

HOUSE No. 04034

The Commonwealth of Massachusetts

PRESENTED BY:

Bradley H. Jones, Jr. and 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 passage of the accompanying bill:

An Act relative to reducing the healthcare burden on businesses.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Bradley H. Jones, Jr.</i>	<i>20th Middlesex</i>
<i>Bruce E. Tarr</i>	<i>First Essex and Middlesex</i>
<i>George N. Peterson, Jr.</i>	<i>9th Worcester</i>
<i>Bradford Hill</i>	<i>4th Essex</i>
<i>Elizabeth A. Poirier</i>	<i>14th Bristol</i>
<i>Viriato Manuel deMacedo</i>	<i>1st Plymouth</i>
<i>Angelo L. D'Emilia</i>	<i>8th Plymouth</i>
<i>Geoff Diehl</i>	<i>7th Plymouth</i>
<i>F. Jay Barrows</i>	<i>1st Bristol</i>
<i>Richard Bastien</i>	<i>2nd Worcester</i>
<i>Nicholas A. Boldyga</i>	<i>3rd Hampden</i>
<i>Peter J. Durant</i>	<i>6th Worcester</i>
<i>Keiko M. Orrall</i>	<i>12th Bristol</i>
<i>John H. Rogers</i>	<i>12th Norfolk</i>
<i>Donald H. Wong</i>	<i>9th Essex</i>
<i>Matthew A. Beaton</i>	<i>11th Worcester</i>
<i>Kimberly N. Ferguson</i>	<i>1st Worcester</i>

<i>George T. Ross</i>	<i>2nd Bristol</i>
<i>Paul Adams</i>	<i>17th Essex</i>
<i>Ryan C. Fattman</i>	<i>18th Worcester</i>
<i>Paul K. Frost</i>	<i>7th Worcester</i>
<i>Susan Williams Gifford</i>	<i>2nd Plymouth</i>
<i>Marc T. Lombardo</i>	<i>22nd Middlesex</i>
<i>Sheila C. Harrington</i>	<i>1st Middlesex</i>
<i>Steven S. Howitt</i>	<i>4th Bristol</i>
<i>Donald F. Humason, Jr.</i>	<i>4th Hampden</i>
<i>Randy Hunt</i>	<i>5th Barnstable</i>
<i>Daniel K. Webster</i>	<i>6th Plymouth</i>
<i>Kevin J. Kuros</i>	<i>8th Worcester</i>
<i>Steven L. Levy</i>	<i>4th Middlesex</i>
<i>James J. Lyons, Jr.</i>	<i>18th Essex</i>
<i>Shaunna O'Connell</i>	<i>3rd Bristol</i>
<i>Todd M. Smola</i>	<i>1st Hampden</i>
<i>Daniel B. Winslow</i>	<i>9th Norfolk</i>
<i>Robert L. Hedlund</i>	<i>Plymouth and Norfolk</i>
<i>Michael R. Knapik</i>	<i>Second Hampden and Hampshire</i>
<i>Michael J. Rodrigues</i>	<i>First Bristol and Plymouth</i>
<i>Richard J. Ross</i>	<i>Norfolk, Bristol, and Middlesex</i>
<i>David T. Vieira</i>	<i>3rd Barnstable</i>

HOUSE No. 04034

By Representative Jones of North Reading and Senator Tarr, a joint petition (subject to Joint Rule 12) of Bradley H. Jones, Jr., Bruce E. Tarr and others relative to health care services. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

An Act relative to reducing the healthcare burden on businesses.

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. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official
2 Edition, is hereby amended by striking subsection (a) and inserting in place thereof the
3 following:-
4 (a) For the purposes of this section, a mandated health benefit proposal is one that mandates
5 health insurance coverage for specific health services, specific diseases or certain providers of
6 health care services or that affects the operations of health insurers in the administration of
7 health insurance coverage as part of a policy or policies of group life and accidental death and
8 dismemberment insurance covering persons in the service of the commonwealth, and group
9 general or blanket insurance providing hospital, surgical, medical, dental, and other health
10 insurance benefits covering persons in the service of the commonwealth, and their dependents
11 organized under chapter 32A , individual or group health insurance policies offered by an insurer

12 licensed or otherwise authorized to transact accident or health insurance organized under chapter
13 175, a nonprofit hospital service corporation organized under chapter 176A, a nonprofit medical
14 service corporation organized under chapter 176B, a health maintenance organization organized
15 under chapter 176G, or an organization entering into a preferred provider arrangement under
16 chapter 176I, any health plan issued, renewed, or delivered within or without the commonwealth
17 to a natural person who is a resident of the commonwealth, including a certificate issued to an
18 eligible natural person which evidences coverage under a policy or contract issued to a trust or
19 association for said natural person and his dependent, including said person's spouse organized
20 under chapter 176M.

21 SECTION 2. Subsection (d) of said section 38C of said chapter 3, as so appearing, is hereby
22 amended by striking subdivision (1) and inserting in place thereof the following:-

23 (1) the financial impact of mandating the benefit, including the extent to which the proposed
24 insurance coverage would increase or decrease the cost of the treatment or service over the next
25 5 years, the extent to which the proposed coverage might increase the appropriate or
26 inappropriate use of the treatment or service over the next 5 years, the extent to which the
27 mandated treatment or service might serve as an alternative for more expensive or less expensive
28 treatment or service, the extent to which the insurance coverage may affect the number and types
29 of providers of the mandated treatment or service over the next 5 years, the effects of mandating
30 the benefit on the cost of health care, particularly the premium, administrative expenses and
31 indirect costs of municipalities, large employers, small employers, employees and nongroup
32 purchasers, the potential benefits and savings to municipalities, large employers, small
33 employers, employees and nongroup purchasers, the effect of the proposed mandate on cost
34 shifting between private and public payors of health care coverage, the cost to health care

35 consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed
36 treatment and the effect on the overall cost of the health care delivery system in the
37 commonwealth;

38 SECTION 3. Section 1 of chapter 111M of the General Laws, as appearing in the 2010 Official
39 Edition, is hereby amended by inserting, in line 46, at the end of the definition of the term
40 “Creditable coverage” the following:-

41 Minimum creditable coverage, as defined by the board under the authority granted herein, shall
42 not require, in the case of individuals subject to chapter 58 of the acts of 2006, coverage for
43 prescription drugs.

44 SECTION 4. Section 12C of chapter 112 of the General Laws, as appearing in the 2010 Official
45 Edition, is hereby amended by inserting at the end thereof the following:—

46 No physician or nurse who is registered by the Commonwealth in the Massachusetts System for
47 Advance Registration of Volunteer Health Professionals or its successor entity shall be liable in
48 civil suit for damages for any act or omission on his part related to his voluntary participation in
49 any disaster preparedness or response activity.

50 SECTION 5. Chapter 118G of the General Laws, as appearing in the 2010 Official Edition, is
51 hereby amended by inserting the following section:-

52 Section 42. (a) For the purposes of this section, a mandated health benefit is a statutory or
53 regulatory requirement that mandates health insurance coverage for specific health services,
54 specific diseases or certain providers of health care services as part of a policy or policies of
55 group life and accidental death and dismemberment insurance covering persons in the service of

56 the commonwealth, and group general or blanket insurance providing hospital, surgical, medical,
57 dental, and other health insurance benefits covering persons in the service of the commonwealth,
58 and their dependents organized under chapter 32A , individual or group health insurance policies
59 offered by an insurer licensed or otherwise authorized to transact accident or health insurance
60 organized under chapter 175 , a nonprofit hospital service corporation organized under chapter
61 176A , a nonprofit medical service corporation organized under chapter 176B , a health
62 maintenance organization organized under chapter 176G , or an organization entering into a
63 preferred provider arrangement under chapter 176I , any health plan issued, renewed, or
64 delivered within or without the commonwealth to a natural person who is a resident of the
65 commonwealth, including a certificate issued to an eligible natural person which evidences
66 coverage under a policy or contract issued to a trust or association for said natural person and his
67 dependent, including said person's spouse organized under chapter 176M.

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

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

79 (d) Any state agency or any board created by statute, including but not limited to the Board of
80 the Commonwealth Connector, the Department of Health, the Division of Medical Assistance or
81 the Division of Insurance that proposes to add a mandated health benefit by rule, bulletin or other
82 guidance must request that a review and evaluation of that proposed mandated health benefit be
83 conducted by the division of health care finance and policy pursuant to this section. The report
84 on the mandated health benefit by the division of health care finance and policy must be received
85 by the agency or board and available to the public at least 30 days prior to any public hearing on
86 the proposal. If the division of health care finance and policy fails to report to the agency or
87 board within 45 days of the request, said agency or board may proceed with a public hearing on
88 the mandated health benefit proposal without including a review and evaluation from the
89 division.

90 (e) Any party or organization on whose behalf the mandated health benefit was proposed shall
91 provide the division of health care finance and policy with any cost or utilization data that they
92 have. All interested parties supporting or opposing the proposal shall provide the division of
93 health care finance and policy with any information relevant to the division's review. The
94 division shall enter into interagency agreements as necessary with the division of medical
95 assistance, the group insurance commission, the department of public health, the division of
96 insurance, and other state agencies holding utilization and cost data relevant to the division's
97 review under this section. Such interagency agreements shall ensure that the data shared under
98 the agreements is used solely in connection with the division's review under this section, and that
99 the confidentiality of any personal data is protected. The division of health care finance and
100 policy may also request data from insurers licensed or otherwise authorized to transact accident
101 or health insurance under chapter 175 , nonprofit hospital service corporations organized under

102 chapter 176A , nonprofit medical service corporations organized under chapter 176B , health
103 maintenance organizations organized under chapter 176G , and their industry organizations to
104 complete its analyses. The division of health care finance and policy may contract with an
105 actuary, or economist as necessary to complete its analysis.

106 The report shall include, at a minimum and to the extent that information is available, the
107 following: (1) the financial impact of mandating the benefit, including the extent to which the
108 proposed insurance coverage would increase or decrease the cost of the treatment or service over
109 the next 5 years, the extent to which the proposed coverage might increase the appropriate or
110 inappropriate use of the treatment or service over the next 5 years, the extent to which the
111 mandated treatment or service might serve as an alternative for more expensive or less expensive
112 treatment or service, the extent to which the insurance coverage may affect the number and types
113 of providers of the mandated treatment or service over the next 5 years, the effects of mandating
114 the benefit on the cost of health care, particularly the premium, administrative expenses and
115 indirect costs of municipalities, large employers, small employers, employees and nongroup
116 purchasers, the potential benefits and savings to municipalities, large employers, small
117 employers, employees and nongroup purchasers, the effect of the proposed mandate on cost
118 shifting between private and public payors of health care coverage, the cost to health care
119 consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed
120 treatment and the effect on the overall cost of the health care delivery system in the
121 commonwealth; (2) the medical efficacy of mandating the benefit, including the impact of the
122 benefit to the quality of patient care and the health status of the population and the results of any
123 research demonstrating the medical efficacy of the treatment or service compared to alternative
124 treatments or services or not providing the treatment or service; and (3) if the proposal seeks to

125 mandate coverage of an additional class of practitioners, the results of any professionally
126 acceptable research demonstrating the medical results achieved by the additional class of
127 practitioners relative to those already covered and the methods of the appropriate professional
128 organization that assures clinical proficiency.

129 SECTION 6. Section 188 of chapter 149 of the General Laws, as most recently amended by
130 chapter 3 of the Acts of 2011, is hereby further amended in the definition of “Employee” by
131 inserting, after the word “individual” the following words:- ,who is a resident of the
132 commonwealth,

133 SECTION 7. Section 188 of chapter 149, as appearing in the 2010 Official Edition, is hereby
134 further amended by striking, in line 19, the number “11” and inserting in place thereof the
135 following: 50

136 SECTION 8. Subsection (c) of section 188 of said chapter 149 is hereby amended by inserting at
137 the end thereof the following paragraph:

138 (11) For the purpose of the fair share contribution compliance test, an employer may count
139 employees that have qualifying health insurance coverage from a spouse, a parent, a veteran’s
140 plan, Medicare, Medicaid, or a plan or plans due to a disability or retirement towards their
141 qualifying take-up rate as a “contributing employer”, as defined by the Division of Health Care
142 Finance and Policy. The employer is still required to offer group medical insurance and must
143 keep and maintain proof of their employee’s insurance status.

144 SECTION 9. Section 1 of chapter 175, as appearing in the 2010 Official Edition, is hereby
145 amended by inserting, in line 15, after the word “commonwealth”, the following definition:—

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

148 ; and further, in line 30, after the word “inclusive”, the following definition:

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 this
151 chapter.

152 ; and, further, in line 38, after the word “context”, the following definition:

153 “State mandated health benefits” means coverage required or required to be offered in the
154 general or special laws as part of a policy of accident or sickness insurance that:

- 155 1. includes coverage for specific health care services or benefits;
- 156 2. places limitations or restrictions on deductibles, coinsurance, copayments, or
157 any annual or lifetime maximum benefit amounts; or
- 158 3. includes a specific category of licensed health care practitioner from whom an
159 insured is entitled to receive care.

160 SECTION 10. Section 108 of said chapter 175, as so appearing, is hereby amended by inserting
161 after subsection 12 the following subsection:—

162 13. A carrier authorized to transact individual policies of accident or sickness insurance under
163 this section may offer a flexible health benefit policy, provided however, that for each sale of a
164 flexible health benefit policy the carrier shall provide to the prospective policyholder written

165 notice describing the state mandated health benefits that are not included in the policy and
166 provide to the prospective individual policyholder the option of purchasing at least one health
167 insurance policy that provides all state mandated health benefits.

168 SECTION 11. Section 110 of said chapter 175, as so appearing, is hereby amended by inserting
169 after subsection (P) the following:—

170 (Q) A carrier authorized to transact group policies of accident or sickness insurance under this
171 section may offer one or more flexible health benefit policies; provided however, that for each
172 sale of a flexible health benefit policy the carrier shall provide to the prospective group
173 policyholder written notice describing the state mandated benefits that are not included in the
174 policy and provide to the prospective group policyholder the option of purchasing at least on
175 health insurance policy that provides all state mandated benefits. The carrier shall provide each
176 subscriber under a group policy upon enrollment with written notice stating that this a flexible
177 health benefit policy and describing the state mandated health benefits that are not included in
178 the policy.

179 SECTION 12. Said chapter 175, as so appearing, is hereby amended by inserting after section
180 111H the following:-

181 Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not
182 disapprove a policy of accident and sickness insurance which provides hospital expense and
183 surgical expense insurance solely on the basis that it does not include coverage for at least 1
184 mandated benefit.

185 (b) The commissioner shall not approve a policy of accident and sickness insurance which
186 provides hospital expense and surgical expense insurance unless it provides, at a minimum,
187 coverage for:

188 (1) pregnant women, infants and children as set forth in section 47C;

189 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

190 (3) cytologic screening and mammographic examination as set forth in section 47G;

191 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

192 (4) early intervention services as set forth in said section 47C; and

193 (5) mental health services as set forth in section 47B; provided however, that if the policy
194 limits coverage for outpatient physician office visits, the commissioner shall not disapprove the
195 policy on the basis that coverage for outpatient mental health services is not as extensive as
196 required by said section 47B, if the coverage is at least as extensive as coverage under the policy
197 for outpatient physician services.

198 (c) The commissioner shall not approve a policy of accident and sickness insurance which
199 provides hospital expense and surgical expense insurance that does not include coverage for at
200 least one mandated benefit unless the carrier continues to offer at least one policy that provides
201 coverage that includes all mandated benefits.

202 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that
203 requires coverage for specific health services, specific diseases or certain providers of health
204 care.

205 (e) The commissioner may promulgate rules and regulations as are necessary to carry out this
206 section.

207 (f) Notwithstanding any special or general law to the contrary, no plan approved by the
208 commissioner under this section shall be available to an employer who has provided a policy of
209 accident and sickness insurance to any employee within 12 months.

210 SECTION 13. Chapter 176A, as appearing in the 2010 Official Edition, is hereby amended by
211 adding after section 1D the following two sections:—

212 Section 1E. Definitions

213 The following words, as used in this chapter, unless the text otherwise requires or a different
214 meaning is specifically required, shall mean-

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

217 "State mandated health benefits," coverage required or required to be offered

218 in the general or special laws as part of a policy of accident or sickness insurance that:

219 1. includes coverage for specific health care services or benefits;

220 2. places limitations or restrictions on deductibles, coinsurance, copayments, or

221 any annual or lifetime maximum benefit amounts; or

222 3. includes a specific category of licensed health care practitioner from whom an

223 insured is entitled to receive care.

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

227 Section 1F. (a) Except as otherwise provided in this section, the commissioner shall not
228 disapprove a contract between a subscriber and the corporation under an individual or group
229 hospital services plan solely on the basis that it does not include coverage for at least one
230 mandated benefit.

231 (b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage
232 for:

233 (1) pregnant women, infants and children as set forth in section 47C;

234 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

235 (3) cytologic screening and mammographic examination as set forth in section 47G;

236 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

237 (4) early intervention services as set forth in said section 47C; and

238 (5) mental health services as set forth in section 47B; provided however, that if the policy
239 limits coverage for outpatient physician office visits, the commissioner shall not disapprove the
240 policy on the basis that coverage for outpatient mental health services is not as extensive as
241 required by said section 47B, if the coverage is at least as extensive as coverage under the policy
242 for outpatient physician services.

243 (c) The commissioner shall not approve a contract that does not include coverage for at least one
244 mandated benefit unless the corporation continues to offer at least one contract that provides
245 coverage that includes all mandated benefits.

246 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that
247 requires coverage for specific health services, specific diseases or certain providers of health
248 care.

249 (e) The commissioner may promulgate rules and regulations as are necessary to carry out this
250 section.

251 (f) Notwithstanding any special or general law to the contrary, no plan approved by the
252 commissioner under this section shall be available to an employer who has provided a hospital
253 services plan, to any employee within 12 months.

254 SECTION 14. Section 8 of chapter 176A, as so appearing, is hereby amended by inserting after
255 subsection (g) the following:—

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

263 (i) A non-profit hospital service corporation authorized to transact group policies of accident or
264 sickness insurance under this section may offer one or more flexible health benefit policies;
265 provided however, that for each sale of a flexible health benefit policy the non-profit hospital
266 service corporation shall provide to the prospective group policyholder written notice describing
267 the state mandated benefits that are not included in the policy and provide to the prospective
268 group policyholder the option of purchasing at least one health insurance policy that provides all
269 state mandated benefits. The non-profit hospital service corporation shall provide each
270 subscriber under a group policy upon enrollment with written notice stating that this a flexible
271 health benefit policy and describing the state mandated health benefits that are not included in
272 the policy.

273 SECTION 15. Section 1 of Chapter 176B, as appearing in the 2010 Official Edition, is hereby
274 amended by inserting, in line 11, after the word “support”, the following new definition:—

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

277 ; and, further, in line 56, after the word “corporation”, the following definition:

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

281 ; and, further, in line 62, after the word “twelve”, the following definition:

282 "State mandated health benefits" means coverage required or required to be offered in the
283 general or special laws as part of a policy of accident or sickness insurance that:

- 284 1. includes coverage for specific health care services or benefits;
- 285 2. places limitations or restrictions on deductibles, coinsurance, copayments, or
- 286 any annual or lifetime maximum benefit amounts; or
- 287 3. includes a specific category of licensed health care practitioner from whom an
- 288 insured is entitled to receive care.

289 SECTION 16. Section 4 of chapter 176B, as so appearing, is hereby amended by inserting the

290 following paragraphs at the end thereof:—

291 A medical service corporation authorized to transact individual policies of accident or sickness

292 insurance under this chapter may offer a one flexible health benefit policy, provided however,

293 that for each sale of a flexible health benefit policy the medical service corporation shall provide

294 to the prospective policyholder written notice describing the state mandated health benefits that

295 are not included in the policy and provide to the prospective individual policyholder the option

296 of purchasing at least one health insurance policy that provides all state mandated health

297 benefits.

298 A medical service corporation authorized to transact group policies of accident or sickness

299 insurance under this section may offer one or more flexible health benefit policies; provided

300 however, that for each sale of a flexible health benefit policy the medical service corporation

301 shall provide to the prospective group policyholder written notice describing the state mandated

302 benefits that are not included in the policy and provide to the prospective group policyholder the

303 option of purchasing at least on health insurance policy that provides all state mandated benefits.

304 The medical service corporation shall provide each subscriber under a group policy upon
305 enrollment with written notice stating that this a flexible health benefit policy and describing the
306 state mandated health benefits that are not included in the policy.

307 SECTION 17. Said chapter 176B, as so appearing, is hereby amended by inserting after section
308 6B the following section:-

309 Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not
310 disapprove a subscription certificate solely on the basis that it does not include coverage for at
311 least one mandated benefit.

312 (b) The commissioner shall not approve a subscription certificate unless it provides, at a
313 minimum, coverage for:

314 (1) pregnant women, infants and children as set forth in section 47C;

315 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

316 (3) cytologic screening and mammographic examination as set forth in section 47G;

317 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

318 (4) early intervention services as set forth in said section 47C; and

319 (5) mental health services as set forth in section 47B; provided however, that if the policy
320 limits coverage for outpatient physician office visits, the commissioner shall not disapprove the
321 policy on the basis that coverage for outpatient mental health services is not as extensive as
322 required by said section 47B, if the coverage is at least as extensive as coverage under the policy
323 for outpatient physician services.

324 (c) The commissioner shall not approve a subscription certificate that does not include coverage
325 for at least 1 mandated benefit unless the corporation continues to offer at least one subscription
326 certificate that provides coverage that includes all mandated benefits.

327 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that
328 requires coverage for specific health services, specific diseases or certain providers of health
329 care.

330 (e) The commissioner may promulgate rules and regulations as are necessary to carry out this
331 section.

332 (f) Notwithstanding any special or general law to the contrary, no plan approved by the
333 commissioner under this section shall be available to an employer who has provided a
334 subscription certificate, to any employee within 12 months.

335 SECTION 18. Section 1 of chapter 176G, as appearing in the 2010 Official Edition, is hereby
336 amended by inserting, in line 42, after the word "entitled" the following new definition:—

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

339 ; and, further, in line 102, after the words "chapter 175", the following definitions:

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

343 "State mandated health benefits" means coverage required or required to be offered in the
344 general or special laws as part of a policy of accident or sickness insurance that:

- 345 1. includes coverage for specific health care services or benefits;
- 346 2. places limitations or restrictions on deductibles, coinsurance, copayments, or
- 347 any annual or lifetime maximum benefit amounts; or
- 348 3. includes a specific category of licensed health care practitioner from whom an
- 349 insured is entitled to receive care.

350 SECTION 19. Section 4 of chapter 176G, as appearing in the 2010 Official Edition, is hereby

351 amended by adding the following paragraph at the end thereof:—

352 A health maintenance organization authorized to transact individual policies of accident or

353 sickness insurance under this chapter may offer a one flexible health benefit policy, provided

354 however, that for each sale of a flexible health benefit policy the health maintenance

355 organization shall provide to the prospective policyholder written notice describing the state

356 mandated health benefits that are not included in the policy and provide to the prospective

357 individual policyholder the option of purchasing at least one health insurance policy that

358 provides all state mandated health benefits.

359 SECTION 20. Chapter 176G, as appearing in the 2010 Official Edition is hereby amended by

360 inserting after section 4V the following section:-

361 Section 4W. A health maintenance organization authorized to transact group policies of accident

362 or sickness insurance under this chapter may offer one or more flexible health benefit policies;

363 provided however, that for each sale of a flexible health benefit policy the health maintenance

364 organization shall provide to the prospective group policyholder written notice describing the

365 state mandated benefits that are not included in the policy and provide to the prospective group

366 policyholder the option of purchasing at least one health insurance policy that provides all state
367 mandated benefits. The health maintenance organization shall provide each subscriber under a
368 group policy upon enrollment with written notice stating that this is a flexible health benefit policy
369 and describing the state mandated health benefits that are not included in the policy.

370 SECTION 21. Chapter 176G of the General Laws, as appearing in the 2010 Official Edition, is
371 hereby amended by inserting after Section 16B the following section:-

372 Section 16C. (a) Except as otherwise provided in this section, the commissioner shall not
373 disapprove a health maintenance contract solely on the basis that it does not include coverage for
374 at least one mandated benefit.

375 (b) The commissioner shall not approve a health maintenance contract unless it provides
376 coverage for:

377 (1) pregnant women, infants and children as set forth in section 47C;

378 (2) prenatal care, childbirth and postpartum care as set forth in section 47F;

379 (3) cytologic screening and mammographic examination as set forth in section 47G;

380 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

381 (4) early intervention services as set forth in said section 47C; and

382 (5) mental health services as set forth in section 47B; provided however, that if the policy
383 limits coverage for outpatient physician office visits, the commissioner shall not disapprove the
384 policy on the basis that coverage for outpatient mental health services is not as extensive as

385 required by said section 47B, if the coverage is at least as extensive as coverage under the policy
386 for outpatient physician services.

387 (c) The commissioner shall not approve a health maintenance contract that does not include
388 coverage for at least one mandated benefit unless the health maintenance organization continues
389 to offer at least one health maintenance contract that provides coverage that includes all
390 mandated benefits.

391 (d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that
392 requires coverage for specific health services, specific diseases or certain providers of health
393 care.

394 (e) The commissioner may promulgate rules and regulations as are necessary to carry out the
395 provisions of this section.

396 (f) Notwithstanding any special or general law to the contrary, no plan approved by the
397 commissioner under this section shall be available to an employer who has provided a health
398 maintenance contract, to any employee within 12 months.

399 SECTION 22. Section 1 of chapter 176M, as appearing in the 2010 Official Edition, is hereby
400 amended by inserting, in line 101, after the word "claims" the following new definition:—

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

403 ; and, further, in line 255, after the word "basis", the following definition:

404 "State mandated health benefits" means coverage required to be offered any general or special
405 law that:

- 406 1. includes coverage for specific health care services or benefits;
- 407 2. places limitations or restrictions on deductibles, coinsurance, copayments, or
- 408 any annual or lifetime maximum benefit amounts; or
- 409 3. includes a specific category of licensed health care practitioner from whom an
- 410 insured is entitled to receive care.

411 SECTION 23. Section 2 of chapter 176M, as appearing in the 2010 Official Edition, is hereby

412 further amended by striking out the first sentence of subsection (d) and inserting in place thereof

413 the following:-

414 A carrier that participates in the nongroup health insurance market shall make available to

415 eligible individuals a standard guaranteed health plan established pursuant to paragraph (c) and

416 may additionally make available to eligible individuals no more than two alternative guaranteed

417 issue health plans, one of which may be a flexible health benefit policy, with benefits and cost

418 sharing requirements, including deductibles, that differ from the standard guaranteed issue health

419 plan.

420 SECTION 24. Chapter 231 of the General Laws, as so appearing, is hereby amended by adding

421 after section 60K, the following new sections:

422 Section 60L. In any action for malpractice, error or mistake against a provider of health care

423 licensed pursuant to section 2 of chapter 112, including actions pursuant to section 60B of this

424 chapter, an expert witness shall be board certified in the same specialty as the defendant licensed

425 pursuant to section 2 of chapter 112, as so appearing.

426 Section 60M. In every action for malpractice, negligence, error, omission, mistake or the
427 unauthorized rendering of professional services against a provider of health care the court may,
428 at the request of either party, enter a judgment ordering that money damages or its equivalent for
429 future damages of the judgment creditor be paid in whole or in part by periodic payments rather
430 than by a lump-sum payment if the award equals or exceeds \$50,000 in future damages. In
431 entering a judgment ordering the payment of future damages by periodic payments, the court
432 shall make a specific finding as to the dollar amount of periodic payments which will
433 compensate the judgment creditor for such future damages, and court shall require a defendant
434 who is not adequately insured to post security adequate to assure full payment of such damages
435 awarded by the judgment. Upon termination of periodic payments of future damages, the court
436 shall order the return of this security, or so much as remains, to the defendant.

437 (a)(1) The judgment ordering the payment of future damages by periodic payments shall specify
438 the recipient or recipients of the payments, the dollar amount of the payments, the interval
439 between payments, and the number of payments or the period of time over which payments shall
440 be made. Such payments shall only be subject to modification in the event of the death of the
441 judgment creditor.

442 (2) In the event that the court finds that the defendant has exhibited a continuing pattern of
443 failing to make the payments as specified in paragraph (1), the court shall find the defendant in
444 contempt of court and, in addition to the required periodic payments, shall order the defendant to
445 pay the plaintiff all damages caused by the failure to make such periodic payments, including
446 court costs and attorney's fees.

447 (b) Money damages awarded for loss of future earnings shall not be reduced or payments
448 terminated by reason of the death of the plaintiff, but shall be paid to persons to whom the
449 plaintiff owed a duty of support, as provided by law, immediately prior to his death, or to whom
450 the plaintiff assigned, transferred, or bequeathed his right to receive payment. In such cases the
451 court which rendered the original judgment, may, upon petition of any party in interest, modify
452 the judgment to award and apportion the unpaid future damages in accordance with this
453 subdivision.

454 (c) Following the occurrence or expiration of all obligations specified in the periodic payment
455 judgment, any obligation of the defendant to make future payments shall cease and any security
456 given, pursuant to this section shall revert to the defendant.

457 Section 60N. In any action for malpractice, error, omission, mistake or the unauthorized
458 rendering of professional services against a provider of health care, the liability of each
459 defendant for damages shall be several only and shall not be joint. Each defendant shall be liable
460 only for the amount of damages allocated to that defendant in direct proportion to that
461 defendant's percentage of fault, and a separate judgment shall be rendered against that defendant
462 for that amount.

463 SECTION 25. Chapter 233 of the General Laws, as so appearing, is hereby amended by
464 inserting after section 79K the following section:-

465 Section 79L. (a) As used in this section, the following terms shall have the following meaning:

466 "Health care provider", any of the following health care professionals licensed pursuant to
467 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist,
468 optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social

469 worker, speech-language pathologist, audiologist, marriage and family therapist and a mental
470 health counselor. The term shall also include any corporation, professional corporation,
471 partnership, limited liability company, limited liability partnership, authority, or other entity
472 comprised of such health care providers.

473 “Facility”, a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health
474 agency. The term shall also include any corporation, professional corporation, partnership,
475 limited liability company, limited liability partnership, authority, or other entity comprised of
476 such facilities.

477 “Unanticipated outcome” means the outcome of a medical treatment or procedure, whether or
478 not resulting from an intentional act, that differs from an intended result of such medical
479 treatment or procedure.

480 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
481 experiencing an unanticipated outcome of medical care, statements, affirmations, gestures,
482 activities or conduct expressing benevolence, regret, apology, sympathy, commiseration,
483 condolence, compassion, mistake, error, or a general sense of concern which are made by a
484 health care provider, facility or an employee or agent of a health care provider or facility, to the
485 patient, a relative of the patient, or a representative of the patient and which relate to the
486 unanticipated outcome shall be inadmissible as evidence in any judicial or administrative
487 proceeding and shall not constitute an admission of liability or an admission against interest.

488 SECTION 26. Notwithstanding any general or special law to the contrary, it shall be the policy
489 of the general court to impose a moratorium on all new mandated health benefit legislation until
490 December 31, 2013.