HOUSE DOCKET, NO. 515 FILED ON: 1/13/2017

HOUSE . . . . . No. 522

The Commonwealth of Massachusetts

PRESENTED BY:

Tricia Farley-Bouvier

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 to promote value-based insurance design in the Commonwealth.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Tricia Farley-Bouvier	*3rd Berkshire*	*1/13/2017*
Jason M. Lewis	*Fifth Middlesex*	*1/24/2017*
José F. Tosado	*9th Hampden*	*1/24/2017*
Jack Lewis	*7th Middlesex*	
Denise Provost	*27th Middlesex*	
Sarah K. Peake	*4th Barnstable*	
Jennifer E. Benson	*37th Middlesex*	
Carmine L. Gentile	*13th Middlesex*	
Linda Dorcena Forry	*First Suffolk*	
Solomon Goldstein-Rose	*3rd Hampshire*	
David Paul Linsky	*5th Middlesex*	
Marjorie C. Decker	*25th Middlesex*	
Ruth B. Balser	*12th Middlesex*	
Kay Khan	*11th Middlesex*	
Patrick M. O'Connor	*Plymouth and Norfolk*	
Angelo J. Puppolo, Jr.	*12th Hampden*	
Mike Connolly	*26th Middlesex*	
Paul R. Heroux	*2nd Bristol*	

Edward F. Coppinger	*10th Suffolk*	
Barbara A. L'Italien	*Second Essex and Middlesex*	
Mary S. Keefe	*15th Worcester*	
Christine P. Barber	*34th Middlesex*	
John W. Scibak	*2nd Hampshire*	
Elizabeth A. Malia	*11th Suffolk*	
Peter V. Kocot	*1st Hampshire*	
Natalie Higgins	*4th Worcester*	
Jonathan Hecht	*29th Middlesex*	
James B. Eldridge	*Middlesex and Worcester*	
Michelle M. DuBois	*10th Plymouth*	

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HOUSE . . . . . No. 522

By Ms. Farley-Bouvier of Pittsfield, a petition (accompanied by bill, House, No. 522) of Tricia Farley-Bouvier and others for legislation to promote value-based health insurance design in the Commonwealth. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

An Act to promote value-based insurance design in the Commonwealth.

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. Chapter 6A of the General Laws is hereby amended by adding after section 16Y the following section:-

Section 16Z (a) The secretary of health and human services shall by regulation determine which medical and behavioral health services, treatments and prescription drugs shall be deemed high-value cost-effective services for the purposes of this section. To advise the secretary in making said determinations, there shall be a Value-Based Insurance Expert Panel as established by subsection (c). Any regulation making a determination pursuant to this section, that is promulgated prior to July 1 of any year, shall take effect on January 1 of the following year. In determining medical and behavioral health services, treatments and prescription drugs to be deemed high-value cost-effective services, the secretary may limit the effect of the determination to people with one or more specific diagnoses or risk factors for a disease, condition, or disorder.

(b) Insurance plans, health coverage, and medical assistance and medical benefit programs shall not charge cost sharing for high-value cost-effective medical and behavioral health services, for coverage subject to section 17P of chapter 32A, section 10K of chapter 118E, section 47JJ of chapter 175, section 8LL of chapter 176A, section 4JJ of chapter 176B, section 4DD of chapter 176G, and section 13 of chapter 176I. For the purposes of this section, cost sharing shall include payments required from a consumer in connection with the provision of a health care service, including, but not limited to, copayments, coinsurance, and deductibles. Reimbursement to providers shall not be reduced on the basis of a service, treatment or drug being determined a high-value cost effective service.

(c) The secretary shall establish the Value-Based Insurance Expert Panel to make recommendations regarding high-value cost-effective medical or behavioral health services, treatments or prescription drugs that should not be subject to cost sharing. The panel shall be comprised of up to ten people, eight of whom shall be appointed by the secretary. In making appointments to the panel, the secretary shall include at least one primary care physician, one primary care provider at a community health center, one pediatrician, one licensed mental health clinician, and one community pharmacist, and shall further ensure that the panel represents expertise in health economics, actuarial sciences, health care cost effectiveness, women's health, medical ethics, and consumer advocacy. The panel shall further include representatives of the department of public health, the office of Medicaid, and the division of insurance, appointed by the respective commissioners or directors of said agencies. No member of the panel shall have any significant financial conflict of interest in any decision of the panel.

The secretary shall designate one member to serve as chair of the panel. They shall serve a term of 3 years, and may be reappointed, provided that the secretary may designate up to half

of the original members appointed to the board to serve for two years. Panel members shall receive no compensation for their services but shall be entitled to reimbursement for reasonable travel and other expenses.

The panel shall, with each report, review its previous recommendations and may recommend that a medical or behavioral health service, treatment or prescription drug be no longer deemed a high-value cost-effective service for purposes of this section. The panel shall report its recommendations by majority vote to the secretary no later than March 1 of each year.

In making recommendations for high-value cost-effective services, treatments and prescription drugs that should not be subject to cost sharing, the Value-Based Insurance Expert Panel shall consider appropriate medical and behavioral health services, treatments and prescription drugs that are

(1) out-patient or ambulatory services, including medications, lab tests, procedures, and office visits, generally offered in the primary care or medical home setting;

(2) of clear benefit, strongly supported by clinical evidence to be cost-effective;

(3) likely to reduce hospitalizations or emergency department visits, or reduce future exacerbations of illness progression, or improve quality of life;

(4) relatively low cost when compared to the cost of an acute illness or incident prevented or delayed by the use of the service, treatment or drug; and

(5) at low risk for overutilization, abuse, addiction, diversion or fraud.

In making recommendations, the panel may limit a recommended high-value cost-effective service as applicable only to patients with one or more specific diagnoses or risk factors for a disease, condition or disorder.

The panel shall consult with health insurance carriers and the group insurance commission before issuing its recommendations. The panel shall further develop an educational plan for both insureds and health care providers on high-value versus low-value services, treatments and prescription drugs pertaining to the recommendations as approved by the secretary.

(d) Every two years, the center for health information and analysis shall evaluate the effect of this section. The evaluation shall include the impact of this section on treatment adherence, incidence of related acute events, premiums and cost sharing, overall health, long-term health costs, and other issues that the center may determine. The center may collaborate with an independent research organization to conduct the evaluation.

(e) Notwithstanding subsection (b), cost sharing may be charged if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 2. Chapter 32A of the General Laws is hereby amended by inserting after section 17O the following section:-

Section 17P. The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission, coverage without cost sharing for all medical and behavioral services, treatments and prescription drugs determined to

be high-value cost-effective services by the secretary of health and human services pursuant to section 16Z of chapter 6A.

SECTION 3. Chapter 118E of the General Laws is hereby amended by inserting after section 10J the following section:-

Section 10K. The division shall cover without cost sharing all medical and behavioral health services determined to be high-value cost-effective services by the secretary of health and human services pursuant to section 16Z of chapter 6A.

SECTION 4. Chapter 175 of the General Laws is hereby amended by inserting after section 47II the following section:-

Section 47JJ. An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance and any group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance, which is issued or renewed within or without the commonwealth, shall cover without cost sharing all medical and behavioral health services determined to be high-value cost-effective services by the secretary of health and human services pursuant to section 16Z of chapter 6A.

SECTION 5. Chapter 176A of the General Laws is hereby amended by inserting after section 8KK the following section:-

Section 8LL. A contract between a subscriber and the corporation under an individual or group hospital service plan which provides hospital expense and surgical expense insurance, except contracts providing supplemental coverage to Medicare or other governmental programs,

delivered, issued or renewed by agreement between the insurer and the policyholder, within or without the commonwealth, shall cover without cost sharing all medical and behavioral health services, treatments and prescription drugs determined to be high-value cost-effective services by the secretary of health and human services pursuant to section 16Z of chapter 6A; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 6. Chapter 176B of the General Laws is hereby amended by inserting after section 4KK the following section:-

Section 4JJ. Any subscription certificate under an individual or group medical service agreement, except certificates that provide supplemental coverage to Medicare or other governmental programs, issued, delivered or renewed within or without the commonwealth, shall cover without cost sharing all services, treatments and prescription drugs determined to be high-value cost-effective medical and behavioral health services by secretary of health and human services pursuant to section 16Z of chapter 6A; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 7. Chapter 176G of the General Laws is hereby amended by inserting after section 4CC the following section:-

Section 4DD. A health maintenance contract issued or renewed within or without the commonwealth shall cover without cost sharing all services, treatments and prescription drugs

determined to be high-value cost-effective medical and behavioral health services by the secretary of health and human services pursuant to section 16Z of chapter 6A; provided, however, that co-payments, coinsurance or deductibles shall be required if the applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on co-payments, coinsurance or deductibles for these services.

SECTION 8. Chapter 176I of the General Laws is hereby amended by adding the following section:-

Section 13. An organization entering into a preferred provider contract shall cover without cost sharing all medical and behavioral health services, treatments and prescription drugs determined to be high-value cost-effective services by the secretary of health and human services pursuant to section 16Z of chapter 6A.