

# SENATE NO. 602

## **AN ACT** PROVIDING FINANCIAL PROTECTIONS FOR CONSUMERS ENROLLED IN HEALTH MAINTENANCE ORGANIZATIONS

*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. Chapter 176G of the General Laws is hereby amended by inserting after section 3  
2 the following section:-

3 Section 3A. (a) As used in this section, the following terms shall have the following meanings  
4 unless the context clearly requires otherwise:

5 “Co-insurance”, a percentage of costs paid by an insured for covered benefits, in addition to any  
6 prepaid premium amount.

7 “Co-payment”, a predetermined fixed amount that an insured pays for covered benefits, in  
8 addition to any prepaid premium amount.

9 “Cost-sharing”, any fees paid by the insured for covered benefits including co-payments, co-  
10 insurance and deductibles

11 "Covered benefits" or "benefits", health care services to which an insured is entitled under the  
12 terms of the health benefit plan.

13 “Deductible”, the portion of an insured’s covered expenses that must be paid by the  
14 insured before any coverage or portion of coverage begins.

15 "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued  
16 by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care  
17 services.

18 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier,  
19 including an individual whose eligibility as an insured of a carrier is in dispute or under review.

20 "Out-of-pocket maximum", the maximum amount of cost-sharing an insured must pay out-of-  
21 pocket for covered benefits during a contract year, including any deductible, co-payment and  
22 co-insurance amounts; once this limit is reached, all covered benefits are paid for by the health  
23 maintenance organization up to the maximum level of coverage.

24 "Preventive health care", any periodic, routine, screening or other services designed for the  
25 prevention and early detection of illness that a carrier is required to provide pursuant to  
26 Massachusetts or federal law. This includes, but is not limited to, immunizations; periodic  
27 health exams for adults and children, as well as those mammograms, cytological exams and  
28 diagnostic tests associated with periodic health exams; prenatal maternity care; well child care,  
29 including vision and auditory screening; voluntary family planning; nutrition counseling; and  
30 health education. Preventive health care shall also include supplies, equipment, medication and  
31 specialist provided treatments and services for insureds with chronic illnesses and/or disabling  
32 conditions.

33 (b) Any health maintenance organization's health benefit plan that includes cost-sharing of any  
34 covered benefits shall include an out-of-pocket maximum on all such health benefit plans. The  
35 out-of-pocket maximum shall not be greater than the minimum annual deductible that is  
36 consistent with the requirements for a high deductible health plan as defined in section 223 of  
37 the Internal Revenue Code and implementing regulations of guidelines.

38 (c) Any health maintenance organization's health benefit plan that imposes higher cost-sharing  
39 for specialist visits or tertiary care hospitals shall allow insureds with chronic illnesses or  
40 disabling conditions to pay the lower cost-sharing of the primary care provider or community  
41 hospital.

42 (d) Deductibles may apply only to inpatient, outpatient and ambulatory treatment, but not to  
43 emergency care or preventive health care.

44 SECTION 2. (a) The department of public health and the division of health care finance and  
45 policy are hereby directed to make an investigation and study relative to the effects of high cost-  
46 sharing health maintenance organizations on affected parties. These parties include hospitals,  
47 the uncompensated care pool (as of October 1, 2007, the health safety net), and consumers. In  
48 respect to consumers, the department and division shall analyze all relevant factors, including  
49 but not limited to access to care, utilization, financial costs and health status.

50 (b) The department and division shall report the results of the investigation and study and  
51 recommendations, if any, together with drafts of legislation necessary to carry out the  
52 recommendations to the joint committee on health care financing, joint committee on financial  
53 services, and the house and senate committees on ways and means on or before January 1, 2009.

54 SECTION 3. If any provision of this Act or its application to any person or circumstances is  
55 held invalid, the invalidity does not affect other provisions or applications of the Act which can  
56 be given effect without the invalid provision or application, and to this end the provisions of this  
57 Act are severable.