HOUSE DOCKET, NO. 4309 FILED ON: 3/9/2012

HOUSE . . . . . No. 4034

The Commonwealth of Massachusetts

PRESENTED BY:

Bradley H. Jones, Jr. and 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 adoption of the accompanying bill:

An Act relative to reducing the healthcare burden on businesses.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Bradley H. Jones, Jr.	*20th Middlesex*	*3/9/2012*
Bruce E. Tarr		*3/12/2012*
George N. Peterson, Jr.	*9th Worcester*	*3/12/2012*
Bradford Hill	*4th Essex*	*3/14/2012*
Elizabeth A. Poirier	*14th Bristol*	*3/12/2012*
Viriato Manuel deMacedo	*1st Plymouth*	*3/9/2012*
Angelo L. D'Emilia	*8th Plymouth*	*3/9/2012*
Geoff Diehl	*7th Plymouth*	*3/9/2012*
F. Jay Barrows	*1st Bristol*	*3/12/2012*
Richard Bastien	*2nd Worcester*	*3/11/2012*
Nicholas A. Boldyga	*3rd Hampden*	*3/12/2012*
Peter J. Durant	*6th Worcester*	*3/10/2012*
Keiko M. Orrall	*12th Bristol*	*3/10/2012*
John H. Rogers	*12th Norfolk*	*3/12/2012*
Donald H. Wong	*9th Essex*	*3/9/2012*
Matthew A. Beaton	*11th Worcester*	*3/12/2012*
Kimberly N. Ferguson	*1st Worcester*	*3/12/2012*
George T. Ross	*2nd Bristol*	*3/12/2012*

Paul Adams	*17th Essex*	*3/13/2012*
Ryan C. Fattman	*18th Worcester*	*3/14/2012*
Paul K. Frost	*7th Worcester*	*3/14/2012*
Susan Williams Gifford	*2nd Plymouth*	*3/13/2012*
Marc T. Lombardo	*22nd Middlesex*	*3/14/2012*
Sheila C. Harrington	*1st Middlesex*	*3/14/2012*
Steven S. Howitt	*4th Bristol*	*3/13/2012*
Donald F. Humason, Jr.	*4th Hampden*	*3/13/2012*
Randy Hunt	*5th Barnstable*	*3/14/2012*
Daniel K. Webster	*6th Plymouth*	*3/14/2012*
Kevin J. Kuros	*8th Worcester*	*3/14/2012*
Steven L. Levy	*4th Middlesex*	*3/14/2012*
James J. Lyons, Jr.	*18th Essex*	*3/14/2012*
Shaunna O'Connell	*3rd Bristol*	*3/13/2012*
Todd M. Smola	*1st Hampden*	*3/13/2012*
Daniel B. Winslow	*9th Norfolk*	*3/14/2012*
Robert L. Hedlund		*3/14/2012*
Michael R. Knapik		*3/16/2012*
Michael J. Rodrigues		*3/14/2012*
Richard J. Ross	*Norfolk, Bristol and Middlesex*	*3/15/2012*
David T. Vieira	*3rd Barnstable*	*3/14/2012*

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HOUSE . . . . . No. 4034

By Representative Jones of North Reading and Senator Tarr, a joint petition (subject to Joint Rule 12) of Bradley H. Jones, Jr., Bruce E. Tarr and others relative to health care services. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

An Act relative to reducing the healthcare burden on businesses.

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. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking subsection (a) and inserting in place thereof the following:-

(a) For the purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services or that affects the operations of health insurers in the administration of health insurance coverage as part of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical, dental, and other health insurance benefits covering persons in the service of the commonwealth, and their dependents organized under chapter 32A , individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized under chapter 175, a nonprofit hospital service corporation organized under chapter

176A, a nonprofit medical service corporation organized under chapter 176B, a health maintenance organization organized under chapter 176G, or an organization entering into a preferred provider arrangement under chapter 176I, any health plan issued, renewed, or delivered within or without the commonwealth to a natural person who is a resident of the commonwealth, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association for said natural person and his dependent, including said person's spouse organized under chapter 176M.

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

(1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years, the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years, the extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of municipalities, large employers, small employers, employees and nongroup purchasers, the potential benefits and savings to municipalities, large employers, small employers, employees and nongroup purchasers, the effect of the proposed mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed

treatment and the effect on the overall cost of the health care delivery system in the commonwealth;

SECTION 3. Section 1 of chapter 111M of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 46, at the end of the definition of the term “Creditable coverage” the following:-

Minimum creditable coverage, as defined by the board under the authority granted herein, shall not require, in the case of individuals subject to chapter 58 of the acts of 2006, coverage for prescription drugs.

SECTION 4. Section 12C of chapter 112 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting at the end thereof the following:—

No physician or nurse who is registered by the Commonwealth in the Massachusetts System for Advance Registration of Volunteer Health Professionals or its successor entity shall be liable in civil suit for damages for any act or omission on his part related to his voluntary participation in any disaster preparedness or response activity.

SECTION 5. Chapter 118G of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting the following section:-

Section 42. (a) For the purposes of this section, a mandated health benefit is a statutory or regulatory requirement that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical,

dental, and other health insurance benefits covering persons in the service of the commonwealth, and their dependents organized under chapter 32A , individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized under chapter 175 , a nonprofit hospital service corporation organized under chapter 176A , a nonprofit medical service corporation organized under chapter 176B , a health maintenance organization organized under chapter 176G , or an organization entering into a preferred provider arrangement under chapter 176I , any health plan issued, renewed, or delivered within or without the commonwealth to a natural person who is a resident of the commonwealth, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association for said natural person and his dependent, including said person's spouse organized under chapter 176M.

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

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

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

(e) Any party or organization on whose behalf the mandated health benefit was proposed shall provide the division of health care finance and policy with any cost or utilization data that they have. All interested parties supporting or opposing the proposal shall provide the division of health care finance and policy with any information relevant to the division's review. The division shall enter into interagency agreements as necessary with the division of medical assistance, the group insurance commission, the department of public health, the division of insurance, and other state agencies holding utilization and cost data relevant to the division's review under this section. Such interagency agreements shall ensure that the data shared under the agreements is used solely in connection with the division's review under this section, and that the confidentiality of any personal data is protected. The division of health care finance and policy may also request data from insurers licensed or otherwise authorized to transact accident or health insurance under chapter 175 , nonprofit hospital service corporations organized under

chapter 176A , nonprofit medical service corporations organized under chapter 176B , health maintenance organizations organized under chapter 176G , and their industry organizations to complete its analyses. The division of health care finance and policy may contract with an actuary, or economist as necessary to complete its analysis.

The report shall include, at a minimum and to the extent that information is available, the following: (1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years, the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years, the extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of municipalities, large employers, small employers, employees and nongroup purchasers, the potential benefits and savings to municipalities, large employers, small employers, employees and nongroup purchasers, the effect of the proposed mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment and the effect on the overall cost of the health care delivery system in the commonwealth; (2) the medical efficacy of mandating the benefit, including the impact of the benefit to the quality of patient care and the health status of the population and the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services or not providing the treatment or service; and (3) if the proposal seeks to

mandate coverage of an additional class of practitioners, the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered and the methods of the appropriate professional organization that assures clinical proficiency.

SECTION 6. Section 188 of chapter 149 of the General Laws, as most recently amended by chapter 3 of the Acts of 2011, is hereby further amended in the definition of “Employee” by inserting, after the word “individual” the following words:- ,who is a resident of the commonwealth,

SECTION 7. Section 188 of chapter 149, as appearing in the 2010 Official Edition, is hereby further amended by striking, in line 19, the number “11” and inserting in place thereof the following: 50

SECTION 8. Subsection (c) of section 188 of said chapter 149 is hereby amended by inserting at the end thereof the following paragraph:

(11) For the purpose of the fair share contribution compliance test, an employer may count employees that have qualifying health insurance coverage from a spouse, a parent, a veteran’s plan, Medicare, Medicaid, or a plan or plans due to a disability or retirement towards their qualifying take-up rate as a “contributing employer”, as defined by the Division of Health Care Finance and Policy. The employer is still required to offer group medical insurance and must keep and maintain proof of their employee’s insurance status.

SECTION 9. Section 1 of chapter 175, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 15, after the word “commonwealth”, the following definition:—

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

; and further, in line 30, after the word “inclusive”, the following definition:

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

; and, further, in line 38, after the word “context”, the following definition:

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

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

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

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

SECTION 10. Section 108 of said chapter 175, as so appearing, is hereby amended by inserting after subsection 12 the following subsection:—

13. A carrier authorized to transact individual policies of accident or sickness insurance under this section may offer a flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective policyholder written

notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION 11. Section 110 of said chapter 175, as so appearing, is hereby amended by inserting after subsection (P) the following:—

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

SECTION 12. Said chapter 175, as so appearing, is hereby amended by inserting after section 111H the following:-

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 13. Chapter 176A, as appearing in the 2010 Official Edition, is hereby amended by adding after section 1D the following two sections:—

Section 1E. Definitions

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

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

"State mandated health benefits," coverage required or required to be offered

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 14. Section 8 of chapter 176A, as so appearing, is hereby amended by inserting after subsection (g) the following:—

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

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

SECTION 15. Section 1 of Chapter 176B, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 11, after the word "support", the following new definition:—

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

; and, further, in line 56, after the word "corporation", the following definition:

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

; and, further, in line 62, after the word "twelve", the following definition:

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

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

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

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

SECTION 16. Section 4 of chapter 176B, as so appearing, is hereby amended by inserting the following paragraphs at the end thereof:—

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

A medical service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group

policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits.

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

SECTION 17. Said chapter 176B, as so appearing, is hereby amended by inserting after section 6B the following section:-

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 18. Section 1 of chapter 176G, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 42, after the word “entitled” the following new definition:—

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

; and, further, in line 102, after the words “chapter 175”, the following definitions:

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

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

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

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

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

SECTION 19. Section 4 of chapter 176G, as appearing in the 2010 Official Edition, is hereby amended by adding the following paragraph at the end thereof:—

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

SECTION 20. Chapter 176G, as appearing in the 2010 Official Edition is hereby amended by inserting after section 4V the following section:-

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

SECTION 21. Chapter 176G of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after Section 16B the following section:-

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 22. Section 1 of chapter 176M, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 101, after the word “claims” the following new definition:—

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

; and, further, in line 255, after the word “basis”, the following definition:

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

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

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

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

SECTION 23. Section 2 of chapter 176M, as appearing in the 2010 Official Edition, is hereby further amended by striking out the first sentence of subsection (d) and inserting in place thereof the following:-

A carrier that participates in the nongroup health insurance market shall make available to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c) and may additionally make available to eligible individuals no more than two alternative guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits

and cost sharing requirements, including deductibles, that differ from the standard guaranteed issue health plan.

SECTION 24. Chapter 231 of the General Laws, as so appearing, is hereby amended by adding after section 60K, the following new sections:

Section 60L. In any action for malpractice, error or mistake against a provider of health care licensed pursuant to section 2 of chapter 112, including actions pursuant to section 60B of this chapter, an expert witness shall be board certified in the same specialty as the defendant licensed pursuant to section 2 of chapter 112, as so appearing.

Section 60M. In every action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care the court may, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds $50,000 in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages, and court shall require a defendant who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the defendant.

(a)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which

payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the defendant has exhibited a continuing pattern of failing to make the payments as specified in paragraph (1), the court shall find the defendant in contempt of court and, in addition to the required periodic payments, shall order the defendant to pay the plaintiff all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(b)Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the plaintiff, but shall be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately prior to his death, or to whom the plaintiff assigned, transferred, or bequeathed his right to receive payment. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(c) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the defendant to make future payments shall cease and any security given, pursuant to this section shall revert to the defendant.

Section 60N. In any action for malpractice, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care, the liability of each defendant for damages shall be several only and shall not be joint. Each defendant shall be liable only for the amount of damages allocated to that defendant in direct proportion to that

defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount.

SECTION 25. Chapter 233 of the General Laws, as so appearing, is hereby amended by inserting after section 79K the following section:-

Section 79L. (a) As used in this section, the following terms shall have the following meaning:

"Health care provider", any of the following heath care professionals licensed pursuant to chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist and a mental health counselor. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

"Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health agency. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such facilities.

"Unanticipated outcome" means the outcome of a medical treatment or procedure, whether or not resulting from an intentional act, that differs from an intended result of such medical treatment or procedure.

(b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding and shall not constitute an admission of liability or an admission against interest.

SECTION 26. Notwithstanding any general or special law to the contrary, it shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until December 31, 2013.