

**SENATE . . . . . No. 469**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

*Bruce E. Tarr*

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

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

An Act relative to health care mandates..

PETITION OF:

NAME:

*Bruce E. Tarr*

DISTRICT/ADDRESS:

**SENATE . . . . . No. 469**

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

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

**The Commonwealth of Massachusetts**

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**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:*

1           SECTION 1. Subsection (b) of section 38C of Chapter 3 of the General Laws, as  
2 appearing in the 2008 Official Edition, is hereby amended by inserting at the end thereof the  
3 following: Notwithstanding the foregoing or any general or special law or regulation to the  
4 contrary, no mandated health benefit bill shall be reported favorably by any joint committee of  
5 the general court or the house or senate committees on ways and means, unless and until the rate  
6 of increase in the Consumer Price Index (CPI) for medical care services as reported by the  
7 United States Bureau of Labor Statistics remains at zero or below zero for two consecutive  
8 years. The Division of Health Care Finance and Policy shall file an annual report with the house  
9 and senate committees on ways and means, the joint committee on insurance and the joint  
10 committee on health care no later than the last day of January for the previous year certifying the  
11 rate of increase in the CPI for medical care services.

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

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

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

19 "State mandated health benefits" means coverage required or required to be offered in the  
20 general or special laws as part of a policy of accident or sickness insurance that: 1. includes  
21 coverage for specific health care services or benefits; 2. places limitations or restrictions on  
22 deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or 3  
23 includes a specific category of licensed health care practitioner from whom an insured is entitled  
24 to receive care.

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

28 4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or  
29 provider under a policy of accident and sickness insurance which is delivered or issued for  
30 delivery in the commonwealth, and which provides hospital expense, medical expense, surgical  
31 expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished  
32 by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not  
33 made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment

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

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

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

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

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

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

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

71         SECTION 6. Section 110 of chapter 175, as so appearing, is hereby amended by  
72 inserting the following new paragraph at the end thereof:- A carrier authorized to transact group  
73 policies of accident or sickness insurance under this section may offer one or more flexible  
74 health benefit policies; provided however, that for each sale of a flexible health benefit policy the  
75 carrier shall provide to the prospective group policyholder written notice describing the state  
76 mandated benefits that are not included in the policy and provide to the prospective group  
77 policyholder the option of purchasing at least one health insurance policy that provides all state

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

81 SECTION 7. Chapter 176A of the General Laws, as appearing in the 20082 Official  
82 Edition, is hereby amended by inserting the following new section:-

83 Section 1D. Definitions The following words, as used in this chapter, unless the text  
84 otherwise requires or a different meaning is specifically required, shall mean-

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

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

90 "State mandated health benefits" means coverage required or required to be offered in the  
91 general or special laws as part of a policy of accident or sickness insurance that: 1. includes  
92 coverage for specific health care services or benefits; 2. places limitations or restrictions on  
93 deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts;  
94 or 3. includes a specific category of licensed health care practitioner from whom an insured is  
95 entitled to receive care.

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

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

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

115 SECTION 9. Section one of Chapter 176B of the General Laws, as appearing in the 2002  
116 Official Edition, is hereby amended by inserting the following new definitions:- “Flexible health  
117 benefit policy” means a health insurance policy that in whole or in part, does not offer state  
118 mandated health benefits. "State mandated health benefits" means coverage required or required  
119 to be offered in the general or special laws as part of a policy of accident or sickness insurance  
120 that: 1. includes coverage for specific health care services or benefits; 2 places limitations or

121 restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit  
122 amounts; or 3 includes a specific category of licensed health care practitioner from whom  
123 an insured is entitled to receive care.

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

127 SECTION 10. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby  
128 further amended by adding the following paragraphs at the end thereof:- A medical service  
129 corporation authorized to transact individual policies of accident or sickness insurance under this  
130 chapter may offer a one flexible health benefit policy, provided however, that for each sale of a  
131 flexible health benefit policy the medical service corporation shall provide to the prospective  
132 policyholder written notice describing the state mandated health benefits that are not included in  
133 the policy and provide to the prospective individual policyholder the option of purchasing at least  
134 one health insurance policy that provides all state mandated health benefits. A medical service  
135 corporation authorized to transact group policies of accident or sickness insurance under this  
136 section may offer one or more flexible health benefit policies; provided however, that for each  
137 sale of a flexible health benefit policy the medical service corporation shall provide to the  
138 prospective group policyholder written notice describing the state mandated benefits that are not  
139 included in the policy and provide to the prospective group policyholder the option of purchasing  
140 at least on health insurance policy that provides all state mandated benefits. The medical service  
141 corporation shall provide each subscriber under a group policy upon enrollment with written  
142 notice stating that this a flexible health benefit policy and describing the state mandated health  
143 benefits that are not included in the policy.



144 SECTION 11. Section one of Chapter 176G of the General Laws, as appearing in the  
145 2008 Official Edition, is hereby amended by inserting the following new definitions:-

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

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

151 "State mandated health benefits" means coverage required or required to be offered in the  
152 general or special laws as part of a policy of accident or sickness insurance that: (1) includes  
153 coverage for specific health care services or benefits; (2) places limitations or restrictions on  
154 deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or  
155 (3) includes a specific category of licensed health care practitioner from whom an insured is  
156 entitled to receive care.

157 SECTION 12. Section 4 of chapter 176G of the General Laws, as so appearing, is hereby  
158 further amended by adding the following paragraph at the end thereof:-

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

166 SECTION 13. Chapter 176G, as so appearing, is hereby further amended by inserting  
167 after Section 4 the following new section:

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

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

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

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

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

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

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

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

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

233 (b) Standards for controlling health care costs;

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

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

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

250 Beginning on January 1, 2012, the provisions of this paragraph shall only apply to claims for  
251 reimbursement submitted electronically

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

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

256           "State mandated health benefits" means coverage required to be offered any general or  
257 special law that: 1. includes coverage for specific health care services or benefits; 2. places  
258 limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime  
259 maximum benefit amounts; or 3. includes a specific category of licensed health care practitioner  
260 from whom an insured is entitled to receive care.

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

263           A carrier that participates in the non-group health insurance market shall make available  
264 to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c)  
265 and may additionally make available to eligible individuals no more than two alternative  
266 guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits  
267 and cost sharing requirements, including deductibles, that differ from the standard guaranteed  
268 issue health plan.