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	

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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.

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 on 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.