

SENATE No. 547

The Commonwealth of Massachusetts

PRESENTED BY:

Anthony W. Petrucci

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 applying mandate review to regulatory agencies.

PETITION OF:

NAME:

Anthony W. Petrucci

DISTRICT/ADDRESS:

SENATE No. 547

By Mr. Petrucci, a petition (accompanied by bill, Senate, No. 547) of Anthony W. Petrucci
for legislation to apply mandate review to regulatory agencies. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act applying mandate review to regulatory agencies.

*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. Chapter 118G of the General Laws is hereby amended by inserting the
2 following new section:-

3 Section 40 - Review and evaluation of regulatory changes on health insurance

4 Section 40 (a) For the purposes of this section, a mandated health benefit is a statutory or
5 regulatory requirement that mandates health insurance coverage for specific health services,
6 specific diseases or certain providers of health care services as part of a policy or policies of
7 group life and accidental death and dismemberment insurance covering persons in the service of
8 the commonwealth, and group general or blanket insurance providing hospital, surgical, medical,
9 dental, and other health insurance benefits covering persons in the service of the commonwealth,
10 and their dependents organized under chapter 32A , individual or group health insurance policies
11 offered by an insurer licensed or otherwise authorized to transact accident or health insurance
12 organized under chapter 175 , a nonprofit hospital service corporation organized under chapter
13 176A , a nonprofit medical service corporation organized under chapter 176B , a health

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

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

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

31 (d) Any state agency or any board created by statute, including but not limited to the
32 Board of the Commonwealth Connector, the Department of Health, the Division of Medical
33 Assistance or the Division of Insurance that proposes to add a mandated health benefit by rule,
34 bulletin or other guidance must request that a review and evaluation of that proposed mandated
35 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.