

# HOUSE . . . . . No. 4620

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## The Commonwealth of Massachusetts

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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..

**HOUSE . . . . . No. 4620**

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**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:*

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

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

9           SECTION 3. Said section 16D of said chapter 6A, as so appearing, is hereby further  
10 amended by striking out, in lines 22 and 23, the words “department of public health established  
11 by section 217 of chapter 111, and the managed care bureau in the division of insurance” and  
12 inserting in place thereof the following words:- health policy commission established by section  
13 2 of chapter 6D, and the managed care bureau in the division of health insurance.

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

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

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 Section 16N of chapter 6A of the General Laws is hereby repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

95           “Technical advisory committee”, the technical advisory committee of the health policy  
96 commission established by section 4A.

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

262 SECTION 31. Said chapter 6D is hereby further amended by striking out sections 9 and  
263 10 and inserting in place thereof the following 3 sections:-

264 Section 9. (a) The board shall establish a health care cost growth benchmark for the  
265 average annual growth in total health care expenditures in the commonwealth during a period of  
266 3 consecutive calendar years. The commission shall establish the health care cost growth  
267 benchmark not later than April 15 of the year immediately preceding the first calendar year of a  
268 benchmark cycle.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

371 (6) any other factors the commission considers relevant.

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

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

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

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

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

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

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

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

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

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

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

427 (p) If the commission determines that a health care entity or payer has: (i) willfully  
428 neglected to file a performance improvement plan with the commission within 45 days as  
429 required under subsection (d); (ii) failed to file an acceptable performance improvement plan in  
430 good faith with the commission; (iii) failed to implement the performance improvement plan in  
431 good faith; or (iv) knowingly failed to provide information required by this section to the  
432 commission or that knowingly falsifies the same, the commission may: (i) assess a civil penalty  
433 to the health care entity or payer of not more than \$500,000 for a first violation, not more than  
434 \$750,000 for a second violation, and not more than \$1,000,000 for a third or subsequent  
435 violation; (ii) stay consideration of any material change notice submitted under section 13 by the  
436 health care entity or payer until the commission determines that the health care entity or payer is  
437 in compliance with this section; and (iii) notify the department of public health that the health  
438 care entity, if applying for a notice of determination of need, is not in compliance with this  
439 section. The commission shall seek to promote compliance with this section and shall only  
440 impose a civil penalty as a last resort.

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

444 SECTION 32. Section 11 of said chapter 6D of the General Laws, as appearing in the  
445 2022 Official Edition, is hereby amended by striking out, in lines 5, 34, and 40, each time they  
446 appear, the words “division of insurance” and inserting in place thereof, in each instance, the  
447 following words:- division of health insurance.

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

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

454 SECTION 35. Chapter 6D of the General Laws is hereby amended by striking out section  
455 13, as so appearing, and inserting in place thereof the following section:-

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



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

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

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

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

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

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

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

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

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

534 products; (iii) net cost of private health insurance and total medical expense by market segment,  
535 including individual, small group, large group, self-insured, student and Medicare Advantage  
536 markets, and compared to similar payers; (iv) performance against the health care cost growth  
537 benchmark established in section 9 of chapter 6D and the rate equity target established in section  
538 9A; (v) premiums for different plans, including compared to other carriers for the similar  
539 insurance products; (vi) enrollment and demographic data, coverage, premium, product, network,  
540 and benefit design; (vii) administrative costs and profits, including all categories of  
541 administrative expenditures, net additions to reserves, rate dividends or rebates, profits or losses,  
542 taxes and fees; (viii) adoption of alternative payment models and standards and payer's  
543 compliance with standard quality measures; (ix) consumer concerns, including claims denials,  
544 prior authorization denials, medical necessity, tiering, and cost sharing, inclusive of out-of-  
545 pocket maximums, copayments, coinsurance, and deductibles; and (x) any other factors that the  
546 commission determines to be in the public interest.

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

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

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

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

573 (h) A provider, provider organization or payer that meets the criteria in subsection (e)  
574 shall be presumed to be engaged in an unfair method of competition or unfair and deceptive trade  
575 practice subject to an action brought by the attorney general pursuant to section 4 of chapter  
576 93A; provided, however, that a provider, provider organization or payer that meets the criteria of  
577 subsection (e) shall not be subject to an action brought pursuant to sections 9 or 11 of said

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

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

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

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

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

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

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

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

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

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

612 (17) any other requirements the commission considers necessary.

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

720 SECTION 46. Section 11F of chapter 12 of the of the General Laws, as appearing in the  
721 2022 Official Edition, is hereby amended by striking out, in lines 6 and 7, the words “division of  
722 insurance within the department of banking and insurance” and inserting in place thereof the  
723 following words:- the division of insurance or the division of health insurance within the  
724 department of banking, insurance, and health insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

968 “Board”, the patient safety and medical errors reduction board.

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

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

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

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

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

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



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

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

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

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

1000 SECTION 77. Chapter 12C of the General Laws is hereby amended by striking out  
1001 section 17 and inserting in place thereof the following section:-

1002 Section 17. The attorney general may review and analyze any information submitted by a  
1003 provider, provider organization, significant equity investor, health care real estate investment  
1004 trust, management services organization or payer to the center under sections 8, 9 and 10, and to  
1005 the health policy commission under section 8 of chapter 6D. The attorney general may require  
1006 that such entities produce documents, answer interrogatories and provide testimony under oath  
1007 related to health care costs and cost trends, factors that contribute to cost growth within the  
1008 commonwealth's health care system and the relationship between provider costs and payer

1009 premium rates. The attorney general shall keep confidential all nonpublic information and  
1010 documents obtained under this section and shall not disclose the information or documents to any  
1011 person without the consent of the entity that produced the information or documents; provided,  
1012 however that the attorney general may disclose such information or documents during (i) the  
1013 annual hearing conducted under section 8 of chapter 6D, (ii) a rate hearing before the division of  
1014 health insurance, or (iii) in a case brought by the attorney general, if the attorney general believes  
1015 that such disclosure will promote the health care cost containment goals of the commonwealth  
1016 and that the disclosure would be in the public interest after taking into account any privacy, trade  
1017 secret or anti-competitive considerations. The confidential information and documents shall not  
1018 be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of  
1019 chapter 4 or section 10 of chapter 66.

1020 SECTION 78. Said chapter 12C is hereby further amended by striking out section 18 and  
1021 inserting in place thereof the following section:-

1022 Section 18. (a) For the purposes of this section “health care entity” shall mean a clinic,  
1023 hospital, ambulatory surgical center, physician organization, accountable care organization or  
1024 payer.

1025 (b) The center shall perform ongoing analysis of data it receives under this chapter to  
1026 identify any health care entity whose:

1027 (1) Contribution to health care spending growth, including but not limited to spending  
1028 levels and growth as measured by health status adjusted total medical expense, is considered  
1029 excessive and who threaten the ability of the state to meet the health care cost growth benchmark  
1030 established by the health policy commission under section 9 of chapter 6D; provided, that the

1031 center shall establish differential standards for excessive growth rates, based on a health care  
1032 entity's baseline spending, pricing levels and payer mix; or

1033 (2) Data is not submitted to the center in a proper, timely, or complete manner.

1034 (c) The center shall confidentially provide a list of the health care entities to the health  
1035 policy commission such that the commission may pursue further action under section 10 of  
1036 chapter 6D. Confidential referrals under this section shall not preclude the center from using its  
1037 authority to assess penalties for noncompliance under section 11 of this chapter.

1038 SECTION 79. Section 10 of chapter 13 of the General Laws, as so appearing, is hereby  
1039 amended by striking out the last paragraph and inserting in place thereof the following  
1040 paragraph:-

1041 The board: (i) shall adopt, amend and rescind such rules and regulations as it deems  
1042 necessary to carry out the this chapter; provided, however, that prior to adoption, amendment or  
1043 rescission, any rule or regulation shall be submitted to the commissioner of public health for  
1044 approval; (ii) may, subject to the approval of the commissioner of public health, appoint an  
1045 executive director and a legal counsel; (iii) may appoint such other assistants as may be required;  
1046 and (iv) may make contracts and arrangements for the performance of administrative and similar  
1047 services required, or appropriate, in the performance of the duties of the board.

1048 SECTION 80. Said chapter 13 is hereby further amended by striking out section 10A, as  
1049 so appearing, and inserting in place thereof the following section:-

1050 Section 10A. The commissioner of public health shall review and approve any rule or  
1051 regulation proposed by the board of registration in medicine pursuant to section 10. Such rule or

1052 regulation shall be deemed disapproved unless approved within 30 days of submission to the  
1053 commissioner pursuant to said section 10.

1054 SECTION 81. Section 1 of chapter 24A of the General Laws, as most recently amended  
1055 by section 138 and 139 of chapter 7 of the Acts of 2023, is hereby further amended by striking  
1056 out, in line 15, the words “department of banking and insurance” and inserting in place thereof  
1057 the following words:- department of banking, insurance, and health insurance.

1058 SECTION 82. Chapter 26 of the General Laws is hereby amended by striking out section  
1059 1, as appearing in the 2022 Official Edition, and inserting in place thereof the following section:-

1060 Section 1. (a) There shall be a department of banking, insurance, and health insurance  
1061 consisting of a division of banks and loan agencies, a division of insurance, and a division of  
1062 health insurance. The division of health insurance shall have authority to oversee the health  
1063 insurance market in the commonwealth and regulate companies organized to transact business  
1064 and offering policies of accident and sickness insurance under chapter 175; nonprofit hospital  
1065 service corporations under chapter 176A; nonprofit medical service corporations under chapter  
1066 176B; nonprofit medical service plans under chapter 176C; dental service corporations under  
1067 chapter 176E; optometric service corporations under chapter 176F; health maintenance  
1068 organizations under chapter 176G; preferred provider arrangements under chapter 176I; health  
1069 benefit plans under chapter 176J; Medicare supplemental insurance or Medicare select insurance  
1070 contracts authorized under chapter 176K; nongroup health plans under chapter 176M; risk-  
1071 bearing provider organizations under chapter 176T; long-term care insurance policies under  
1072 chapter 176U; and dental benefit insurance plans under chapter 176X. The division of insurance  
1073 shall have authority for oversight over all other insurance markets.

1074 (b) Each division shall be in charge of a commissioner who shall be known, respectively,  
1075 as the commissioner of banks, the commissioner of insurance, and the commissioner of health  
1076 insurance. The commissioners shall act as a board in all matters concerning the department as a  
1077 whole.

1078 SECTION 83. Said chapter 26 is hereby further amended by striking out section 7A and  
1079 inserting in place thereof the following section:-

1080 Section 7A. (a) As used in this section, the following words shall, unless the context  
1081 clearly requires otherwise, have the following meanings:-

1082 “Commissioner”, the commissioner of the division of health insurance.

1083 “Division”, the division of health insurance.

1084 “Rate review”, any examination performed by the commissioner of the rates of payment  
1085 proposed in contracts submitted for review pursuant to sections 5, 6 and 10 of chapter 176A;  
1086 section 4 of chapter 176B; section 4 of chapter 176E; section 6 of chapter 176F; section 16 of  
1087 chapter 176G; section 6 of chapter 176J; section 2 of chapter 176K; and section 2 of chapter  
1088 176X.

1089 (b) There shall be a commissioner within the division of health insurance who shall be  
1090 the executive and administrative head of the division, with the authority to oversee the health  
1091 insurance market in the commonwealth. The commissioner shall: (i) protect the interests of  
1092 consumers of health insurance; (ii) encourage fair treatment of health care providers by health  
1093 insurers; (iii) enhance equity, access, quality and affordability in the health care system; (iv)  
1094 guard the solvency of health insurers; (v) work cooperatively with the health policy commission

1095 and the center for health information and analysis to monitor health care spending; and (v)  
1096 prioritize affordability of health insurance products during rate review.

1097 (c) The commissioner shall develop affordability standards for the approval of rates  
1098 subject to rate review. Such standards shall consider the following:

1099 (i) affordability for consumers, including the totality of costs paid by consumers of health  
1100 insurance for covered benefits including, but not limited to, the enrollee's share of premium, out-  
1101 of-pocket maximum amounts, deductibles, copays, coinsurance, and other forms of cost sharing  
1102 for health insurance coverage;

1103 (ii) affordability for purchasers, including the totality of costs paid by purchasers of  
1104 health insurance, including, but not limited to, premium costs, actuarial value of coverage for  
1105 covered benefits and the value delivered on health care spending in terms of improved quality  
1106 and cost efficiency;

1107 (iii) the impact of the proposed rates on the commonwealth's performance against the  
1108 health care cost growth benchmark established in section 9 of chapter 6D; and

1109 (iv) whether the proposed rates exhibit excessive variation in any rate of payment to any  
1110 provider or class of providers in excess of the rate equity target established in section 9A of  
1111 chapter 6D.

1112 (d) The commissioner shall perform an ongoing analysis of data and documents  
1113 submitted to the division including but not limited to, any materials submitted as part of rate  
1114 reviews, to examine the causes of rate increases and provider price variation, including, but not  
1115 limited to, the role of provider rate increases.

1116 (e) The commissioner shall be appointed by the governor to serve for a term coterminous  
1117 with that of the governor and shall devote their full time during business hours to the duties of  
1118 the office. The position of commissioner shall be classified in accordance with section 45 of  
1119 chapter 30, and the salary shall be determined in accordance with section 46C of said chapter 30.  
1120 The commissioner shall appoint, at a minimum, the following employees: a first deputy, a  
1121 general counsel, a chief health economist, a chief actuary, a chief research analyst, and a chief  
1122 examiner. The appointed employees shall devote their full time to the duties of their offices, shall  
1123 be exempt from chapters 30 and 31, and shall serve at the pleasure of the commissioner. In case  
1124 of a vacancy in the office of commissioner, and during their absence or disability, the first deputy  
1125 shall perform the duties of the office, or in case of the absence or disability of such first deputy,  
1126 the general counsel. The commissioner may appoint and remove additional employees, including  
1127 deputies, economists, analysts, examiners, assistant actuaries, inspectors, clerks and other  
1128 assistants as the work of the division may require. Such additional employees shall perform such  
1129 duties as the commissioner may prescribe.

1130 (f) The commissioner shall make and collect an assessment against the carriers licensed  
1131 under chapters 175, 176A, 176B, 176E, 176F and 176G to pay for the expenses of the division.  
1132 The assessment shall be at a rate sufficient to produce \$2,000,000 annually. In addition to that  
1133 amount, the assessment shall include an amount to be credited to the General Fund which shall  
1134 be equal to the total amount of funds estimated by the secretary for administration and finance to  
1135 be expended from the General Fund for indirect and fringe benefit costs attributable to the  
1136 personnel costs of the division. The assessment shall be allocated on a fair and reasonable basis  
1137 among all carriers licensed under said chapters. The funds produced by the assessments shall be  
1138 expended by the division, in addition to any other funds which may be appropriated, to assist in

1139 defraying the general operating expenses of the division, and may be used to compensate  
1140 consultants retained by the division. A carrier licensed under said chapters shall pay the amount  
1141 assessed against it within 30 days after the date of the notice of assessment from the  
1142 commissioner.

1143 SECTION 84. Section 7B of said chapter 26, as appearing in the 2022 Official Edition, is  
1144 hereby amended by inserting, after the word “commissioner” in line 2, the following words:- of  
1145 health insurance.

1146 SECTION 85. Said section 7B of said chapter 26, as so appearing, is hereby further  
1147 amended by striking out, in line 9, the word “bureau” and inserting in place thereof the following  
1148 words:- division of health insurance.

1149 SECTION 86. Section 8H of said chapter 26, as so appearing, is hereby amended by  
1150 striking out the first and second paragraphs.

1151 SECTION 87. Said section 8H of said chapter 26, as so appearing, is hereby further  
1152 amended by striking out, in lines 48, 55, and 73 and 74, each time they appear, the words  
1153 “division of insurance” and inserting in place thereof, in each instance, the following words:-  
1154 division of health insurance.

1155 SECTION 88. Said section 8H of said chapter 26, as so appearing, is hereby further  
1156 amended by striking out, in line 90, the words “commissioner of insurance” and inserting in  
1157 place thereof the following words:- commissioner of health insurance.

1158 SECTION 89. Subsection (a) of section 8K of said chapter 26 of the General Laws, as  
1159 most recently amended by section 22 of chapter 177 of the acts of 2022, is hereby further



1160 amended by striking out the words “commissioner of insurance” and inserting in place thereof  
1161 the following words:- commissioner of health insurance.

1162 SECTION 90. Said subsection (a) of said section 8K of said Chapter 26 of the General  
1163 Laws, as most recently amended by section 22 of chapter 177 of the acts of 2022, is hereby  
1164 further amended by striking out the words “division of insurance” and inserting in place thereof  
1165 the following words:- division of health insurance.

1166 SECTION 91. Section 8M of chapter 26 of the General Laws, as appearing in the 2022  
1167 Official Edition, is hereby amended by striking out, in lines 6 and 74 and in line 75, each time  
1168 they appear, the words “commissioner of insurance” and inserting in place thereof, in each  
1169 instance, the following words:- commissioner of health insurance.

1170 SECTION 92. Said section 8M of said chapter 26, as so appearing, is hereby further  
1171 amended by striking out, in lines 128 and 129, the words “division of insurance” and inserting in  
1172 place thereof the following words:- division of health insurance.

1173 SECTION 93. Subsection (b) of section 7H½ of chapter 29 of the General Laws, as so  
1174 appearing, is hereby amended by striking out the first sentence and inserting in place thereof the  
1175 following sentence:- On or before January 15 in the year immediately preceding the start of a  
1176 benchmark cycle, as defined in section 1 of chapter 6D, the secretary of administration and  
1177 finance shall meet with the house and senate committees on ways and means and shall jointly  
1178 develop a growth rate of potential gross state product for the ensuing benchmark cycle which  
1179 shall be agreed to by the secretary and the committees.

1180 SECTION 94. Section 3 of chapter 32A of the General Laws, as so appearing, is hereby  
1181 amended by striking out, in line 5, the words “commissioner of insurance” and inserting in place  
1182 thereof the following words:- commissioner of health insurance.

1183 SECTION 95 Section 17Q of said chapter 32A, as so appearing, is hereby amended by  
1184 striking out, in lines 5 and 6 and in line 7, each time they appear, the words “division of  
1185 insurance” and inserting in place thereof, in each instance, the following words:- division of  
1186 health insurance.

1187 SECTION 96. Section 22B of said chapter 32A, as so appearing, is hereby amended by  
1188 striking out, in lines 7 and in lines 101 and 102, each time they appear, the words “commissioner  
1189 of insurance” and inserting in place thereof, in each instance, the following words:-  
1190 commissioner of health insurance.

1191 SECTION 97. Section 25 of said chapter 32A, as so appearing, is hereby amended by  
1192 striking out, in lines 78 and 79 and in line 94, each time they appear, the words “commissioner of  
1193 insurance” and inserting in place thereof the following words:- commissioner of health  
1194 insurance.

1195 SECTION 98. Subsection (c) of section 8B of chapter 62C of the General Laws, as so  
1196 appearing, is hereby amended by striking out the third and fourth sentences and inserting in place  
1197 thereof the following words:- The commissioner of revenue, in consultation with the  
1198 commissioner of health insurance, may specify the content and format of the statements and  
1199 reports. The commissioner of revenue may disclose the information in the statements and reports  
1200 to the division of health insurance, the center for health information and analysis and the  
1201 commonwealth health insurance connector.

1202 SECTION 99. Subsection (d) of said section 8B of said chapter 62C, as so appearing, is  
1203 hereby amended by striking out, in lines 35 and 36, the words “commissioner of insurance” and  
1204 inserting in place thereof the following words:- commissioner of health insurance.

1205 SECTION 100. Subsection (b) of section 21 of said chapter 62C, as so appearing, is  
1206 hereby amended by inserting after the word “insurance”, in line 146, the following words: , the  
1207 division of health insurance.

1208 SECTION 101. Section 12 of chapter 62E of the General Laws, as so appearing, is  
1209 hereby amended by inserting after the word “insurance”, in lines 19 and 20, the following words:  
1210 , the division of health insurance.

1211 SECTION 102. Section 26 of chapter 63 of the General Laws, as so appearing, is hereby  
1212 amended by striking out the words “and the commissioner of insurance”, in lines 3 and 4, and  
1213 inserting in place thereof the following words:- , the commissioner of insurance and the  
1214 commissioner of health insurance.

1215 SECTION 103. Section 9-609 of chapter 106 of the General Laws, as appearing in the  
1216 2022 Official Edition, is hereby amended by inserting after subsection (c) the following  
1217 subsection:-

1218 (d) In the case of a debtor that is a hospital licensed by the department of public health  
1219 under section 51 chapter 111, and collateral that is a medical device, a secured party shall send  
1220 notice to the department of public health 60 days prior to taking possession of the collateral,  
1221 rendering equipment unusable or disposing of the collateral on the debtor’s premises pursuant to  
1222 subsection (a). For the purposes of subsection (d), “medical device” shall have the same meaning  
1223 as that term is defined in section 1 of chapter 111N.

1224 SECTION 104. Chapter 110C of the of the General Laws is hereby amended by striking  
1225 out section 11, as so appearing, and inserting in place thereof the following section:-

1226 Section 11. If the offeror or a target company is an insurance company subject to  
1227 regulation under chapter 175 to chapter 175C, inclusive, the commissioner of insurance  
1228 appointed pursuant to section 6 of chapter 26, or their designee, or (2) the commissioner of  
1229 health insurance appointed pursuant to section 7A of chapter 26, or their designee, as appropriate  
1230 shall for all purposes of this section be substituted for the secretary. This section shall not be  
1231 construed to limit or modify in any way any responsibility, authority, power, or jurisdiction of  
1232 the secretary, the commissioner of insurance or the commissioner of health insurance pursuant to  
1233 any other provisions of law.

1234 SECTION 105. Section 24N of chapter 111 of the General Laws, as so appearing, is  
1235 hereby amended by striking out, in line 71, the words “commissioner of insurance” and inserting  
1236 in place thereof the following words:- commissioner of health insurance.

1237 SECTION 106. The first paragraph of section 25A of chapter 111 of the General Laws,  
1238 as so appearing, is hereby amended by striking out the first sentence and inserting in place  
1239 thereof the following sentence:- Under the direction of the health resource planning council  
1240 established in section 22 of chapter 6D, the department shall establish and maintain, on a current  
1241 basis, an inventory of all health care resources together with all other reasonably pertinent  
1242 information concerning such resources, in order to identify the location, distribution and nature  
1243 of all such resources in the commonwealth.

1244 SECTION 107. Said section 25A of said chapter 111, as so appearing, is hereby further  
1245 amended by striking out, in lines 17 and 18, the words “in a designated office of the department”

1246 and inserting in place thereof the following words:- as determined by the health resource  
1247 planning council established in section 22 of chapter 6D.

1248 SECTION 108. Said section 25A of said chapter 111, as so appearing, is hereby further  
1249 amended by striking out the fourth paragraph.

1250 SECTION 109. Section 25C of chapter 111 is hereby amended by striking out  
1251 subsections (f) and (g) and inserting in place thereof the following 2 subsections:-

1252 (f) Except as provided in section 25C½, a person or agency of the commonwealth or any  
1253 political subdivision thereof shall not acquire an existing health care facility unless the person or  
1254 agency files a determination of need application pursuant to this section.

1255 (g) The department, in making any determination of need, shall encourage appropriate  
1256 allocation of private and public health care resources and the development of alternative or  
1257 substitute methods of delivering health care services so that adequate health care services will be  
1258 made reasonably available to every person within the commonwealth at the lowest reasonable  
1259 aggregate cost. The department, in making any determination of need, shall consider: (i) the state  
1260 health plan pursuant to section 22 of chapter 6D, (ii) the commonwealth's cost containment  
1261 goals, (iii) the impacts on the applicant's patients, the workforce of surrounding health care  
1262 providers, and on other residents of the commonwealth, (iv) any comments and relevant data  
1263 from the center for health information and analysis, the health policy commission, including but  
1264 not limited to any cost and market impact review report pursuant to subsection (l) of section 13  
1265 of chapter 6D, and from any other state agency. The department may impose reasonable terms  
1266 and conditions on the approval of a determination of need as the department determines are  
1267 necessary to achieve the purposes and intent of this section. The department may also recognize

1268 the special needs and circumstances of projects that: (1) are essential to the conduct of research  
1269 in basic biomedical or health care delivery areas or to the training of health care personnel; (2)  
1270 are unlikely to result in any increase in the clinical bed capacity or outpatient load capacity of the  
1271 facility; and (3) are unlikely to cause an increase in the total patient care charges of the facility to  
1272 the public for health care services, supplies, and accommodations, as such charges shall be  
1273 defined from time to time in accordance with section 5 of chapter 409 of the acts of 1976.

1274 SECTION 110. Subsection (h) of said section 25C is hereby amended by inserting after  
1275 the word “applicant”, in line 129, the following words:- by an entity selected by the department  
1276 from a list of 3 entities submitted by the applicant.

1277 SECTION 111. Said section 25C of said chapter 111, as so appearing, is hereby further  
1278 amended by striking out subsection (i) and inserting in place thereof the following subsection:-

1279 (i) Except in the case of an emergency situation determined by the department as  
1280 requiring immediate action to prevent further damage to the public health or to a health care  
1281 facility, the department shall not act upon an application for such determination unless: (i) the  
1282 application has been on file with the department for at least 30 days; (ii) the center for health  
1283 information and analysis, the health policy commission, the state and appropriate regional  
1284 comprehensive health planning agencies and, in the case of long-term care facilities only, the  
1285 department of elder affairs, or in the case of any facility providing inpatient services for the  
1286 mentally ill or developmentally disabled, the departments of mental health or developmental  
1287 services, respectively, have been provided copies of such application and supporting documents  
1288 and given reasonable opportunity to supply required information and comment on such  
1289 application; and (iii) a public hearing has been held on such application when requested by the

1290 applicant, the state or appropriate regional comprehensive health planning agency, any 10  
1291 taxpayers of the commonwealth and any other party of record as defined in section 25C¼. If, in  
1292 any filing period, an individual application is filed, which would implicitly decide any other  
1293 application filed during such period, the department shall not act only upon an individual.

1294 SECTION 112. Said section 25C is hereby amended by striking out subsection (j) and  
1295 inserting in place thereof the following subsection:-

1296 (j) The department shall so approve or disapprove in whole or in part each such  
1297 application for a determination of need within 4 months after filing with the department;  
1298 provided, however, that the department may, on 1 occasion only, delay the action for up to 2  
1299 months after the applicant has provided information which the department has reasonably  
1300 requested; provided further, that the period for review of an application for which an independent  
1301 cost-analysis is required shall be stayed until a completed independent cost-analysis is received  
1302 and accepted by the department. Any determination of need issued to a holder that is subject to a  
1303 cost and market impact review under section 13 of chapter 6D shall not go into effect until a  
1304 minimum of 30 days after the issuance of a final report under subsection (f) of section 13 of  
1305 chapter 6D; provided further, that any determination of need issued to a holder that is subject to a  
1306 performance improvement plan pursuant to section 10 of said chapter 6D shall not go into effect  
1307 until 30 days after a determination by the health policy commission that the holder is  
1308 implementing or has implemented said performance improvement plan; provided, however, that  
1309 the health policy commission may rescind its determination that the holder is implementing a  
1310 performance improvement plan at any time prior to successful completion of the performance  
1311 improvement plan. Applications remanded to the department by the health facilities appeals  
1312 board under section 25E shall be acted upon by the department within the same time limits

1313 provided in this section for the department to approve or disapprove applications for a  
1314 determination of need. If an application has not been acted upon by the department within such  
1315 time limits, the applicant may, within a reasonable period of time, bring an action in the nature of  
1316 mandamus in the superior court to require the department to act upon the application.

1317 SECTION 113. Said chapter 111 is hereby further amended by inserting after section  
1318 25C, as so appearing, the following new section:-

1319 Section 25C¼. (a) For the purposes of this section, the following words shall, unless the  
1320 context clearly requires otherwise, have the following meanings:

1321 “Independent community hospital”, any hospital that has been: (i) designated by the  
1322 health policy commission as an independent community hospital for the year in which an  
1323 application for a determination of need is filed; or (ii) qualified in the year 2021 as an eligible  
1324 hospital as defined in subsection (d) of section 63 of chapter 260 of the acts of 2020.

1325 “Party of record”, an applicant for a determination of need; the attorney general; the  
1326 center for health information and analysis; the health policy commission; any government  
1327 agency with relevant oversight or licensure authority over the proposed project or components  
1328 therein; any 10 taxpayers of the commonwealth; or an independent community hospital whose  
1329 primary service area overlaps with the primary service area of the applicant’s proposed project.  
1330 A party of record may review an application for determination of need as well as provide written  
1331 comment for consideration by the department.

1332 “Primary service area”, the contiguous geographic area from which a health care facility  
1333 draws 75 per cent of its commercial discharges, as measured by the zip codes closest to the  
1334 facility by drive time, and for which the facility represents a minimum proportion of the total



1335 discharges in a zip code, as determined by the department in consultation with the health policy  
1336 commission and based on the best available data using a methodology determined by the  
1337 department in consultation with the health policy commission.

1338 “Proposed project”, a project for the construction of a freestanding ambulatory surgery  
1339 center for which a notice of determination of need is a prerequisite of licensure.

1340 (b) For any application for a determination of need for which the primary service area of  
1341 the proposed project overlaps with the primary service area of an existing independent  
1342 community hospital, the applicant shall obtain and include in such application a letter of support  
1343 from the independent community hospital’s chief executive officer and board chair; provided,  
1344 however, that a proposed project that constitutes a joint venture between the applicant and the  
1345 independent community hospital shall be exempt from this subsection. The department shall  
1346 conduct a preliminary review of each application to determine compliance with this subsection.  
1347 If the department determines that an application is not in compliance, the department shall  
1348 identify to the applicant any independent community hospital whose support is required by this  
1349 subsection, and dismiss said application without prejudice. If the department fails to conduct a  
1350 preliminary review of an application or fails to dismiss an application that does not satisfy the  
1351 requirements of this subsection, the independent community hospital whose primary service area  
1352 overlaps with the primary service area of the proposed project may, within a reasonable period of  
1353 time, bring a civil action in the nature of mandamus in the superior court to require the  
1354 department to act in accordance with this subsection.

1355 SECTION 114. Section 25F of said chapter 111, as so appearing, is hereby amended by  
1356 inserting after the word “care”, in line 7, the following word:- financing.

1357 SECTION 115. Section 25G of said chapter 111, as so appearing, is hereby amended by  
1358 inserting after the word “agency”, in line 3, the following words:- , an independent community  
1359 hospital, as defined by section 25C¼, whose primary service area overlaps with the primary  
1360 service area of a proposed project under said section 25C¼.

1361 SECTION 116. Chapter 111 of the General Laws is hereby amended by striking  
1362 subsection (4) of section 51G, as so appearing, and inserting in place thereof the following  
1363 section:-

1364 (4)(a) Any hospital shall inform the department 90 days prior to the closing of the  
1365 hospital or the discontinuance of any essential health service provided therein. The department  
1366 shall by regulation define “essential health service” for the purposes of this section. The  
1367 department shall, in the event that a hospital proposes to discontinue an essential health service  
1368 or services, conduct a public hearing on the closure of said essential services or of the hospital.  
1369 The department shall determine whether any such discontinued services are necessary for  
1370 preserving access and health status in the hospital’s service area and shall require hospitals to  
1371 submit a plan for assuring access to such necessary services following the hospital’s closure of  
1372 the service, and assure continuing access to such services in the event that the department  
1373 determines that their closure will significantly reduce access to necessary services. The  
1374 department shall conduct a public hearing prior to a determination on the closure of said essential  
1375 services or of the hospital.

1376 (b) The health policy commission may conduct an essential service closure impact  
1377 assessment to analyze the impact of the proposed essential service closure on health care access,  
1378 cost, quality or market function. To support its analysis, the health policy commission may

1379 require the hospital to submit information concerning the essential service closure, including, but  
1380 not limited to, the organizational structure, input costs, pricing, utilization, and revenue. The  
1381 service closure impact assessment shall evaluate factors that impact the hospital's ability to  
1382 maintain the essential health service and shall include, but shall not be limited to, an analysis of  
1383 the following: (i) the hospital's overall financial position and the financial position of the service  
1384 line, including quality of earnings assessment; (ii) significant factors influencing the hospital's  
1385 financial position, including those within and outside of the hospital's control; (iii) other  
1386 operating conditions, including but not limited to staffing, supplies and patient demand; and (iv)  
1387 the impact of the service closure on the functioning of the health care system, particularly on  
1388 vulnerable populations and on the state health plan developed pursuant to section 22 of chapter  
1389 6D. The essential service closure impact assessment may include recommendations on an  
1390 appropriate hospital plan for ensuring access following the essential service closure or  
1391 recommendations to the department concerning strategies to address challenges in maintaining  
1392 such services.

1393 (c) No original license shall be granted to establish or maintain an acute-care hospital, as  
1394 defined by section 25B, unless the applicant submits a plan, to be approved by the department,  
1395 for the provision of community benefits, including the identification and provision of essential  
1396 health services. In approving the plan, the department may take into account the applicant's  
1397 existing commitment to primary and preventive health care services and community  
1398 contributions as well as the primary and preventive health care services and community  
1399 contributions of the predecessor hospital. The department may waive this requirement, in whole  
1400 or in part, at the request of the applicant which has provided or at the time the application is

1401 filed, is providing, substantial primary and preventive health care services and community  
1402 contributions in its service area.

1403 SECTION 117. Said section 51G of said chapter 111 of the General Laws, as so  
1404 appearing, is hereby further amended by inserting the following subsection:-

1405 (7) No license shall be granted to establish or maintain an acute care hospital as defined  
1406 by section 25B if said acute care hospital is not the owner in fee simple of the real property upon  
1407 which the hospital is located; provided, however, that for a transfer of ownership of any acute  
1408 care hospital licensed as of April 1, 2024 which does not own in fee simple the real property  
1409 upon which the hospital is located, the transferee, and subsequent transferees, shall be issued a  
1410 license if the transferee otherwise satisfies all other requirements for licensure under this chapter.

1411 SECTION 118. Section 51H of said chapter 111, as so appearing, is hereby amended by  
1412 striking out the definition of “Facility” and inserting in place thereof the following definition:-

1413 “Facility”, a hospital, institution for the care of unwed mothers, clinic providing  
1414 ambulatory surgery as defined in section 25B, limited service clinic licensed pursuant to section  
1415 51J, office-based surgery facility licensed pursuant to section 51M, or urgent care center licensed  
1416 pursuant to section 51N.

1417 SECTION 119. Said section 51H of said chapter 111, as so appearing, is hereby further  
1418 amended by inserting after the definition of “Healthcare-associated infection” the following  
1419 definition:-

1420 “Operational impairment event”, any action, or notice of impending action, including a  
1421 notice of financial delinquency, concerning the repossession of medical equipment or supplies  
1422 necessary for the provision of patient care.

1423 SECTION 120. Subsection (b) of said section 51H of said chapter 111, as so appearing, is  
1424 hereby amended by inserting the following paragraph:-

1425 An operational impairment event shall be reported by a facility not later than 1 calendar  
1426 day after it occurs. Notwithstanding any general or special law to the contrary, no contract  
1427 between a facility and a lessor of medical equipment shall authorize the repossession of medical  
1428 equipment or supplies unless the lessor provides a notice of financial delinquency to the  
1429 department not less than 60 days prior to repossession of any medical equipment or supplies  
1430 necessary for the provision of patient care. Any provision of any contract or other document  
1431 between a lessor of medical equipment and a facility which does not comply with this paragraph  
1432 shall be void as against public policy of the commonwealth.

1433 SECTION 121. Said chapter 111 is hereby further amended by inserting after section  
1434 51L the following 2 sections:-

1435 Section 51M. (a) For the purposes of this section the following words shall, unless the  
1436 context clearly requires otherwise, have the following meanings:-

1437 “Deep sedation”, a drug-induced depression of consciousness during which (i) the patient  
1438 cannot be easily awakened but responds purposefully following repeated painful stimulation; (ii)  
1439 the patient’s ability to maintain independent ventilatory function may be impaired; (iii) the  
1440 patient may require assistance in maintaining a patent airway and spontaneous ventilation may

1441 be inadequate; and (iv) the patient’s cardiovascular function is usually maintained without  
1442 assistance.

1443 “General anesthesia”, a drug-induced depression of consciousness during which (i) the  
1444 patient is not able to be awakened, even by painful stimulation; (ii) the patient’s ability to  
1445 maintain independent ventilatory function is often impaired; (iii) the patient, in many cases, often  
1446 requires assistance in maintaining a patent airway and positive pressure ventilation may be  
1447 required because of depressed spontaneous ventilation or drug-induced depression of  
1448 neuromuscular function; and (iv) the patient’s cardiovascular function may be impaired.

1449 “Minimal sedation”, a drug-induced state during which (i) patients respond normally to  
1450 verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory  
1451 and cardiovascular functions are unaffected.

1452 “Minor procedures”, (i) procedures that can be performed safely with a minimum of  
1453 discomfort where the likelihood of complications requiring hospitalization is minimal; (ii)  
1454 procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less  
1455 than 500cc of fat under un-supplemented local anesthesia.

1456 “Moderate sedation”, a drug-induced depression of consciousness during which: (i) the  
1457 patient responds purposefully to verbal commands, either alone or accompanied by light tactile  
1458 stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous  
1459 ventilation is adequate; and (iv) the patient’s cardiovascular function is usually maintained  
1460 without assistance.

1461 “Office-based surgical center”, an office, group of offices, or a facility, or any portion  
1462 thereof owned, leased or operated by 1 or more practitioners engaged in a solo or group practice,

1463 however organized, whether conducted for profit or not for profit, which is advertised,  
1464 announced, established, or maintained for the purpose of providing office-based surgical  
1465 services; provided, however, that “office-based surgical center” shall not include: (i) a hospital  
1466 licensed under section 51 or by the federal government, (ii) an ambulatory surgical center as  
1467 defined pursuant to section 25B and licensed under section 51, or (iii) a surgical center  
1468 performing services in accordance with sections 12I to 12U, inclusive, of chapter 112.

1469 “Office-based surgical services”, any ambulatory surgical or other invasive procedure  
1470 requiring (i) general anesthesia, (ii) moderate sedation, or (iii) deep sedation, and any liposuction  
1471 procedure, excluding minor procedures and procedures requiring minimal sedation, where such  
1472 surgical or other invasive procedure or liposuction is performed by a practitioner at an office-  
1473 based surgical center.

1474 (b) The department shall establish rules, regulations, and practice standards for the  
1475 licensing of office-based surgical centers licensed under this section. In determining regulations  
1476 and practice standards necessary for licensure as an office-based surgical center, the department  
1477 may, at its discretion determine which regulations applicable to an ambulatory surgical center, as  
1478 defined by section 25B, shall apply to an office-based surgical center pursuant to this section.

1479 (c) The department shall issue for a term of 2 years, and renew for a like term, a license  
1480 to maintain an office-based surgical center to an entity or organization that demonstrates to the  
1481 department that it is responsible and suitable to maintain such a center. An office-based surgical  
1482 center license shall list the specific locations on the premises where surgical services are  
1483 provided. In the case of the transfer of ownership of an office-based surgical center, the

1484 application of the new owner for a license, when filed with the department on the date of transfer  
1485 of ownership, shall have the effect of a license for a period of 3 months.

1486 (d) An office-based surgical center license shall be subject to suspension, revocation or  
1487 refusal to issue or to renew for cause if, in its reasonable discretion, the department determines  
1488 that the issuance of such license would be inconsistent with or opposed to the best interests of the  
1489 public health, welfare or safety. Nothing in this subsection shall limit the authority of the  
1490 department to require a fee, impose a fine, conduct surveys and investigations or to suspend,  
1491 revoke or refuse to renew a license pursuant to subsection (c).

1492 (e) Initial application and renewal fees for the license shall be established pursuant to  
1493 section 3B of chapter 7.

1494 (f) The department may impose a fine of up to \$10,000 on a person or entity that  
1495 advertises, announces, establishes, maintains an office-based surgical center without a license  
1496 granted by the department. The department may impose a fine of not more than \$10,000 on a  
1497 licensed office-based surgical center that violates this section or any rule or regulation  
1498 promulgated hereunder. Each day during which a violation continues shall constitute a separate  
1499 offense. The department may conduct surveys and investigations to enforce compliance with this  
1500 section.

1501 (g) Notwithstanding any general or special rule to the contrary, the department may issue  
1502 a 1-time provisional license to an applicant for an office-based surgical center licensed pursuant  
1503 to this section if such office-based surgical center holds a current accreditation from the  
1504 Accreditation Association for Ambulatory Health Care, American Association for Accreditation  
1505 of Ambulatory Surgery Facilities, Inc., or The Joint Commission, or holds a current certification



1506 for participation in either Medicare or Medicaid. The department may approve such a provisional  
1507 application upon a finding of responsibility and suitability and that the center meets all other  
1508 licensure requirements as determined by the department. Such provisional license issued to an  
1509 office-based surgical center shall not be extended or renewed.

1510 Section 51N. (a) For the purposes of this section the following words shall, unless the  
1511 context clearly requires otherwise, have the following meanings:-

1512 “Emergency services”, as defined in section 1 of chapter 6D.

1513 “Urgent care center”, a clinic owned or operated by an entity that is not corporately  
1514 affiliated with a hospital licensed under section 51, however organized, whether conducted for  
1515 profit or not for profit, which is advertised, announced, established, or maintained for the  
1516 purpose of providing urgent care services in an office or a group of offices, or any portion  
1517 thereof, or an entity which is advertised, announced, established or maintained under a name  
1518 which includes the words “urgent care” or which suggests that urgent care services are provided  
1519 therein; provided, however, that “urgent care center” shall not include: (i) a hospital licensed  
1520 under section 51 or operated by the federal government or by the commonwealth, (iii) a limited  
1521 service clinic licensed under section 51J or (iv) a community health center receiving a grant  
1522 under 42 U.S.C. 254b.

1523 “Urgent care services” a model of episodic care for the diagnosis, treatment, management  
1524 or monitoring of acute and chronic disease or injury that is: (i) for the treatment of illness or  
1525 injury that is immediate in nature but does not require emergency services; (ii) provided on a  
1526 walk-in basis without a prior appointment; (iii) available to the general public during times of the

1527 day, weekends or holidays when primary care provider offices are not customarily open; and (iv)  
1528 is not intended, and should not be used for, preventative or routine services.

1529 (b) The department shall establish rules, regulations, and practice standards for the  
1530 licensing of urgent care centers licensed under this section. In determining regulations and  
1531 practice standards necessary for licensure as an urgent care center, the department may, at its  
1532 discretion determine which regulations applicable to a clinic licensed under section 51, shall  
1533 apply to an urgent care center pursuant to this section.

1534 (c) The department shall issue for a term of 2 years, and renew for a like term, a license  
1535 to maintain an urgent care center to an entity or organization that demonstrates to the department  
1536 that it is responsible and suitable to maintain such a center. In the case of the transfer of  
1537 ownership of an urgent care center, the application of the new owner for a license, when filed  
1538 with the department on the date of transfer of ownership, shall have the effect of a license for a  
1539 period of 3 months.

1540 (d) An urgent care center license shall be subject to suspension, revocation or refusal to  
1541 issue or to renew for cause if, in its reasonable discretion, the department determines that the  
1542 issuance of such license would be inconsistent with or opposed to the best interests of the public  
1543 health, welfare or safety. Nothing in this subsection shall limit the authority of the department to  
1544 require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to  
1545 renew a license pursuant to subsection (c).

1546 (e) Initial application and renewal fees for the license shall be established pursuant to  
1547 section 3B of chapter 7.

1548 (f) The department may impose a fine of up to \$10,000 on a person or entity that  
1549 advertises, announces, establishes, maintains an urgent care center without a license granted by  
1550 the department. The department may impose a fine of not more than \$10,000 on a licensed  
1551 urgent care center that violates this section or any rule or regulation promulgated hereunder.  
1552 Each day during which a violation continues shall constitute a separate offense. The department  
1553 may conduct surveys and investigations to enforce compliance with this section.

1554 (g) Notwithstanding any general or special rule to the contrary, the department may issue  
1555 a 1-time provisional license to an applicant for an urgent care center licensed pursuant to this  
1556 section if such urgent care center holds a current accreditation from the Accreditation  
1557 Association for Ambulatory Health Care, Urgent Care Association of America, or The Joint  
1558 Commission, or holds a current certification for participation in either Medicare or Medicaid.  
1559 The department may approve such provisional application upon a finding of responsibility and  
1560 suitability and that the center meets all other licensure requirements as determined by the  
1561 department. Such provisional license issued to an urgent care center shall not be extended or  
1562 renewed.

1563 SECTION 122. Section 52 of said chapter 111 is hereby amended by inserting after the  
1564 definition of “Certified clinical specialist in psychiatric and mental health nursing” the following  
1565 definition:-

1566 “Clinic”, any entity, however organized, whether conducted for profit or not for profit,  
1567 which is advertised, announced, established, or maintained for the purpose of providing  
1568 ambulatory medical, surgical, dental, physical rehabilitation, or mental health services. In  
1569 addition, “clinic” shall include any entity, however organized, whether conducted for profit or

1570 not for profit, which is advertised, announced, established, or maintained under a name which  
1571 includes the word “clinic”, “dispensary”, or “institute”, and which suggests that ambulatory  
1572 medical, surgical, dental, physical rehabilitation, or mental health services are rendered therein.  
1573 For purposes of this section, clinic shall not include a clinic conducted by a hospital licensed  
1574 under section 51 or by the federal government or the commonwealth.

1575 SECTION 123. Said chapter 111 is hereby further amended by inserting after section  
1576 53H the following section:-

1577 Section 53I. (a) A clinic shall notify the department not less than 180 days prior to any  
1578 sale, relocation, or closure. The department may conduct a public hearing on the proposed clinic  
1579 sale, relocation, or closure not less than 90 days prior to the proposed date of such event. The  
1580 hearing shall consider the potential impacts of the proposed transaction, including, but not  
1581 limited to:

1582 (i) the potential loss or change in access to services for the population served by the clinic  
1583 in the 24 months immediately preceding the notice to sell, relocate or close;

1584 (ii) alternative providers and locations where the population served by the clinic will be  
1585 able to obtain the health services that were provided by the clinic during the 24 months following  
1586 the sale, relocation, or closure;

1587 (iii) options available to the department to mitigate the impact of the sale, relocation, or  
1588 closure on priority patient populations, as defined in section 1 of chapter 6D.

1589 (b) Any clinic that intends to sell, relocate or close, shall notify their patients in writing  
1590 not less than 90 days prior to the date of such sale, relocation or closure. The written notice shall

1591 be sent via certified mail, return receipt requested, and by any other means required by the  
1592 department and shall notify the patient that the clinic will continue to provide services to the  
1593 patient for 90 days. Such notice shall also offer the patient resources to assist in finding a  
1594 substitute health care provider and include the name and contact information for the entity  
1595 assuming responsibility for the management of the patient’s medical records.

1596 SECTION 124. Section 206A of said chapter 111, as so appearing, is hereby amended by  
1597 striking out, in lines 1 and 2, the words “division of insurance” and inserting in place thereof the  
1598 following words:- division of health insurance.

1599 SECTION 125. Section 218 of said chapter 111, as so appearing, is hereby amended by  
1600 striking out, in line 2, the words “commissioner of insurance” and inserting in place thereof the  
1601 following words:- commissioner of health insurance.

1602 SECTION 126. Said section 218 of said chapter 111, as so appearing, is hereby further  
1603 amended by striking out, in line 28, the words “Maintenance Organizations” and inserting in  
1604 place thereof the following word:- Plans.

1605 SECTION 127. Section 2 of chapter 111K of the General Laws, as so appearing, is  
1606 hereby amended by striking out, in lines 4 and 5, the words “commissioner of insurance” and  
1607 inserting in place thereof the following words:- commissioner of health insurance.

1608 SECTION 128. Section 1 of chapter 111M of the General Laws, as so appearing, is  
1609 hereby amended by striking out, in lines 34 and 35, the words “commissioner of insurance” and  
1610 inserting in place thereof the following words:- commissioner of health insurance.

1611 SECTION 129. Chapter 112 of the General Laws is hereby amended by inserting after  
1612 section 5O the following section:-

1613 Section 5P. (a) Any physician licensed by the board who intends to terminate a  
1614 physician-patient relationship, or who intends to sell, relocate or close a medical practice, shall  
1615 notify their patients in writing not less than 90 days prior to the date of such termination, sale,  
1616 relocation or closure and their resulting unavailability. The written notice of termination shall be  
1617 sent via certified mail, return receipt requested, and by any other means required by the board  
1618 and shall notify the patient that the licensee's care of the patient will continue for 90 days or until  
1619 such date as the patient notifies the licensee of the name and address of the patient's new  
1620 physician, whichever occurs first. Such notice shall also offer the patient resources to assist in  
1621 finding a substitute health care provider and include the name and contact information for the  
1622 entity assuming responsibility for the management of the patient's medical records. Such  
1623 requirements do not apply to physicians treating patients in an emergency room or under other  
1624 emergent circumstances. Any physician who terminates a physician-patient relationship without  
1625 providing notice to a patient as provided for in this section shall be subject to discipline by the  
1626 board.

1627 (b) Any physician licensed by the board who intends to terminate a physician-patient  
1628 relationship, or who intends to sell, relocate or close a medical practice shall cause to be  
1629 published once during each week for 4 consecutive weeks, in the newspaper of greatest  
1630 circulation in each county served by the physician practice and in a local newspaper that serves  
1631 the immediate practice area, a notice which shall contain the date of termination, sale, or  
1632 relocation and an a copy of said notice shall also be submitted to the board not less than 90 days  
1633 prior to the date of termination, sale, or relocation of the practice. The physician may also place a

1634 sign in a conspicuous location on the façade of the physician’s office. The notice, or sign if  
1635 applicable, shall advise the physician’s patients of their opportunity and right to transfer or  
1636 receive copies of their records.

1637 SECTION 130. Section 9C of chapter 118E, as so appearing, is hereby amended by  
1638 striking out, in lines 43 and 44, and in lines 147 and 148, each time they appear, the words  
1639 “commissioner of insurance” and inserting in place thereof, in each instance, the following  
1640 words:- commissioner of health insurance.

1641 SECTION 131. Said Section 9C of said chapter 118E, as so appearing, is hereby further  
1642 amended by striking out, in line 161, the words “committee on health care” and inserting in place  
1643 thereof the following words:- joint committee on health care financing.

1644 SECTION 132. Section 9D of said chapter 118E, as so appearing, is hereby amended by  
1645 striking out, in line 183, the words “division of insurance” and inserting in place thereof the  
1646 following words:- division of health insurance.

1647 SECTION 133. Section 13D of said chapter 118E, as so appearing, is hereby amended by  
1648 striking out, in line 17, each time they appear, the words “division of insurance” and inserting in  
1649 place thereof, in each instance, the following words:- division of health insurance.

1650 SECTION 134. Section 69 of said chapter 118E, as so appearing, is hereby amended by  
1651 striking out, in line 58, the words “division of insurance” and inserting in place thereof the  
1652 following words:- division of health insurance.

1653 SECTION 135. Section 189 of chapter 149 of the General Laws, as so appearing, is  
1654 hereby amended by striking out, in lines 68 and 69, the words “and (iv) the commissioner of

1655 insurance or a designee” and inserting in place thereof the following words:- (iv) the  
1656 commissioner of insurance or a designee; and (v) the commissioner of health insurance or a  
1657 designee.

1658 SECTION 136. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby  
1659 amended by striking out the definition of “Commissioner” and inserting in place thereof the  
1660 following definition:-

1661 “Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of  
1662 chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance  
1663 appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter  
1664 applies to companies that are regulated by the division of health insurance pursuant to section 1  
1665 of said chapter 26.

1666 SECTION 137. Said section 1 of said chapter 175, as so appearing, is hereby further  
1667 amended inserting after the definition of “Contract on a Variable Basis” the following  
1668 definition:-

1669 “Division”, the division of insurance or the division of health insurance, as appropriate.

1670 SECTION 138. Section 4 of said chapter 175, as so appearing, is hereby amended by  
1671 striking out, in line 9, the words “of insurance”.

1672 SECTION 139. Section 24D of said chapter 175, as so appearing, is hereby amended, in  
1673 lines 19, 32 and 33, 59, and 99, by inserting after the words “commissioner of insurance”, each  
1674 time they appear, the following words, in each instance:- and the commissioner of health  
1675 insurance.



1676 SECTION 140. Section 24E of said chapter 175, as so appearing, is hereby amended by  
1677 inserting after the word “insurance”, in line 70, the following words:- and the commissioner of  
1678 health insurance.

1679 SECTION 141. Said section 24E of said chapter 175, as so appearing, is hereby further  
1680 amended by inserting after the word “insurance”, in line 102, the following words:- or the  
1681 commissioner of health insurance.

1682 SECTION 142. Section 24F of said chapter 175, as so appearing, is hereby amended, in  
1683 lines 17, 29 and 30, 65, and 83, by inserting, each time they appear, the words “commissioner of  
1684 insurance” the following words, in each instance:- and the commissioner of health insurance.

1685 SECTION 143. Said section 24F of said chapter 175, as so appearing, s hereby further  
1686 amended by inserting after the word “insurance”, in line 100, the following words:- or the  
1687 commissioner of health insurance.

1688 SECTION 144. Section 47B of said chapter 175, as so appearing, is hereby amended by  
1689 striking out, in line 142, the words “division of insurance” and inserting in place thereof the  
1690 following words:- division of health insurance.

1691 SECTION 145. Section 47J of said chapter 175, as so appearing, is hereby amended by  
1692 striking out, in line 11, the words “commissioner of insurance” and inserting in place thereof the  
1693 following words:- commissioner of health insurance.

1694 SECTION 146. Section 47W of said chapter 175, as so appearing, is hereby amended by  
1695 striking out, in line 117, the words “commissioner of insurance” and inserting in place thereof  
1696 the following words:- commissioner of health insurance.

1697 SECTION 147. Section 47AA of said chapter 175, as so appearing, is hereby amended by  
1698 striking out, in lines 83 and 84 and line 99, each time they appear, the words “commissioner of  
1699 insurance” and inserting in place thereof, in each instance, the following words:- commissioner  
1700 of health insurance.

1701 SECTION 148. Section 47KK of said chapter 175, as so appearing, is hereby amended by  
1702 striking out, in lines 7 and 8, and in line 10, each time they appear, the words “division of  
1703 insurance” and inserting in place thereof, in each instance, the following words:- division of  
1704 health insurance.

1705 SECTION 149. Section 47TT of said chapter 175, as so appearing, is hereby amended by  
1706 striking out, in line 51, the words “division of insurance” and inserting in place thereof the  
1707 following words:- division of health insurance.

1708 SECTION 150. Section 108 of said chapter 175, as so appearing, is hereby amended by  
1709 striking out, in lines 681 and 682, the words “commissioner of insurance” and inserting in place  
1710 thereof the following words:- commissioner of health insurance.

1711 SECTION 151. Section 108I of said chapter 175, as so appearing, is hereby amended by  
1712 striking out, in line 58, the words “of insurance”.

1713 SECTION 152. Section 108M of said chapter 175, as so appearing, is hereby amended by  
1714 striking out, in line 10, the words “of insurance”.

1715 SECTION 153. Section 110I of said chapter 175, as so appearing, is hereby amended by  
1716 striking out, in line 23, the words “of insurance”.

1717 SECTION 154. Section 110J of said chapter 175, as so appearing, is hereby amended by  
1718 striking out, in line 22, the words “of insurance”.

1719 SECTION 155. Section 206 of said chapter 175 of the General Laws, as so appearing, is  
1720 hereby amended by striking out the definition of “Commissioner” and inserting in place thereof  
1721 the following definition:-

1722 “Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of  
1723 chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance  
1724 appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter  
1725 applies to companies that are regulated by the division of health insurance pursuant to section 1  
1726 of said chapter 26.

1727 SECTION 156. Said section 206 of said chapter 175, as so appearing, is hereby further  
1728 amended by striking out the definition of “Division” and inserting in place thereof the following  
1729 definition:-

1730 “Division”, the division of insurance or the division of health insurance, as appropriate.

1731 SECTION 157. Section 206C of said chapter 175, as so appearing, is hereby amended by  
1732 striking out, in lines 647 and 648, the words “division of insurance’s” and inserting in place  
1733 thereof the following words:- division’s.

1734 SECTION 158. Chapter 175B, as appearing in the 2022 Official Edition, is hereby  
1735 amended by inserting after section 1 the following section:-

1736 Section 1A. (a) For the purposes of this section, the term “commissioner” shall mean (1)  
1737 the commissioner of insurance appointed pursuant to section 6 of chapter 26, or their designee,

1738 or, as appropriate, (2) the commissioner of health insurance appointed pursuant to section 7A of  
1739 chapter 26, or their designee, to the extent that this chapter applies to companies that are  
1740 regulated by the division of health insurance pursuant to section 1 of said chapter 26.

1741 SECTION 159. Section 2 of said chapter 175B, as so appearing, is hereby amended by  
1742 striking out, in lines 9, 18, and 20 and 21, each time they appear, the words “of insurance”.

1743 SECTION 160. Section 3A of said chapter 175B, as so appearing, is hereby amended by  
1744 striking out, in line 7, the words “of insurance”.

1745 SECTION 161. Section 1 of chapter 175D, as appearing in the 2022 Official Edition,  
1746 amended by striking out the definition of “Commissioner” and inserting in place thereof the  
1747 following definition:-

1748 “Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of  
1749 chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance  
1750 appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter  
1751 applies to companies that are regulated by the division of health insurance pursuant to section 1  
1752 of said chapter 26.

1753 SECTION 162. Section 2 of chapter 175I of the General Laws, as appearing in the 2022  
1754 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
1755 inserting in place thereof the following definition:-

1756 “Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of  
1757 chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance  
1758 appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter

1759 applies to companies that are regulated by the division of health insurance pursuant to section 1  
1760 of said chapter 26.

1761 SECTION 163. Section 9 of said chapter 175I, as so appearing, is hereby amended by  
1762 striking out, in lines 21 and 22, the words “of insurance”.

1763 SECTION 164. Section 2 of chapter 176A of the General Laws, as appearing in the 2022  
1764 Official Edition, is hereby amended by striking out, in lines 11 and 12, and in lines 13 and 14,  
1765 each time they appear, the words “commissioner of insurance” and inserting in place thereof, in  
1766 each instance, the following words:- commissioner of health insurance.

1767 SECTION 165. Section 3 of said chapter 176A, as so appearing, is hereby amended by  
1768 striking out, in lines 3 and 4, the words “commissioner of insurance” and inserting in place  
1769 thereof the following words:- and the commissioner of health insurance.

1770 SECTION 166. Section 5 of chapter 176A, as so appearing, is hereby amended by  
1771 inserting after the word “corporation”, in line 44, the following words:- For the purposes of the  
1772 review of rates of payment under this section, “not excessive” shall include considerations of  
1773 affordability for consumers and purchasers of health insurance products.

1774 SECTION 167. Said section 5 of said chapter 176A, as so appearing, is hereby amended  
1775 by striking out, in lines 205 and 206, the words “commissioner of insurance shall on December  
1776 thirty-first, nineteen hundred and seventy and annually thereafter” and inserting in place thereof  
1777 the following words:- commissioner of health insurance shall require, annually on December 31,.

1778 SECTION 168. Section 6 of said chapter 176A, as so appearing, is hereby amended by  
1779 inserting after the word “discriminatory”, in line 10, the following words:- For the purposes of

1780 the review of rates of payment under this section, “not excessive” shall include considerations of  
1781 affordability for consumers and purchasers of health insurance products.

1782 SECTION 169. Section 7 of said chapter 176A, as so appearing, is hereby amended by  
1783 striking out, in line 1 and in line 11, each time they appear, the words “commissioner of  
1784 insurance” and inserting in place thereof, in each instance, the following words:- commissioner  
1785 of health insurance.

1786 SECTION 170. Section 8 of said chapter 176A, as so appearing, is hereby amended by  
1787 striking out, in line 27, the words “commissioner of insurance” and inserting in place thereof the  
1788 following words:- commissioner of health insurance.

1789 SECTION 171. Section 8A of said chapter 176A, as so appearing, is hereby amended by  
1790 striking out, in line 142, the words “division of insurance” and inserting in place thereof the  
1791 following words:- division of health insurance.

1792 SECTION 172. Section 8F of said chapter 176A, as so appearing, is hereby amended by  
1793 striking out, in line 19, the words “commissioner of insurance” and inserting in place thereof the  
1794 following words:- commissioner of health insurance.

1795 SECTION 173. Section 8M of said chapter 176A, as so appearing, is hereby amended by  
1796 striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the  
1797 following words:- commissioner of health insurance.

1798 SECTION 174. Section 8W of said chapter 176A, as so appearing, is hereby amended by  
1799 striking out, in line 114, the words “commissioner of insurance” and inserting in place thereof  
1800 the following words:- commissioner of health insurance.

1801 SECTION 175. Section 8DD of said chapter 176A of the General Laws, as so appearing,  
1802 is hereby amended by striking out, in lines 81 and 82, and line 97, each time they appear, the  
1803 words “commissioner of insurance” and inserting in place thereof, in each instance, the  
1804 following words:- and the commissioner of health insurance.

1805 SECTION 176. Section 8MM of said chapter 176A of the General Laws, as so appearing,  
1806 is hereby amended by striking out, in line 7 and 9, each time they appear, the words “division of  
1807 insurance” and inserting in place thereof, in each instance, the following words:- division of  
1808 health insurance.

1809 SECTION 177. Section 8UU of said chapter 176A, as so appearing, is hereby amended  
1810 by striking out, in line 41, the words “division of insurance” and inserting in place thereof the  
1811 following words:- division of health insurance.

1812 SECTION 178. Section 10 of said chapter 176A, as so appearing, is hereby amended by  
1813 striking out, in line 25, the words “commissioner of insurance” and inserting in place thereof the  
1814 following words:- commissioner of health insurance.

1815 SECTION 179. Section 10 of said chapter 176A, as so appearing, is hereby amended by  
1816 inserting after the word “discriminatory”, in line 43, the following words:- For the purposes of  
1817 the review of rates of payment under this section, “not excessive” shall include considerations of  
1818 affordability for consumers and purchasers of health insurance products.

1819 SECTION 180. Section 11 of said chapter 176A, as so appearing, is hereby amended by  
1820 striking out, in line 13, the words “commissioner of insurance” and inserting in place thereof the  
1821 words:- commissioner of health insurance.

1822 SECTION 181. Section 15 of said chapter 176A, as so appearing, is hereby amended by  
1823 striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the  
1824 words:- commissioner of health insurance.

1825 SECTION 182. Section 16 of said chapter 176A, as so appearing, is hereby amended by  
1826 striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the  
1827 words:- commissioner of health insurance.

1828 SECTION 183. Section 17 of said chapter 176A of the General Laws, as so appearing, is  
1829 hereby amended, in lines 9 and 11, by inserting after the words “commissioner of insurance”,  
1830 each time they appear, the following words, in each instance:- and the commissioner of health  
1831 insurance.

1832 SECTION 184. Section 18 of said chapter 176A, as so appearing, is hereby amended by  
1833 striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the  
1834 following words:- commissioner of health insurance.

1835 SECTION 185. Section 20 of said chapter 176A, as so appearing, is hereby amended by  
1836 striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the  
1837 following words:- commissioner of health insurance.

1838 SECTION 186. Section 21 of said chapter 176A, as so appearing, is hereby amended by  
1839 striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the  
1840 following words:- commissioner of health insurance.



1841 SECTION 185. Section 22 of said chapter 176A, as so appearing, is hereby amended by  
1842 striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the  
1843 following words:- commissioner of health insurance.

1844 SECTION 187. Section 23 of said chapter 176A, as so appearing, is hereby amended by  
1845 striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the  
1846 following words:- commissioner of health insurance.

1847 SECTION 188. Section 24 of said chapter 176A, as so appearing, is hereby amended by  
1848 striking out, in line 19, the words “commissioner of insurance” and inserting in place thereof the  
1849 following words:- commissioner of health insurance.

1850 SECTION 189. Section 25 of said chapter 176A, as so appearing, is hereby amended by  
1851 striking out, in line 4, the words “commissioner of insurance” and inserting in place thereof the  
1852 following words:- commissioner of health insurance.

1853 SECTION 190. Section 31 of said chapter 176A, as so appearing, is hereby amended by  
1854 striking out, in line 5, the words “commissioner of insurance” and inserting in place thereof the  
1855 following words:- commissioner of health insurance.

1856 SECTION 191. Section 37 of said chapter 176A, as so appearing, is hereby amended by  
1857 striking out, in line 10, the words “division of insurance” and inserting in place thereof the  
1858 following words:- division of health insurance.

1859 SECTION 192. Section 1 of chapter 176B of the General Laws, as appearing in the 2022  
1860 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
1861 inserting in place thereof the following definition:-

1862           “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
1863 of chapter 26, or their designee.

1864           SECTION 193. Said section 1 of said chapter 176B, as so appearing, is hereby further  
1865 amended inserting after the definition of “Dependent” the following definition:-

1866           “Division”, the division of insurance or the division of health insurance, as appropriate.

1867           SECTION 194. Section 4 of chapter 176B of the General Laws, as so appearing, is  
1868 hereby amended by inserting after the word “discriminatory”, in line 41, the following words:-  
1869 For the purposes of the review of rates of payment under this section, “not excessive” shall  
1870 include considerations of affordability for consumers and purchasers of health insurance  
1871 products.

1872           SECTION 195. Section 4 of said chapter 176B, as so appearing, is hereby amended by  
1873 striking out, in line 48, the words “commissioner of insurance” and inserting in place thereof the  
1874 following words:- commissioner of health insurance.

1875           SECTION 196. Section 4A of said chapter 176B, as so appearing, is hereby amended by  
1876 striking out, in line 137, the words “division of insurance” and inserting in place thereof the  
1877 following words:- division of health insurance.

1878           SECTION 197. Section 4M of said chapter 176B, as so appearing, is hereby amended by  
1879 striking out, in line 1, the words “commissioner of insurance” and inserting in place thereof the  
1880 following words:- commissioner of health insurance.

1881           SECTION 198. Section 4DD of said chapter 176B, as so appearing, is hereby amended  
1882 by striking out, in lines 80 and 81, and line 96, each time they appear, the words “commissioner

1883 of insurance” and inserting in place thereof, in each instance, the following words:-  
1884 commissioner of health insurance.

1885 SECTION 199. Section 4MM of said chapter 176B, as so appearing, as so appearing, is  
1886 hereby amended by striking out, in lines 7 and 9, each time they appear, the words “division of  
1887 insurance” and inserting in place thereof, in each instance, the following words:- division of  
1888 health insurance.

1889 SECTION 200. Section 4UU of said chapter 176B, as so appearing, is hereby amended  
1890 by striking out, in line 40, the words “division of insurance” and inserting in place thereof the  
1891 following words:- division of health insurance.

1892 SECTION 201. Section 6 of said chapter 176B, as so appearing, is hereby amended by  
1893 striking out, in line 16, the words “commissioner of insurance” and inserting in place thereof the  
1894 following words:- commissioner of health insurance.

1895 SECTION 202. Section 6B of said chapter 176B, as so appearing, is hereby amended by  
1896 striking out, in lines 18 and 19, the words “commissioner of insurance” and inserting in place  
1897 thereof the following words:- commissioner of health insurance.

1898 SECTION 203. Section 10 of said chapter 176B, as so appearing, is hereby amended by  
1899 striking out, in line 34, the words “commissioner of insurance” and inserting in place thereof the  
1900 following words:- commissioner of health insurance.

1901 SECTION 204. Section 12 of said chapter 176B, as so appearing, is hereby amended by  
1902 striking out, in lines 8 and 9, the words “division of insurance” and inserting in place thereof the  
1903 following words:- division of health insurance.

1904 SECTION 205. Section 24 of said chapter 176B, as so appearing, is hereby amended by  
1905 striking out, in line 10, the words “division of insurance” and inserting in place thereof the  
1906 following words:- division of health insurance.

1907 SECTION 206. Section 9 of chapter 176C of the General Laws, as appearing in the 2022  
1908 Official Edition, is hereby amended by striking out, in line 2 and 3 in lines 6 and 7, each time  
1909 they appear, the words “commissioner of insurance” and inserting in place thereof, in each  
1910 instance, the following words:- commissioner of health insurance.

1911 SECTION 207. Section 10 of said chapter 176C, as so appearing, is hereby amended by  
1912 striking out, in lines 1, 9, and 13, each time they appear, the words “commissioner of insurance”  
1913 and inserting in place thereof, in each instance, the following words:- commissioner of health  
1914 insurance.

1915 SECTION 208. Section 17 of said chapter 176C, as so appearing, is hereby amended by  
1916 striking out, in line 6, the words “commissioner of insurance” and inserting in place thereof the  
1917 following words:- commissioner of health insurance.

1918 SECTION 209. Section 1 of chapter 176D, as appearing in the 2022 Official Edition, is  
1919 hereby amended by striking out the definition of “Commissioner” and inserting in place thereof  
1920 the following definition:-

1921 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
1922 of chapter 26, or their designee.

1923 SECTION 210. Section 3B of said chapter 176D, as so appearing, is hereby amended by  
1924 striking out, in line 120, the words “commissioner of the division of insurance” and inserting in  
1925 place thereof the following words:- commissioner of health insurance.

1926 SECTION 2011. Section 1 of chapter 176E of the General Laws, as appearing in the  
1927 2022 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
1928 inserting in place thereof the following definition:-

1929 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
1930 of chapter 26, or their designee.

1931 SECTION 212. Section 4 of chapter 176E, as so appearing, is hereby amended by  
1932 inserting after the word “discriminatory”, in line 44, the following words:- For the purposes of  
1933 the review of rates of payment under this section, “not excessive” shall include considerations of  
1934 affordability for consumers and purchasers of health insurance products.

1935 SECTION 213. Section 6 of said chapter 176E, as so appearing, is hereby amended by  
1936 striking out, in line 22, the words “commissioner of insurance” and inserting in place thereof the  
1937 following words:- commissioner of health insurance.

1938 SECTION 214. Section 12 of said chapter 176E, as so appearing, is hereby amended by  
1939 striking out, in lines 6 and 7, the words “division of insurance” and inserting in place thereof the  
1940 following words:- division of health insurance.

1941 SECTION 215. Section 1 of chapter 176F of the General Laws, as appearing in the 2022  
1942 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
1943 inserting in place thereof the following definition:-

1944           “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
1945 of chapter 26, or their designee.

1946           SECTION 216. Section 6 of chapter 176F of the General Laws, as so appearing, is hereby  
1947 amended by inserting after the word “discriminatory”, in line 17, the following words:- For the  
1948 purposes of the review of rates of payment under this section, “not excessive” shall include  
1949 considerations of affordability for consumers and purchasers of health insurance products.

1950           SECTION 217. Section 12 of said chapter 176F, as so appearing, is hereby amended by  
1951 striking out, in line 7, the words “division of insurance” and inserting in place thereof the  
1952 following words:- division of health insurance.

1953           SECTION 218. Section 1 of chapter 176G of the General Laws, as appearing in the 2022  
1954 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
1955 inserting in place thereof the following definition:-

1956           “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
1957 of chapter 26, or their designee.

1958           SECTION 219. Section 4M of said chapter 176G, as so appearing, is hereby amended by  
1959 striking out, in line 134, the words “division of insurance” and inserting in place thereof the  
1960 following words:- division of health insurance.

1961           SECTION 220. Section 4V of said chapter 176G, as so appearing, is hereby amended by  
1962 striking out, in lines 80 and 81, and line 96, each time they appear, the words “commissioner of  
1963 insurance” and inserting in place thereof, in each instance, the following words:- commissioner  
1964 of health insurance.

1965 SECTION 221. Section 4EE of said chapter 176G, as so appearing, is hereby amended by  
1966 striking out, in lines 6 and 8, each time they appear, the words “division of insurance” and  
1967 inserting in place thereof the following words:- division of health insurance.

1968 SECTION 222. Section 4MM of said chapter 176G, as so appearing, is hereby amended  
1969 by striking out, in line 40, the words “division of insurance” and inserting in place thereof the  
1970 following words:- division of health insurance.

1971 SECTION 223. Section 5A of said chapter 176G, as so appearing, is hereby amended by  
1972 striking out, in lines 18 and 19, the words “commissioner of insurance” and inserting in place  
1973 thereof the following words:- commissioner of health insurance.

1974 SECTION 224. Section 8 of said chapter 176G, as so appearing, is hereby amended by  
1975 striking out, in line 7, the words “division of insurance” and inserting in place thereof the  
1976 following words:- division of health insurance.

1977 SECTION 225. Section 16 of chapter 176G of the General Laws, as so appearing, is  
1978 hereby amended by inserting after the word “discriminatory”, in line 5, the following words:-  
1979 For the purposes of the review of rates of payment under this section, “not excessive” shall  
1980 include considerations of affordability for consumers and purchasers of health insurance  
1981 products.

1982 SECTION 226. Section 17 of said chapter 176G, as so appearing, is hereby amended by  
1983 striking out, in line 8, the words “commissioner of insurance” and inserting in place thereof the  
1984 following words:- commissioner of health insurance.

1985 SECTION 227. Section 32 of said chapter 176G, as so appearing, is hereby amended by  
1986 striking out, in line 10, the words “division of insurance” and inserting in place thereof the  
1987 following words:- division of health insurance.

1988 SECTION 228. Section 1 of chapter 176I of the General Laws, as appearing in the 2022  
1989 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
1990 inserting in place thereof the following definition:-

1991 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
1992 of chapter 26, or their designee.

1993 SECTION 229. Section 8 of said chapter 176I, as so appearing, is hereby amended by  
1994 striking out, in line 16, the words “commissioner of insurance” and inserting in place thereof the  
1995 following words:- commissioner of health insurance.

1996 SECTION 230. Section 1 of chapter 176J of the General Laws, as appearing in the 2022  
1997 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
1998 inserting in place thereof the following definition:-

1999 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2000 of chapter 26, or their designee.

2001 SECTION 231. Section 4 of said section 176J, as so appearing, is hereby amended by  
2002 striking out, in lines 75 and 80, each time they appear, the words “commissioner of insurance”  
2003 and inserting in place thereof, in each instance, the following words:- commissioner of health  
2004 insurance.



2005 SECTION 232. Section 6 of chapter 176J of the General Laws, as so appearing, is hereby  
2006 amended by inserting after the word “charged”, in line 49, the following words:- For the  
2007 purposes of the review of rates of payment under this section, “not excessive” shall include  
2008 considerations of affordability for consumers and purchasers of health insurance products.

2009 SECTION 233. Section 6 of said section 176J, as so appearing, is hereby amended by  
2010 striking out, in lines 110 and 111, and 125, each time they appear, the words “division of  
2011 insurance” and inserting in place thereof, in each instance, the following words:- division of  
2012 health insurance.

2013 SECTION 234. Section 10 of said section 176J, as so appearing, is hereby amended by  
2014 striking out, in lines 1 and 11, each time they appear, the words “division of insurance” and  
2015 inserting in place thereof, in each instance, the following words:- division of health insurance.

2016 SECTION 235. Section 11 of said section 176J, as so appearing, is hereby amended by  
2017 striking out, in lines 16, and in lines 69 and 70, each time they appear, the words “commissioner  
2018 of insurance” and inserting in place thereof, in each instance, the following words:-  
2019 commissioner of health insurance.

2020 SECTION 236. Said section 11 of said section 176J, as so appearing, is hereby further  
2021 amended by striking out, in lines 35, 93, 95, and 107, each time they appear, the words “division  
2022 of insurance” and inserting in place thereof, in each instance, the following words:- division of  
2023 health insurance.

2024 SECTION 237. Said section 11A of said chapter 176J, as so appearing, is hereby further  
2025 amended by striking out, in lines 31 and 32, the words “division of health care finance and

2026 policy” and inserting in place thereof the following words:- center for health information and  
2027 analysis.

2028 SECTION 238. Section 17 of said chapter 176J, as so appearing, is hereby amended by  
2029 striking out, in line10, the words “division of insurance” and inserting in place thereof the  
2030 following words:- division of health insurance.

2031 SECTION 239. Section 1 of chapter 176K of the General Laws, as appearing in the 2022  
2032 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2033 inserting in place thereof the following definition:-

2034 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2035 of chapter 26, or their designee.

2036 SECTION 240. Section 2 of chapter 176K of the General Laws, as so appearing, is  
2037 hereby amended by inserting after the word “chapter”, in line 47, the following words:- For the  
2038 purposes of the review of rates of payment under this section, “not excessive” shall include  
2039 considerations of affordability for consumers and purchasers of health insurance products.

2040 SECTION 241. Section 1 of chapter 176M of the General Laws, as appearing in the 2022  
2041 Official Edition, is hereby amended by striking out, in lines 21 and 22, the words “commissioner  
2042 of insurance” and inserting in place thereof the following words:- commissioner of health  
2043 insurance.

2044 SECTION 242. Said section 1 of said chapter 176M, as so appearing, is hereby further  
2045 amended by striking out the definition of “Commissioner” and inserting in place thereof the  
2046 following definition:-

2047 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2048 of chapter 26, or their designee.

2049 SECTION 243. Section 2 of said chapter 176M, as so appearing, is hereby amended by  
2050 striking out, in line 156, the words “commissioner of insurance” and inserting in place thereof  
2051 the following words:- commissioner of health insurance.

2052 SECTION 244. Section 3 said chapter 176M, as so appearing, is hereby amended by  
2053 striking out, in line 107, the words “commissioner of insurance” and inserting in place thereof  
2054 the following words:- commissioner of health insurance.

2055 SECTION 245. Section 1 of chapter 176N of the General Laws, as appearing in the 2022  
2056 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2057 inserting in place thereof the following definition:-

2058 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2059 of chapter 26, or their designee.

2060 SECTION 246. Section 1 of chapter 176O of the General Laws, as appearing in the 2022  
2061 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2062 inserting in place thereof the following definition:-

2063 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2064 of chapter 26, or their designee.

2065 SECTION 247. Said section 1 of said chapter 176O, as so appearing, is hereby further  
2066 amended by striking out the definition of “Division” and inserting in place thereof the following  
2067 definition:-

2068 “Division”, the division of health insurance.

2069 SECTION 248. Section 2 of said chapter 176O is hereby amended by striking out, in  
2070 lines 79, 83, and 90, each time they appear, the words “commissioner of insurance” and inserting  
2071 in place thereof the following words:- commissioner of health insurance.

2072 SECTION 249. Section 5B of said chapter 176O, as so appearing, is hereby amended by  
2073 striking out, in lines 3 and 4, the words “division of insurance” and inserting in place thereof the  
2074 following words:- division of health insurance.

2075 SECTION 250. Section 12B said chapter 176O, as so appearing, is hereby amended by  
2076 striking out, in line 3, the words “commissioner of insurance” and inserting in place thereof the  
2077 following words:- commissioner of health insurance.

2078 SECTION 251. Section 14 said chapter 176O, as amended by section 2 of chapter 20 of  
2079 the Acts of 2023, is hereby amended by striking out, in line 13, the words “commissioner of  
2080 insurance” and inserting in place thereof the following words”- commissioner of health  
2081 insurance.

2082 SECTION 252. Said section 14 said chapter 176O, as amended by section 2 of chapter 20  
2083 of the Acts of 2023, is hereby further amended by striking out, in line 3, the words “division of  
2084 insurance” and inserting in place thereof the following words:- commissioner of health  
2085 insurance.

2086 SECTION 253. Section 1 of chapter 176Q of the General Laws, as appearing in the 2022  
2087 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2088 inserting in place thereof the following definition:-

2089           “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2090 of chapter 26, or their designee.

2091           SECTION 254. Section 2 of said chapter 176Q, as so appearing, is hereby amended by  
2092 striking out, in lines 18 and 19, the words “commissioner of insurance” and inserting in place  
2093 thereof the following words:- commissioner of health insurance.

2094           SECTION 255. Section 3 of said chapter 176Q, as so appearing, is hereby amended by  
2095 striking out, in line 86, the words “division of insurance” and inserting in place thereof the  
2096 following words:- division of health insurance.

2097           SECTION 256. Section 1 of chapter 176R of the General Laws, as appearing in the 2022  
2098 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2099 inserting in place thereof the following definition:-

2100           “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2101 of chapter 26, or their designee.

2102           SECTION 257. Section 1 of chapter 176S of the General Laws, as appearing in the 2022  
2103 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2104 inserting in place thereof the following definition:-

2105           “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2106 of chapter 26, or their designee.

2107           SECTION 258. Section 1 of chapter 176T of the General Laws, as appearing in the 2022  
2108 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2109 inserting in place thereof the following definition:-

2110 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2111 of chapter 26, or their designee.

2112 SECTION 259. Section 1 of chapter 176U of the General Laws, as appearing in the 2022  
2113 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2114 inserting in place thereof the following definition:-

2115 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2116 of chapter 26, or their designee.

2117 SECTION 260. Section 6 of said chapter 176U, as so appearing, is hereby amended by  
2118 striking out, in lines 42 and 43, the words “division of insurance” and inserting in place thereof  
2119 the following words:- division of health insurance.

2120 SECTION 261. Section 7 of said chapter 176U, as so appearing, is hereby amended by  
2121 striking out, in line 26, the words “division of insurance” and inserting in place thereof the  
2122 following words:- division of health insurance.

2123 SECTION 262. Section 1 of chapter 175V of the General Laws, as appearing in the 2022  
2124 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2125 inserting in place thereof the following definition:-

2126 “Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of  
2127 chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance  
2128 appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter  
2129 applies to companies that are regulated by the division of health insurance pursuant to section 1  
2130 of said chapter 26.

2131 SECTION 263. Section 1 of chapter 175W of the General Laws, as appearing in the 2022  
2132 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2133 inserting in place thereof the following definition:-

2134 “Commissioner”, (1) the commissioner of insurance appointed pursuant to section 6 of  
2135 chapter 26, or their designee, or, as appropriate, (2) the commissioner of health insurance  
2136 appointed pursuant to section 7A of chapter 26, or their designee, to the extent that this chapter  
2137 applies to companies that are regulated by the division of health insurance pursuant to section 1  
2138 of said chapter 26.

2139 SECTION 264. Said section 1 of said chapter 176W, as so appearing, is hereby further  
2140 amended by striking out the definition of “Division” and inserting in place thereof the following  
2141 definition:-

2142 “Division”, the division of insurance or the division of health insurance, as appropriate.

2143 SECTION 265. Section 1 of chapter 176X of the General Laws, as appearing in the 2022  
2144 Official Edition, is hereby amended by striking out the definition of “Commissioner” and  
2145 inserting in place thereof the following definition:-

2146 “Commissioner”, the commissioner of health insurance appointed pursuant to section 7A  
2147 of chapter 26, or their designee.

2148 SECTION 266. Section 2 of said chapter 176X, as so appearing, is hereby amended by  
2149 striking out, in line 3, the words “division of insurance” and inserting in place thereof the  
2150 following words:- division of health insurance.

2151 SECTION 267. Section 2 of chapter 176X is hereby amended by inserting after the word  
2152 “charged”, in line 38, the following words:- For the purposes of the review of rates of payment  
2153 under this section, “not excessive” shall include considerations of affordability for consumers  
2154 and purchasers of health insurance products.

2155 SECTION 268. Notwithstanding any general or special law, rule or regulation to the  
2156 contrary, the health resource planning council established in section 22 of chapter 16D of the  
2157 General Laws shall submit a state health plan to the governor and the general court, as required  
2158 by section 22 of chapter 6D of the General Laws, on or before January 1, 2026.