SENATE DOCKET, NO. 686 FILED ON: 1/20/2011

SENATE . . . . . No. 469

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 adoption of the accompanying bill:

An Act relative to health care mandates..

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Bruce E. Tarr	

SENATE DOCKET, NO. 686 FILED ON: 1/20/2011

SENATE . . . . . No. 469

By Mr. Tarr, a petition (accompanied by bill, Senate, No. 469) of Bruce E. Tarr for legislation relative to health care mandates. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *514* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to health care mandates..

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. Subsection (b) of section 38C of Chapter 3 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting at the end thereof the following: Notwithstanding the foregoing or any general or special law or regulation to the contrary, no mandated health benefit bill shall be reported favorably by any joint committee of the general court or the house or senate committees on ways and means, unless and until the rate of increase in the Consumer Price Index (CPI) for medical care services as reported by the United States Bureau of Labor Statistics remains at zero or below zero for two consecutive years. The Division of Health Care Finance and Policy shall file an annual report with the house and senate committees on ways and means, the joint committee on insurance and the joint committee on health care no later than the last day of January for the previous year certifying the rate of increase in the CPI for medical care services.

SECTION 2 Section one of Chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting the following new definitions:-

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

“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.

“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 3 Section 108 of Chapter 175 of the General Laws, as appearing in the Official Edition, is hereby amended by striking out subsection 4(c) and inserting in place thereof the following:

4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or provider under a policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment

or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2012, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 4. Section 108 of chapter 175 of the General Laws, as so appearing, is hereby further amended by adding the following new paragraph at the end thereof:-

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

(G) For purposes of this section the term ""notice of a claim" shall mean any notification whether in writing or otherwise, to an insurer or its authorized agent, by any person, firm,

association, or corporation asserting right to payment under a policy of insurance which reasonably apprises the insurer of the existence of a claim.

Within fifteen days after an insurer's receipt of notice of claim by a claimant under a general or blanket policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2012, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 6. Section 110 of chapter 175, as so appearing, is hereby amended by inserting the following new paragraph at the end thereof:- 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 7. Chapter 176A of the General Laws, as appearing in the 20082 Official Edition, is hereby amended by inserting the following new section:-

Section 1D. 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” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

“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 8. Section 8 of Chapter 176A of the General Laws, as so appearing, is hereby further amended by adding the following paragraphs at the end thereof:-

(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 9. Section one of Chapter 176B of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new definitions:- “Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits. "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.

"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 10. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby further amended by adding 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 11. Section one of Chapter 176G of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting the following new definitions:-

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

“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 12. Section 4 of chapter 176G of the General Laws, as so appearing, is hereby further 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 13. Chapter 176G, as so appearing, is hereby further amended by inserting after Section 4 the following new section:

Section 4A. 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 14. Chapter 176G of the General Laws, as appearing in the Official Edition, is hereby amended by striking out section 6 and inserting in place thereof the following:

Section 6. A health maintenance organization may enter into contractual arrangements with any other person or company for the provision, to the health maintenance organization, of health services, insurance, reinsurance and administrative, marketing, underwriting or other services on a nondiscriminatory basis. A health maintenance organization shall not refuse to contract with or compensate for covered services an otherwise eligible provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients.

No contract between a participating provider of health care services and a health maintenance organization shall be issued or delivered in the commonwealth unless it contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the provider of health care services, the health maintenance organization shall (i) make payments for such services provided, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the health maintenance organization fails to comply with this paragraph for any claims related to the provision of health care services, said health maintenance organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the health maintenance organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the health maintenance organization is investigating because of suspected fraud. Beginning on January 1, 2012, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 15. Section 14 of Chapter 176G, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following:- A license granted to a health maintenance organization pursuant to this section shall be renewed every two years. The fee for such renewal in an amount determined by the commissioner shall be no less than $1000.

SECTION 16. Chapter 176I of the General Laws, as appearing in the Official Edition, is hereby amended by striking section 2 and inserting in place thereof the following:

Section 2. An organization may enter into a preferred provider arrangement with one or more health care providers upon a determination by the commissioner that the organization and the arrangement comply with the requirements of this chapter and the regulations hereunder. An organization shall not condition its willingness to allow any health care provider to participate in a preferred provider arrangement on such health care provider's agreeing to enter into other contracts or arrangements with the organization that are not part of or related to such preferred provider arrangements. An organization shall not refuse to contract with or compensate for covered services an otherwise eligible participating or nonparticipating provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients.

An organization shall submit information concerning any proposed preferred provider arrangements to the commissioner for approval in accordance with regulations promulgated by the commissioner. Said regulations shall comply with the applicable provisions of chapter thirty A of the General Laws. Said information shall include at least the following: (a) a description of the health services and any other benefits to which the covered person is entitled; (b) a description of the locations where and the manner in which health services and other benefits may be obtained; (c) a copy of the evidence of coverage; (d) copies of any contracts with preferred providers; (e) a description of the rating methodology and rates. The arrangement shall meet the following standards:

(a) Standards for maintaining quality health care, including satisfying any quality assurance regulations promulgated by any state agency;

(b) Standards for controlling health care costs;

(c) Standards for assuring reasonable levels of access of health care services and an adequate number and geographical distribution of preferred providers to render those services;

(d) Standards for assuring appropriate utilization of health care service; and

(e) Other standards deemed appropriate by the commissioner. No organization may enter into a preferred provider arrangement with one or more health care providers unless said written arrangement contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the health care provider, the organization shall (i) make payments for the provision of such services, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the organization fails to comply with the provisions of this paragraph for any claims related to the provision of health care services, said organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the organization is investigating because of suspected fraud. Beginning on January 1, 2012, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically

SECTION 17. Chapter 176M of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting in section one the following new definitions:-

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

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

A carrier that participates in the non-group 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.