

**SENATE . . . . . No. 570**

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The Commonwealth of Massachusetts

PRESENTED BY:

*Bruce E. Tarr*

*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 relative to mandated benefits.

PETITION OF:

NAME:

*Bruce E. Tarr*

DISTRICT/ADDRESS:

*First Essex and Middlesex*

**SENATE . . . . . No. 570**

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By Mr. Tarr, a petition (accompanied by bill, Senate, No. 570) of Bruce E. Tarr for legislation relative to mandated benefits. Health Care Financing.

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The Commonwealth of Massachusetts

An Act relative to mandated benefits.

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

1 SECTION 1. Section 38C of chapter 3 of the General Laws, as most recently amended by  
2 section 1 of chapter 288 of the Acts of 2010, is hereby further amended by striking subsection (a)  
3 and inserting in place thereof the following:-

4 “(a) For the purposes of this section, a mandated health benefit proposal is one that  
5 mandates health insurance coverage for specific health services, specific diseases or certain  
6 providers of health care services or that affects the operations of health insurers in the  
7 administration of health insurance coverage as part of a policy or policies of group life and  
8 accidental death and dismemberment insurance covering persons in the service of the  
9 commonwealth, and group general or blanket insurance providing hospital, surgical, medical,  
10 dental, and other health insurance benefits covering persons in the service of the commonwealth,  
11 and their dependents organized under chapter 32A , individual or group health insurance policies  
12 offered by an insurer licensed or otherwise authorized to transact accident or health insurance  
13 organized under chapter 175 , a nonprofit hospital service corporation organized under chapter  
14 176A, a nonprofit medical service corporation organized under chapter 176B , a health  
15 maintenance organization organized under chapter 176G , or an organization entering into a  
16 preferred provider arrangement under chapter 176I , any health plan issued, renewed, or  
17 delivered within or without the commonwealth to a natural person who is a resident of the  
18 commonwealth, including a certificate issued to an eligible natural person which evidences  
19 coverage under a policy or contract issued to a trust or association for said natural person and his  
20 dependent, including said person's spouse organized under chapter 176M.”.

21 SECTION 2. Subsection (d) of said section 38C of said chapter 3, as so appearing, is  
22 hereby amended by striking subdivision (1) and inserting in place thereof the following:-

23 “(1) the financial impact of mandating the benefit, including the extent to which the  
24 proposed insurance coverage would increase or decrease the cost of the treatment or service over

25 the next 5 years, the extent to which the proposed coverage might increase the appropriate or  
26 inappropriate use of the treatment or service over the next 5 years, the extent to which the  
27 mandated treatment or service might serve as an alternative for more expensive or less expensive  
28 treatment or service, the extent to which the insurance coverage may affect the number and types  
29 of providers of the mandated treatment or service over the next 5 years, the effects of mandating  
30 the benefit on the cost of health care, particularly the premium, administrative expenses and  
31 indirect costs of municipalities, large employers, small employers, employees and nongroup  
32 purchasers, the potential benefits and savings to municipalities, large employers, small  
33 employers, employees and nongroup purchasers, the effect of the proposed mandate on cost  
34 shifting between private and public payors of health care coverage, the cost to health care  
35 consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed  
36 treatment and the effect on the overall cost of the health care delivery system in the  
37 commonwealth;”.

38 SECTION 3. Chapter 118G of the General Laws, as appearing in the 2008 Official  
39 Edition, is hereby amended by inserting the following section:-

40 “Section 42. (a) For the purposes of this section, a mandated health benefit is a statutory  
41 or regulatory requirement that mandates health insurance coverage for specific health services,  
42 specific diseases or certain providers of health care services as part of a policy or policies of  
43 group life and accidental death and dismemberment insurance covering persons in the service of  
44 the commonwealth, and group general or blanket insurance providing hospital, surgical, medical,  
45 dental, and other health insurance benefits covering persons in the service of the commonwealth,  
46 and their dependents organized under chapter 32A , individual or group health insurance policies  
47 offered by an insurer licensed or otherwise authorized to transact accident or health insurance  
48 organized under chapter 175 , a nonprofit hospital service corporation organized under chapter  
49 176A , a nonprofit medical service corporation organized under chapter 176B , a health  
50 maintenance organization organized under chapter 176G , or an organization entering into a  
51 preferred provider arrangement under chapter 176I , any health plan issued, renewed, or  
52 delivered within or without the commonwealth to a natural person who is a resident of the  
53 commonwealth, including a certificate issued to an eligible natural person which evidences  
54 coverage under a policy or contract issued to a trust or association for said natural person and his  
55 dependent, including said person's spouse organized under chapter 176M.

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

60 (c) Upon request of a joint standing committee of the general court having jurisdiction or  
61 the committee on ways and means of either branch, the division of health care finance and policy  
62 shall conduct a review and evaluation of the mandated health benefit proposal, in consultation

63 with other relevant state agencies, and shall report to the committee within 90 days of the  
64 request. If the division of health care finance and policy fails to report to the appropriate  
65 committee within 45 days, said committee may report favorably on the mandated health benefit  
66 bill without including a review and evaluation from the division.

67 (d) Any state agency or any board created by statute, including but not limited to the  
68 Board of the Commonwealth Connector, the Department of Health, the Division of Medical  
69 Assistance or the Division of Insurance that proposes to add a mandated health benefit by rule,  
70 bulletin or other guidance must request that a review and evaluation of that proposed mandated  
71 health benefit be conducted by the division of health care finance and policy pursuant to this  
72 section. The report on the mandated health benefit by the division of health care finance and  
73 policy must be received by the agency or board and available to the public at least 30 days prior  
74 to any public hearing on the proposal. If the division of health care finance and policy fails to  
75 report to the agency or board within 45 days of the request, said agency or board may proceed  
76 with a public hearing on the mandated health benefit proposal without including a review and  
77 evaluation from the division.

78 (e) Any party or organization on whose behalf the mandated health benefit was proposed  
79 shall provide the division of health care finance and policy with any cost or utilization data that  
80 they have. All interested parties supporting or opposing the proposal shall provide the division of  
81 health care finance and policy with any information relevant to the division's review. The  
82 division shall enter into interagency agreements as necessary with the division of medical  
83 assistance, the group insurance commission, the department of public health, the division of  
84 insurance, and other state agencies holding utilization and cost data relevant to the division's  
85 review under this section. Such interagency agreements shall ensure that the data shared under  
86 the agreements is used solely in connection with the division's review under this section, and that  
87 the confidentiality of any personal data is protected. The division of health care finance and  
88 policy may also request data from insurers licensed or otherwise authorized to transact accident  
89 or health insurance under chapter 175 , nonprofit hospital service corporations organized under  
90 chapter 176A , nonprofit medical service corporations organized under chapter 176B , health  
91 maintenance organizations organized under chapter 176G , and their industry organizations to  
92 complete its analyses. The division of health care finance and policy may contract with an  
93 actuary, or economist as necessary to complete its analysis.

94 The report shall include, at a minimum and to the extent that information is available, the  
95 following: (1) the financial impact of mandating the benefit, including the extent to which the  
96 proposed insurance coverage would increase or decrease the cost of the treatment or service over  
97 the next 5 years, the extent to which the proposed coverage might increase the appropriate or  
98 inappropriate use of the treatment or service over the next 5 years, the extent to which the  
99 mandated treatment or service might serve as an alternative for more expensive or less expensive  
100 treatment or service, the extent to which the insurance coverage may affect the number and types  
101 of providers of the mandated treatment or service over the next 5 years, the effects of mandating

102 the benefit on the cost of health care, particularly the premium, administrative expenses and  
103 indirect costs of municipalities, large employers, small employers, employees and nongroup  
104 purchasers, the potential benefits and savings to municipalities, large employers, small  
105 employers, employees and nongroup purchasers, the effect of the proposed mandate on cost  
106 shifting between private and public payors of health care coverage, the cost to health care  
107 consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed  
108 treatment and the effect on the overall cost of the health care delivery system in the  
109 commonwealth; (2) the medical efficacy of mandating the benefit, including the impact of the  
110 benefit to the quality of patient care and the health status of the population and the results of any  
111 research demonstrating the medical efficacy of the treatment or service compared to alternative  
112 treatments or services or not providing the treatment or service; and (3) if the proposal seeks to  
113 mandate coverage of an additional class of practitioners, the results of any professionally  
114 acceptable research demonstrating the medical results achieved by the additional class of  
115 practitioners relative to those already covered and the methods of the appropriate professional  
116 organization that assures clinical proficiency.”.

117 SECTION 4. Section 1 of chapter 175, as so appearing, is hereby amended by inserting  
118 the following definitions:—

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

121 “State mandated health benefits” means coverage required or required to be offered in the  
122 general or special laws as part of a policy of accident or sickness insurance that:

- 123 1. includes coverage for specific health care services or benefits;
- 124 2. places limitations or restrictions on deductibles, coinsurance, copayments, or any  
125 annual or lifetime maximum benefit amounts; or
- 126 3. includes a specific category of licensed health care practitioner from whom an insured  
127 is entitled to receive care.

128 “Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or  
129 kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47  
130 of this chapter.”.

131 SECTION 5. Section 108 of said chapter 175, as so appearing, is hereby amended by  
132 inserting after subsection 12 the following subsection:—

133 “13. A carrier authorized to transact individual policies of accident or sickness insurance  
134 under this section may offer a flexible health benefit policy, provided however, that for each sale  
135 of a flexible health benefit policy the carrier shall provide to the prospective policyholder written  
136 notice describing the state mandated health benefits that are not included in the policy and

137 provide to the prospective individual policyholder the option of purchasing at least one health  
138 insurance policy that provides all state mandated health benefits.”.

139 SECTION 6. Section 110 of said chapter 175, as so appearing, is hereby amended by  
140 inserting after subsection (P) the following:—

141 “(Q) A carrier authorized to transact group policies of accident or sickness insurance  
142 under this section may offer one or more flexible health benefit policies; provided however, that  
143 for each sale of a flexible health benefit policy the carrier shall provide to the prospective group  
144 policyholder written notice describing the state mandated benefits that are not included in the  
145 policy and provide to the prospective group policyholder the option of purchasing at least on  
146 health insurance policy that provides all state mandated benefits. The carrier shall provide each  
147 subscriber under a group policy upon enrollment with written notice stating that this a flexible  
148 health benefit policy and describing the state mandated health benefits that are not included in  
149 the policy.”.

150 SECTION 7. Said chapter 175, as so appearing, is hereby amended by inserting after  
151 section 111H the following:-

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

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

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

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

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

162 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

181 SECTION 8. Chapter 176A, as so appearing, is hereby amended by adding after section  
182 1D the following two sections:—

183 “Section 1E. Definitions

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

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

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

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

191 2. places limitations or restrictions on deductibles, coinsurance, copayments, or any  
192 annual or lifetime maximum benefit amounts; or

193 3. includes a specific category of licensed health care practitioner from whom an insured  
194 is entitled to receive care.

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

198 Section 1F. (a) Except as otherwise provided in this section, the commissioner shall not  
199 disapprove a contract between a subscriber and the corporation under an individual or group

200 hospital services plan solely on the basis that it does not include coverage for at least one  
201 mandated benefit.

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

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

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

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

207 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

225 SECTION 9. Section 8 of chapter 176A, as so appearing, is hereby amended by inserting  
226 after subsection (g) the following:—

227 “(h) A non-profit hospital service corporation authorized to transact individual policies  
228 of accident or sickness insurance under this section may offer a one flexible health benefit  
229 policy, provided however, that for each sale of a flexible health benefit policy the non-profit  
230 hospital service corporation shall provide to the prospective policyholder written notice  
231 describing the state mandated health benefits that are not included in the policy and provide to

232 the prospective individual policyholder the option of purchasing at least one health insurance  
233 policy that provides all state mandated health benefits.

234 (i) A non-profit hospital service corporation authorized to transact group policies of  
235 accident or sickness insurance under this section may offer one or more flexible health benefit  
236 policies; provided however, that for each sale of a flexible health benefit policy the non-profit  
237 hospital service corporation shall provide to the prospective group policyholder written notice  
238 describing the state mandated benefits that are not included in the policy and provide to the  
239 prospective group policyholder the option of purchasing at least on health insurance policy that  
240 provides all state mandated benefits. The non-profit hospital service corporation shall provide  
241 each subscriber under a group policy upon enrollment with written notice stating that this a  
242 flexible health benefit policy and describing the state mandated health benefits that are not  
243 included in the policy.”.

244 SECTION 10. Section 1 of Chapter 176B, as so appearing, is hereby amended by  
245 inserting the following new definitions:—

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

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

- 250 1. includes coverage for specific health care services or benefits;
- 251 2. places limitations or restrictions on deductibles, coinsurance, copayments, or any  
252 annual or lifetime maximum benefit amounts; or
- 253 3. includes a specific category of licensed health care practitioner from whom an insured  
254 is entitled to receive care.

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

258 SECTION 11. Section 4 of chapter 176B, as so appearing, is hereby amended by  
259 inserting the following paragraphs at the end thereof:—

260 “A medical service corporation authorized to transact individual policies of accident or  
261 sickness insurance under this chapter may offer a one flexible health benefit policy, provided  
262 however, that for each sale of a flexible health benefit policy the medical service corporation  
263 shall provide to the prospective policyholder written notice describing the state mandated health  
264 benefits that are not included in the policy and provide to the prospective individual policyholder

265 the option of purchasing at least one health insurance policy that provides all state mandated  
266 health benefits.

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

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

277 SECTION 12. Said chapter 176B, as so appearing, is hereby amended by inserting after  
278 section 6B the following section:-

279 “Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not  
280 disapprove a subscription certificate solely on the basis that it does not include coverage for at  
281 least one mandated benefit.

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

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

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

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

287 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

302 (f) Notwithstanding any special or general law to the contrary, no plan approved by the  
303 commissioner under this section shall be available to an employer who has provided a  
304 subscription certificate, to any employee within 12 months.”.

305 SECTION 13. Section 1 of chapter 176G, as so appearing, is hereby amended by  
306 inserting the following new definitions:—

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

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

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

312 2. places limitations or restrictions on deductibles, coinsurance, copayments, or any  
313 annual or lifetime maximum benefit amounts; or

314 3. includes a specific category of licensed health care practitioner from whom an insured  
315 is entitled to receive care.

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

319 SECTION 14. Section 4 of chapter 176G, as most recently amended by section 97 of  
320 chapter 131 of the acts of 2010, hereby further amended by adding the following paragraph at the  
321 end thereof:—

322 “A health maintenance organization authorized to transact individual policies of accident  
323 or sickness insurance under this chapter may offer a one flexible health benefit policy, provided  
324 however, that for each sale of a flexible health benefit policy the health maintenance  
325 organization shall provide to the prospective policyholder written notice describing the state  
326 mandated health benefits that are not included in the policy and provide to the prospective  
327 individual policyholder the option of purchasing at least one health insurance policy that  
328 provides all state mandated health benefits.”.

329 SECTION 15. Chapter 176G, as most recently amended by section 5 of chapter 207 of  
330 the acts of 2010, is hereby further amended by inserting after section 4V the following section:-

331 “Section 4W. A health maintenance organization authorized to transact group policies of  
332 accident or sickness insurance under this chapter may offer one or more flexible health benefit  
333 policies; provided however, that for each sale of a flexible health benefit policy the health  
334 maintenance organization shall provide to the prospective group policyholder written notice  
335 describing the state mandated benefits that are not included in the policy and provide to the  
336 prospective group policyholder the option of purchasing at least one health insurance policy that  
337 provides all state mandated benefits. The health maintenance organization shall provide each  
338 subscriber under a group policy upon enrollment with written notice stating that this a flexible  
339 health benefit policy and describing the state mandated health benefits that are not included in  
340 the policy.”.

341 SECTION 16. Chapter 176G of the General Laws, as appearing in the 2008 Official  
342 Edition, is hereby amended by inserting after Section 16B the following section:-

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

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

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

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

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

351 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

370 SECTION 17. Section 1 of chapter 176M, as so appearing, is hereby amended by  
371 inserting the following new definitions:—

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

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

- 376 1. includes coverage for specific health care services or benefits;
- 377 2. places limitations or restrictions on deductibles, coinsurance, copayments, or any  
378 annual or lifetime maximum benefit amounts; or
- 379 3. includes a specific category of licensed health care practitioner from whom an insured  
380 is entitled to receive care.”.

381 SECTION 18. Section 2 of chapter 176M, as most recently amended by section 35 of  
382 chapter 288 of the acts of 2010, is hereby further amended by striking out the first sentence of  
383 subsection (d) and inserting in place thereof the following:-

384 “A carrier that participates in the nongroup health insurance market shall make available  
385 to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c)  
386 and may additionally make available to eligible individuals no more than two alternative  
387 guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits  
388 and cost sharing requirements, including deductibles, that differ from the standard guaranteed  
389 issue health plan.”.