirements and compliance monitoring, as determined by the commission. The commission shall provide assistance to the health care entity or payer in the successful implementation of the performance improvement plan.

(l) All health care entities and payers shall, in good faith, work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan the health care entity or payer may file amendments to the performance improvement plan, subject to approval of the commission.

(m) At the conclusion of the timetable established in the performance improvement plan, the health care entity or payer shall report to the commission regarding the outcome of the performance improvement plan. If the commission finds that the performance improvement plan was unsuccessful, the commission shall either: (i) extend the implementation timetable of the existing performance improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity or payer; (iii) require the health care entity or payer to submit a new performance improvement plan, including requiring specific elements for approval, notwithstanding the limitation in subsection (j) on the commission's authority during its review of an initial plan proposal; (iv) waive or delay the requirement to file any additional performance improvement plans; or (v) conduct a cost and market impact review of the health care entity or payer under section 13.

(n) Upon the successful completion of the performance improvement plan, the identity of the health care entity or payer shall be removed from the list of entities currently implementing a performance improvement plan on the commission's website.

(o) The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the commonwealth's health care quality and spending sustainability objectives, assist health care entities and carriers with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section.

(p) If the commission determines that a health care entity or payer has: (i) willfully neglected to file a performance improvement plan with the commission within 45 days as required under subsection (d); (ii) failed to file an acceptable performance improvement plan in good faith with the commission; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the commission or that knowingly falsifies the same, the commission may: (i) assess a civil penalty to the health care entity or payer of not more than $500,000 for a first violation, not more than $750,000 for a second violation, and not more than $1,000,000 for a third or subsequent violation; (ii) stay consideration of any material change notice submitted under section 13 by the health care entity or payer until the commission determines that the health care entity or payer is in compliance with this section; and (iii) notify the department of public health that the health care entity, if applying for a notice of determination of need, is not in compliance with this section. The commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(q) The commission shall promulgate regulations necessary to implement this section; provided, however, that notice of any proposed regulations shall be filed with the joint committee on health care financing at least 180 days before adoption.

SECTION 32. Section 11 of said chapter 6D of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 5, 34, and 40, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 33. Said section 11 of chapter 6D, as so appearing, is hereby amended by inserting after the word “affiliates”, in line 17, the following words:- , significant equity investors, health care real estate investment trusts, management services organizations.

SECTION 34. Section 12 of said chapter 6D, as so appearing, is hereby amended by striking out, in lines 8 and 9, the words “carriers or third party administrators” and inserting in place thereof the following word:- payers.

SECTION 35. Chapter 6D of the General Laws is hereby amended by striking out section 13, as so appearing, and inserting in place thereof the following section:-

Section 13. (a) Every provider, provider organization or payer shall, before making any material change to its operations or governance structure, submit notice to the commission, the center and the attorney general of such change, not fewer than 60 days before the date of the proposed change. Material changes shall include, but not be limited to: (i) significant expansions in a provider or provider organization’s capacity; (ii) a corporate merger, acquisition or affiliation of a provider or provider organization and a carrier; (iii) mergers or acquisitions of a carrier by another carrier; (iv) mergers or acquisitions of hospitals or hospital systems; (v) acquisition of insolvent provider organizations; (vi) transactions between a significant equity investor and a provider, provider organization or a carrier; (vii) significant transfers of assets including, but not limited to, real estate sale lease-back arrangements; (viii) conversion of a

provider, provider organization or payer from a non-profit entity to a for-profit entity; and (ix) mergers or acquisitions of provider organizations which will result in a provider organization having a near-majority of market share in a given service or region.

Within 30 days of receipt of a notice filed under the commission's regulations, the commission shall conduct a preliminary review to determine whether the material change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 9, or on the competitive market. If the commission finds that the material change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, or on the competitive market, the commission may conduct a cost and market impact review under this section.

(b) In addition to the grounds for a cost and market impact review set forth in subsection (a), if the commission finds, based on the center's final benchmark cycle report under subsection (d) of section 16 of chapter 12C, that the percentage change in total health care expenditures during the benchmark cycle exceeded the health care cost growth benchmark, the commission may conduct a cost and market impact review of any provider, provider organization or payer identified by the center under section 18 of chapter 12C.

(c) The commission shall initiate a cost and market impact review by sending the provider, provider organization or payer notice of a cost and market impact review which shall explain the basis for the review and the particular factors that the commission seeks to examine through the review. The provider, provider organization, or payer shall submit to the commission, within 21 days of the commission's notice, a written response to the notice, including, but not limited to, any information or documents sought by the commission which are

described in the commission's notice. The commission may require that any provider, provider organization, or payer submit documents and information in connection with a notice of material change or a cost and market impact review under this section. The commission shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the provider, or payer that produced the information or documents, except in a preliminary report or final report under this section if the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

(d)(1) A cost and market impact review may examine factors relating to the provider, provider organization's business and its relative market position, including, but not limited to:

(i) the provider or provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) the provider or provider organization's prices for services, including its relative price compared to other providers for the same services in the same market; (iii) the provider or provider organization's health status adjusted total medical expense, including its health status adjusted total medical expense compared to similar providers; (iv) the quality of the services it provides, including patient experience; (v) provider cost and cost trends in comparison to total health care expenditures statewide; (vi) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider or provider organization within its primary service areas and dispersed service areas; (vii) the provider or provider organization's impact on competing options for the delivery of health care services within its primary service

areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (viii) the methods used by the provider or provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (ix) the role of the provider or provider organization in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (x) the role of the provider or provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (xi) consumer concerns, including but not limited to, complaints or other allegations that the provider or provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; (xii) the size and market share of any corporate affiliates or significant equity investors of the provider or provider organization; (xiii) the inventory of health care resources maintained by the department of public health, pursuant to section 25A of chapter 111, and any related data or reports from the health resource planning council, established by section 22; and (xiv) any other factors that the commission determines to be in the public interest.

(2) A cost and market impact review may examine factors relating to a payer’s business and its relative market position, including, but not limited to, the payer’s: (i) relative market position, including, but not limited to, the payer’s size and market share within its geographic area and lines of business; (ii) financial data and information, including cost and price detail, claims data, encounter data, and payment methods to evaluate cost and utilization trends of different services and providers, including compared to other payers with similar insurance

products; (iii) net cost of private health insurance and total medical expense by market segment, including individual, small group, large group, self-insured, student and Medicare Advantage markets, and compared to similar payers; (iv) performance against the health care cost growth benchmark established in section 9 of chapter 6D and the rate equity target established in section 9A; (v) premiums for different plans, including compared to other carriers for the similar insurance products; (vi) enrollment and demographic data, coverage, premium, product, network, and benefit design; (vii) administrative costs and profits, including all categories of administrative expenditures, net additions to reserves, rate dividends or rebates, profits or losses, taxes and fees; (viii) adoption of alternative payment models and standards and payer's compliance with standard quality measures; (ix) consumer concerns, including claims denials, prior authorization denials, medical necessity, tiering, and cost sharing, inclusive of out-of-pocket maximus, copayments, coinsurance, and deductibles; and (x) any other factors that the commission determines to be in the public interest.

(e) The commission shall make factual findings and issue a preliminary report on the cost and market impact review. In the report, the commission shall identify any provider, provider organization or payer that meets all of the following criteria: (i) the provider, provider organization or payer has, or likely will have as a result of the proposed material change, a dominant market share for the services it provides; (ii) the provider, provider organization or payer charges, or likely will charge as a result of the proposed material change, prices for services that are materially higher than the median prices charged by all other providers for the same services in the same market; and (iii) the provider, provider organization or payer has, or likely will have as a result of the proposed material change, a health status adjusted total medical

expense that is materially higher than the median total medical expense for all other providers or payers for the same service in the same market.

(f) Within 30 days after issuance of a preliminary report, the provider, provider organization or payer may respond in writing to the findings in the report. The commission shall then issue its final report. The commission shall refer to the attorney general its report on any provider, provider organization or payer that meets all 3 criteria under subsection (e). The commission shall issue its final report on the cost and market impact review within 185 days from the date that the provider, provider organization or payer has submitted notice to the commission; provided, that the provider, provider organization or payer has certified substantial compliance with the commission's requests for data and information pursuant to subsection (c) within 21 days of the commission's notice, or by a later date set by mutual agreement of the provider, provider organization or payer and the commission.

(g) Nothing in this section shall prohibit a proposed material change under subsection (a); provided, however, that any proposed material change shall not be completed: (i) until at least 30 days after the commission has issued its final report; or (ii) if the attorney general brings an action as described in subsection (h), while such action is pending and prior to a final judgment being issued by a court of competent jurisdiction.

(h) A provider, provider organization or payer that meets the criteria in subsection (e) shall be presumed to be engaged in an unfair method of competition or unfair and deceptive trade practice subject to an action brought by the attorney general pursuant to section 4 of chapter 93A; provided, however, that a provider, provider organization or payer that meets the criteria of subsection (e) shall not be subject to an action brought pursuant to sections 9 or 11 of said

chapter 93A if the sole basis of the action is the fact that the provider, provider organization or payer meets the criteria in subsection (e). When the commission, under subsection (f), refers a report on a provider, provider organization or payer to the attorney general, the attorney general may take action under said chapter 93A or any other law to protect consumers in the health care market. The commission's final report may be evidence in any such action.

(i) Nothing in this section shall limit the authority of the attorney general to protect consumers in the health care market under any other law.

(j) The commission shall adopt regulations for conducting cost and market impact reviews and for administering this section. These regulations shall include definitions of material change and non-material change, primary service areas, dispersed service areas, dominant market share, materially higher prices and materially higher health status adjusted total medical expenses, and any other terms as necessary. All regulations promulgated by the commission shall comply with chapter 30A.

(k) Nothing in this section shall limit the application of other laws or regulations that may be applicable to a provider or provider organization, including laws and regulations governing insurance.

(l) Upon issuance of its final report pursuant to subsection (f), the commission shall provide a copy of said final report to the department of public health, which shall be included in the written record and considered by the department of public health during its review of an application for determination of need and considered where relevant in connection with licensure or other regulatory actions involving the provider or provider organization. The commission

shall provide a copy of a final report concerning a payer to the commissioner of health insurance in connection with the review of rate filings or other regulatory actions involving the carrier.

SECTION 36. Section 15 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 38, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 37. Paragraph (15) of subsection (c) of said section 15 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 168, the word “and”.

SECTION 38. Said subsection (c) of said section 15 of said chapter 6D, as so appearing, is hereby amended by striking out paragraph (16) and inserting in place thereof the following 2 paragraphs:-

(16) to ensure ACOs demonstrate, in care delivered in-person and via telehealth, compliance with standards that meet or exceed the standards to attain the certification of the National Committee for Quality Assurance for the distinction in multicultural health care; and

(17) any other requirements the commission considers necessary.

SECTION 39. Section 16 of said chapter 6D, as so appearing, is hereby amended by striking out, in lines 9, 12, and 67, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 40. Said section 16 of said chapter 6D, as so appearing, is hereby further amended by striking out, in lines 43 and 44, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 41. Said chapter 6D is hereby further amended by adding the following section:-

Section 22. (a) There is hereby established within the commission a health resource planning council, consisting of the executive director of the health policy commission who shall serve as co-chair, the secretary of health and human services or a designee, who shall serve as co-chair, the commissioner of public health or a designee, the director of the office of Medicaid or a designee, the commissioner of mental health or a designee, the commissioner of health insurance or a designee, the secretary of elder affairs or a designee, the executive director of the center for health information and analysis or a designee, and 3 members appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall have experience in health care market planning and service line analysis and 1 of whom shall have experience in health care administration and delivery.

(b)(1) The council shall develop a state health plan to identify: (i) the anticipated needs of the commonwealth for health care services and facilities; (ii) the existing health care resources available to meet those needs; (iii) the projected resources necessary to meet those anticipated needs; and (iv) the priorities for addressing those needs.

(2) The state health plan developed by the council shall be a forecast of anticipated demand, supply and distribution of health care resources during a 5-year planning period, and shall include the location, distribution and nature of all health care resources in the commonwealth, including: (i) acute care units; (ii) non-acute care units; (iii) specialty care units, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post-operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and

intensive care units; (iv) skilled nursing facilities; (v) assisted living facilities; (vi) long-term care facilities; (vii) ambulatory surgical centers; (viii) office-based surgical centers; (ix) urgent care centers; (x) home health; (xi) adult and pediatric behavioral health and mental health services and supports; (xii) substance use disorder treatment and recovery services; (xiii) emergency care; (xiv) ambulatory care services; (xv) primary care resources; (xvi) pediatric care services; (xvii) family planning services; (xviii) obstetrics and gynecology and maternal health services; (xix) allied health services including, but not limited to, optometric care, chiropractic services, oral health care and midwifery services; (xx) federally qualified health centers and free clinics; (xxi) numbers of technologies or equipment defined as innovative services or new technologies by the department of public health pursuant to section 25C of chapter 111; (xxii) hospice and palliative care service; and (xxiii) health screening and early intervention services; (xiv) and any other service or resource identified by the council.

(3) The state health plan shall also make recommendations for the supply and distribution of health care resources on a state-wide or regional basis based on an assessment of need during the 5-year plan and options for implementing such recommendations. The recommendations shall reflect, at a minimum, the following goals: (i) to maintain or improve the quality of and access to health care services; (ii) to support the commonwealth's efforts to meet the health care cost growth benchmark established pursuant to section 9; (iii) to support innovative health care delivery and alternative payment models as identified by the commission; (iv) to reduce unnecessary duplication of health care resources; (v) to advance health equity and to reduce address disparities in the health care system based on the needs of particular demographic factors, including, but not limited to, race, ethnicity, immigration status, sexual orientation, gender identity, geographic location, age, language spoken, ability and socioeconomic status;

(vi) to support efforts to integrate oral health, mental health, behavioral and substance use disorder treatment services with overall medical care; (vii) to reflect the latest trends in utilization and support the best standards of care; and (viii) to ensure equitable access to health care resources across geographic regions of the commonwealth .

(c) The council shall provide direction to the department of public health to establish and maintain on a current basis an inventory of all such health care resources together with all other reasonably pertinent information concerning such resources. Agencies of the commonwealth that license, register, regulate or otherwise collect cost, quality or other data concerning health care resources shall cooperate with the council and the department of public health in coordinating such data and information collected pursuant to this section and section 25A of chapter 111. The inventory compiled pursuant to this section and said section 25A of said chapter 111 and all related information shall be maintained in a form usable by the general public and shall constitute a public record; provided, however, that any item of information which is confidential or privileged in nature under any other law shall not be regarded as a public record pursuant to this section.

(d) The council shall establish an advisory committee of not more than 15 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care providers and provider organizations, public and private third-party payers, consumer representatives and labor organizations representing health care workers. Not fewer than 2 members of the advisory committee shall have expertise in rural health matters and rural health needs in the commonwealth. The advisory committee shall review drafts and provide recommendations to the council during the development of the state health plan described in subsection (b).

(e) The council shall conduct at least 5 public hearings, in geographically diverse areas throughout the commonwealth, during the development of the state health plan and shall give interested persons an opportunity to submit their views orally and in writing. In addition, the council may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(f) The council shall publish analyses, reports and interpretations of information collected pursuant to this section to promote awareness of the distribution and nature of health care resources in the commonwealth.

(g) The council shall file a report annually by January 1 with the joint committee on health care financing concerning the activities of the council in general and, in particular, describing the progress to date in developing the state health plan and recommending such further legislative action as it considers appropriate.

(h) Nothing in this section shall be construed to impose caps on health care resources in the commonwealth or a particular region in the commonwealth.

SECTION 42. Section 5A of chapter 12 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the words “or “knowingly””, in line 26, and inserting in place thereof the following words:- “knowingly” or “knows”.

SECTION 43. Said section 5A of said chapter 12, as so appearing, is hereby further amended by inserting after the definition of “Original source” the following definition:-

“Ownership or investment interest”, any: (1) direct or indirect possession of equity in the capital, stock, or profits totaling more than 10 per cent of an entity; (2) interest held by an

investor or group of investors who engages in the raising or returning of capital and who invests, develops, or disposes of specified assets; or (3) interest held by a pool of funds by investors, including a pool of funds managed or controlled by private limited partnerships, if those investors or the management of that pool or private limited partnership employ investment strategies of any kind to earn a return on that pool of funds.

SECTION 44. Said section 5A of said chapter 12, as so appearing, is hereby further amended by striking out, in line 29, the word “or”, the second time it appears.

SECTION 45. Said section 5A of said chapter 12, as so appearing, is herby further amended by inserting after the word “applicable” in lines 38 and 39, the following words:- ; or (11) has an ownership or investment interest in any person who violates sections (1) through (10), knows about the violation, and fails to disclose the violation to the commonwealth or a political subdivision thereof within 60 days of identifying the violation

SECTION 46. Section 11F of chapter 12 of the of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 6 and 7, the words “division of insurance within the department of banking and insurance” and inserting in place thereof the following words:- the division of insurance or the division of health insurance within the department of banking, insurance, and health insurance.

SECTION 47. Section 11N of said chapter 12 of the General Laws, as so appearing, is hereby amended by striking out the words “or provider organization”, in line 7, and inserting in place thereof the following words:- , provider organization, significant equity investor, health care real estate investment trust or management services organization.

SECTION 48. Section 11N of chapter 12 of the General Laws, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) The attorney general may, upon a referral by the health policy commission pursuant to section 13 of chapter 6D, investigate and bring any appropriate action, including for injunctive relief, as may be necessary pursuant to chapter 93A or any other law, to restrain unfair methods of competition or unfair and deceptive trade practices by a provider, provider organization or payer and to protect consumers in the health care market.

SECTION 49. Section 1 of chapter 12C of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after the definition of "Ambulatory surgical center services", the following definition:-

"Benchmark cycle", a fixed, predetermined period of 3 consecutive calendar years during which the projected average annual percentage change in total health care expenditures in the commonwealth is calculated pursuant to section 9 of chapter 6D, and monitored for compliance pursuant to section 10 of said chapter 6D.

SECTION 50. Said section 1 of said chapter 12C, as so appearing, is hereby amended by striking out the definitions of "Health care professional" and "Health care cost growth benchmark" and inserting in place thereof the following 3 definitions:-

"Health care cost growth benchmark", the projected average annual percentage change in total health care expenditures in the commonwealth during a benchmark cycle, as established in section 9 of chapter 6D.

"Health care professional", a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with law.

"Health care real estate investment trust", a real estate investment trust, as defined by 28 U.S.C section 856, whose assets consist of real property held in connection with the use or operations of a provider or provider organization.

SECTION 51. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Health care services" the following 2 definitions:-

"Health disparities", preventable differences in the opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities, including, but not limited to, preventable differences between groups in health insurance coverage, affordability, and access to quality health care services.

"Health equity", the state in which a health system offers the infrastructure, facilities, services, geographic coverage, affordability and all other relevant features, conditions and capabilities that will provide all people with the opportunity and reasonable expectation that they can reach their full health potential and well-being and are not disadvantaged in access to health care by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or their socially determined circumstances.

SECTION 52. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Major service category" the following definition:-

"Management services organization", any organization that is contracted by a provider or provider organization to perform management or administrative services relating to, supporting, or facilitating the provision of patient care.

SECTION 53. Said section 1 of said chapter 12C, as so appearing, is hereby amended by striking out, in lines 189 and 190, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 54. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Patient-centered medical home" the following definition:-

"Payer", any entity, other than an individual, that pays providers for the provision of health care services; provided, that "payer" shall include both governmental and private entities; provided further, that "payer" shall not include ERISA plans.

SECTION 55. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Primary service area" the following 2 definitions:-

"Priority patient population", a patient population that is disproportionately impacted by health disparities.

"Private equity company", a publicly traded or non-publicly traded company that collects capital investments from individuals or entities and purchases a direct or indirect ownership share of a provider or provider organization.

SECTION 56. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Self-insured group" the following definition:-

"Significant equity investor", (i) any private equity company with a financial interest in a provider or provider organization, or (ii) an investor, group of investors or other entity with a direct or indirect possession of equity in the capital, stock or profits totaling more than 10 per cent of a provider or provider organization.

SECTION 57. Section 2A of said chapter 12C, as so appearing, is hereby amended by striking out, in lines 6 and 7, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 58. Section 3 of said chapter 12C, as so appearing, is hereby amended by striking out, in lines 19 and 20, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 59. Section 7 of said chapter 12C of the General Laws, as so appearing, is hereby amended by striking out the first two paragraphs and inserting in place thereof the following paragraphs:-

Each acute hospital, ambulatory surgical center, non-hospital provider organization, and surcharge payor shall pay to the commonwealth an amount for the estimated expenses of the center and for the other purposes described in this chapter which shall include any transfer made to the Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter 29. For the purposes of this section, "non-hospital provider organization" shall mean a clinical laboratory, imaging facility or affiliated network of urgent care centers required to register under section 11 of chapter 6D.

The assessed amount for hospitals, ambulatory surgical centers, and non-hospital provider organizations shall be not less than 33 per cent of the amount appropriated by the

general court for the expenses of the center and for the other purposes described in this chapter which shall include any transfer made to the Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter 29 minus amounts collected from (1) filing fees; (2) fees and charges generated by the center's publication or dissemination of reports and information; and (3) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Each acute hospital, ambulatory surgical center, and non-hospital provider organization shall pay such assessed amount multiplied by the ratio of the hospital's, ambulatory surgical center's or non-hospital provider organization's gross patient service revenues to the total gross patient services revenues of all such hospitals, ambulatory surgical centers, and non-hospital provider organizations. Each acute hospital, ambulatory surgical center, and non-hospital provider organization shall make a preliminary payment to the center on October 1 of each year in an amount equal to 1/2 of the previous year's total assessment. Thereafter, each hospital, ambulatory surgical center, and non-hospital provider organization shall pay, within 30 days notice from the center, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The center shall subsequently adjust the assessment for any variation in actual and estimated expenses of the center and for changes in hospital, ambulatory surgical center, and non-hospital provider organization gross patient service revenue. Such estimated and actual expenses shall include an amount equal to the cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29. In the event of late payment by any such hospital, ambulatory surgical center or non-hospital provider organization, the treasurer shall advance the amount of due and unpaid funds to the center prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to such

assessments and the center shall reimburse the treasurer for such advances upon receipt of such revenues. This section shall not apply to any state institution or to any acute hospital which is operated by a city or town.

SECTION 60. Section 8 of chapter 12C, as so appearing, is hereby amended by inserting after the word “entities”, in line 5, the following words:- including significant equity investors, health care real estate investment trusts and management services organizations.

SECTION 61. Said section 8 of said chapter 12C, as so appearing, is hereby further amended by inserting after the word “statements”, in line 23, the following words:- , including the audited financial statements of the parent organization’s out-of-state operations, significant equity investors, health care real estate investment trusts and management services organizations,.

SECTION 62. Said section 8 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 49, the words “and (6)” and inserting in place thereof the following words:- (6) margins, including margins by payer type; (7) investments; (8) information on affiliated significant equity investors, health care real estate investment trusts and management service organizations; and (9).

SECTION 63. Section 9 of said chapter 12C, as so appearing, is hereby amended by striking out the words “entities and corporate affiliates”, in line 21, and inserting in place thereof the following words:- entities, including their out-of-state operations, and corporate affiliates, including significant equity investors, health care real estate investment trusts and management services organizations,.

SECTION 64. Section 9 of said chapter 12C, as so appearing, is hereby further amended by striking out, in lines 31, 34 and 35, and 36, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 65. Said section 9 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 32, the words “and (10)” and inserting in place thereof the following words:- (10) information regarding other assets and liabilities that may affect the financial condition of the provider organization or the provider organization’s facilities, including, but not limited to, significant equity investors and real estate sale-leaseback arrangements with health care real estate investment trusts; and (11).

SECTION 66. Section 10 of said chapter 12C, as so appearing, is hereby amended by striking out, in lines 24 and 25, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 67. Said section 10 of said chapter 12C, as so appearing, is hereby further amended by striking out, in lines 96 and 97, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 68. Said section 11 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 11, the figure “$1,000” and inserting in place thereof the following figure:- $25,000.

SECTION 69. Said section 11 of said chapter 12C, as so appearing, is hereby further amended by striking out, in lines 13 to 16, inclusive, the words “notice; provided, however, that

the maximum annual penalty against a private payer, provider or provider organization under this section shall be $50,000” and inserting in place thereof the following word:- notice.

SECTION 70. Said section 11 of said chapter 12C, as so appearing, is hereby further amended by inserting the following sentence:- The center shall notify the commission and the department of public health if a provider or provider organization fails to timely report in accordance with this section, or if the center has assessed a penalty under this section. Such notification shall be considered by the commission in a review under section 13 of chapter 6D, and by the department in determining licensure and suitability in accordance with section 51 of chapter 111 and shall be considered by the department in a determination under section 25C of chapter 111.

SECTION 71. Said chapter 12C is hereby further amended by striking out section 14, as so appearing, and inserting in place thereof the following section:-

Section 14. (a)(1) The center, in consultation with the statewide advisory committee established pursuant to subsection (c) shall, not later than March 1 in each even-numbered year, establish a standard set of measures of health care provider quality and health system performance, hereinafter referred to as the “standard quality measure set”, for use in: (i) contracts between payers, including the commonwealth and carriers, and health care providers, provider organizations and accountable care organizations, which incorporate quality measures into payment terms, including the designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii) consumer transparency websites and other methods of providing consumer information; and (iv) monitoring system-wide performance.

(2) The standard quality measure set shall designate: (i) core measures that shall be used in contracts between payers, including the commonwealth and carriers, and health care providers, including provider organizations and accountable care organizations, that incorporate quality measures into payment terms, and shall meet the core criteria set by the statewide advisory committee pursuant to paragraph (3) of subsection (c); and (ii) a menu of non-core measures that may be used in such contracts. The standard quality measure set shall allow for innovation and the development of outcome measures. If the standard quality measure set established by the center differs from the recommendations of the statewide advisory committee, the center shall issue a written report detailing each area of disagreement and the rational for the center's decision.

(b) The center shall develop the uniform reporting of the standard quality measure set for each health care provider facility, medical group or provider group in the commonwealth.

(c)(1) The center shall convene a statewide advisory committee which shall make recommendations for the standard quality measure set to: (i) ensure consistency in the use of quality measures in contracts between payers, including the commonwealth and carriers, and health care providers in the commonwealth; (ii) ensure consistency in methods for the assignment of tiers to providers in the design of any health plan; (iii) improve quality of care; (iv) improve transparency for consumers and employers; (v) improve health system monitoring and oversight by relevant state agencies; and (vi) reduce administrative burden.

(2) The statewide advisory committee shall consist of commissioner of the division of health insurance and the executive director of the health policy commission, or their designees, who shall serve as co-chairs, and shall include the following members or their designees: the

executive director of the center; the executive director of the Betsy Lehman center for patient safety and medical error reduction; the executive director of the group insurance commission;; the secretary of elder affairs; the assistant secretary for MassHealth; the commissioner of the department of public health; the commissioner of the department of mental health; and 11 members who shall be appointed by the governor, 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be a representative the Massachusetts Medical Society, 1 of whom shall a registered nurse licensed to practice in Massachusetts who practices in a patient care setting, 1 of whom shall be a representative of a labor organizations representing health care workers, 1 of whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of a specialty pediatric provider, and 1 of whom shall be a representative for consumers. Members appointed to the statewide advisory committee shall have experience with and expertise in health care quality measurement.

(3) The statewide advisory committee shall meet quarterly to develop recommendations for the core measure and non-core measures to be adopted in the standard quality measure set for use in: (i) contracts between payers, including the commonwealth and carriers, and health care providers, provider organizations and accountable care organizations, including the designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii) consumer transparency websites and other methods of providing consumer information; and (iv) monitoring system-wide performance.

(4) In developing its recommendations for the standard quality measure set, the statewide advisory committee shall incorporate nationally recognized quality measures including, but not limited to, recommendations from the executive office of health and human services performance measurement alignment task force, measures used by the Centers for Medicare and Medicaid Services, the group insurance commission, carriers and providers and provider organizations in the commonwealth and other states, as well as other valid measures of health care provider performance, outcomes, including patient-reported outcomes and functional status, patient experience, disparities and population health. The statewide advisory committee shall consider measures applicable to primary care providers, specialists, hospitals, provider organizations, accountable care organizations, oral health providers and other types of providers and measures applicable to different patient populations.

(5) The statewide advisory committee shall, not later than January 1 in each even-numbered year, submit to the center its recommendations on the core measures and non-core measures to be adopted, changed or updated by the center in the standard quality measure set, along with a report in support of its recommendations.

SECTION 72. Subsection (a) of section 15 of said chapter 12C is hereby amended by striking out, in line 4, the word “injury” and inserting in place thereof the following word:- harm.

SECTION 73. Said subsection (a) of said section 15 of said chapter 12C is hereby further amended by striking out the definition of “Board” and inserting in place thereof the following 3 definitions:-

“Agency”, any agency of the executive branch of the commonwealth, including but not limited to any constitutional or other office, executive office, department, division, bureau,

board, commission or committee thereof; or any authority created by the general court to serve a public purpose, having either statewide or local jurisdiction.

"Board", the patient safety and medical errors reduction board.

"Healthcare-associated infection", an infection that a patient acquires during the course of receiving treatment for other conditions within a healthcare setting.

SECTION 74. Said subsection (a) of said section 15 of said chapter 12C, as so appearing, is hereby further amended by inserting after the definition of "Patient safety" the following definition:-

"Patient safety information", data and information related to patient safety, including adverse events, incidents, medical errors or healthcare-associated infections that is collected or maintained by agencies.

SECTION 75. Said section 15 of said chapter 12C, as so appearing, is hereby amended by striking out subsection (f) and inserting in place thereof the following 3 subsections:-

(f) Notwithstanding any general or special law to the contrary, the Lehman center and each agency that collects or maintains patient safety information may transmit such information, including personal data pursuant to section 1 of chapter 66A, to each other through an agreement, which may be an interagency service agreement, that provides for any safeguards necessary to protect the privacy and security of the information; provided, that the provision of such information shall be consistent with federal law.

(g) The Lehman center may adopt rules and regulations necessary to carry out the purpose and provisions of this section. The Lehman center may contract with any federal, state

or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity to manage its affairs or carry out the purpose and provisions of this section.

(h) The Lehman center shall report annually to the joint committee on health care financing regarding the progress made in improving patient safety and medical error reduction. The Lehman center shall seek federal and foundation support to supplement state resources to carry out the Lehman center's patient safety and medical error reduction goals.

SECTION 76. Section 16 of said chapter 12C, as so appearing, is hereby amended by inserting after subsection (c) the following subsection:-

(d) The center's report on the third year of a benchmark cycle shall be a final benchmark cycle report and shall compare the costs and cost trends for the entire benchmark cycle with the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D.

SECTION 77. Chapter 12C of the General Laws is hereby amended by striking out section 17 and inserting in place thereof the following section:-

Section 17. The attorney general may review and analyze any information submitted by a provider, provider organization, significant equity investor, health care real estate investment trust, management services organization or payer to the center under sections 8, 9 and 10, and to the health policy commission under section 8 of chapter 6D. The attorney general may require that such entities produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends, factors that contribute to cost growth within the commonwealth's health care system and the relationship between provider costs and payer

premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the entity that produced the information or documents; provided, however that the attorney general may disclose such information or documents during (i) the annual hearing conducted under section 8 of chapter 6D, (ii) a rate hearing before the division of health insurance, or (iii) in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that the disclosure would be in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

SECTION 78. Said chapter 12C is hereby further amended by striking out section 18 and inserting in place thereof the following section:-

Section 18. (a) For the purposes of this section “health care entity” shall mean a clinic, hospital, ambulatory surgical center, physician organization, accountable care organization or payer.

(b) The center shall perform ongoing analysis of data it receives under this chapter to identify any health care entity whose:

(1) Contribution to health care spending growth, including but not limited to spending levels and growth as measured by health status adjusted total medical expense, is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D; provided, that the

center shall establish differential standards for excessive growth rates, based on a health care entity's baseline spending, pricing levels and payer mix; or

(2) Data is not submitted to the center in a proper, timely, or complete manner.

(c) The center shall confidentially provide a list of the health care entities to the health policy commission such that the commission may pursue further action under section 10 of chapter 6D. Confidential referrals under this section shall not preclude the center from using its authority to assess penalties for noncompliance under section 11 of this chapter.

SECTION 79. Section 10 of chapter 13 of the General Laws, as so appearing, is hereby amended by striking out the last paragraph and inserting in place thereof the following paragraph:-

The board: (i) shall adopt, amend and rescind such rules and regulations as it deems necessary to carry out the this chapter; provided, however, that prior to adoption, amendment or rescission, any rule or regulation shall be submitted to the commissioner of public health for approval; (ii) may, subject to the approval of the commissioner of public health, appoint an executive director and a legal counsel; (iii) may appoint such other assistants as may be required; and (iv) may make contracts and arrangements for the performance of administrative and similar services required, or appropriate, in the performance of the duties of the board.

SECTION 80. Said chapter 13 is hereby further amended by striking out section 10A, as so appearing, and inserting in place thereof the following section:-

Section 10A. The commissioner of public health shall review and approve any rule or regulation proposed by the board of registration in medicine pursuant to section 10. Such rule or

regulation shall be deemed disapproved unless approved within 30 days of submission to the commissioner pursuant to said section 10.

SECTION 81. Section 1 of chapter 24A of the General Laws, as most recently amended by section 138 and 139 of chapter 7 of the Acts of 2023, is hereby further amended by striking out, in line 15, the words “department of banking and insurance” and inserting in place thereof the following words:- department of banking, insurance, and health insurance.

SECTION 82. Chapter 26 of the General Laws is hereby amended by striking out section 1, as appearing in the 2022 Official Edition, and inserting in place thereof the following section:-

Section 1. (a) There shall be a department of banking, insurance, and health insurance consisting of a division of banks and loan agencies, a division of insurance, and a division of health insurance. The division of health insurance shall have authority to oversee the health insurance market in the commonwealth and regulate companies organized to transact business and offering policies of accident and sickness insurance under chapter 175; nonprofit hospital service corporations under chapter 176A; nonprofit medical service corporations under chapter 176B; nonprofit medical service plans under chapter 176C; dental service corporations under chapter 176E; optometric service corporations under chapter 176F; health maintenance organizations under chapter 176G; preferred provider arrangements under chapter 176I; health benefit plans under chapter 176J; Medicare supplemental insurance or Medicare select insurance contracts authorized under chapter 176K; nongroup health plans under chapter 176M; risk-bearing provider organizations under chapter 176T; long-term care insurance policies under chapter 176U; and dental benefit insurance plans under chapter 176X. The division of insurance shall have authority for oversight over all other insurance markets.

(b) Each division shall be in charge of a commissioner who shall be known, respectively, as the commissioner of banks, the commissioner of insurance, and the commissioner of health insurance. The commissioners shall act as a board in all matters concerning the department as a whole.

SECTION 83. Said chapter 26 is hereby further amended by striking out section 7A and inserting in place thereof the following section:-

Section 7A. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Commissioner", the commissioner of the division of health insurance.

"Division", the division of health insurance.

"Rate review", any examination performed by the commissioner of the rates of payment proposed in contracts submitted for review pursuant to sections 5, 6 and 10 of chapter 176A; section 4 of chapter 176B; section 4 of chapter 176E; section 6 of chapter 176F; section 16 of chapter 176G; section 6 of chapter 176J; section 2 of chapter 176K; and section 2 of chapter 176X.

(b) There shall be a commissioner within the division of health insurance who shall be the executive and administrative head of the division, with the authority to oversee the health insurance market in the commonwealth. The commissioner shall: (i) protect the interests of consumers of health insurance; (ii) encourage fair treatment of health care providers by health insurers; (iii) enhance equity, access, quality and affordability in the health care system; (iv) guard the solvency of health insurers; (v) work cooperatively with the health policy commission

and the center for health information and analysis to monitor health care spending; and (v) prioritize affordability of health insurance products during rate review.

(c) The commissioner shall develop affordability standards for the approval of rates subject to rate review. Such standards shall consider the following:

(i) affordability for consumers, including the totality of costs paid by consumers of health insurance for covered benefits including, but not limited to, the enrollee's share of premium, out-of-pocket maximum amounts, deductibles, copays, coinsurance, and other forms of cost sharing for health insurance coverage;

(ii) affordability for purchasers, including the totality of costs paid by purchasers of health insurance, including, but not limited to, premium costs, actuarial value of coverage for covered benefits and the value delivered on health care spending in terms of improved quality and cost efficiency;

(iii) the impact of the proposed rates on the commonwealth's performance against the health care cost growth benchmark established in section 9 of chapter 6D; and

(iv) whether the proposed rates exhibit excessive variation in any rate of payment to any provider or class of providers in excess of the rate equity target established in section 9A of chapter 6D.

(d) The commissioner shall perform an ongoing analysis of data and documents submitted to the division including but not limited to, any materials submitted as part of rate reviews, to examine the causes of rate increases and provider price variation, including, but not limited to, the role of provider rate increases.

(e) The commissioner shall be appointed by the governor to serve for a term coterminous with that of the governor and shall devote their full time during business hours to the duties of the office. The position of commissioner shall be classified in accordance with section 45 of chapter 30, and the salary shall be determined in accordance with section 46C of said chapter 30. The commissioner shall appoint, at a minimum, the following employees: a first deputy, a general counsel, a chief health economist, a chief actuary, a chief research analyst, and a chief examiner. The appointed employees shall devote their full time to the duties of their offices, shall be exempt from chapters 30 and 31, and shall serve at the pleasure of the commissioner. In case of a vacancy in the office of commissioner, and during their absence or disability, the first deputy shall perform the duties of the office, or in case of the absence or disability of such first deputy, the general counsel. The commissioner may appoint and remove additional employees, including deputies, economists, analysts, examiners, assistant actuaries, inspectors, clerks and other assistants as the work of the division may require. Such additional employees shall perform such duties as the commissioner may prescribe.

(f) The commissioner shall make and collect an assessment against the carriers licensed under chapters 175, 176A, 176B, 176E, 176F and 176G to pay for the expenses of the division. The assessment shall be at a rate sufficient to produce $2,000,000 annually. In addition to that amount, the assessment shall include an amount to be credited to the General Fund which shall be equal to the total amount of funds estimated by the secretary for administration and finance to be expended from the General Fund for indirect and fringe benefit costs attributable to the personnel costs of the division. The assessment shall be allocated on a fair and reasonable basis among all carriers licensed under said chapters. The funds produced by the assessments shall be expended by the division, in addition to any other funds which may be appropriated, to assist in

defraying the general operating expenses of the division, and may be used to compensate consultants retained by the division. A carrier licensed under said chapters shall pay the amount assessed against it within 30 days after the date of the notice of assessment from the commissioner.

SECTION 84. Section 7B of said chapter 26, as appearing in the 2022 Official Edition, is hereby amended by inserting, after the word “commissioner” in line 2, the following words:- of health insurance.

SECTION 85. Said section 7B of said chapter 26, as so appearing, is hereby further amended by striking out, in line 9, the word “bureau” and inserting in place thereof the following words:- division of health insurance.

SECTION 86. Section 8H of said chapter 26, as so appearing, is hereby amended by striking out the first and second paragraphs.

SECTION 87. Said section 8H of said chapter 26, as so appearing, is hereby further amended by striking out, in lines 48, 55, and 73 and 74, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 88. Said section 8H of said chapter 26, as so appearing, is hereby further amended by striking out, in line 90, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 89. Subsection (a) of section 8K of said chapter 26 of the General Laws, as most recently amended by section 22 of chapter 177 of the acts of 2022, is hereby further

amended by striking out the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 90. Said subsection (a) of said section 8K of said Chapter 26 of the General Laws, as most recently amended by section 22 of chapter 177 of the acts of 2022, is hereby further amended by striking out the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 91. Section 8M of chapter 26 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 6 and 74 and in line 75, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 92. Said section 8M of said chapter 26, as so appearing, is hereby further amended by striking out, in lines 128 and 129, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 93. Subsection (b) of section 7H½ of chapter 29 of the General Laws, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- On or before January 15 in the year immediately preceding the start of a benchmark cycle, as defined in section 1 of chapter 6D, the secretary of administration and finance shall meet with the house and senate committees on ways and means and shall jointly develop a growth rate of potential gross state product for the ensuing benchmark cycle which shall be agreed to by the secretary and the committees.

SECTION 94. Section 3 of chapter 32A of the General Laws, as so appearing, is hereby amended by striking out, in line 5, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 95 Section 17Q of said chapter 32A, as so appearing, is hereby amended by striking out, in lines 5 and 6 and in line 7, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 96. Section 22B of said chapter 32A, as so appearing, is hereby amended by striking out, in lines 7 and in lines 101 and 102, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 97. Section 25 of said chapter 32A, as so appearing, is hereby amended by striking out, in lines 78 and 79 and in line 94, each time they appear, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 98. Subsection (c) of section 8B of chapter 62C of the General Laws, as so appearing, is hereby amended by striking out the third and fourth sentences and inserting in place thereof the following words:- The commissioner of revenue, in consultation with the commissioner of health insurance, may specify the content and format of the statements and reports. The commissioner of revenue may disclose the information in the statements and reports to the division of health insurance, the center for health information and analysis and the commonwealth health insurance connector.

SECTION 99. Subsection (d) of said section 8B of said chapter 62C, as so appearing, is hereby amended by striking out, in lines 35 and 36, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 100. Subsection (b) of section 21 of said chapter 62C, as so appearing, is hereby amended by inserting after the word “insurance”, in line 146, the following words: , the division of health insurance.

SECTION 101. Section 12 of chapter 62E of the General Laws, as so appearing, is hereby amended by inserting after the word “insurance”, in lines 19 and 20, the following words: , the division of health insurance.

SECTION 102. Section 26 of chapter 63 of the General Laws, as so appearing, is hereby amended by striking out the words “and the commissioner of insurance”, in lines 3 and 4, and inserting in place thereof the following words:- , the commissioner of insurance and the commissioner of health insurance.

SECTION 103. Section 9-609 of chapter 106 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after subsection (c) the following subsection:-

(d) In the case of a debtor that is a hospital licensed by the department of public health under section 51 chapter 111, and collateral that is a medical device, a secured party shall send notice to the department of public health 60 days prior to taking possession of the collateral, rendering equipment unusable or disposing of the collateral on the debtor’s premises pursuant to subsection (a). For the purposes of subsection (d), “medical device” shall have the same meaning as that term is defined in section 1 of chapter 111N.

SECTION 104. Chapter 110C of the of the General Laws is hereby amended by striking out section 11, as so appearing, and inserting in place thereof the following section:-

Section 11. If the offeror or a target company is an insurance company subject to regulation under chapter 175 to chapter 175C, inclusive, the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, as appropriate shall for all purposes of this section be substituted for the secretary. This section shall not be construed to limit or modify in any way any responsibility, authority, power, or jurisdiction of the secretary, the commissioner of insurance or the commissioner of health insurance pursuant to any other provisions of law.

SECTION 105. Section 24N of chapter 111 of the General Laws, as so appearing, is hereby amended by striking out, in line 71, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 106. The first paragraph of section 25A of chapter 111 of the General Laws, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- Under the direction of the health resource planning council established in section 22 of chapter 6D, the department shall establish and maintain, on a current basis, an inventory of all health care resources together with all other reasonably pertinent information concerning such resources, in order to identify the location, distribution and nature of all such resources in the commonwealth.

SECTION 107. Said section 25A of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 17 and 18, the words “in a designated office of the department”

and inserting in place thereof the following words:- as determined by the health resource planning council established in section 22 of chapter 6D.

SECTION 108. Said section 25A of said chapter 111, as so appearing, is hereby further amended by striking out the fourth paragraph.

SECTION 109. Section 25C of chapter 111 is hereby amended by striking out subsections (f) and (g) and inserting in place thereof the following 2 subsections:-

(f) Except as provided in section 25C½, a person or agency of the commonwealth or any political subdivision thereof shall not acquire an existing health care facility unless the person or agency files a determination of need application pursuant to this section.

(g) The department, in making any determination of need, shall encourage appropriate allocation of private and public health care resources and the development of alternative or substitute methods of delivering health care services so that adequate health care services will be made reasonably available to every person within the commonwealth at the lowest reasonable aggregate cost. The department, in making any determination of need, shall consider: (i) the state health plan pursuant to section 22 of chapter 6D, (ii) the commonwealth's cost containment goals, (iii) the impacts on the applicant's patients, the workforce of surrounding health care providers, and on other residents of the commonwealth, (iv) any comments and relevant data from the center for health information and analysis, the health policy commission, including but not limited to any cost and market impact review report pursuant to subsection (l) of section 13 of chapter 6D, and from any other state agency. The department may impose reasonable terms and conditions on the approval of a determination of need as the department determines are necessary to achieve the purposes and intent of this section. The department may also recognize

the special needs and circumstances of projects that: (1) are essential to the conduct of research in basic biomedical or health care delivery areas or to the training of health care personnel; (2) are unlikely to result in any increase in the clinical bed capacity or outpatient load capacity of the facility; and (3) are unlikely to cause an increase in the total patient care charges of the facility to the public for health care services, supplies, and accommodations, as such charges shall be defined from time to time in accordance with section 5 of chapter 409 of the acts of 1976.

SECTION 110. Subsection (h) of said section 25C is hereby amended by inserting after the word “applicant”, in line 129, the following words:- by an entity selected by the department from a list of 3 entities submitted by the applicant.

SECTION 111. Said section 25C of said chapter 111, as so appearing, is hereby further amended by striking out subsection (i) and inserting in place thereof the following subsection:-

(i) Except in the case of an emergency situation determined by the department as requiring immediate action to prevent further damage to the public health or to a health care facility, the department shall not act upon an application for such determination unless: (i) the application has been on file with the department for at least 30 days; (ii) the center for health information and analysis, the health policy commission, the state and appropriate regional comprehensive health planning agencies and, in the case of long-term care facilities only, the department of elder affairs, or in the case of any facility providing inpatient services for the mentally ill or developmentally disabled, the departments of mental health or developmental services, respectively, have been provided copies of such application and supporting documents and given reasonable opportunity to supply required information and comment on such application; and (iii) a public hearing has been held on such application when requested by the

applicant, the state or appropriate regional comprehensive health planning agency, any 10 taxpayers of the commonwealth and any other party of record as defined in section 25C¼. If, in any filing period, an individual application is filed, which would implicitly decide any other application filed during such period, the department shall not act only upon an individual.

SECTION 112. Said section 25C is hereby amended by striking out subsection (j) and inserting in place thereof the following subsection:-

(j) The department shall so approve or disapprove in whole or in part each such application for a determination of need within 4 months after filing with the department; provided, however, that the department may, on 1 occasion only, delay the action for up to 2 months after the applicant has provided information which the department has reasonably requested; provided further, that the period for review of an application for which an independent cost-analysis is required shall be stayed until a completed independent cost-analysis is received and accepted by the department. Any determination of need issued to a holder that is subject to a cost and market impact review under section 13 of chapter 6D shall not go into effect until a minimum of 30 days after the issuance of a final report under subsection (f) of section 13 of chapter 6D; provided further, that any determination of need issued to a holder that is subject to a performance improvement plan pursuant to section 10 of said chapter 6D shall not go into effect until 30 days after a determination by the health policy commission that the holder is implementing or has implemented said performance improvement plan; provided, however, that the health policy commission may rescind its determination that the holder is implementing a performance improvement plan at any time prior to successful completion of the performance improvement plan. Applications remanded to the department by the health facilities appeals board under section 25E shall be acted upon by the department within the same time limits

provided in this section for the department to approve or disapprove applications for a determination of need. If an application has not been acted upon by the department within such time limits, the applicant may, within a reasonable period of time, bring an action in the nature of mandamus in the superior court to require the department to act upon the application.

SECTION 113. Said chapter 111 is hereby further amended by inserting after section 25C, as so appearing, the following new section:-

Section 25C¼. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Independent community hospital", any hospital that has been: (i) designated by the health policy commission as an independent community hospital for the year in which an application for a determination of need is filed; or (ii) qualified in the year 2021 as an eligible hospital as defined in subsection (d) of section 63 of chapter 260 of the acts of 2020.

"Party of record", an applicant for a determination of need; the attorney general; the center for health information and analysis; the health policy commission; any government agency with relevant oversight or licensure authority over the proposed project or components therein; any 10 taxpayers of the commonwealth; or an independent community hospital whose primary service area overlaps with the primary service area of the applicant's proposed project. A party of record may review an application for determination of need as well as provide written comment for consideration by the department.

"Primary service area", the contiguous geographic area from which a health care facility draws 75 per cent of its commercial discharges, as measured by the zip codes closest to the facility by drive time, and for which the facility represents a minimum proportion of the total

discharges in a zip code, as determined by the department in consultation with the health policy commission and based on the best available data using a methodology determined by the department in consultation with the health policy commission.

"Proposed project", a project for the construction of a freestanding ambulatory surgery center for which a notice of determination of need is a prerequisite of licensure.

(b) For any application for a determination of need for which the primary service area of the proposed project overlaps with the primary service area of an existing independent community hospital, the applicant shall obtain and include in such application a letter of support from the independent community hospital's chief executive officer and board chair; provided, however, that a proposed project that constitutes a joint venture between the applicant and the independent community hospital shall be exempt from this subsection. The department shall conduct a preliminary review of each application to determine compliance with this subsection. If the department determines that an application is not in compliance, the department shall identify to the applicant any independent community hospital whose support is required by this subsection, and dismiss said application without prejudice. If the department fails to conduct a preliminary review of an application or fails to dismiss an application that does not satisfy the requirements of this subsection, the independent community hospital whose primary service area overlaps with the primary service area of the proposed project may, within a reasonable period of time, bring a civil action in the nature of mandamus in the superior court to require the department to act in accordance with this subsection.

SECTION 114. Section 25F of said chapter 111, as so appearing, is hereby amended by inserting after the word "care", in line 7, the following word:- financing.

SECTION 115. Section 25G of said chapter 111, as so appearing, is hereby amended by inserting after the word “agency”, in line 3, the following words:- , an independent community hospital, as defined by section 25C¼, whose primary service area overlaps with the primary service area of a proposed project under said section 25C¼.

SECTION 116. Chapter 111 of the General Laws is hereby amended by striking subsection (4) of section 51G, as so appearing, and inserting in place thereof the following section:-

(4)(a) Any hospital shall inform the department 90 days prior to the closing of the hospital or the discontinuance of any essential health service provided therein. The department shall by regulation define “essential health service” for the purposes of this section. The department shall, in the event that a hospital proposes to discontinue an essential health service or services, conduct a public hearing on the closure of said essential services or of the hospital. The department shall determine whether any such discontinued services are necessary for preserving access and health status in the hospital’s service area and shall require hospitals to submit a plan for assuring access to such necessary services following the hospital’s closure of the service, and assure continuing access to such services in the event that the department determines that their closure will significantly reduce access to necessary services. The department shall conduct a public hearing prior to a determination on the closure of said essential services or of the hospital.

(b) The health policy commission may conduct an essential service closure impact assessment to analyze the impact of the proposed essential service closure on health care access, cost, quality or market function. To support its analysis, the health policy commission may

require the hospital to submit information concerning the essential service closure, including, but not limited to, the organizational structure, input costs, pricing, utilization, and revenue. The service closure impact assessment shall evaluate factors that impact the hospital's ability to maintain the essential health service and shall include, but shall not be limited to, an analysis of the following: (i) the hospital's overall financial position and the financial position of the service line, including quality of earnings assessment; (ii) significant factors influencing the hospital's financial position, including those within and outside of the hospital's control; (iii) other operating conditions, including but not limited to staffing, supplies and patient demand; and (iv) the impact of the service closure on the functioning of the health care system, particularly on vulnerable populations and on the state health plan developed pursuant to section 22 of chapter 6D. The essential service closure impact assessment may include recommendations on an appropriate hospital plan for ensuring access following the essential service closure or recommendations to the department concerning strategies to address challenges in maintaining such services.

(c) No original license shall be granted to establish or maintain an acute-care hospital, as defined by section 25B, unless the applicant submits a plan, to be approved by the department, for the provision of community benefits, including the identification and provision of essential health services. In approving the plan, the department may take into account the applicant's existing commitment to primary and preventive health care services and community contributions as well as the primary and preventive health care services and community contributions of the predecessor hospital. The department may waive this requirement, in whole or in part, at the request of the applicant which has provided or at the time the application is

filed, is providing, substantial primary and preventive health care services and community contributions in its service area.

SECTION 117. Said section 51G of said chapter 111 of the General Laws, as so appearing, is hereby further amended by inserting the following subsection:-

(7) No license shall be granted to establish or maintain an acute care hospital as defined by section 25B if said acute care hospital is not the owner in fee simple of the real property upon which the hospital is located; provided, however, that for a transfer of ownership of any acute care hospital licensed as of April 1, 2024 which does not own in fee simple the real property upon which the hospital is located, the transferee, and subsequent transferees, shall be issued a license if the transferee otherwise satisfies all other requirements for licensure under this chapter.

SECTION 118. Section 51H of said chapter 111, as so appearing, is hereby amended by striking out the definition of "Facility" and inserting in place thereof the following definition:-

"Facility", a hospital, institution for the care of unwed mothers, clinic providing ambulatory surgery as defined in section 25B, limited service clinic licensed pursuant to section 51J, office-based surgery facility licensed pursuant to section 51M, or urgent care center licensed pursuant to section 51N.

SECTION 119. Said section 51H of said chapter 111, as so appearing, is hereby further amended by inserting after the definition of "Healthcare-associated infection" the following definition:-

“Operational impairment event”, any action, or notice of impending action, including a notice of financial delinquency, concerning the repossession of medical equipment or supplies necessary for the provision of patient care.

SECTION 120. Subsection (b) of said section 51H of said chapter 111, as so appearing, is hereby amended by inserting the following paragraph:-

An operational impairment event shall be reported by a facility not later than 1 calendar day after it occurs. Notwithstanding any general or special law to the contrary, no contract between a facility and a lessor of medical equipment shall authorize the repossession of medical equipment or supplies unless the lessor provides a notice of financial delinquency to the department not less than 60 days prior to repossession of any medical equipment or supplies necessary for the provision of patient care. Any provision of any contract or other document between a lessor of medical equipment and a facility which does not comply with this paragraph shall be void as against public policy of the commonwealth.

SECTION 121. Said chapter 111 is hereby further amended by inserting after section 51L the following 2 sections:-

Section 51M. (a) For the purposes of this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

“Deep sedation”, a drug-induced depression of consciousness during which (i) the patient cannot be easily awakened but responds purposefully following repeated painful stimulation; (ii) the patient’s ability to maintain independent ventilatory function may be impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous ventilation may

be inadequate; and (iv) the patient's cardiovascular function is usually maintained without assistance.

"General anesthesia", a drug-induced depression of consciousness during which (i) the patient is not able to be awakened, even by painful stimulation; (ii) the patient's ability to maintain independent ventilatory function is often impaired; (iii) the patient, in many cases, often requires assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function; and (iv) the patient's cardiovascular function may be impaired.

"Minimal sedation", a drug-induced state during which (i) patients respond normally to verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory and cardiovascular functions are unaffected.

"Minor procedures", (i) procedures that can be performed safely with a minimum of discomfort where the likelihood of complications requiring hospitalization is minimal; (ii) procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less than 500cc of fat under un-supplemented local anesthesia.

"Moderate sedation", a drug-induced depression of consciousness during which: (i) the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous ventilation is adequate; and (iv) the patient's cardiovascular function is usually maintained without assistance.

"Office-based surgical center", an office, group of offices, or a facility, or any portion thereof owned, leased or operated by 1 or more practitioners engaged in a solo or group practice,

however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained for the purpose of providing office-based surgical services; provided, however, that "office-based surgical center" shall not include: (i) a hospital licensed under section 51 or by the federal government, (ii) an ambulatory surgical center as defined pursuant to section 25B and licensed under section 51, or (iii) a surgical center performing services in accordance with sections 12I to 12U, inclusive, of chapter 112.

"Office-based surgical services", any ambulatory surgical or other invasive procedure requiring (i) general anesthesia, (ii) moderate sedation, or (iii) deep sedation, and any liposuction procedure, excluding minor procedures and procedures requiring minimal sedation, where such surgical or other invasive procedure or liposuction is performed by a practitioner at an office-based surgical center.

(b) The department shall establish rules, regulations, and practice standards for the licensing of office-based surgical centers licensed under this section. In determining regulations and practice standards necessary for licensure as an office-based surgical center, the department may, at its discretion determine which regulations applicable to an ambulatory surgical center, as defined by section 25B, shall apply to an office-based surgical center pursuant to this section.

(c) The department shall issue for a term of 2 years, and renew for a like term, a license to maintain an office-based surgical center to an entity or organization that demonstrates to the department that it is responsible and suitable to maintain such a center. An office-based surgical center license shall list the specific locations on the premises where surgical services are provided. In the case of the transfer of ownership of an office-based surgical center, the

application of the new owner for a license, when filed with the department on the date of transfer of ownership, shall have the effect of a license for a period of 3 months.

(d) An office-based surgical center license shall be subject to suspension, revocation or refusal to issue or to renew for cause if, in its reasonable discretion, the department determines that the issuance of such license would be inconsistent with or opposed to the best interests of the public health, welfare or safety. Nothing in this subsection shall limit the authority of the department to require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to renew a license pursuant to subsection (c).

(e) Initial application and renewal fees for the license shall be established pursuant to section 3B of chapter 7.

(f) The department may impose a fine of up to $10,000 on a person or entity that advertises, announces, establishes, maintains an office-based surgical center without a license granted by the department. The department may impose a fine of not more than $10,000 on a licensed office-based surgical center that violates this section or any rule or regulation promulgated hereunder. Each day during which a violation continues shall constitute a separate offense. The department may conduct surveys and investigations to enforce compliance with this section.

(g) Notwithstanding any general or special rule to the contrary, the department may issue a 1-time provisional license to an applicant for an office-based surgical center licensed pursuant to this section if such office-based surgical center holds a current accreditation from the Accreditation Association for Ambulatory Health Care, American Association for Accreditation of Ambulatory Surgery Facilities, Inc., or The Joint Commission, or holds a current certification

for participation in either Medicare or Medicaid. The department may approve such a provisional application upon a finding of responsibility and suitability and that the center meets all other licensure requirements as determined by the department. Such provisional license issued to an office-based surgical center shall not be extended or renewed.

Section 51N. (a) For the purposes of this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Emergency services", as defined in section 1 of chapter 6D.

"Urgent care center", a clinic owned or operated by an entity that is not corporately affiliated with a hospital licensed under section 51, however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained for the purpose of providing urgent care services in an office or a group of offices, or any portion thereof, or an entity which is advertised, announced, established or maintained under a name which includes the words "urgent care" or which suggests that urgent care services are provided therein; provided, however, that "urgent care center" shall not include: (i) a hospital licensed under section 51 or operated by the federal government or by the commonwealth, (iii) a limited service clinic licensed under section 51J or (iv) a community health center receiving a grant under 42 U.S.C. 254b.

"Urgent care services" a model of episodic care for the diagnosis, treatment, management or monitoring of acute and chronic disease or injury that is: (i) for the treatment of illness or injury that is immediate in nature but does not require emergency services; (ii) provided on a walk-in basis without a prior appointment; (iii) available to the general public during times of the

day, weekends or holidays when primary care provider offices are not customarily open; and (iv) is not intended, and should not be used for, preventative or routine services.

(b) The department shall establish rules, regulations, and practice standards for the licensing of urgent care centers licensed under this section. In determining regulations and practice standards necessary for licensure as an urgent care center, the department may, at its discretion determine which regulations applicable to a clinic licensed under section 51, shall apply to an urgent care center pursuant to this section.

(c) The department shall issue for a term of 2 years, and renew for a like term, a license to maintain an urgent care center to an entity or organization that demonstrates to the department that it is responsible and suitable to maintain such a center. In the case of the transfer of ownership of an urgent care center, the application of the new owner for a license, when filed with the department on the date of transfer of ownership, shall have the effect of a license for a period of 3 months.

(d) An urgent care center license shall be subject to suspension, revocation or refusal to issue or to renew for cause if, in its reasonable discretion, the department determines that the issuance of such license would be inconsistent with or opposed to the best interests of the public health, welfare or safety. Nothing in this subsection shall limit the authority of the department to require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to renew a license pursuant to subsection (c).

(e) Initial application and renewal fees for the license shall be established pursuant to section 3B of chapter 7.

(f) The department may impose a fine of up to $10,000 on a person or entity that advertises, announces, establishes, maintains an urgent care center without a license granted by the department. The department may impose a fine of not more than $10,000 on a licensed urgent care center that violates this section or any rule or regulation promulgated hereunder. Each day during which a violation continues shall constitute a separate offense. The department may conduct surveys and investigations to enforce compliance with this section.

(g) Notwithstanding any general or special rule to the contrary, the department may issue a 1-time provisional license to an applicant for an urgent care center licensed pursuant to this section if such urgent care center holds a current accreditation from the Accreditation Association for Ambulatory Health Care, Urgent Care Association of America, or The Joint Commission, or holds a current certification for participation in either Medicare or Medicaid. The department may approve such provisional application upon a finding of responsibility and suitability and that the center meets all other licensure requirements as determined by the department. Such provisional license issued to an urgent care center shall not be extended or renewed.

SECTION 122. Section 52 of said chapter 111 is hereby amended by inserting after the definition of "Certified clinical specialist in psychiatric and mental health nursing" the following definition:-

"Clinic", any entity, however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained for the purpose of providing ambulatory medical, surgical, dental, physical rehabilitation, or mental health services. In addition, "clinic" shall include any entity, however organized, whether conducted for profit or

not for profit, which is advertised, announced, established, or maintained under a name which includes the word “clinic”, “dispensary”, or “institute”, and which suggests that ambulatory medical, surgical, dental, physical rehabilitation, or mental health services are rendered therein. For purposes of this section, clinic shall not include a clinic conducted by a hospital licensed under section 51 or by the federal government or the commonwealth.

SECTION 123. Said chapter 111 is hereby further amended by inserting after section 53H the following section:-

Section 53I. (a) A clinic shall notify the department not less than 180 days prior to any sale, relocation, or closure. The department may conduct a public hearing on the proposed clinic sale, relocation, or closure not less than 90 days prior to the proposed date of such event. The hearing shall consider the potential impacts of the proposed transaction, including, but not limited to:

(i) the potential loss or change in access to services for the population served by the clinic in the 24 months immediately preceding the notice to sell, relocate or close;

(ii) alternative providers and locations where the population served by the clinic will be able to obtain the health services that were provided by the clinic during the 24 months following the sale, relocation, or closure;

(iii) options available to the department to mitigate the impact of the sale, relocation, or closure on priority patient populations, as defined in section 1 of chapter 6D.

(b) Any clinic that intends to sell, relocate or close, shall notify their patients in writing not less than 90 days prior to the date of such sale, relocation or closure. The written notice shall

be sent via certified mail, return receipt requested, and by any other means required by the department and shall notify the patient that the clinic will continue to provide services to the patient for 90 days. Such notice shall also offer the patient resources to assist in finding a substitute health care provider and include the name and contact information for the entity assuming responsibility for the management of the patient's medical records.

SECTION 124. Section 206A of said chapter 111, as so appearing, is hereby amended by striking out, in lines 1 and 2, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 125. Section 218 of said chapter 111, as so appearing, is hereby amended by striking out, in line 2, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 126. Said section 218 of said chapter 111, as so appearing, is hereby further amended by striking out, in line 28, the words "Maintenance Organizations" and inserting in place thereof the following word:- Plans.

SECTION 127. Section 2 of chapter 111K of the General Laws, as so appearing, is hereby amended by striking out, in lines 4 and 5, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 128. Section 1 of chapter 111M of the General Laws, as so appearing, is hereby amended by striking out, in lines 34 and 35, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 129. Chapter 112 of the General Laws is hereby amended by inserting after section 5O the following section:-

Section 5P. (a) Any physician licensed by the board who intends to terminate a physician-patient relationship, or who intends to sell, relocate or close a medical practice, shall notify their patients in writing not less than 90 days prior to the date of such termination, sale, relocation or closure and their resulting unavailability. The written notice of termination shall be sent via certified mail, return receipt requested, and by any other means required by the board and shall notify the patient that the licensee's care of the patient will continue for 90 days or until such date as the patient notifies the licensee of the name and address of the patient's new physician, whichever occurs first. Such notice shall also offer the patient resources to assist in finding a substitute health care provider and include the name and contact information for the entity assuming responsibility for the management of the patient's medical records. Such requirements do not apply to physicians treating patients in an emergency room or under other emergent circumstances. Any physician who terminates a physician-patient relationship without providing notice to a patient as provided for in this section shall be subject to discipline by the board.

(b) Any physician licensed by the board who intends to terminate a physician-patient relationship, or who intends to sell, relocate or close a medical practice shall cause to be published once during each week for 4 consecutive weeks, in the newspaper of greatest circulation in each county served by the physician practice and in a local newspaper that serves the immediate practice area, a notice which shall contain the date of termination, sale, or relocation and an a copy of said notice shall also be submitted to the board not less than 90 days prior to the date of termination, sale, or relocation of the practice. The physician may also place a

sign in a conspicuous location on the façade of the physician's office. The notice, or sign if applicable, shall advise the physician's patients of their opportunity and right to transfer or receive copies of their records.

SECTION 130. Section 9C of chapter 118E, as so appearing, is hereby amended by striking out, in lines 43 and 44, and in lines 147 and 148, each time they appear, the words "commissioner of insurance" and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 131. Said Section 9C of said chapter 118E, as so appearing, is hereby further amended by striking out, in line 161, the words "committee on health care" and inserting in place thereof the following words:- joint committee on health care financing.

SECTION 132. Section 9D of said chapter 118E, as so appearing, is hereby amended by striking out, in line 183, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 133. Section 13D of said chapter 118E, as so appearing, is hereby amended by striking out, in line 17, each time they appear, the words "division of insurance" and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 134. Section 69 of said chapter 118E, as so appearing, is hereby amended by striking out, in line 58, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 135. Section 189 of chapter 149 of the General Laws, as so appearing, is hereby amended by striking out, in lines 68 and 69, the words "and (iv) the commissioner of

insurance or a designee" and inserting in place thereof the following words:- (iv) the commissioner of insurance or a designee; and (v) the commissioner of health insurance or a designee.

SECTION 136. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:-

"Commissioner", (1) the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter applies to companies that are regulated by the division of health insurance pursuant to section 1 of said chapter 26.

SECTION 137. Said section 1 of said chapter 175, as so appearing, is hereby further amended inserting after the definition of "Contract on a Variable Basis" the following definition:-

"Division", the division of insurance or the division of health insurance, as appropriate.

SECTION 138. Section 4 of said chapter 175, as so appearing, is hereby amended by striking out, in line 9, the words "of insurance".

SECTION 139. Section 24D of said chapter 175, as so appearing, is hereby amended, in lines 19, 32 and 33, 59, and 99, by inserting after the words "commissioner of insurance", each time they appear, the following words, in each instance:- and the commissioner of health insurance.

SECTION 140. Section 24E of said chapter 175, as so appearing, is hereby amended by inserting after the word “insurance”, in line 70, the following words:- and the commissioner of health insurance.

SECTION 141. Said section 24E of said chapter 175, as so appearing, is hereby further amended by inserting after the word “insurance”, in line 102, the following words:- or the commissioner of health insurance.

SECTION 142. Section 24F of said chapter 175, as so appearing, is hereby amended, in lines 17, 29 and 30, 65, and 83, by inserting, each time they appear, the words “commissioner of insurance” the following words, in each instance:- and the commissioner of health insurance.

SECTION 143. Said section 24F of said chapter 175, as so appearing, s hereby further amended by inserting after the word “insurance”, in line 100, the following words:- or the commissioner of health insurance.

SECTION 144. Section 47B of said chapter 175, as so appearing, is hereby amended by striking out, in line 142, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 145. Section 47J of said chapter 175, as so appearing, is hereby amended by striking out, in line 11, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 146. Section 47W of said chapter 175, as so appearing, is hereby amended by striking out, in line 117, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 147. Section 47AA of said chapter 175, as so appearing, is hereby amended by striking out, in lines 83 and 84 and line 99, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 148. Section 47KK of said chapter 175, as so appearing, is hereby amended by striking out, in lines 7 and 8, and in line 10, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 149. Section 47TT of said chapter 175, as so appearing, is hereby amended by striking out, in line 51, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 150. Section 108 of said chapter 175, as so appearing, is hereby amended by striking out, in lines 681 and 682, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 151. Section 108I of said chapter 175, as so appearing, is hereby amended by striking out, in line 58, the words “of insurance”.

SECTION 152. Section 108M of said chapter 175, as so appearing, is hereby amended by striking out, in line 10, the words “of insurance”.

SECTION 153. Section 110I of said chapter 175, as so appearing, is hereby amended by striking out, in line 23, the words “of insurance”.

SECTION 154. Section 110J of said chapter 175, as so appearing, is hereby amended by striking out, in line 22, the words “of insurance”.

SECTION 155. Section 206 of said chapter 175 of the General Laws, as so appearing, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter applies to companies that are regulated by the division of health insurance pursuant to section 1 of said chapter 26.

SECTION 156. Said section 206 of said chapter 175, as so appearing, is hereby further amended by striking out the definition of “Division” and inserting in place thereof the following definition:-

“Division”, the division of insurance or the division of health insurance, as appropriate.

SECTION 157. Section 206C of said chapter 175, as so appearing, is hereby amended by striking out, in lines 647 and 648, the words “division of insurance’s” and inserting in place thereof the following words:- division’s.

SECTION 158. Chapter 175B, as appearing in the 2022 Official Edition, is hereby amended by inserting after section 1 the following section:-

Section 1A. (a) For the purposes of this section, the term “commissioner” shall mean (1) the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee,

or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter applies to companies that are regulated by the division of health insurance pursuant to section 1 of said chapter 26.

SECTION 159. Section 2 of said chapter 175B, as so appearing, is hereby amended by striking out, in lines 9, 18, and 20 and 21, each time they appear, the words “of insurance”.

SECTION 160. Section 3A of said chapter 175B, as so appearing, is hereby amended by striking out, in line 7, the words “of insurance”.

SECTION 161. Section 1 of chapter 175D, as appearing in the 2022 Official Edition, amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter applies to companies that are regulated by the division of health insurance pursuant to section 1 of said chapter 26.

SECTION 162. Section 2 of chapter 175I of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter

applies to companies that are regulated by the division of health insurance pursuant to section 1 of said chapter 26.

SECTION 163. Section 9 of said chapter 175I, as so appearing, is hereby amended by striking out, in lines 21 and 22, the words “of insurance”.

SECTION 164. Section 2 of chapter 176A of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 11 and 12, and in lines 13 and 14, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 165. Section 3 of said chapter 176A, as so appearing, is hereby amended by striking out, in lines 3 and 4, the words “commissioner of insurance” and inserting in place thereof the following words:- and the commissioner of health insurance.

SECTION 166. Section 5 of chapter 176A, as so appearing, is hereby amended by inserting after the word “corporation”, in line 44, the following words:- For the purposes of the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 167. Said section 5 of said chapter 176A, as so appearing, is hereby amended by striking out, in lines 205 and 206, the words “commissioner of insurance shall on December thirty-first, nineteen hundred and seventy and annually thereafter” and inserting in place thereof the following words:- commissioner of health insurance shall require, annually on December 31,.

SECTION 168. Section 6 of said chapter 176A, as so appearing, is hereby amended by inserting after the word “discriminatory”, in line 10, the following words:- For the purposes of

the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 169. Section 7 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 1 and in line 11, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 170. Section 8 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 27, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 171. Section 8A of said chapter 176A, as so appearing, is hereby amended by striking out, in line 142, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 172. Section 8F of said chapter 176A, as so appearing, is hereby amended by striking out, in line 19, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 173. Section 8M of said chapter 176A, as so appearing, is hereby amended by striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 174. Section 8W of said chapter 176A, as so appearing, is hereby amended by striking out, in line 114, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 175. Section 8DD of said chapter 176A of the General Laws, as so appearing, is hereby amended by striking out, in lines 81 and 82, and line 97, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- and the commissioner of health insurance.

SECTION 176. Section 8MM of said chapter 176A of the General Laws, as so appearing, is hereby amended by striking out, in line 7 and 9, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 177. Section 8UU of said chapter 176A, as so appearing, is hereby amended by striking out, in line 41, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 178. Section 10 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 25, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 179. Section 10 of said chapter 176A, as so appearing, is hereby amended by inserting after the word “discriminatory”, in line 43, the following words:- For the purposes of the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 180. Section 11 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 13, the words “commissioner of insurance” and inserting in place thereof the words:- commissioner of health insurance.

SECTION 181. Section 15 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the words:- commissioner of health insurance.

SECTION 182. Section 16 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the words:- commissioner of health insurance.

SECTION 183. Section 17 of said chapter 176A of the General Laws, as so appearing, is hereby amended, in lines 9 and 11, by inserting after the words “commissioner of insurance”, each time they appear, the following words, in each instance:- and the commissioner of health insurance.

SECTION 184. Section 18 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 185. Section 20 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 186. Section 21 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 185. Section 22 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 187. Section 23 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 188. Section 24 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 19, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 189. Section 25 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 4, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 190. Section 31 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 5, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 191. Section 37 of said chapter 176A, as so appearing, is hereby amended by striking out, in line 10, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 192. Section 1 of chapter 176B of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 193. Said section 1 of said chapter 176B, as so appearing, is hereby further amended inserting after the definition of "Dependent" the following definition:-

"Division", the division of insurance or the division of health insurance, as appropriate.

SECTION 194. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the word "discriminatory", in line 41, the following words:- For the purposes of the review of rates of payment under this section, "not excessive" shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 195. Section 4 of said chapter 176B, as so appearing, is hereby amended by striking out, in line 48, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 196. Section 4A of said chapter 176B, as so appearing, is hereby amended by striking out, in line 137, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 197. Section 4M of said chapter 176B, as so appearing, is hereby amended by striking out, in line 1, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 198. Section 4DD of said chapter 176B, as so appearing, is hereby amended by striking out, in lines 80 and 81, and line 96, each time they appear, the words "commissioner

of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 199. Section 4MM of said chapter 176B, as so appearing, as so appearing, is hereby amended by striking out, in lines 7 and 9, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 200. Section 4UU of said chapter 176B, as so appearing, is hereby amended by striking out, in line 40, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 201. Section 6 of said chapter 176B, as so appearing, is hereby amended by striking out, in line 16, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 202. Section 6B of said chapter 176B, as so appearing, is hereby amended by striking out, in lines 18 and 19, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 203. Section 10 of said chapter 176B, as so appearing, is hereby amended by striking out, in line 34, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 204. Section 12 of said chapter 176B, as so appearing, is hereby amended by striking out, in lines 8 and 9, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 205. Section 24 of said chapter 176B, as so appearing, is hereby amended by striking out, in line 10, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 206. Section 9 of chapter 176C of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in line 2 and 3 in lines 6 and 7, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 207. Section 10 of said chapter 176C, as so appearing, is hereby amended by striking out, in lines 1, 9, and 13, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 208. Section 17 of said chapter 176C, as so appearing, is hereby amended by striking out, in line 6, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 209. Section 1 of chapter 176D, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 210. Section 3B of said chapter 176D, as so appearing, is hereby amended by striking out, in line 120, the words “commissioner of the division of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 2011. Section 1 of chapter 176E of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 212. Section 4 of chapter 176E, as so appearing, is hereby amended by inserting after the word “discriminatory”, in line 44, the following words:- For the purposes of the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 213. Section 6 of said chapter 176E, as so appearing, is hereby amended by striking out, in line 22, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 214. Section 12 of said chapter 176E, as so appearing, is hereby amended by striking out, in lines 6 and 7, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 215. Section 1 of chapter 176F of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 216. Section 6 of chapter 176F of the General Laws, as so appearing, is hereby amended by inserting after the word "discriminatory", in line 17, the following words:- For the purposes of the review of rates of payment under this section, "not excessive" shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 217. Section 12 of said chapter 176F, as so appearing, is hereby amended by striking out, in line 7, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 218. Section 1 of chapter 176G of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 219. Section 4M of said chapter 176G, as so appearing, is hereby amended by striking out, in line 134, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 220. Section 4V of said chapter 176G, as so appearing, is hereby amended by striking out, in lines 80 and 81, and line 96, each time they appear, the words "commissioner of insurance" and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 221. Section 4EE of said chapter 176G, as so appearing, is hereby amended by striking out, in lines 6 and 8, each time they appear, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 222. Section 4MM of said chapter 176G, as so appearing, is hereby amended by striking out, in line 40, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 223. Section 5A of said chapter 176G, as so appearing, is hereby amended by striking out, in lines 18 and 19, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 224. Section 8 of said chapter 176G, as so appearing, is hereby amended by striking out, in line 7, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 225. Section 16 of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the word “discriminatory”, in line 5, the following words:- For the purposes of the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 226. Section 17 of said chapter 176G, as so appearing, is hereby amended by striking out, in line 8, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 227. Section 32 of said chapter 176G, as so appearing, is hereby amended by striking out, in line 10, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 228. Section 1 of chapter 176I of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 229. Section 8 of said chapter 176I, as so appearing, is hereby amended by striking out, in line 16, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 230. Section 1 of chapter 176J of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 231. Section 4 of said section 176J, as so appearing, is hereby amended by striking out, in lines 75 and 80, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 232. Section 6 of chapter 176J of the General Laws, as so appearing, is hereby amended by inserting after the word “charged”, in line 49, the following words:- For the purposes of the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 233. Section 6 of said section 176J, as so appearing, is hereby amended by striking out, in lines 110 and 111, and 125, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 234. Section 10 of said section 176J, as so appearing, is hereby amended by striking out, in lines 1 and 11, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 235. Section 11 of said section 176J, as so appearing, is hereby amended by striking out, in lines 16, and in lines 69 and 70, each time they appear, the words “commissioner of insurance” and inserting in place thereof, in each instance, the following words:- commissioner of health insurance.

SECTION 236. Said section 11 of said section 176J, as so appearing, is hereby further amended by striking out, in lines 35, 93, 95, and 107, each time they appear, the words “division of insurance” and inserting in place thereof, in each instance, the following words:- division of health insurance.

SECTION 237. Said section 11A of said chapter 176J, as so appearing, is hereby further amended by striking out, in lines 31 and 32, the words “division of health care finance and

policy” and inserting in place thereof the following words:- center for health information and analysis.

SECTION 238. Section 17 of said chapter 176J, as so appearing, is hereby amended by striking out, in line10, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 239. Section 1 of chapter 176K of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 240. Section 2 of chapter 176K of the General Laws, as so appearing, is hereby amended by inserting after the word “chapter”, in line 47, the following words:- For the purposes of the review of rates of payment under this section, “not excessive” shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 241. Section 1 of chapter 176M of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out, in lines 21 and 22, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 242. Said section 1 of said chapter 176M, as so appearing, is hereby further amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 243. Section 2 of said chapter 176M, as so appearing, is hereby amended by striking out, in line 156, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 244. Section 3 said chapter 176M, as so appearing, is hereby amended by striking out, in line 107, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 245. Section 1 of chapter 176N of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 246. Section 1 of chapter 176O of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 247. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by striking out the definition of “Division” and inserting in place thereof the following definition:-

“Division”, the division of health insurance.

SECTION 248. Section 2 of said chapter 176O is hereby amended by striking out, in lines 79, 83, and 90, each time they appear, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 249. Section 5B of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 3 and 4, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 250. Section 12B said chapter 176O, as so appearing, is hereby amended by striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 251. Section 14 said chapter 176O, as amended by section 2 of chapter 20 of the Acts of 2023, is hereby amended by striking out, in line 13, the words “commissioner of insurance” and inserting in place thereof the following words”- commissioner of health insurance.

SECTION 252. Said section 14 said chapter 176O, as amended by section 2 of chapter 20 of the Acts of 2023, is hereby further amended by striking out, in line 3, the words “division of insurance” and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 253. Section 1 of chapter 176Q of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 254. Section 2 of said chapter 176Q, as so appearing, is hereby amended by striking out, in lines 18 and 19, the words "commissioner of insurance" and inserting in place thereof the following words:- commissioner of health insurance.

SECTION 255. Section 3 of said chapter 176Q, as so appearing, is hereby amended by striking out, in line 86, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 256. Section 1 of chapter 176R of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 257. Section 1 of chapter 176S of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 258. Section 1 of chapter 176T of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 259. Section 1 of chapter 176U of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:-

"Commissioner", the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 260. Section 6 of said chapter 176U, as so appearing, is hereby amended by striking out, in lines 42 and 43, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 261. Section 7 of said chapter 176U, as so appearing, is hereby amended by striking out, in line 26, the words "division of insurance" and inserting in place thereof the following words:- division of health insurance.

SECTION 262. Section 1 of chapter 175V of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:-

"Commissioner", (1) the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter applies to companies that are regulated by the division of health insurance pursuant to section 1 of said chapter 26.

SECTION 263. Section 1 of chapter 175W of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter applies to companies that are regulated by the division of health insurance pursuant to section 1 of said chapter 26.

SECTION 264. Said section 1 of said chapter 176W, as so appearing, is hereby further amended by striking out the definition of “Division” and inserting in place thereof the following definition:-

“Division”, the division of insurance or the division of health insurance, as appropriate.

SECTION 265. Section 1 of chapter 176X of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:-

“Commissioner”, the commissioner of health insurance appointed pursuant to section 7A of chapter 26, or their designee.

SECTION 266. Section 2 of said chapter 176X, as so appearing, is hereby amended by striking out, in line 3, the words “division of insurance” and inserting in place thereof the following words:- division of health insurance.

SECTION 267. Section 2 of chapter 176X is hereby amended by inserting after the word "charged", in line 38, the following words:- For the purposes of the review of rates of payment under this section, "not excessive" shall include considerations of affordability for consumers and purchasers of health insurance products.

SECTION 268. Notwithstanding any general or special law, rule or regulation to the contrary, the health resource planning council established in section 22 of chapter 16D of the General Laws shall submit a state health plan to the governor and the general court, as required by section 22 of chapter 6D of the General Laws, on or before January 1, 2026.