

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

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**The Commonwealth of Massachusetts**

PRESENTED BY:

**Richard R. Tisei**

*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 passage of the accompanying bill:

**An Act Relative to Health Care Mandates.**

PETITION OF:

NAME:

Richard R. Tisei

DISTRICT/ADDRESS:

Middlesex and Essex

# The Commonwealth of Massachusetts

In the Year Two Thousand and Nine

## 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 appearing in  
2 the 2008 Official Edition, is hereby amended by inserting at the end thereof the following:  
3 Notwithstanding the foregoing or any general or special law or regulation to the contrary, no  
4 mandated health benefit bill shall be reported favorably by any joint committee of the general  
5 court or the house or senate committees on ways and means, unless and until the rate of increase  
6 in the Consumer Price Index (CPI) for medical care services as reported by the United States  
7 Bureau of Labor Statistics remains at zero or below zero for two consecutive years. The  
8 Division of Health Care Finance and Policy shall file an annual report with the house and senate  
9 committees on ways and means, the joint committee on insurance and the joint committee on  
10 health care no later than the last day of January for the previous year certifying the rate of  
11 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 Official  
13 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, does not  
15 offer state mandated health benefits.

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

23 or 3. includes a specific category of licensed health care practitioner from whom an insured is  
24 entitled to receive care.

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

28 4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or provider  
29 under a policy of accident and sickness insurance which is delivered or issued for delivery in the  
30 commonwealth, and which provides hospital expense, medical expense, surgical expense or  
31 dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for  
32 filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the  
33 insurer shall notify the claimant in writing specifying the reasons for the nonpayment or  
34 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, 2010, 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 further  
43 amended by adding the following new paragraph at the end thereof:-

44 A carrier authorized to transact individual policies of accident or sickness insurance under this  
45 section may offer a flexible health benefit policy, provided however, that for each sale of a  
46 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 Official  
51 Edition, is hereby further amended by striking out subsection (G) and inserting in place thereof  
52 the following:

53 (G) For purposes of this section the term ""notice of a claim" shall mean any notification whether  
54 in writing or otherwise, to an insurer or its authorized agent, by any person, firm, association, or  
55 corporation asserting right to payment under a policy of insurance which reasonably apprises the  
56 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 general or  
58 blanket policy of accident and sickness insurance which is delivered or issued for delivery in the  
59 commonwealth, and which provides hospital expense, medical expense, surgical expense or  
60 dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for  
61 filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the

62 insurer shall notify the claimant in writing specifying the reasons for the nonpayment or  
63 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, 2010, the provisions  
70 of this paragraph shall only apply to claims for reimbursement submitted electronically.

71

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

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

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

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

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

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

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

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

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

116 **SECTION 9.** Section one of Chapter 176B of the General Laws, as appearing in the 2002  
117 Official Edition, is hereby amended by inserting the following new definitions:- “Flexible health  
118 benefit policy” means a health insurance policy that in whole or in part, does not offer state  
119 mandated health benefits. "State mandated health benefits" means coverage required or required  
120 to be offered in the general or special laws as part of a policy of accident or sickness insurance  
121 that: 1. includes coverage for specific health care services or benefits; 2. places limitations or  
122 restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit  
123 amounts; or 3. includes a specific category of licensed health care practitioner from whom  
124 an insured is entitled to receive care.

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

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

141 at least on health insurance policy that provides all state mandated benefits. The medical service  
142 corporation shall provide each subscriber under a group policy upon enrollment with written  
143 notice stating that this a flexible health benefit policy and describing the state mandated health  
144 benefits that are not included in the policy.

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

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

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

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

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

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

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

169 Section 4A. A health maintenance organization authorized to transact group policies of accident  
170 or sickness insurance under this chapter may offer one or more flexible health benefit policies;  
171 provided however, that for each sale of a flexible health benefit policy the health maintenance  
172 organization shall provide to the prospective group policyholder written notice describing the  
173 state mandated benefits that are not included in the policy and provide to the prospective group  
174 policyholder the option of purchasing at least on health insurance policy that provides all state  
175 mandated benefits. The health maintenance organization shall provide each subscriber under a  
176 group policy upon enrollment with written notice stating that this a flexible health benefit policy  
177 and describing the state mandated health benefits that are not included in 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 with any  
181 other person or company for the provision, to the health maintenance organization, of health  
182 services, insurance, reinsurance and administrative, marketing, underwriting or other services on  
183 a nondiscriminatory basis. A health maintenance organization shall not refuse to contract with or  
184 compensate for covered services an otherwise eligible provider solely because such provider has  
185 in good faith communicated with one or more of his current, former or prospective patients  
186 regarding the provisions, terms or requirements of the organization's products as they relate to  
187 the needs of such provider's patients.

188 No contract between a participating provider of health care services and a health maintenance  
189 organization shall be issued or delivered in the commonwealth unless it contains a provision  
190 requiring that within 45 days after the receipt by the organization of completed forms for  
191 reimbursement to the provider of health care services, the health maintenance organization shall  
192 (i) make payments for such services provided, (ii) notify the provider in writing of the reason or  
193 reasons for nonpayment, or (iii) notify the provider in writing of what additional information or  
194 documentation is necessary to complete said forms for such reimbursement. If the health  
195 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, 2010, 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 striking out  
205 the second paragraph and inserting in place thereof the following:- A license granted to a  
206 health maintenance organization pursuant to this section shall be renewed every two years. The  
207 fee for such renewal in an amount determined by the commissioner shall be no less than \$1000.

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

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

219 prospective patients regarding the provisions, terms or requirements of the organization's  
220 products as they relate to the needs of such provider's patients.

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

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

232 (b) Standards for controlling health care costs;

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

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

236 (e) Other standards deemed appropriate by the commissioner. No organization may enter into a  
237 preferred provider arrangement with one or more health care providers unless said written  
238 arrangement contains a provision requiring that within 45 days after the receipt by the  
239 organization of completed forms for reimbursement to the health care provider, the organization  
240 shall (i) make payments for the provision of such services, (ii) notify the provider in writing of  
241 the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional  
242 information or documentation is necessary to complete said forms for such reimbursement. If the  
243 organization fails to comply with the provisions of this paragraph for any claims related to the  
244 provision of health care services, said organization shall pay, in addition to any reimbursement  
245 for health care services provided, interest on such benefits, which shall accrue beginning 45 days  
246 after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month,  
247 not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments  
248 shall not apply to a claim that the organization is investigating because of suspected fraud.  
249 Beginning on January 1, 2010, the provisions of this paragraph shall only apply to claims for  
250 reimbursement submitted electronically.

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

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

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



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

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