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Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Materially Changed from H.4620	Category	State Fiscal Impact?
1	6A	16	Eliminates language including the Betsy Lehman Center within EOHHS.			
2	6A	16D	Replaces reference to Commissioner of Insurance with Commissioner of Health Insurance (created in the bill).			
3	6A	16D	Updates references to the Managed Care Oversight board to include membership from the newly created Division of Health Insurance and makes a technical change clarifying that the Office of Patient Protection is housed within the HPC.			
4	6A	16G	Updates statute related to agencies within the Department of Consumer Affairs and Business Regulation to include the newly created Division of Health Insurance.			
5	6A	16N	Repeals Commission to study the feasibility of reducing or eliminating contributions to the Uncompensated Care Trust Fund.			
6	6A	16Q	Updates the membership of the Children's Behavioral Health Advisory Council to replace Commissioner of Insurance in the membership with the Commissioner of Health Insurance.			
7	6A	16T	Eliminates the Health Planning Council within EOHHS.			
8	6A	16Z	Updates the membership of the Pulmonary Hypertension Task Force to replace Commissioner of Insurance in the membership with the Commissioner of Health Insurance.			
9 through 18	6D	1	Creates or amends 11 definitions within HPC statute. New definitions are: • Benchmark cycle - a fixed 3 year calendar period during which the projected average annual % change in total health care expenditures (THCE) is monitored for compliance • Health care real estate investment trust fund • Health care resource • Health disparities • Health equity • Management services organization • Private equity company • Significant equity investor • Technical advisory committee In addition, these sections amend the following definitions • Health care cost growth benchmark - now defined as the projected average annual percentage change in THCE during a 3 year benchmark cycle • Net cost of private health insurance - updates reference to the Division of Health Insurance • Payer - eliminates exclusion of ERISA plans	Y	Health Equity	
19	6D	2	Changes the membership of the HPC. Under the changes: • Total membership reduced from 11 to 9 members • Eliminates membership of ANF secretary and adds the Commissioner of Health Insurance • Increases Governor appointments from 3 to 5 (additional members to be nominated by the Speaker and Senate President) • Eliminates three auditor appointments • Reduces Attorney General appointments from 3 to 2 • The Chair must have experience with health care administration and finance. • One appointment must have experience representing hospitals or hospital systems • The appointment related to innovation now explicitly includes those with experience in pharmaceuticals and biotech The new section also provides Commission members with a stipend, aside from the Secretary of EOHHS and the Commissioner of Health Insurance. Members are required to disclose employment, affiliation, or financial interest with a health care entity. Any such interest shall be considered prior to appointment.	Y		
20	6D	4A	Creates a statutory Technical Advisory Committee within the HPC. The group must have a broad range of experience from providers and payers. The Committee shall: • Consist of 16 members (chaired by the HPC ED in a non-voting capacity) • 12 of whom are HPC appointments that must meet certain eligibility or nomination criteria (and will be considered special state employees) • Establish the cost growth benchmark adjustment factor • Provide technical assistance, recommendations and produce an annual report	Y		Potential administrative costs
21	6D	5	Adds to the HPC's role in monitoring the health care system by requiring the HPC monitor the location and distribution of health care services and resources.			
22	6D	6	Adds non-hospital provider organizations to the list of entities assessed to support the operations of the HPC. Non-hospital provider organizations include clinical labs, image facilities and urgent care centers or non-hospital-based physician practices with at least $500M in annual gross patient service revenue. The assessment for non-hospital provider organizations is not less than 5 percent of the total assessment for hospitals, ambulatory surgical centers, and non-hospital provider organizations.	Y		
23	6D	7	Adds an eligible criterion for receipt of funds from the HPC's Healthcare Payment Reform Fund. The new category is the advancement of health equity.	Y	Health Equity	
24	6D	8	Updates the charge of the Health Care Cost Benchmark Hearing to monitor annual growth as compared to the benchmark.			

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25	6D	8	Adds to the list of required witnesses at the Health Care Cost Benchmark hearing to include significant equity investors, REITs or management services organizations associated with a provider; a representative from the Division of Health Insurance, the Executive Director of the Connector, and the EOHHS Assistant Secretary for MassHealth.	Y		
26	6D	8	Eliminates the word "and" from the phrase "premium costs and rate increases" related to Cost Growth Benchmark testimony.			
27	6D	8	Defines Health Care Cost Benchmark Hearing testimony for the EOHHS Assistant Secretary for MassHealth to include information on the MassHealth program including program structure, benefits, eligibility, and financing.			
28	6D	8	Updates the section governing Health Care Cost Benchmark hearing lines of inquiry triggered when costs exceed the cost benchmark to reflect the new benchmark period.			
29	6D	8	Amends the language governing the annual Health Care Cost Growth progress reports to account for the newly proposed benchmark cycle. The report's recommendation in the amended report would relate to spending trends that threaten the state's ability to meet the benchmark along with legislative language.			
30	6D	9	Amends the health care cost benchmark process. Under the new process: • The benchmark will cover a three year period • The benchmark will be state's potential gross state product plus an adjustment factor to be adopted based on the recommendations of the HPC Technical Advisory Committee The HPC Technical Advisory Committee shall make recommendations on the factor by February 15th in the year prior to the first year of the benchmark cycle. The adjustment factor: • Shall not be greater than 1 percent or less than negative 1 percent • Is based on historical growth in state's GSP, economic conditions including medical inflation, labor costs, new drug, medical devices and other technologies • Must be approved by a majority of the Advisory Committee • Is zero if the Advisory Committee fails to agree on an adjustment The HPC must hold a public hearing prior to accepting or rejecting the adjustment factor. The factor can be adopted with a majority vote of the HPC.	Y		
30	6D	9A	Defines "low historic relative price hospital" as a hospital with an average relative price across all carriers during a 5 year period of less than 0.85 and is either independent or affiliated with 2 or more acute hospitals but negotiates carrier contracts separately and on its own behalf. The HPC's Rate Equity Target will apply to these hospitals and will be: • For benchmark cycle 2026 to 2029, a carrier shall not pay in-network low historic relative price hospitals less than 15 percent below the average relative price of all acute hospitals in network • For 2029 to 2032, the average annual reimbursement rate for a carrier to a qualifying hospital shall be not less than 2 percent above the health care cost growth benchmark • For 2032 to 2035, the average annual reimbursement rate for a carrier to a qualifying hospital shall be not less than 1 percent above the health care cost growth benchmark • For 2035 to 2038, the average annual reimbursement rate for a carrier to a qualifying hospital shall be not less than the health care cost growth benchmark	Y		
30	6D	10	Amends the HPC Performance Improvement Plan Process. Under the new process: • Health care entities can be subject to a PIP in cases where they exceed the cost benchmark. • Payers are subject to a PIP in cases where they exceeded the cost benchmark and failed to meet the rate equity targets The HPC has the discretion to make information provided by providers and payers participating in the process public. The HPC can grant extensions or waive the necessity of a PIP process based on six extenuating factors laid out in the section. The section then defines the process for the development and implementation of PIPs and what happens in cases where PIPs are not faithfully executed.	Y		Potential administrative costs
31	6D	11	Amends HPC statute governing provider registration to replace the Division of Insurance with the newly proposed Division of Health Insurance.			
32	6D	11	Requires that providers seeking registration or renewal to provide information as to significant equity investors, health care real estate investment trusts, and management service organizations.			
33	6D	12	Amends the registered provider reporting threshold to include any provider with $25M or more in annual net service revenue from all payers, including public payers, not just carriers and third party administrators.			

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34	6D	13	Amends the HPC Material Change notification process. Under the new process, additional activities would be defined as material changes, including: • Significant expansions in capacity • Mergers or acquisitions • Transactions between a provider and a significant equity investor that result in charge of ownership or control • Significant transfers of assets (including real estate lease backs) • Conversion from a non-profit to a for-profit organization The new language also: • Updates how the cost growth benchmark will interact with cost and market impact reviews • Expands the scope of consideration for market cost and impact reviews • Allows the review to consider what is likely to result from the proposed change • Defines providers that are ID'd as having or likely to have a dominant market share or charge materially higher than median prices as a result of the change to be presumed to be engaging in unfair/deceptive business practices and subject to AG powers under 93A (but powers of the AG are limited in certain cases). An HPC referral to the AG shall create a presumption of engaging in an unfair or deceptive practice • The final report of a market cost and impact review process shall be provided to DPH and considered as relevant in its DON process	Y		Potential administrative costs
35	6D	15	Updates reference to the newly created Division of Health Insurance in HPC ACO registration statute.			
36	6D	15	Makes a technical change to the HPC ACT registration statute.			
37	6D	15	Adds a new goal for HPC registration of ACOs: ensuring that ACOs demonstrate compliance with the National Committee for Quality Assurance regarding the provision of multicultural health care.		Health Equity	
38 through 39	6D	16	Makes several updates to the HPC Office of Patient Protection statute to reflect the newly created Division of Health Insurance.			
40	6D	***22***	Establishes the Health Planning Council within the HPC. The Council would be: • Chaired by the HPC and EOHHS • Make up of 11 people (8 named and 3 appointed by Gov.) • Tasked with developing a state health plan to meet anticipated needs, ID existing resources, project future resource needs, and prioritize among those needs • Advised by a 15 member Advisory Committee The plans will cover 5 year periods and the resource index will cover at least 23 specific data elements, as well as other resources selected by the Council. The Council must hold at least 5 public hearings during the development of the plan. The Council will make recommendations for the supply and distribution of health resources on a statewide or regional basis based on the assessment on need during the 5 year plan. The recommendations must consider 10 goals related to the appropriate and equitable distribution of health resources including a stable and adequate workforce and efforts to align housing, health care and home care to improve outcomes and reduce cost. The Council will also publish analyses as appropriate and publish an annual report. The Council will provide direction to DPH on the establishment of a health care resource inventory for the state and the inventory will be developed in cooperation of other relevant state agencies.	Y	Health Equity	Potential administrative costs
41	12	5A	Amends the AGO false claims statute definition of 'knowing/knowingly' to also include 'knows'.			
42	12	5A	Adds a definition to the false claim statute for "Ownership or investment interest." Applies to direct ownership of 10% or more as well as two categories of investment involvement.			
43 through 44	12	5B	Expands false claims liability to include those with an ownership or investment interest in a person who is subject to false claims liability and knows but fails to disclose the violation.			
45	12	11F	Amends the Attorney General insurance company intervention statute to update and reflect the newly proposed Division of Health Insurance.			
46	12	11N	Amends the scope of health care entities the AG can get information from to include significant equity investors, health care real estate investment trusts, and management services organizations.			
47	12	11N	Amends the provision governing what the AG can do in cases of referral from the HPC under MGL 6D:13 to include injunctive relief.	Y		

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48 through 55	12C	1	Adds or amends 12 definitions to the CHIA statute: • Benchmark cycle (new) • Health care cost growth benchmark (amended) • Health care professional (amended) • Health care real estate investment trust (new) • Health disparities (new) • Health equity (new) • Division of Health Insurance (amended from Division of Insurance) • Management services organization (new) • Payer (new) • Private equity company (new) • Significant equity investor (new)	Y	Health Equity	
56	12C	2A	Amends CHIA Health Information and Analysis Oversight council statute to reflect the newly proposed Commissioner of Health Insurance.			
57	12C	3	Amends statute enumerating CHIA powers to reflect the newly proposed Division of Health Insurance.			
58	12C	7	Adds non-hospital provider organizations to the list of entities assessed to support the operations of CHIA. Non-hospital provider organizations include clinical labs, image facilities and urgent care centers or non-hospital-based physician practices with at least $500M in annual gross patient service revenue. The assessment for non-hospital provider organizations is not less than 5 percent of the total assessment for hospitals, ambulatory surgical centers, and non-hospital provider organizations.	Y		
59	12C	8	Adds significant equity investors, health care real estate investment trusts and management services organizations to the list of affiliated entities from whom CHIA can request information.			
60	12C	8	Expands the scope of the audited financial statements that CHIA can request to include those of significant equity investors, health care real estate investment trusts and management services organizations.			
61	12C	8	Directs CHIA to analyze health care data on margins (including by payer type), investments, and information on significant equity investors, health care real estate investment trusts and management services organizations.	Y		
62	12C	9	Clarifies that parent entities also required to report must include information on out of state operations and that corporate affiliates includes significant equity investors, health care real estate investment trusts and management services organizations.			
63	12C	9	Amends statute governing data reporting to CHIA to reflect the newly proposed Division of Health Insurance.			
64	12C	9	Requires reporting entities to provide CHIA with information on other assets and liabilities that may affect the financial condition of the organization including significant equity investors and real estate sale leaseback arrangements.	Y		
65 through 66	12C	10	Amends statute governing data reporting to CHIA to reflect the newly proposed Division/Commissioner of Health Insurance.			
67 through 69	12C	11	Increases the weekly fine for failing to meet CHIA reporting requirements from $1K to $25K and eliminates $50K cap on fines. Requires CHIA to notify the HPC and the DPH of failure to meet reporting requirements. Such failure shall be a consideration in material change analyses, licensure, and determination of need proceedings.			Yes
70	12C	14	Amends the CHIA Standard Quality Measure Set. Under the new process: • CHIA, in consultation with its Advisory Committee, will establish a standard set of health care provider quality and health system performance measures (the Standard Quality Measure Set) • The set is to be established by 3/1 on even numbered years The set is to be used: • In contracts between payers • In assigning tiers to health care providers in plan design • In consumer transparency websites • Monitoring system-wide performance The set shall designate core measures to be used in provider/payer contracts that incorporate quality measures. The set must meet standards set by the Advisory Committee. CHIA must report on any differences between its set and the recommendations of the Advisory Committee. The Statewide Advisory Committee will consist of 19 members (8 ex officio) and be chaired by the HPC and the Division of Health Insurance. The Committee will meet quarterly and make recommendations on the set. The recommendations must incorporate nationally recognized standards as well as recommendations by state entities. Recommendations from the group are due by January 1st of even numbered years.	Y	Health Equity	Potential administrative costs

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71 through 74	12C	15	Amends the Lehman Center statute to: • Add or amend four definitions • Allow it to share information with other agencies that collect patient safety information through an ISA. It also explicitly allows the Lehman Center to adopt rules and regulations necessary for its operation and to contract with another entity to manage its affairs or carry out the purpose of the section.			
75	12C	16	Establishes CHIA's annual report every third year (coinciding with the benchmark cycle) to be the final benchmark cycle report and compare costs and cost trends for the cycle with the benchmark.			
76	12C	17	Expands the information reported to CHIA available to the AG to include information by significant equity investors, health care real estate investment trusts, and management service organizations. It also allows the AG to use information provided during the HPC Annual Cost Trend Hearing and in cases brought by the AG.			
77	12C	18	Amends the requirements for CHIA analysis of data submitted by health care entities. CHIA would continue to ID insurance carriers and providers contributing to health care cost growth, but CHIA is directed to establish different standards for excessive growth based on cohorts of similar health care entities, an entity's baseline spending, pricing levels and payer mix. CHIA report would also include entities that have not submitted information in a timely manner. CHIA is directed to confidentially provide the HPC with a list of entities that the HPC may want to review for PIP purposes given these criteria.	Y		
78	13	10	Updates the Board of Registration in Medicine statute to allow the board to hire an ED, general counsel, and other staff as appropriate and to enter contracts/arrangements necessary for operation of the board.			Potential administrative costs
79	13	10A	Establishes that any proposed rule or regulation not approved by DPH with 30 days will be deemed disapproved.			
80	24A	1	Updates Office of Consumer Affairs and Business Regulation statute to reflect the newly proposed Division of Health Insurance.			
81	26		Amends the title of Chapter 26 to incorporate the newly proposed DOHI.	Y		
82	26	1	Updates the statute creating the division of banking and insurance to include the newly proposed Division of Health Insurance. The Division of Health Insurance is given authority to "oversee the health insurance market in the commonwealth and regulate companies..." governed by MGL 175, 176A, 176C, 176F, 176G, 176J, 176K, 176M, 176T, 176U, 176X.	Y		
83	26	7A	Replaces the current Health Care Access Bureau (within DOI) with the new Division of Health Insurance Statute. The Division is directed to protect the interest of consumers, encourage fair treatment of providers, enhance equity, access, quality and affordability, guard solvency, work with the HPC, and prioritize affordability during rate review. The section defines "rate review" as the examination of aggregate rates of payment proposed by insurance companies governed by various chapters overseen by DOHI. The new statute empowers the Division to oversee a rate review process for eligible health insurance rates. The affordability standards for approval of rates will consider (in addition to principles of solvency and actuarial soundness): • Consumer affordability • Purchaser affordability • Impact on the health care cost benchmark DOHI will examine all documents provided to examine causes of premium rate increases and excessive provider price variation. Regulated insurance companies will be assessed $2M for the operation of the Division.	Y	Health Equity	Potential administrative costs
84 through 85	26	7B	Amends the Department of Banking and Insurance statutes to reflect the newly proposed Division of Health Insurance			
86 through 88	26	8H	Amends the statute governing the Division of Insurance assessment and minimum standards for health insurers to eliminate current assessment language (now covered through section 7A) and update appropriate references to the newly proposed Division of Health Insurance.			
89 through 90	26	8K	Amends the mental health parity federal compliance statute to reflect the newly proposed Division of Health Insurance.			
91 through 92	26	8M	Amends health insurance reporting requirements for behavioral health benefits to reflect the newly proposed Division of Health insurance.			
93	29	7H 1/2	Amends the statute governing the establishment of potential gross state product to reflect the proposed three year benchmark cycle.			
94	32A	3	Amends the GIC statute to reflect the newly proposed Division of Health Insurance.			
95	32A	17Q	Amends the GIC statute to reflect the newly proposed Division of Health Insurance.			
96	32A	22B	Amends the GIC statute to reflect the newly proposed Division of Health Insurance.			
97	32A	25	Amends the GIC statute to reflect the newly proposed Division of Health Insurance.			
98	62C	8B	Amends tax statutes to reflect the newly proposed Division of Health Insurance.			
99	62C	8B	Amends tax statutes to reflect the newly proposed Division of Health Insurance.			
100	62C	21	Amends tax statutes to reflect the newly proposed Division of Health Insurance.			
101	62C	12	Amends tax statutes to reflect the newly proposed Division of Health Insurance.			

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102	62E	26	Amends tax statutes to reflect the newly proposed Division of Health Insurance.			
103	106	9-109	Amends the Uniform Commercial Code related to secured transactions to require 60 days notice to DPH in any case where a secured party is looking to possess collateral in the form of a medical device.			
104	110C	11	Amends the statute related to insurance company acquisition to reflect the newly proposed Division of Health Insurance.			
105	111	24N	Amends the childhood vaccine program statute to reflect the newly proposed Division of Health Insurance.			
106 through 108	111	25A	Amends the DPH health care resources inventory statute to reflect a proposal to put the Health Planning Council under the HPC.			
109	111	25C	Amends the DPH Determination of Need (DON) Process. Under the proposed process: • DPH would consider several factors in making a DON: the state health plan, cost containment goals, impact on the applicant's patients, impact on the workforce of surrounding providers, impact on residents of the Commonwealth, any relevant HPC cost and market impact review, other data as relevant •DPH may impose reasonable terms on the DON as necessary to accomplish enumerated goals DPH may also consider special circumstances as they relate to workforce, research, capacity, and cost.	Y		Potential administrative costs
110	111	25C	Changes the independent cost analysis provision to allow DPH to choose the entity from a list of three provided by the applicant.			
111	111	25C	Amends the process for comment for DON by allowing the state to submit required information and to allow other parties of record (established in 111:25 1/4) to request a public hearing.			
112	111	25C	Amends the timeline for DPH action on DON. The period review of an application with an independent cost review would be put on hold until the analysis is received and accepted by the department. The amended language would also prevent a DON from going into effect for at least 30 days after an HPC market cost and impact review is completed (if one is ongoing at the time of the DON). Similarly, a DON would not go into effect until 30 days after a determination by the HPC that the applicant is implementing or has implemented a PIP (when applicable). HPC can rescind such determination at any time.			
113	111	***25C 1/4***	Creates a new DON section which establishes a different process in cases where the DON overlaps with an existing independent community hospital. In such a case, the applicant must obtain the approval of the hospital (not necessary if the proposal is a joint venture between the two). If an affected independent community hospital does not consent to the project or is not consulted, the independent community hospital can bring a civil action to superior court under the section.			
114	111	25F	Updates the DON legislative reporting requirement section to reflect the Joint Committee on Health Care Financing.			
115	111	25G	Adds an independent community hospital (as defined under MGL 111:25 C 1/4) to the list of entities able to request enforcement of DON provisions.			
116	111	51G	Amends the process for DPH notification of closure of an essential health service. Under the new language, the HPC can conduct an Essential Closure Impact Assessment to consider impacts on access, cost, quality, or market function. HPC can require information from the relevant hospital. The analysis shall consider the hospital's financial position, factors influencing that position, other operating conditions including staffing, and the impact of the closure on a functioning health care system. The review can also include recommendations for ensuring access post closure. In order to receive or maintain a license, an acute care hospital must submit a DPH approved plan for the provision of community benefits, including the provision of essential services. This requirement may be waived if a provider is providing substantial primary and preventative health care services and contributions in its community. HPC is required to keep confidential information and documents obtained under this section (except in summary form), unless distribution is agreed to by the hospital. Information shall not be a public record.	Y	Health Equity	Potential administrative costs
117	111	51G	Prohibits an original hospital license from being granted if the main campus is leased from a health care real estate investment trust. Any acute hospital leasing its main campus from such an entity as of 4/1/2024 will be exempt for this section and that exempt status will be maintained to any subsequent transfer. Prohibits any original license from being granted to establish or maintain an acute-care hospital unless all documents related to the lease/license for use are disclosed. Prohibits any original license from being granted to establish or maintain an acute-care hospital unless the applicant is in compliance with all CHIA reporting requirements.	Y		
118 through 120	111	51H	Amends DPH reporting requirements related to serious medical events to add a provision for an "operational impairment event." An operational impairment event pertains to financial delinquency including related potential repossession of medical equipment. Under the language, hospitals would be required to report relevant events within 1 day of their occurrence. The language also prohibits any medical equipment contracts from allowing for repossession in fewer than 60 days from notice to DPH.			

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121	111	***51M***	Creates a DPH licensing process for office-based surgical centers. Licenses will be granted/renewed for 2 years. The section defines the conditions under which a facility would be subject to regulation under the section.			Potential administrative costs
121	111	***51N***	Creates a DPH licensing process for urgent care centers. Licenses will be granted/renewed for 2 years. The section defines the conditions under which a facility would be subject to regulation under the section.			Potential administrative costs
122	111	***53I***	Requires clinics or physician practices licensed under MGL 112:4A (registered physician practices) to notify DPH at least 180 days prior to sale, relocation, or closure. DPH is empowered to hold a public hearing on the proposed event which will consider the potential financial and health care impacts. Clinics & physician practices would be required to notify patients 90 days prior to the event.	Y		
123	111	206A	Updates DPH statute to reflect the newly proposed Division of Health Insurance.			
124	111	218	Updates DPH statute to reflect the newly proposed Division of Health Insurance.			
125	111	218	Updates DPH statute to replace MAHMO with MAHP.			
126	111K	2	Updates Catastrophic Illness in Children Commission statute to reflect the newly proposed Division of Health Insurance.			
127	111M	1	Updates creditable coverage insurance mandate statute to reflect the newly proposed Division of Health Insurance.			
128	112	2	Removes reference to "his or her" specialties in the information required upon licensure.	Y		
129	112	***4A***	Directs the Board of Registration of Physicians to maintain a registry of all practices of more than 10 physicians engaged in a wholly owned or controlled group practice. The section specifies the information that must be provided to the Board when a physician practice is registered: • Identity of the applicant • Identity of any substantial equity investor • Any management services organization under contract with the practice • Copy of the certification of organization	Y		Potential administrative costs
130	112	***5P***	Requires physicians to notify patients, with whom the physician has a role in ongoing care and treatment, 90 days prior to terminating a patient relationship. Notice shall offer assistance to find a new provider.	Y		
131	118E	9C	Updates MassHealth statute to reflect the newly proposed Division of Health Insurance.			
132	118E	9C	Updates MassHealth statute to reflect the correct name of the Joint Committee on Health Care Financing.			
133	118E	9D	Updates MassHealth statute to reflect the newly proposed Division of Health Insurance.			
134	118E	13D	Updates MassHealth statute to reflect the newly proposed Division of Health Insurance.			
135	118E	69	Updates MassHealth statute to reflect the newly proposed Division of Health Insurance.			
136	149	189	Updates the EMAC statute to reflect the newly proposed Division of Health Insurance.			
137	175	1	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
138	175	1	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
139	175	4	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
140	175	24D	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
141	175	24E	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
142	175	24E	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
143	175	24F	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
144	175	24F	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
145	175	47B	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
146	175	47J	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
147	175	47W	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
148	175	47AA	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
149	175	47KK	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
150	175	47TT	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
151	175	108	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
152	175	108I	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
153	175	108M	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
154	175	110I	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
155	175	110J	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
156	175	206	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
157	175	206	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
158	175	206C	Updates MGL 175 to reflect the newly proposed Division of Health Insurance.			
159	175B	1A	Updates MGL 175B to reflect the newly proposed Division of Health Insurance.			
160	175B	2	Updates MGL 175B to reflect the newly proposed Division of Health Insurance.			
161	175B	3A	Updates MGL 175B to reflect the newly proposed Division of Health Insurance.			
162	175D	1	Updates MGL 175D to reflect the newly proposed Division of Health Insurance.			
163	175I	2	Updates MGL 175I to reflect the newly proposed Division of Health Insurance.			

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164	175I	9	Updates MGL 175I to reflect the newly proposed Division of Health Insurance.			
165	176A	2	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
166	176A	3	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
167	176A	5	Requires the newly proposed Division of Health Insurance to consider affordability of health insurance products when reviewing rates submitted under this section.			
168	176A	5	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
169	176A	6	Requires the newly proposed Division of Health Insurance to consider affordability of health insurance products when reviewing rates submitted under this section.			
170	176A	7	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
171	176A	8	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
172	176A	8A	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
173	176A	8F	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
174	176A	8M	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
175	176A	8W	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
176	176A	8DD	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
177	176A	8MM	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
178	176A	8UU	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
179	176A	10	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
180	176A	10	Requires the newly proposed Division of Health Insurance to consider affordability of health insurance products when reviewing rates submitted under this section.			
181	176A	11	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
182	176A	15	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
183	176A	16	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
184	176A	17	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
185	176A	18	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
186	176A	20	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
187	176A	21	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
188	176A	22	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
189	176A	23	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
190	176A	24	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
191	176A	25	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
192	176A	31	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
193	176A	37	Updates MGL 176A to reflect the newly proposed Division of Health Insurance.			
194	176B	1	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
195	176B	1	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
196	176B	4	Requires the newly proposed Division of Health Insurance to consider affordability of health insurance products when reviewing rates submitted under this section.			
197	176B	4	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
198	176B	4A	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
199	176B	4M	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
200	176B	4DD	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
201	176B	4MM	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
202	176B	4UU	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
203	176B	6	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
204	176B	6B	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
205	176B	10	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
206	176B	12	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
207	176B	24	Updates MGL 176B to reflect the newly proposed Division of Health Insurance.			
208	176C	9	Updates MGL 176C to reflect the newly proposed Division of Health Insurance.			
209	176C	10	Updates MGL 176C to reflect the newly proposed Division of Health Insurance.			
210	176C	17	Updates MGL 176C to reflect the newly proposed Division of Health Insurance.			
211	176D	1	Updates MGL 176D to reflect the newly proposed Division of Health Insurance.			
212	176E	3B	Updates MGL 176D to reflect the newly proposed Division of Health Insurance.			
213	176E	1	Updates MGL 176E to reflect the newly proposed Division of Health Insurance.			
214	176E	6	Updates MGL 176E to reflect the newly proposed Division of Health Insurance.			
215	176E	12	Updates MGL 176E to reflect the newly proposed Division of Health Insurance.			

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Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Materially Changed from H.4620	Category	State Fiscal Impact?
216	176F	1	Updates MGL 176F to reflect the newly proposed Division of Health Insurance.			
217	176F	12	Updates MGL 176F to reflect the newly proposed Division of Health Insurance.			
218	176G	1	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
219	176G	4M	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
220	176G	4V	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
221	176G	4EE	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
222	176G	4MM	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
223	176G	5A	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
224	176G	8	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
225	176G	16	Requires the newly proposed Division of Health Insurance to consider affordability of health insurance products when reviewing rates submitted under this section.			
226	176G	17	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
227	176G	32	Updates MGL 176G to reflect the newly proposed Division of Health Insurance.			
228	176I	1	Updates MGL 176I to reflect the newly proposed Division of Health Insurance.			
229	176I	8	Updates MGL 176I to reflect the newly proposed Division of Health Insurance.			
230	176J	1	Updates MGL 176J to reflect the newly proposed Division of Health Insurance.			
231	176J	4	Updates MGL 176J to reflect the newly proposed Division of Health Insurance.			
232	176J	6	Updates MGL 176J to reflect the newly proposed Division of Health Insurance.			
233	176J	6	Requires the newly proposed Division of Health Insurance to consider affordability of health insurance products when reviewing rates submitted under this section.			
234	176J	10	Updates MGL 176J to reflect the newly proposed Division of Health Insurance.			
235	176J	11	Updates MGL 176J to reflect the newly proposed Division of Health Insurance.			
236	176J	11	Updates MGL 176J to reflect the newly proposed Division of Health Insurance.			
237	176J	11A	Updates MGL 176J to replace reference with DHCFP with CHIA.			
238	176J	17	Updates MGL 176J to reflect the newly proposed Division of Health Insurance.			
239	176K	1	Updates MGL 176K to reflect the newly proposed Division of Health Insurance.			
240	176K	7	Requires the newly proposed Division of Health Insurance to consider affordability of health insurance products when reviewing rates submitted under this section.			
241	176M	1	Updates MGL 176M to reflect the newly proposed Division of Health Insurance.			
242	176M	1	Updates MGL 176M to reflect the newly proposed Division of Health Insurance.			
243	176M	2	Updates MGL 176M to reflect the newly proposed Division of Health Insurance.			
244	176M	3	Updates MGL 176M to reflect the newly proposed Division of Health Insurance.			
245	176N	1	Updates MGL 176N to reflect the newly proposed Division of Health Insurance.			
246	176O	1	Updates MGL 176O to reflect the newly proposed Division of Health Insurance.			
247	176O	1	Updates MGL 176O to reflect the newly proposed Division of Health Insurance.			
248	176O	2	Updates MGL 176O to reflect the newly proposed Division of Health Insurance.			
249	176O	5B	Updates MGL 176O to reflect the newly proposed Division of Health Insurance.			
250	176O	12B	Updates MGL 176O to reflect the newly proposed Division of Health Insurance.			
251	176O	14	Updates MGL 176O to reflect the newly proposed Division of Health Insurance.			
252	176O	14	Updates MGL 176O to reflect the newly proposed Division of Health Insurance.			
253	176Q	1	Updates MGL 176Q to reflect the newly proposed Division of Health Insurance.			
254	176Q	2	Updates MGL 176Q to reflect the newly proposed Division of Health Insurance.			
255	176Q	3	Updates MGL 176Q to reflect the newly proposed Division of Health Insurance.			
256	176R	1	Updates MGL 176R to reflect the newly proposed Division of Health Insurance.			
257	176S	1	Updates MGL 176R to reflect the newly proposed Division of Health Insurance.			
258	176T	1	Updates MGL 176T to reflect the newly proposed Division of Health Insurance.			
259	176U	1	Updates MGL 176U to reflect the newly proposed Division of Health Insurance.			
260	176U	6	Updates MGL 176U to reflect the newly proposed Division of Health Insurance.			
261	176U	7	Updates MGL 176U to reflect the newly proposed Division of Health Insurance.			
262	176V	1	Updates MGL 176V to reflect the newly proposed Division of Health Insurance.			
263	176W	1	Updates MGL 176W to reflect the newly proposed Division of Health Insurance.			
264	176W	1	Updates MGL 176W to reflect the newly proposed Division of Health Insurance.			
265	176X	1	Updates MGL 176X to reflect the newly proposed Division of Health Insurance.			
266	176X	2	Updates MGL 176X to reflect the newly proposed Division of Health Insurance.			

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Bill Section	MGL Chapter	MGL Section	Bill Section Summary	Materially Changed from H.4620	Category	State Fiscal Impact?
267	NWS		For the purposes of monitoring and enforcing the health care cost growth benchmark between years 2021 and 2025: • CHIA shall apply data collection, reporting and referral standards as set forth in this bill • The HPC shall apply health care cost growth benchmark processes and notification of excess cost growth as set forth in this bill. However, The HPC is prohibited from requiring a health care entity to file and implement a performance improvement plan unless a provider has TME cost growth over greater than 4 percent in any three year period with the final year occurring between 2021 and 2025.	Y		
268	NWS		Requires the Health Resource Planning Council to submit a state health plan by 1/1/2026.			
269	NWS		Makes the changes to the HPC board effective 1/1/2025.	Y		
270	NWS		Requires all practices required to register pursuant to section 129 of the bill to do so by 1/1/2026.	Y		