HOUSE DOCKET, NO. 3455 FILED ON: 1/21/2011

HOUSE . . . . . No. 2784

The Commonwealth of Massachusetts

PRESENTED BY:

Harriett L. Stanley

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying:

An Act to begin to contain health care costs.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Harriett L. Stanley	*2nd Essex*

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HOUSE . . . . . No. 2784

By Ms. Stanley of West Newbury, a petition (accompanied by bill, House, No. 2784) of Harriett L. Stanley relative to the determination of need process. Health Care Financing.

The Commonwealth of Massachusetts

An Act to begin to contain health care costs.

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

SECTION 1. Chapter 305 of the Acts of 2008 is hereby amended by deleting Section 7 and replacing it with the following new language:

"Expenditure minimum with respect to substantial capital expenditures", with respect to expenditures and acquisitions made by or for: (1) acute care hospitals and comprehensive cancer centers as defined in section 1 of chapter 118G, only, $7,500,000, except that expenditures for, or the acquisition of, major movable equipment not otherwise defined by the department as new technology or innovative services shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; and (2) health care facilities, other than acute care hospitals, and facilities subject to licensing under chapter 111B, with respect to: (a) expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, $400,000; and (b) all other expenditures and acquisitions, $800,000; provided, however, that expenditures for, or the acquisition of, any replacement of medical, diagnostic or therapeutic equipment defined as new technology or innovative services for which a determination of need has issued or which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $7,500,000, in which case a determination of need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

Chapter 305 of the Acts of 2008 is hereby further amended by in Section 11 deleting the last paragraph and replacing it with the following new language:

25 Section 53G. Any entity that is certified or seeking certification as an ambulatory
26 surgical center by the Centers for Medicare and Medicaid Services for participation in the
27 Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be
28 deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if
29 it is accredited to provide ambulatory surgery services by the Accreditation Association for
30 Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare
31 Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or
32 any other national accrediting body that the department determines provides reasonable
33 assurances that such conditions are met. No original license shall be issued pursuant to said
34 section 51 to establish any such ambulatory surgical clinic unless there is a determination by the
35 department that there is a need for such a facility. For purposes of this section, "clinic" shall
36 include a clinic conducted by a hospital licensed under said section 51 or by the federal
37 government or the commonwealth. The department shall promulgate regulations to implement
38 this section.

39 SECTION 2. Section 25C of Chapter 111 of the General Laws is amended by inserting
40 after the first paragraph the following new paragraph:

41 "The Department shall conduct a statewide planning initiative for the purposes of
42 studying and coordinating the availability and delivery of health care services within the
43 commonwealth. The initiative shall examine the current supply of inpatient and outpatient
44 services, and technologies and develop a plan for the provision of new services, beds,
45 technologies, and structural expansions throughout the commonwealth, and develop a plan for
46 the continued role of community hospitals and health centers within the commonwealth. The
47 Department shall utilize this plan in its evaluation of all applications for a determination of need,
48 as required by this section, in order to determine whether the proposed expansion construction,
49 or acquisition of health care facilities or services is needed in the Commonwealth, or whether the
50 proposed expansion construction, or acquisition of health care facilities or services will
51 unnecessary duplicate ongoing services and increase health care costs in the Commonwealth."

52 SECTION 3. Section 25C of Chapter 111 of the General Laws is amended by inserting
53 at the end of the section the following new paragraph:

54 "Any hospital seeking to expand its emergency department shall file a determination of
55 need with the department. In addition to the information required pursuant to this section, the
56 department shall require hospitals seeking emergency department expansions to demonstrate that
57 prior to filing a determination of need application, the hospital has implemented measures to
58 reduce emergency room overcrowding. The department shall promulgate regulations defining
59 the measures hospitals may take to reduce emergency room overcrowding."

60 Section 25C of Chapter 111 of the General Laws is further amended by inserting at the
61 end of the 2nd paragraph the following language:

62 “Each person or agency of the commonwealth or any political subdivision thereof filing a
63 determination of need to acquire new technology shall, in addition to the information required by
64 this section, file with the department documentation of programs implemented by the health care
65 facility designed to ensure utilization of all new technology in a manner that is consistent with
66 state and national guidelines. The department shall annually publish a list of state and national
67 guidelines governing the utilization of new technology. The department shall promulgate
68 regulations necessary to enforce this section.”

69 Section 25C of Chapter 111 of the General Laws is further amended by deleting the last
70 sentence of the 7th paragraph and replacing it with the following new language:

71 “A reasonable fee, established by the department, shall be paid upon the filing of such
72 application. The department shall be adjusted annually as necessary to accommodate the volume
73 of new applications.”

74 Section 3 of Chapter 17 of the General Laws is hereby amended by deleting Section 3 in
75 its entirety and replacing it with the following new language:

76 Section 3. (a) There shall be a public health council to advise the commissioner of public
77 health and to perform other duties as required by law. The council shall consist of the
78 commissioner of public health as chairperson and 17 members appointed for terms of 6 years
79 under this section. The commissioner may designate 1 of the members as vice chairperson and
80 may appoint subcommittees or special committees as needed.

81

82 (b) Four of the members shall be appointed by the governor: 1 shall be appointed from
83 among the chancellor of the University of Massachusetts Medical School and a list of 3
84 nominated by said chancellor; 1 shall be appointed from among the dean of the University of
85 Massachusetts Amherst School of Public Health or Health Sciences and a list of 3 nominated by
86 said dean; 1 shall be appointed from among the heads of the non-public schools of medicine in
87 the commonwealth or their nominees; and 1 shall be appointed from among the heads of the non-
88 public schools or programs in public health in the commonwealth or their nominees.

89

90 (c) Four of the appointed members shall be providers of health services, appointed by the
91 governor: 1 of whom shall have expertise in acute care hospital management; 1 of whom shall
92 have expertise in long term care management; 1 of whom shall have expertise in home or
93 community-based care management, and 1 of whom shall have expertise in the practice of
94 primary care medicine or public health nursing.

95

96 (d) Six of the appointed members shall be non-providers: 1 shall be appointed by the
97 secretary of elder affairs; 1 shall be appointed by the secretary of veterans' services; 1 shall be
98 appointed by the governor from a list of 3 nominated by Health Care For All, Inc.; 1 shall be
99 appointed by the governor from a list of 3 nominated by the Coalition for the Prevention of
100 Medical Errors, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the
101 Massachusetts Public Health Association; and 1 shall be appointed by the governor from a list of
102 3 nominated by the Massachusetts Community Health Worker Network. Whenever an
103 organization nominates a list of candidates for appointment by the governor under this
104 subsection, the organization may nominate additional candidates if the governor declines to
105 appoint any of those originally nominated.

106 (e) Three of the appointed members shall be payers of health care, appointed by the
107 governor: 1 shall represent a health plan licensed in the Commonwealth; 1 shall represent small
108 businesses; and one shall represent large businesses.

109

110 (f) For purposes of this section, "non-provider" shall mean a person whose background
111 and experience indicate that he is qualified to act on the council in the public interest; who, and
112 whose spouse, parents, siblings or children, have no financial interest in a health care facility;
113 who, and whose spouse has no employment relationship to a health care facility, to a nonprofit
114 service corporation established under chapters 176A to 176E, inclusive, or to a corporation
115 authorized to insure the health of individuals; and who, and whose spouse, is not licensed to
116 practice medicine.

117

118 (g) Upon the expiration of the term of office of an appointive member, his successor shall
119 be appointed in the same manner as the original appointment, for a term of 6 years and until the
120 qualification of his successor. The members shall be appointed not later than 60 days after a
121 vacancy. The council shall meet at least once a month, and at such other times as it shall
122 determine by its rules, or when requested by the commissioner or any 4 members. The
123 appointive members shall receive $100 per day that the council meets, and their reasonably
124 necessary traveling expenses while in the performance of their official duties.

125 SECTION 4. Chapter 111 is hereby amended by inserting the following new section:

126 Section 51 ½. Hospital Billing and Licensure.

127 As used in this section the following terms shall have the following meanings:

128 “Facility of Primary Licensure” means the single physical structure and location where
129 the majority of the hospital’s licensed beds are located.

130 (a) Every acute-care hospital that provides any services at a location other than its
131 "Facility of Primary Licensure" is prohibited from operating a Secondary Facility pursuant to the
132 original license of the Facility of Primary Licensure and is hereby required to obtain from the
133 Department a new license for that location if the facility constitutes a Secondary Facility. A
134 facility constitutes a Secondary Facility if:

135 a. The facility is physically located a distance greater than 500 yards, or

136 b. The facility requires or maintains separate heating, cooling, electric, sewer
137 systems from the Facility of Primary Licensure.

138 (b) The licensed Secondary Facility shall obtain from the federal Centers for Medicare
139 and Medicaid Services a separate National Provider Identification Number.

140 (c) Every health care facility, ambulatory surgical center, or outpatient facility shall bill
141 all public and private payors for services using the National Provider Identification Number
142 assigned to the specific facility and physical locations where the services were provided.

143 (d) No public or private payor shall be required to pay a claim billed by a health care
144 facility, ambulatory surgical center, or outpatient facility not billed in accordance with this
145 section.

146 (e) Subject to any agreement between the parties, a Secondary facility shall bill a carrier
147 for services at a rate negotiated by the parties separately from the rates for the Facility of Primary
148 Licensure or in the absence of an agreement, 110% of Medicare.

149 (f) Notwithstanding the provisions of this chapter the Department shall not grant a license
150 to any Secondary Facility unless there is a determination by the department that there is a need
151 for such a facility pursuant to Section 25C. Secondary Facilities in operation as of the effective
152 date of this section shall be exempt from the Department's determination of need requirements.

153 (g) The Department along with the Office of the Attorney General shall have the
154 authority to enforce the requirements of this section.

155 SECTION 5. Chapter 111: Section 70G. Reduction of Duplicate Diagnostic Services

156 Section 70G. Each hospital in the Commonwealth shall file with the department, within
157 thirty (30) days of the start of the hospital fiscal year, a written plan designed to eliminate the
158 duplication of unnecessary diagnostic services performed on a patient by another hospital or
159 diagnostic facility when there is knowledge of a prior test. The plan shall include the following:

160 1) Current procedures for sending and receiving diagnostic, imaging and other test results
161 from or to another hospital or provider of care;

162 2) A defined procedure for determining whether any such test results can be appropriately
163 used in the patient's treatment;

164 3) A plan to improve the hospital's ability to send and receive such test results from or to
165 other providers of care. The Department shall notify the hospital that the plan has been approved
166 or disapproved within thirty (30) days after filing, based on a determination as to whether the
167 plan adequately addresses the issues of patient safety and costs of duplicating diagnostic tests. If
168 such plan has not been acted upon by the department within thirty (30) days, the plan shall be
169 deemed approved. If the department disapproves of such plan, the hospital shall submit a revised
170 plan within thirty (30) days. If the revised plan continues to be disapproved, or if a hospital fails
171 to submit a plan, the commissioner may issue an order that such a plan be submitted
172 immediately. If such an order is issued, health insurance carriers may deny payment for any
173 duplicate services furnished unless the hospital can establish that the duplicate service was
174 medically necessary and appropriate. In the event that a carrier denies payment for duplicate
175 services, the hospital may not bill the insured for those services.

176 SECTION 6. Section 51 of Chapter 111 of the General Laws is hereby amended by
177 inserting at the end thereof the following:

178 Each hospital in the Commonwealth that operates an Emergency Room shall annually file
179 with the Department, within thirty (30) days of the start of the hospital fiscal year, a written
180 operating plan designed to eliminate emergency room overcrowding and diversions. The plan
181 shall include the following:

182 1) A comprehensive assessment of emergency room wait times for the prior fiscal
183 year, including the average wait time and the number of complaints submitted to the hospital
184 regarding wait times in the emergency room, and a review of steps taken to reduce the wait time.
185 The assessment shall also include the number of hours the emergency room was on diversion
186 status, broken down by day of the week, and the actual number of emergency diversions for the
187 prior fiscal year;

188 2) A summary of the specific measures that the hospital will take in the current fiscal
189 year to eliminate overcrowding in the emergency room, such as adjusting elective surgery
190 schedules to reduce variability;

191 3) The anticipated impact the plan will have on staffing ratios and, after the first
192 year, the actual impact the plan has had for the previous year;

193 4) A defined set of measures by which to assess the plan's success, such as the
194 number of emergency room diversions, the average wait time to receive emergency services,
195 and/or the percentage of patients in a bed within one hour of arriving in the emergency room;

196 The Department shall notify the hospital that the plan has been approved or disapproved
197 within twenty (20) days after filing, based on a determination as to whether the plan adequately
198 addresses the needs of emergency room patients. If such plan has not been acted upon by the
199 Department within twenty (20) days, the plan shall be deemed approved. If the Department
200 disapproves of such plan, the hospital shall submit a revised plan within twenty (20) days. If the
201 revised plan continues to be disapproved, or if a hospital fails to submit a plan, the commissioner
202 may take any action deemed appropriate.

203 SECTION 7. Section 12 of Chapter 118E of the General Laws is hereby amended by
204 inserting at the beginning of the section the following new definitions:

205 "Managed Care Organization", any entity with which the Commonwealth contracts to
206 provide managed care services to eligible MassHealth enrollees on a capitated basis.

207 "Network", a grouping of health care providers who contract with a managed care
208 organization to provide services to MassHealth enrollees covered by the managed care
209 organization's plans, policies, contracts or other arrangements.

210 "Non-network provider", a health care provider who has not entered into a contract with
211 a managed care organization to provide services to MassHealth enrollees.

212 SECTION 8. Section 12 of Chapter 118E of the General Laws is further amended by
213 inserting at the end of the section the following new language:

214 For emergency, post-stabilization, and certain other services that have received a prior
215 approval by a managed care organization contracting with the Commonwealth to provide
216 managed care services to MassHealth enrollees, health care providers not included in a managed
217 care organization's network, must accept a rate equal to the rate paid by Medicaid for the
218 same or similar services. Nothing in this section shall prohibit a managed care organization
219 from denying payment for unapproved services conducted by a non-network provider.

220 SECTION 9. Chapter 118H of the General Laws is hereby amended by the addition of a
221 new Section 7, as follows:

222 Section 7. For emergency, post-stabilization, and certain other services that have received
223 a prior approval by a carrier or managed care organization contracting with the Connector to
224 provide managed care services to Commonwealth Care Health Insurance Program enrollees,
225 health care providers not included in a managed care organization's network, must accept a rate
226 equal to the rate paid by Medicaid for the same or similar services. Nothing in this section shall
227 prohibit a carrier or managed care organization from denying payment for unapproved services
228 conducted by a non-network provider.

229

230 SECTION 10. Chapter 118G is hereby amended by adding the following new Section:

231 As used in this section, the following words shall have the following meanings:

232 "Payor", carrier, as defined by M.G.L. Chapter 176O, the group insurance commission
233 established under chapter 32A; and to the extent legally feasible and otherwise not prohibited by
234 any applicable provision of the Employee Retirement Income Security Act of 1974, other
235 employee welfare benefit plans.

236 Every acute care hospital, health care facility, ambulatory surgical center, or outpatient
237 facility licensed in the commonwealth that does not agree to participate in a payor's network
238 must accept a rate equal 110% of the rate paid by Medicare for the same or similar services.
239 Nothing in this section shall prohibit a payor from denying payment for unapproved services
240 conducted by a non-network provider. Every acute care hospital, health care facility, ambulatory
241 surgical center, or outpatient facility licensed in the commonwealth shall be prohibited from
242 attempting to charge or to collect from the enrollee, or persons acting on the enrollee's behalf,
243 any amount in excess of the amount paid by the payor for that service pursuant to the
244 requirements of this section, other than applicable co-payments, co-insurance and deductibles.

245

246 SECTION 11. Chapter 118G of the General Laws is hereby amended by inserting after
247 section 4 the following new section:

248 4A. Reporting of Hospital Margins

249 If in any fiscal year, an Acute Hospital, as defined in this chapter, reports to the division
250 an operating margin that exceeds 5 percent, the division shall hold a public hearing within 60
251 days. The Acute Hospital shall submit testimony on its overall financial condition and the
252 continued need to sustain an operating margin that exceeds 5 percent. The Acute Hospital shall
253 also submit testimony on efforts the Acute Hospital is making to advance health care cost
254 containment and health care quality improvement; and whether, and in what proportion to the
255 total operating margin, the Acute Hospital will dedicate any funds to reducing health care costs.
256 The division shall review such testimony and issue a final report on the results of the hearing. In
257 implementing the requirements of this Section, the Division shall utilize data collected by
258 hospitals pursuant to the requirements of Section 53 of Chapter 288 of the Acts of 2010.

259 SECTION 12. Chapter 118G of the General Laws is hereby amended by after section 15
260 inserting the following new section:

261 15A: Contracting Rights of Private Payors- Unfair Methods of Competition and Unfair or
262 Deceptive Acts or Practices in the Conduct of Health Care Providers

263 It shall be an unfair business trade practice for any health care provider to attempt to
264 recoup any unreimbursed amounts paid by government payors by increasing charges to other
265 nongovernmental payors. Violations of this section shall be subject to enforcement by the office
266 of the attorney general.

267 The division shall monitor health care provider charges to ensure compliance with this
268 section and shall report any non-compliance to the attorney general. The division of health care
269 finance and policy in cooperation with the office of the attorney general shall promulgate
270 regulations enforcing this subsection, which shall include penalties for noncompliance.

271 SECTION 13. Chapter 118G of the General Laws is hereby amended by inserting the
272 following new section:

273 Section 40 - Review and evaluation of regulatory changes on health insurance

274 Section 40 (a) For the purposes of this section, a mandated health benefit is a statutory or
275 regulatory requirement that mandates health insurance coverage for specific health services,
276 specific diseases or certain providers of health care services as part of a policy or policies of
277 group life and accidental death and dismemberment insurance covering persons in the service of
278 the commonwealth, and group general or blanket insurance providing hospital, surgical, medical,
279 dental, and other health insurance benefits covering persons in the service of the commonwealth,
280 and their dependents organized under chapter 32A , individual or group health insurance policies
281 offered by an insurer licensed or otherwise authorized to transact accident or health insurance
282 organized under chapter 175 , a nonprofit hospital service corporation organized under chapter
283 176A , a nonprofit medical service corporation organized under chapter 176B , a health
284 maintenance organization organized under chapter 176G , or an organization entering into a
285 preferred provider arrangement under chapter 176I , any health plan issued, renewed, or
286 delivered within or without the commonwealth to a natural person who is a resident of the
287 commonwealth, including a certificate issued to an eligible natural person which evidences
288 coverage under a policy or contract issued to a trust or association for said natural person and his
289 dependent, including said person's spouse organized under chapter 176M.

290 (b) Joint committees of the general court and the house and senate committees on ways
291 and means when reporting favorably on mandated health benefits bills referred to them shall
292 include a review and evaluation conducted by the division of health care finance and policy
293 pursuant to this section.

294 (c) Upon request of a joint standing committee of the general court having jurisdiction or
295 the committee on ways and means of either branch, the division of health care finance and policy
296 shall conduct a review and evaluation of the mandated health benefit proposal, in consultation
297 with other relevant state agencies, and shall report to the committee within 90 days of the
298 request. If the division of health care finance and policy fails to report to the appropriate

299 committee within 45 days, said committee may report favorably on the mandated health benefit
300 bill without including a review and evaluation from the division.

301 (d) Any state agency or any board created by statute, including but not limited to the
302 Board of the Commonwealth Connector, the Department of Health, the Division of Medical
303 Assistance or the Division of Insurance that proposes to add a mandated health benefit by rule,
304 bulletin or other guidance must request that a review and evaluation of that proposed mandated
305 health benefit be conducted by the division of health care finance and policy pursuant to this
306 section. The report on the mandated health benefit by the division of health care finance and
307 policy must be received by the agency or board and available to the public at least 30 days prior
308 to any public hearing on the proposal. If the division of health care finance and policy fails to
309 report to the agency or board within 45 days of the request, said agency or board may proceed
310 with a public hearing on the mandated health benefit proposal without including a review and
311 evaluation from the division.

312 (e) Any party or organization on whose behalf the mandated health benefit was proposed
313 shall provide the division of health care finance and policy with any cost or utilization data that
314 they have. All interested parties supporting or opposing the proposal shall provide the division of
315 health care finance and policy with any information relevant to the division's review. The
316 division shall enter into interagency agreements as necessary with the division of medical
317 assistance, the group insurance commission, the department of public health, the division of
318 insurance, and other state agencies holding utilization and cost data relevant to the division's
319 review under this section. Such interagency agreements shall ensure that the data shared under
320 the agreements is used solely in connection with the division's review under this section, and that
321 the confidentiality of any personal data is protected. The division of health care finance and
322 policy may also request data from insurers licensed or otherwise authorized to transact accident
323 or health insurance under chapter 175 , nonprofit hospital service corporations organized under
324 chapter 176A , nonprofit medical service corporations organized under chapter 176B , health
325 maintenance organizations organized under chapter 176G , and their industry organizations to
326 complete its analyses. The division of health care finance and policy may contract with an
327 actuary, or economist as necessary to complete its analysis.

328 The report shall include, at a minimum and to the extent that information is available, the
329 following: (1) the financial impact of mandating the benefit, including the extent to which the
330 proposed insurance coverage would increase or decrease the cost of the treatment or service over
331 the next 5 years, the extent to which the proposed coverage might increase the appropriate or
332 inappropriate use of the treatment or service over the next 5 years, the extent to which the
333 mandated treatment or service might serve as an alternative for more expensive or less expensive
334 treatment or service, the extent to which the insurance coverage may affect the number and types
335 of providers of the mandated treatment or service over the next 5 years, the effects of mandating
336 the benefit on the cost of health care, particularly the premium, administrative expenses and
337 indirect costs of municipalities, large employers, small employers, employees and nongroup

338 purchasers, the potential benefits and savings to municipalities, large employers, small
339 employers, employees and nongroup purchasers, the effect of the proposed mandate on cost
340 shifting between private and public payors of health care coverage, the cost to health care
341 consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed
342 treatment and the effect on the overall cost of the health care delivery system in the
343 commonwealth; (2) the medical efficacy of mandating the benefit, including the impact of the
344 benefit to the quality of patient care and the health status of the population and the results of any
345 research demonstrating the medical efficacy of the treatment or service compared to alternative
346 treatments or services or not providing the treatment or service; and (3) if the proposal seeks to
347 mandate coverage of an additional class of practitioners, the results of any professionally
348 acceptable research demonstrating the medical results achieved by the additional class of
349 practitioners relative to those already covered and the methods of the appropriate professional
350 organization that assures clinical proficiency.

351 SECTION 14. Chapter 118G: Section 19. Reduction of Preventable Hospital
352 Readmissions

353 As used in this section, the following words shall have the following meanings:

354 "Potentially Preventable Readmission" (PPR) shall mean a readmission to a hospital that
355 follows a prior discharge from a hospital within 14 days, and that is clinically-related to the prior
356 hospital admission.

357 "Observed rate of Readmission" shall meant the number of admissions in each hospital
358 that were actually followed by at least one PPR divided by the total number of admissions.

359 "Expected Rate of Readmission" shall mean a risk adjusted rate for each hospital that
360 accounts for the severity of illness, and age of patients at the time of discharge preceding the
361 readmission.

362 "Excess Rate of Readmission" shall mean the difference between the observed rates of
363 potentially preventable readmissions and the expected rate of potentially preventable
364 readmissions for each hospital.

365 (a) Potentially Preventable Readmission criteria.

366 1) A hospital readmission is a return hospitalization following a prior discharge that
367 meets all of the following criteria:

368 a. The readmission could reasonably have been prevented by the provision of
369 appropriate care consistent with accepted standards in the prior discharge or during the post
370 discharge follow-up period.

371 b. The readmission is for a condition or procedure related to the care during the prior
372 hospitalization or the care during the period immediately following the prior discharge and
373 including, but not limited to:

374 i. The same or closely related condition or procedure as the prior discharge.

375 ii. An infection or other complication of care.

376 iii. A condition or procedure indicative of a failed surgical intervention.

377 iv. An acute decompensation of a coexisting chronic disease.

378 c. The readmission is back to the same or to any other hospital.

379 2) Readmissions, for the purposes of determining potentially preventable
380 readmissions, excludes the following circumstances:

381 a. The original discharge was a patient initiated discharge and was Against Medical
382 Advice (AMA) and the circumstances of such discharge and readmission are documented in the
383 patient's medical record.

384 b. The original discharge was for the purpose of securing treatment of a major or
385 metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions.

386 c. The readmission was a planned readmission or one that occurred on or after 15
387 days following an initial admission.

388 (b) The division shall develop a methodology to calculate the expected rate of potentially
389 preventable readmissions for each hospital, and calculate the excess rate of readmission.

390 (c) The division shall measure the observed rate of readmission, and on a regular and
391 ongoing basis; publish on its website the rates of potentially preventable hospital readmission
392 rates for each hospital licensed in the commonwealth using the definitions and criteria set for in
393 this section. The division shall calculate and publish, both by individual hospital and statewide,
394 the observed rate of readmission, the expected rate of readmission and the excess rate of
395 readmission for each hospital. In compiling the data necessary for the calculation, the division
396 shall, to the maximum extent feasible, utilize existing data collected from hospitals and carriers.

397 (d) The division shall convene an advisory committee to develop a standardized
398 methodology to be applied to payments to hospitals that report excess readmissions and make
399 recommendations for a consistent methodology to be adopted across all payers to reduce hospital
400 payments for those hospitals with excess readmissions. The advisory committee shall consist of
401 the commissioner of the division of health care finance and policy, who shall serve as chair; the
402 commissioner of the group insurance commission, or designee; the director of the office of
403 Medicaid, or designee; the commissioner of the department of public health, or designee; the

404 executive director of the commonwealth connector, or designee; one member representing the
405 Massachusetts association of health plans, one member representing the Massachusetts hospital
406 association, one member representing the Massachusetts medical society, one members with
407 expertise in hospital billing and payment, and one member with expertise in hospital
408 reimbursement.

409 The advisory committee shall convene no later than January 1, 2012 and shall develop its
410 recommendation by no later than April 1, 2012, which shall include a plan to implement the
411 recommended methodologies in all state programs including the state Medicaid program, the
412 health safety net care pool, and the commonwealth care program.

413 SECTION 15. Chapter 6A of the General Laws, as appearing in the 2008 official edition,
414 is hereby amended by adding after section 16, the following new section:

415 16A. The division of health care finance and policy shall be the sole repository for health
416 care data collected pursuant to Section 6 of Chapter 118G. The division shall collect, store and
417 maintain such data in a payer and provider claims database created under said section 6. All
418 other agencies, authorities, councils, boards, and commissions of the commonwealth seeking
419 health care data that is collected under said section 6 shall utilize such data prior to requesting
420 any data from health care providers and payers. The division may enter into interagency services
421 agreements for transfer and use of the data.

422 SECTION 16. Section 6 of chapter 118G of the General Laws as amended by chapters
423 131 and 288 of the acts of 2010 is hereby amended by adding at the beginning thereof the
424 following:

425 "(a). The division shall establish an all payer and provider health care claims database to
426 record and maintain all information collected by the division under subsection (b). The division
427 shall be the sole administrator and operator of said database and shall be responsible for
428 safeguarding the privacy of information collected, recorded and maintained.

429 There shall be established a reviewing committee to advise the commissioner on the
430 administration of the data base. The reviewing committee shall be comprised of representatives
431 from the hospital, health plan and provider communities, and shall include, but not be limited to
432 the following: a representative of the Massachusetts Hospital Association, a representative of
433 Blue Cross and Blue Shield of Massachusetts, a representative of the Massachusetts Association
434 of Health Plans, and a representative of the Massachusetts Medical Society. The reviewing
435 committee shall be responsible for advising the division on the standards for release and use of
436 the information submitted and shall ensure that such standards protect patient privacy and guard
437 against utilization of the data for the purpose of anti-competitive behavior.

438 SECTION 17. Said section 6 is hereby further amended by adding at the end thereof the
439 following:

440 (c) The division shall provide access to information recorded and maintained in the
441 database only in accordance with the division's requirements for protecting patient privacy and
442 shall guard against utilization of the data for the purpose of anti-competitive behavior. Health
443 care providers and payers that supply the data under this section may only be charged
444 reasonable administrative fees for access to information in the database

445 SECTION 18. Chapter 176O of the General Laws, as appearing in the 2006 Official
446 Edition, is hereby amended by inserting after section 20, the following new section:

447 Section 21. Beginning January 1, 2010, all hospitals, physician practices and carriers
448 shall conduct the following transactions electronically:

449 1. Eligibility for a health plan transaction, as described under Code of Federal
450 Regulations, title 45, part 162, subpart L;

451 2. Health care payment and remittance advice transaction, as described under Code
452 of Federal Regulations, title 45, part 162, subpart P;

453 3. Health care claims or equivalent encounter information transaction, as described
454 under Code of Federal Regulations, title 45, part 162, subpart K;

455 SECTION 19. Section 108 of Chapter 175 of the General Laws, as appearing in the
456 Official Edition, is hereby amended by striking out subsection 4(c) and inserting in place thereof
457 the following:

458 4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or
459 provider under a policy of accident and sickness insurance which is delivered or issued for
460 delivery in the commonwealth, and which provides hospital expense, medical expense, surgical
461 expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished
462 by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not
463 made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment
464 or whatever further documentation is necessary for payment of said claim within the terms of the
465 policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay,
466 in addition to any benefits which inure to such claimant or provider, interest on such benefits,
467 which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the
468 rate of one and one-half percent per month, not to exceed eighteen percent per year. The
469 provisions of this paragraph relating to interest payments shall not apply to a claim which an
470 insurer is investigating because of suspected fraud. Beginning on January 1, 2006, the provisions
471 of this paragraph shall only apply to claims for reimbursement submitted electronically.

472 SECTION 20. Section 110 of Chapter 175 of the General Laws, as appearing in the
473 Official Edition, is hereby amended by striking out subsection (G) and inserting in place thereof
474 the following:

475 (G) For purposes of this section the term ""notice of a claim" shall mean any notification
476 whether in writing or otherwise, to an insurer or its authorized agent, by any person, firm,
477 association, or corporation asserting right to payment under a policy of insurance which
478 reasonably apprises the insurer of the existence of a claim.

479 Within fifteen days after an insurer's receipt of notice of claim by a claimant under a
480 general or blanket policy of accident and sickness insurance which is delivered or issued for
481 delivery in the commonwealth, and which provides hospital expense, medical expense, surgical
482 expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished
483 by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not
484 made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment
485 or whatever further documentation is necessary for payment of said claim within the terms of the
486 policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay,
487 in addition to any benefits which inure to such claimant or provider, interest on such benefits,
488 which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the
489 rate of one and one-half percent per month, not to exceed eighteen percent per year. The
490 provisions of this paragraph relating to interest payments shall not apply to a claim which an
491 insurer is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions
492 of this paragraph shall only apply to claims for reimbursement submitted electronically.

493 SECTION 21. Chapter 176G of the General Laws, as appearing in the Official Edition, is
494 hereby amended by striking out section 6 and inserting in place thereof the following:

495 Section 6. A health maintenance organization may enter into contractual arrangements
496 with any other person or company for the provision, to the health maintenance organization, of
497 health services, insurance, reinsurance and administrative, marketing, underwriting or other
498 services on a nondiscriminatory basis. A health maintenance organization shall not refuse to
499 contract with or compensate for covered services an otherwise eligible provider solely because
500 such provider has in good faith communicated with one or more of his current, former or
501 prospective patients regarding the provisions, terms or requirements of the organization's
502 products as they relate to the needs of such provider's patients. No contract between a
503 participating provider of health care services and a health maintenance organization shall be
504 issued or delivered in the commonwealth unless it contains a provision requiring that within 45
505 days after the receipt by the organization of completed forms for reimbursement to the provider
506 of health care services, the health maintenance organization shall (i) make payments for such
507 services provided, (ii) notify the provider in writing of the reason or reasons for nonpayment, or
508 (iii) notify the provider in writing of what additional information or documentation is necessary
509 to complete said forms for such reimbursement. If the health maintenance organization fails to
510 comply with this paragraph for any claims related to the provision of health care services, said
511 health maintenance organization shall pay, in addition to any reimbursement for health care
512 services provided, interest on such benefits, which shall accrue beginning 45 days after the health
513 maintenance organization's receipt of request for reimbursement at the rate of 1.5 per cent per

514 month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest
515 payments shall not apply to a claim that the health maintenance organization is investigating
516 because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall
517 only apply to claims for reimbursement submitted electronically.

518 SECTION 22. Chapter 176I of the General Laws, as appearing in the Official Edition, is
519 hereby amended by striking section 2 and inserting in place thereof the following:

520 Section 2. An organization may enter into a preferred provider arrangement with one or
521 more health care providers upon a determination by the commissioner that the organization and
522 the arrangement comply with the requirements of this chapter and the regulations hereunder. An
523 organization shall not condition its willingness to allow any health care provider to participate in
524 a preferred provider arrangement on such health care provider's agreeing to enter into other
525 contracts or arrangements with the organization that are not part of or related to such preferred
526 provider arrangements. An organization shall not refuse to contract with or compensate for
527 covered services an otherwise eligible participating or nonparticipating provider solely because
528 such provider has in good faith communicated with one or more of his current, former or
529 prospective patients regarding the provisions, terms or requirements of the organization's
530 products as they relate to the needs of such provider's patients. An organization shall submit
531 information concerning any proposed preferred provider arrangements to the commissioner for
532 approval in accordance with regulations promulgated by the commissioner. Said regulations shall
533 comply with the applicable provisions of chapter thirty A of the General Laws. Said information
534 shall include at least the following: (a) a description of the health services and any other benefits
535 to which the covered person is entitled; (b) a description of the locations where and the manner
536 in which health services and other benefits may be obtained; (c) a copy of the evidence of
537 coverage; (d) copies of any contracts with preferred providers; (e) a description of the rating
538 methodology and rates. The arrangement shall meet the following standards: (a) Standards for
539 maintaining quality health care, including satisfying any quality assurance regulations
540 promulgated by any state agency; (b) Standards for controlling health care costs; (c) Standards
541 for assuring reasonable levels of access of health care services and an adequate number and
542 geographical distribution of preferred providers to render those services; (d) Standards for
543 assuring appropriate utilization of health care service; and (e) Other standards deemed
544 appropriate by the commissioner.

545 No organization may enter into a preferred provider arrangement with one or more health
546 care providers unless said written arrangement contains a provision requiring that within 45 days
547 after the receipt by the organization of completed forms for reimbursement to the health care
548 provider, the organization shall (i) make payments for the provision of such services, (ii) notify
549 the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in
550 writing of what additional information or documentation is necessary to complete said forms for
551 such reimbursement. If the organization fails to comply with the provisions of this paragraph for
552 any claims related to the provision of health care services, said organization shall pay, in addition

553 to any reimbursement for health care services provided, interest on such benefits, which shall
554 accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate
555 of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph
556 relating to interest payments shall not apply to a claim that the organization is investigating
557 because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall
558 only apply to claims for reimbursement submitted electronically.

559 SECTION 23. Section one of Chapter 175 of the General Laws, as appearing in the 2002
560 Official Edition, is hereby amended by inserting the following new definitions:—

561 "Flexible health benefit policy" means a health insurance policy that in whole or in part,
562 does not offer state mandated health benefits.

563 "State mandated health benefits" means coverage required or required to be offered in
564 the general or special laws as part of a policy of accident or sickness insurance that:

565 1. includes coverage for specific health care services or benefits;

566 2. places limitations or restrictions on deductibles, coinsurance, copayments, or

567 any annual or lifetime maximum benefit amounts; or

568 3. includes a specific category of licensed health care practitioner from whom an

569 insured is entitled to receive care.

570 "Policy of Accident and Sickness Insurance," any policy or contract covering the kind or
571 kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47
572 of this chapter.

573

574 SECTION 24. Section 108 of chapter 175 of the General Laws, as so appearing, is
575 hereby further amended by adding the following new paragraph at the end thereof:—

576 A carrier authorized to transact individual policies of accident or sickness insurance
577 under this section may offer a flexible health benefit policy, provided however, that for each sale
578 of a flexible health benefit policy the carrier shall provide to the prospective policyholder written
579 notice describing the state mandated health benefits that are not included in the policy and
580 provide to the prospective individual policyholder the option of purchasing at least one health
581 insurance policy that provides all state mandated health benefits.

582

583 SECTION 25. Section 110 of chapter 175, as so appearing, is hereby amended by
584 inserting the following new paragraph at the end thereof:—

585 A carrier authorized to transact group policies of accident or sickness insurance under
586 this section may offer one or more flexible health benefit policies; provided however, that for
587 each sale of a flexible health benefit policy the carrier shall provide to the prospective group
588 policyholder written notice describing the state mandated benefits that are not included in the
589 policy and provide to the prospective group policyholder the option of purchasing at least on
590 health insurance policy that provides all state mandated benefits. The carrier shall provide each
591 subscriber under a group policy upon enrollment with written notice stating that this is a flexible
592 health benefit policy and describing the state mandated health benefits that are not included in
593 the policy.

594

595 SECTION 26. Chapter 176A of the General Laws, as appearing in the 2002 Official
596 Edition, is hereby amended by inserting the following new section:—

597 Section 1D. Definitions

598 The following words, as used in this chapter, unless the text otherwise requires or a
599 different meaning is specifically required, shall mean-

600 “Flexible health benefit policy” means a health insurance policy that in whole or in part,
601 does not offer state mandated health benefits.

602 "State mandated health benefits" means coverage required or required to be offered

603 in the general or special laws as part of a policy of accident or sickness insurance that:

604 1. includes coverage for specific health care services or benefits;

605 2. places limitations or restrictions on deductibles, coinsurance, copayments, or

606 any annual or lifetime maximum benefit amounts; or

607 3. includes a specific category of licensed health care practitioner from whom an

608 insured is entitled to receive care.

609 “Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or
610 kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47
611 of chapter 175 of the general laws.

612

613 SECTION 27. Section 8 of chapter 176A of the General Laws, as so appearing, is hereby
614 further amended by adding the following paragraphs at the end thereof:—

615 (h) A non-profit hospital service corporation authorized to transact individual policies of
616 accident or sickness insurance under this section may offer a one flexible health benefit policy,
617 provided however, that for each sale of a flexible health benefit policy the non-profit hospital
618 service corporation shall provide to the prospective policyholder written notice describing the
619 state mandated health benefits that are not included in the policy and provide to the prospective
620 individual policyholder the option of purchasing at least one health insurance policy that
621 provides all state mandated health benefits.

622 (i) A non-profit hospital service corporation authorized to transact group policies of
623 accident or sickness insurance under this section may offer one or more flexible health benefit
624 policies; provided however, that for each sale of a flexible health benefit policy the non-profit
625 hospital service corporation shall provide to the prospective group policyholder written notice
626 describing the state mandated benefits that are not included in the policy and provide to the
627 prospective group policyholder the option of purchasing at least on health insurance policy that
628 provides all state mandated benefits. The non-profit hospital service corporation shall provide
629 each subscriber under a group policy upon enrollment with written notice stating that this is a
630 flexible health benefit policy and describing the state mandated health benefits that are not
631 included in the policy.

632

633 SECTION 28. Section one of Chapter 176B of the General Laws, as appearing in the
634 2002 Official Edition, is hereby amended by inserting the following new definitions:—

635 “Flexible health benefit policy” means a health insurance policy that in whole or in part,
636 does not offer state mandated health benefits.

637 "State mandated health benefits" means coverage required or required to be offered in the
638 general or special laws as part of a policy of accident or sickness insurance that:

639 1. includes coverage for specific health care services or benefits;

640 2. places limitations or restrictions on deductibles, coinsurance, copayments, or

641 any annual or lifetime maximum benefit amounts; or

642 3. includes a specific category of licensed health care practitioner from whom an

643 insured is entitled to receive care.

644

645 “Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or
646 kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47
647 of chapter 175 of the general laws.

648

649 SECTION 29. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby
650 further amended by adding the following paragraphs at the end thereof:—

651 A medical service corporation authorized to transact individual policies of accident or
652 sickness insurance under this chapter may offer a one flexible health benefit policy, provided
653 however, that for each sale of a flexible health benefit policy the medical service corporation
654 shall provide to the prospective policyholder written notice describing the state mandated health
655 benefits that are not included in the policy and provide to the prospective individual policyholder
656 the option of purchasing at least one health insurance policy that provides all state mandated
657 health benefits.

658 A medical service corporation authorized to transact group policies of accident or
659 sickness insurance under this section may offer one or more flexible health benefit policies;
660 provided however, that for each sale of a flexible health benefit policy the medical service
661 corporation shall provide to the prospective group policyholder written notice describing the
662 state mandated benefits that are not included in the policy and provide to the prospective group
663 policyholder the option of purchasing at least on health insurance policy that provides all state
664 mandated benefits.

665 The medical service corporation shall provide each subscriber under a group policy upon
666 enrollment with written notice stating that this is a flexible health benefit policy and describing
667 the state mandated health benefits that are not included in the policy.

668

669 SECTION 30. Section one of Chapter 176G of the General Laws, as appearing in the
670 2002 Official Edition, is hereby amended by inserting the following new definitions:—

671 “Flexible health benefit policy” means a health insurance policy that in whole or in part,
672 does not offer state mandated health benefits.

673 "State mandated health benefits" means coverage required or required to be offered in the
674 general or special laws as part of a policy of accident or sickness insurance that:

675 1. includes coverage for specific health care services or benefits;

676 2. places limitations or restrictions on deductibles, coinsurance, copayments, or

677 any annual or lifetime maximum benefit amounts; or

678 3. includes a specific category of licensed health care practitioner from whom an

679 insured is entitled to receive care.

680 “Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or
681 kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47
682 of chapter 175 of the general laws.

683

684 SECTION 31. Section 4 of chapter 176G of the General Laws, as so appearing, is hereby
685 further amended by adding the following paragraph at the end thereof:—

686 A health maintenance organization authorized to transact individual policies of accident
687 or sickness insurance under this chapter may offer a one flexible health benefit policy, provided
688 however, that for each sale of a flexible health benefit policy the health maintenance
689 organization shall provide to the prospective policyholder written notice describing the state
690 mandated health benefits that are not included in the policy and provide to the prospective
691 individual policyholder the option of purchasing at least one health insurance policy that
692 provides all state mandated health benefits.

693

694 SECTION 32. Chapter 176G, as so appearing, is hereby further amended by inserting the
695 following new section:

696 Section 4A. A health maintenance organization authorized to transact group
697 policies of accident or sickness insurance under this chapter may offer one or more flexible
698 health benefit policies; provided however, that for each sale of a flexible health benefit policy the
699 health maintenance organization shall provide to the prospective group policyholder written
700 notice describing the state mandated benefits that are not included in the policy and provide to
701 the prospective group policyholder the option of purchasing at least on health insurance policy
702 that provides all state mandated benefits. The health maintenance organization shall provide
703 each subscriber under a group policy upon enrollment with written notice stating that this is a
704 flexible health benefit policy and describing the state mandated health benefits that are not
705 included in the policy.

706

707 SECTION 33. Chapter 176M of the General Laws, as appearing in the 2002 Official
708 Edition, is hereby amended by inserting in section one the following new definitions:—

709 “Flexible health benefit policy” means a health insurance that, in whole or in part, does
710 not offer state mandated health benefits.

711 "State mandated health benefits" means coverage required to be offered any general or
712 special law that:

713 1. includes coverage for specific health care services or benefits;

714 2. places limitations or restrictions on deductibles, coinsurance, copayments, or

715 any annual or lifetime maximum benefit amounts; or

716 3. includes a specific category of licensed health care practitioner from whom an

717 insured is entitled to receive care.

718

719 SECTION 34. Section 2 of said chapter 176M is hereby amended by striking out the first
720 sentence of paragraph (d) and inserting in place thereof the following:

721 A carrier that participates in the nongroup health insurance market shall make available
722 to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c)
723 and may additionally make available to eligible individuals no more than two alternative
724 guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits
725 and cost sharing requirements, including deductibles, that differ from the standard guaranteed
726 issue health plan.

727 SECTION 35. Chapter 175 of the General Laws 175 is hereby amended by inserting after
728 section 111H, the following section:--

729 Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not
730 disapprove a policy of accident and sickness insurance which provides hospital expense and
731 surgical expense insurance solely on the basis that it does not include coverage for at least 1
732 mandated benefit.

733 (b) The commissioner shall not approve a policy of accident and sickness insurance
734 which provides hospital expense and surgical expense insurance unless it provides, at a
735 minimum, coverage for:

736 (1) pregnant women, infants and children as set forth in section 47C;

737 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

738 (3) cytologic screening and mammographic examination as set forth in section 47G;

739 (3A)diabetes-related services, medications, and supplies as defined in section 47N;

740 (4) early intervention services as set forth in said section 47C; and

741 (5) mental health services as set forth in section 47B; provided however, that if the
742 policy limits coverage for outpatient physician office visits, the commissioner shall not
743 disapprove the policy on the basis that coverage for outpatient mental health services is not as

744 extensive as required by said section 47B, if the coverage is at least as extensive as coverage
745 under the policy for outpatient physician services.

746 (c) The commissioner shall not approve a policy of accident and sickness insurance
747 which provides hospital expense and surgical expense insurance that does not include coverage
748 for at least one mandated benefit unless the carrier continues to offer at least one policy that
749 provides coverage that includes all mandated benefits.

750 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this
751 chapter that requires coverage for specific health services, specific diseases or certain providers
752 of health care.

753 (e) The commissioner may promulgate rules and regulations as are necessary to carry out
754 this section.

755 (f) Notwithstanding any special or general law to the contrary, no plan approved by the
756 commissioner under this section shall be available to an employer who has provided a policy of
757 accident and sickness insurance to any employee within 12 months.

758 SECTION 36. Chapter 176A of the General Laws is hereby amended by inserting after
759 section 1D the following section:

760 Section 1E. (a) Except as otherwise provided in this section, the commissioner shall not
761 disapprove a contract between a subscriber and the corporation under an individual or group
762 hospital services plan solely on the basis that it does not include coverage for at least one
763 mandated benefit.

764 (b) The commissioner shall not approve a contract unless it provides, at a minimum,
765 coverage for:

766 (1) pregnant women, infants and children as set forth in section 47C;

767 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

768 (3) cytologic screening and mammographic examination as set forth in section 47G;

769 (3A)diabetes-related services, medications, and supplies as defined in section 47N;

770 (4) early intervention services as set forth in said section 47C; and

771 (5) mental health services as set forth in section 47B; provided however, that if the
772 policy limits coverage for outpatient physician office visits, the commissioner shall not
773 disapprove the policy on the basis that coverage for outpatient mental health services is not as
774 extensive as required by said section 47B, if the coverage is at least as extensive as coverage
775 under the policy for outpatient physician services.

776 (c) The commissioner shall not approve a contract that does not include coverage for at
777 least one mandated benefit unless the corporation continues to offer at least one contract that
778 provides coverage that includes all mandated benefits.

779 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this
780 chapter that requires coverage for specific health services, specific diseases or certain providers
781 of health care.

782 (e) The commissioner may promulgate rules and regulations as are necessary to carry out
783 this section.

784 (f) Notwithstanding any special or general law to the contrary, no plan approved by the
785 commissioner under this section shall be available to an employer who has provided a hospital
786 services plan, to any employee within 12 months.

787 SECTION 37. Chapter 176B of the General Laws is hereby further amended by inserting
788 after section 6B, the following section:-- Section 6C. (a) Except as otherwise provided in this
789 section, the commissioner shall not disapprove a subscription certificate solely on the basis that it
790 does not include coverage for at least one mandated benefit.

791 (b) The commissioner shall not approve a subscription certificate unless it provides, at a
792 minimum, coverage for:

793 (1) pregnant women, infants and children as set forth in section 47C;

794 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

795 (3) cytologic screening and mammographic examination as set forth in section 47G;

796 (3A)diabetes-related services, medications, and supplies as defined in section 47N;

797 (4) early intervention services as set forth in said section 47C; and

798 (5) mental health services as set forth in section 47B; provided however, that if the
799 policy limits coverage for outpatient physician office visits, the commissioner shall not
800 disapprove the policy on the basis that coverage for outpatient mental health services is not as
801 extensive as required by said section 47B, if the coverage is at least as extensive as coverage
802 under the policy for outpatient physician services.

803 (c) The commissioner shall not approve a subscription certificate that does not include
804 coverage for at least 1 mandated benefit unless the corporation continues to offer at least one
805 subscription certificate that provides coverage that includes all mandated benefits.

806 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this
807 chapter that requires coverage for specific health services, specific diseases or certain providers
808 of health care.

809 (e) The commissioner may promulgate rules and regulations as are necessary to carry out
810 this section. (f) Notwithstanding any special or general law to the contrary, no plan approved by
811 the commissioner under this section shall be available to an employer who has provided a
812 subscription certificate, to any employee within 12 months.

813 SECTION 38. Chapter 176G of the General Laws is hereby amended by inserting after
814 Section 16 the following new section:

815 Section 16A. (a) Except as otherwise provided in this section, the commissioner shall not
816 disapprove a health maintenance contract solely on the basis that it does not include coverage for
817 at least 1 mandated benefit.

818 (b) The commissioner shall not approve a health maintenance contract unless it provides
819 coverage for:

820 (1) pregnant women, infants and children as set forth in section 47C;

821 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

822 (3) cytologic screening and mammographic examination as set forth in section 47G;

823 (3A)diabetes-related services, medications, and supplies as defined in section 47N;

824 (4) early intervention services as set forth in said section 47C; and

825 (5) mental health services as set forth in section 47B; provided however, that if the
826 policy limits coverage for outpatient physician office visits, the commissioner shall not
827 disapprove the policy on the basis that coverage for outpatient mental health services is not as
828 extensive as required by said section 47B, if the coverage is at least as extensive as coverage
829 under the policy for outpatient physician services.

830 (c) The commissioner shall not approve a health maintenance contract that does not
831 include coverage for at least one mandated benefit unless the health maintenance organization
832 continues to offer at least one health maintenance contract that provides coverage that includes
833 all mandated benefits.

834 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this
835 chapter that requires coverage for specific health services, specific diseases or certain providers
836 of health care.

837 (e) The commissioner may promulgate rules and regulations as are necessary to carry out
838 the provisions of this section.

839 (f) Notwithstanding any special or general law to the contrary, no plan approved by the
840 commissioner under this section shall be available to an employer who has provided a health
841 maintenance contract, to any employee within 12 months.

842 SECTION 39. It shall be the policy of the general court to impose a moratorium on all
843 new mandated health benefit legislation until the later of July 31, 2012, or until the rate of
844 increase in the Consumer Price Index (CPI) for medical care services as reported by the United
845 States Bureau of Labor Statistics remains at zero or below zero for two consecutive years.

846 SECTION 40. Chapter 118E of the General Laws is hereby amended by adding the
847 following new section:

848 Section 62 - The Executive Office of Health and Human Services shall discontinue
849 membership in the MassHealth fee-for-service program and primary care clinician plan, and
850 shall begin to enroll all members meeting eligibility requirements, as established pursuant to
851 applicable federal and state law and regulation, into a Medicaid managed care organization that
852 has contracted with the commonwealth to deliver such managed care services, in accordance
853 with the enrollment and assignment process for other eligible categories and at the appropriate
854 levels of premium.

855 SECTION 41.

856 Section 40 of this act shall take effect on January 1, 2012.