SENATE DOCKET, NO. 2489 FILED ON: 1/17/2025

SENATE . . . . . No. 916

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 to enhance analysis of state health mandates and costs.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Bruce E. Tarr	*First Essex and Middlesex*	
Peter J. Durant	*Worcester and Hampshire*	*3/14/2025*

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SENATE . . . . . No. 916

By Mr. Tarr, a petition (accompanied by bill, Senate, No. 916) of Bruce E. Tarr for legislation to regulate state health insurance mandates and costs. Health Care Financing.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act to enhance analysis of state health mandates and costs.

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 is hereby amended by striking subsection (a) and inserting in place thereof the following:-

Section 38C. (a) For the purposes of this section, a mandated health benefit proposal is one that:

(i) mandates health insurance coverage for specific health services, prescription drugs, specific diseases or certain providers of health care services, including pharmacies;

(ii) mandates reimbursement for health services, prescription drugs, diseases or providers of health care services, including pharmacies;

(iii) prohibits or limits cost sharing or deductibles for health services, prescription drugs, diseases or providers of health care services, including pharmacies;

(iv) mandates specific rates of payment for health care services, prescription drugs, diseases or providers of health care services, or requires an increase in the existing rates of payment for health care services, prescription drugs, diseases or providers of health care services, including pharmacies;

(v) prohibits, limits, or imposes any requirements that would restrict or effectively prohibit the development or implementation of utilization management or medical necessity determinations, including, but not limited to, prior authorization, concurrent review, retrospective review, or step therapy programs; or

(vi) any other statutory or regulatory provision or requirement that would result in any increase in health care cost or 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, any policy, contract or certificate of health insurance provided by the Division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician under chapter 118E, 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. Chapter 12C of the General Laws is hereby amended by inserting after section 24 the following section:-

Section 25: Evaluation of regulatory changes.

(a) For the purposes of this section, a mandated health benefit is a regulatory requirement that:

(i) mandates health insurance coverage for specific health services, prescription drugs, specific diseases or certain providers of health care services, including pharmacies; or

(ii) mandates reimbursement for any health services, prescription drugs, diseases or providers of health care services, including pharmacies; or

(iii) prohibits or limits cost sharing or deductibles for health services, prescription drugs, diseases, or providers of health care services, including pharmacies,

(iv) mandates specific rates of payment for health care services, prescription drugs, diseases or providers of health care services, or requires an increase in the existing rates of payment for health care services, prescription drugs, diseases or providers of health care services, including pharmacies;

(v) prohibits, limits, or imposes any requirements that would restrict or effectively prohibit the development or implementation of utilization management or medical necessity

determinations, including, but not limited to, prior authorization, concurrent review, retrospective review, or step therapy programs; or

(vi) any other statutory or regulatory provision or requirement that would result in any increase in health care cost or 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, any policy, contract or certificate of health insurance provided by the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician under chapter 118E, 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) Any state agency or any board created by statute, including but not limited to the commonwealth health insurance connector, the department of public health, the department of

mental health, the division of medical assistance, and the division of insurance, that proposes to add a mandated health benefit by regulation, rule, bulletin or other guidance shall request that a review and evaluation of that proposed mandated health benefit be conducted by the center of health information and analysis pursuant to the requirements of section 38C of chapter 3. The report on the mandated health benefit by the center 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.

SECTION 3. Section 6 of Chapter 176J of the General Laws is amended by striking subsection (a) in its entirety and inserting in place thereof the following subsection:-

(a) Notwithstanding any general or special law to the contrary, the commissioner may approve health insurance policies submitted to the division of insurance for the purpose of being provided to eligible individuals or eligible small businesses. These health insurance policies shall be subject to this chapter and may include networks that differ from those of a health plan's overall network. The commissioner may approve health insurance policies submitted to the division of insurance that provide coverage of essential health benefits as defined in section 1302(b)(1) of the Patient Protection and Affordable Care Act of 2010. The commissioner shall adopt regulations regarding eligibility criteria.

SECTION 4. Notwithstanding any general or special law to the contrary, it shall be the policy of the general court to impose a moratorium on enactment of new mandated health benefit legislation as defined in subsection (a) of section 38C of chapter 3 of the General Laws until growth in total health care expenditures in the state meets the health care cost growth benchmark established under section 9 of chapter 6D.