

HOUSE No. 2092

The Commonwealth of Massachusetts

PRESENTED BY:

Bradley H. Jones, Jr.

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 adoption of the accompanying bill:

An Act relative to mandated benefits.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Bradley H. Jones, Jr.</i>	<i>20th Middlesex</i>	<i>1/20/2011</i>
<i>Donald F. Humason, Jr.</i>	<i>4th Hampden</i>	<i>1/27/2011</i>
<i>Marc T. Lombardo</i>	<i>22nd Middlesex</i>	<i>2/2/2011</i>
<i>Randy Hunt</i>	<i>5th Barnstable</i>	<i>2/2/2011</i>
<i>F. Jay Barrows</i>	<i>1st Bristol</i>	<i>2/2/2011</i>
<i>Shaunna O'Connell</i>	<i>3rd Bristol</i>	<i>2/2/2011</i>
<i>Susan Williams Gifford</i>	<i>2nd Plymouth</i>	<i>2/2/2011</i>
<i>Daniel K. Webster</i>	<i>6th Plymouth</i>	<i>2/3/2011</i>
<i>Donald H. Wong</i>	<i>9th Essex</i>	<i>2/3/2011</i>
<i>Todd M. Smola</i>	<i>1st Hampden</i>	<i>2/3/2011</i>
<i>Kevin J. Kuros</i>	<i>8th Worcester</i>	<i>2/3/2011</i>
<i>Sheila C. Harrington</i>	<i>1st Middlesex</i>	<i>2/4/2011</i>
<i>Nicholas A. Boldyga</i>	<i>3rd Hampden</i>	<i>2/4/2011</i>
<i>Steven L. Levy</i>	<i>4th Middlesex</i>	<i>2/4/2011</i>
<i>David T. Vieira</i>	<i>3rd Barnstable</i>	<i>2/4/2011</i>
<i>Bruce E. Tarr</i>		<i>2/4/2011</i>
<i>Paul K. Frost</i>	<i>7th Worcester</i>	<i>2/4/2011</i>
<i>Paul Adams</i>	<i>17th Essex</i>	<i>2/4/2011</i>

<i>George N. Peterson, Jr.</i>	<i>9th Worcester</i>	<i>1/26/2011</i>
<i>Bradford Hill</i>	<i>4th Essex</i>	<i>2/4/2011</i>
<i>Elizabeth A. Poirier</i>	<i>14th Bristol</i>	<i>1/21/2011</i>
<i>Viriato Manuel deMacedo</i>	<i>1st Plymouth</i>	<i>2/3/2011</i>

HOUSE No. 2092

By Mr. Jones of North Reading, a petition (accompanied by bill, House, No. 2092) of Bradley H. Jones, Jr. and others relative to mandated health benefits. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

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

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

24 “(1) the financial impact of mandating the benefit, including the extent to which the
25 proposed insurance coverage would increase or decrease the cost of the treatment or service over
26 the next 5 years, the extent to which the proposed coverage might increase the appropriate or
27 inappropriate use of the treatment or service over the next 5 years, the extent to which the
28 mandated treatment or service might serve as an alternative for more expensive or less expensive
29 treatment or service, the extent to which the insurance coverage may affect the number and types
30 of providers of the mandated treatment or service over the next 5 years, the effects of mandating
31 the benefit on the cost of health care, particularly the premium, administrative expenses and
32 indirect costs of municipalities, large employers, small employers, employees and nongroup
33 purchasers, the potential benefits and savings to municipalities, large employers, small
34 employers, employees and nongroup purchasers, the effect of the proposed mandate on cost
35 shifting between private and public payors of health care coverage, the cost to health care

36 consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed
37 treatment and the effect on the overall cost of the health care delivery system in the
38 commonwealth;”.

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

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

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

61 (c) Upon request of a joint standing committee of the general court having jurisdiction or
62 the committee on ways and means of either branch, the division of health care finance and policy
63 shall conduct a review and evaluation of the mandated health benefit proposal, in consultation
64 with other relevant state agencies, and shall report to the committee within 90 days of the
65 request. If the division of health care finance and policy fails to report to the appropriate
66 committee within 45 days, said committee may report favorably on the mandated health benefit
67 bill without including a review and evaluation from the division.

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

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

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

102 of providers of the mandated treatment or service over the next 5 years, the effects of mandating
103 the benefit on the cost of health care, particularly the premium, administrative expenses and
104 indirect costs of municipalities, large employers, small employers, employees and nongroup
105 purchasers, the potential benefits and savings to municipalities, large employers, small
106 employers, employees and nongroup purchasers, the effect of the proposed mandate on cost
107 shifting between private and public payors of health care coverage, the cost to health care
108 consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed
109 treatment and the effect on the overall cost of the health care delivery system in the
110 commonwealth; (2) the medical efficacy of mandating the benefit, including the impact of the
111 benefit to the quality of patient care and the health status of the population and the results of any
112 research demonstrating the medical efficacy of the treatment or service compared to alternative
113 treatments or services or not providing the treatment or service; and (3) if the proposal seeks to
114 mandate coverage of an additional class of practitioners, the results of any professionally
115 acceptable research demonstrating the medical results achieved by the additional class of
116 practitioners relative to those already covered and the methods of the appropriate professional
117 organization that assures clinical proficiency.”.

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

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

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

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

129 “Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or

130 kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47

131 of this chapter.”.

132

133 SECTION 5. Section 108 of said chapter 175, as so appearing, is hereby amended by

134 inserting after subsection 12 the following subsection:—

135 “13. A carrier authorized to transact individual policies of accident or sickness insurance

136 under this section may offer a flexible health benefit policy, provided however, that for each sale

137 of a flexible health benefit policy the carrier shall provide to the prospective policyholder written

138 notice describing the state mandated health benefits that are not included in the policy and

139 provide to the prospective individual policyholder the option of purchasing at least one health

140 insurance policy that provides all state mandated health benefits.”.

141

142 SECTION 6. Section 110 of said chapter 175, as so appearing, is hereby amended by

143 inserting after subsection (P) the following:—

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

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

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

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

- 162 (1) pregnant women, infants and children as set forth in section 47C;
- 163 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;
- 164 (3) cytologic screening and mammographic examination as set forth in section 47G;

165 (3A)diabetes-related services, medications, and supplies as defined in section 47N;
166 (4) early intervention services as set forth in said section 47C; and
167 (5) mental health services as set forth in section 47B; provided however, that if the
168 policy limits coverage for outpatient physician office visits, the commissioner shall not
169 disapprove the policy on the basis that coverage for outpatient mental health services is not as
170 extensive as required by said section 47B, if the coverage is at least as extensive as coverage
171 under the policy for outpatient physician services.

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

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

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

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

184 SECTION 8. Chapter 176A, as so appearing, is hereby amended by adding after section
185 1D the following two sections:—

186 “Section 1E. Definitions

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

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

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

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

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

201

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

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

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

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

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

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

211 (3A)diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

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

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

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

246 flexible health benefit policy and describing the state mandated health benefits that are not
247 included in the policy.”.

248

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

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

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

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

260

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

264

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

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

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

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

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

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

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

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

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

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

294 (3A)diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

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

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

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

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

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

326

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

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

337

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

340 “Section 4W. A health maintenance organization authorized to transact group policies of
341 accident or sickness insurance under this chapter may offer one or more flexible health benefit
342 policies; provided however, that for each sale of a flexible health benefit policy the health
343 maintenance organization shall provide to the prospective group policyholder written notice

344 describing the state mandated benefits that are not included in the policy and provide to the
345 prospective group policyholder the option of purchasing at least on health insurance policy that
346 provides all state mandated benefits. The health maintenance organization shall provide each
347 subscriber under a group policy upon enrollment with written notice stating that this a flexible
348 health benefit policy and describing the state mandated health benefits that are not included in
349 the policy.”.

350

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

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

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

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

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

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

361 (3A)diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

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

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

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

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

391

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

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

401

402 SECTION 19. Notwithstanding any general or special law to the contrary, it shall be the
403 policy of the general court to impose a moratorium on all new mandated health benefit

404 legislation until the later of July 31, 2012, or until the rate of increase in the Consumer Price
405 Index (CPI) for medical care services as reported by the United States Bureau of Labor Statistics
406 remains at zero or below zero for two consecutive years.