HOUSE DOCKET, NO. 4309 FILED ON: 3/9/2012

HOUSE . . . . . No. 4034

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:

An Act relative to reducing the healthcare burden on businesses.

PETITION OF:

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

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

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HOUSE . . . . . No. 4034

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

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:

SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking subsection (a) and inserting in place thereof the following:-

(a) For the purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services or that affects the operations of health insurers in the administration of health insurance coverage as part of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical, dental, and other health insurance benefits covering persons in the service of the commonwealth, and their dependents organized under chapter 32A , individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, a nonprofit medical service corporation organized under chapter 176B, a health maintenance organization organized under chapter 176G, or an organization entering into a preferred provider arrangement under chapter 176I, any health plan issued, renewed, or delivered within or without the commonwealth to a natural person who is a resident of the commonwealth, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association for said natural person and his dependent, including said person's spouse organized under chapter 176M.

SECTION 2. Subsection (d) of said section 38C of said chapter 3, as so appearing, is hereby 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
24 proposed insurance coverage would increase or decrease the cost of the treatment or service over
25 the next 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
39 Official Edition, is hereby amended by inserting, in line 46, at the end of the definition of the
40 term "Creditable coverage" the following:-

41 Minimum creditable coverage, as defined by the board under the authority granted herein,
42 shall 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
45 Official 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
47 System for Advance Registration of Volunteer Health Professionals or its successor entity shall
48 be liable in civil suit for damages for any act or omission on his part related to his voluntary
49 participation in any disaster preparedness or response activity.

50 SECTION 5. Chapter 118G of the General Laws, as appearing in the 2010 Official
51 Edition, is 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
69 and means when reporting favorably on mandated health benefits bills referred to them shall
70 include a review and evaluation conducted by the division of health care finance and policy
71 pursuant to this section.

72 (c) Upon request of a joint standing committee of the general court having jurisdiction or
73 the 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
80 Board of the Commonwealth Connector, the Department of Health, the Division of Medical
81 Assistance or the Division of Insurance that proposes to add a mandated health benefit by rule,
82 bulletin or other guidance must request that a review and evaluation of that proposed mandated
83 health benefit be conducted by the division of health care finance and policy pursuant to this
84 section. The report on the mandated health benefit by the division of health care finance and
85 policy must be received by the agency or board and available to the public at least 30 days prior
86 to any public hearing on the proposal. If the division of health care finance and policy fails to
87 report to the agency or board within 45 days of the request, said agency or board may proceed
88 with a public hearing on the mandated health benefit proposal without including a review and
89 evaluation from the division.

90 (e) Any party or organization on whose behalf the mandated health benefit was proposed
91 shall provide the division of health care finance and policy with any cost or utilization data that
92 they 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
130 by 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
134 hereby 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
137 inserting at the end thereof the following paragraph:

138 (11) For the purpose of the fair share contribution compliance test, an employer may
139 count employees that have qualifying health insurance coverage from a spouse, a parent, a
140 veteran's plan, Medicare, Medicaid, or a plan or plans due to a disability or retirement towards
141 their qualifying take-up rate as a "contributing employer", as defined by the Division of Health
142 Care Finance and Policy. The employer is still required to offer group medical insurance and
143 must 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
145 hereby amended by inserting, in line 15, after the word "commonwealth", the following
146 definition:—

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

149 ; and further, in line 30, after the word "inclusive", the following definition:

150 "Policy of Accident and Sickness Insurance," any policy or contract covering the kind or
151 kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47
152 of this chapter.

153 ; and, further, in line 38, after the word "context", the following definition:

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

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

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

158 any annual or lifetime maximum benefit amounts; or

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

160 insured is entitled to receive care.

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

163 13. A carrier authorized to transact individual policies of accident or sickness insurance
164 under this section may offer a flexible health benefit policy, provided however, that for each sale
165 of a flexible health benefit policy the carrier shall provide to the prospective policyholder written
166 notice describing the state mandated health benefits that are not included in the policy and

167 provide to the prospective individual policyholder the option of purchasing at least one health
168 insurance policy that provides all state mandated health benefits.

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

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

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

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

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

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

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

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

192 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

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

213 Section 1E. Definitions

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

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

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

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

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

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

222 any annual or lifetime maximum benefit amounts; or

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

224 insured is entitled to receive care.

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

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

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

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

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

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

237 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

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

257 (h) A non-profit hospital service corporation authorized to transact individual policies of
258 accident or sickness insurance under this section may offer a one flexible health benefit policy,
259 provided however, that for each sale of a flexible health benefit policy the non-profit hospital

260 service corporation shall provide to the prospective policyholder written notice describing the
261 state mandated health benefits that are not included in the policy and provide to the prospective
262 individual policyholder the option of purchasing at least one health insurance policy that
263 provides all state mandated health benefits.

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

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

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

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

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

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

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

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

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

288 any annual or lifetime maximum benefit amounts; or

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

290 insured is entitled to receive care.

291 SECTION 16. Section 4 of chapter 176B, as so appearing, is hereby amended by
292 inserting the following paragraphs at the end thereof:—

293 A medical service corporation authorized to transact individual policies of accident or
294 sickness insurance under this chapter may offer a one flexible health benefit policy, provided
295 however, that for each sale of a flexible health benefit policy the medical service corporation
296 shall provide to the prospective policyholder written notice describing the state mandated health
297 benefits that are not included in the policy and provide to the prospective individual policyholder
298 the option of purchasing at least one health insurance policy that provides all state mandated
299 health benefits.

300 A medical service corporation authorized to transact group policies of accident or
301 sickness insurance under this section may offer one or more flexible health benefit policies;
302 provided however, that for each sale of a flexible health benefit policy the medical service
303 corporation shall provide to the prospective group policyholder written notice describing the
304 state mandated benefits that are not included in the policy and provide to the prospective group
305 policyholder the option of purchasing at least on health insurance policy that provides all state
306 mandated benefits.

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

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

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

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

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

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

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

320 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

322 (5) mental health services as set forth in section 47B; provided however, that if the
323 policy limits coverage for outpatient physician office visits, the commissioner shall not

324 disapprove the policy on the basis that coverage for outpatient mental health services is not as
325 extensive as required by said section 47B, if the coverage is at least as extensive as coverage
326 under the policy for outpatient physician services.

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

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

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

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

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

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

343 ; and, further, in line 102, after the words “chapter 175”, the following definitions:

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

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

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

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

351 any annual or lifetime maximum benefit amounts; or

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

353 insured is entitled to receive care.

354 SECTION 19. Section 4 of chapter 176G, as appearing in the 2010 Official Edition, is
355 hereby amended by adding the following paragraph at the end thereof:—

356 A health maintenance organization authorized to transact individual policies of accident
357 or sickness insurance under this chapter may offer a one flexible health benefit policy, provided
358 however, that for each sale of a flexible health benefit policy the health maintenance
359 organization shall provide to the prospective policyholder written notice describing the state
360 mandated health benefits that are not included in the policy and provide to the prospective
361 individual policyholder the option of purchasing at least one health insurance policy that
362 provides all state mandated health benefits.

363 SECTION 20. Chapter 176G, as appearing in the 2010 Official Edition is hereby
364 amended by inserting after section 4V the following section:-

365 Section 4W. A health maintenance organization authorized to transact group policies of
366 accident or sickness insurance under this chapter may offer one or more flexible health benefit
367 policies; provided however, that for each sale of a flexible health benefit policy the health
368 maintenance organization shall provide to the prospective group policyholder written notice
369 describing the state mandated benefits that are not included in the policy and provide to the
370 prospective group policyholder the option of purchasing at least on health insurance policy that
371 provides all state mandated benefits. The health maintenance organization shall provide each
372 subscriber under a group policy upon enrollment with written notice stating that this a flexible
373 health benefit policy and describing the state mandated health benefits that are not included in
374 the policy.

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

377 Section 16C. (a) Except as otherwise provided in this section, the commissioner shall not
378 disapprove a health maintenance contract solely on the basis that it does not include coverage for
379 at least 1 mandated benefit.

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

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

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

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

385 (3A) diabetes-related services, medications, and supplies as defined in section 47N;

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

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

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

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

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

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

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

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

409 ; and, further, in line 255, after the word “basis”, the following definition:

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

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

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

414 any annual or lifetime maximum benefit amounts; or

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

416 insured is entitled to receive care.

417 SECTION 23. Section 2 of chapter 176M, as appearing in the 2010 Official Edition, is
418 hereby further amended by striking out the first sentence of subsection (d) and inserting in place
419 thereof the following:-

420 A carrier that participates in the nongroup health insurance market shall make available
421 to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c)
422 and may additionally make available to eligible individuals no more than two alternative
423 guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits
424 and cost sharing requirements, including deductibles, that differ from the standard guaranteed
425 issue health plan.

426 SECTION 24. Chapter 231 of the General Laws, as so appearing, is hereby amended by
427 adding after section 60K, the following new sections:

428 Section 60L. In any action for malpractice, error or mistake against a provider of health
429 care licensed pursuant to section 2 of chapter 112, including actions pursuant to section 60B of
430 this chapter, an expert witness shall be board certified in the same specialty as the defendant
431 licensed pursuant to section 2 of chapter 112, as so appearing.

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

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

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

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

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

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

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

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

473 "Health care provider", any of the following heath care professionals licensed pursuant to
474 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist,
475 optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social
476 worker, speech-language pathologist, audiologist, marriage and family therapist and a mental
477 health counselor. The term shall also include any corporation, professional corporation,
478 partnership, limited liability company, limited liability partnership, authority, or other entity
479 comprised of such health care providers.

480 "Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home
481 health agency. The term shall also include any corporation, professional corporation,
482 partnership, limited liability company, limited liability partnership, authority, or other entity
483 comprised of such facilities.

484 "Unanticipated outcome" means the outcome of a medical treatment or procedure,
485 whether or not resulting from an intentional act, that differs from an intended result of such
486 medical treatment or procedure.

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

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