# HOUSE . . . . . No. 5867

**The Commonwealth of Massachusetts**

HOUSE OF REPRESENTATIVES, June 3, 1986.

The committee on Insurance, to whom was referred the petition (accompanied by bill, House, No. 5108) of Kevin W. Fitzgerald for legislation to provide health maintenance organization coverage for uninsured residents of the Commonwealth, reports recommending that the accompanying bill (House, No. 5867) ought to pass.

For the committee,

FRANCIS H. WOODWARD.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Eighty-Six.

AN ACT RELATIVE TO PROVIDING HEALTH MAINTENANCE ORGANIZATION COVERAGE FOR UNINSURED RESIDENTS OF THE COMMONWEALTH.

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

The General Laws are hereby amended by inserting after chapter 6A the following chapter: —

## CHAPTER 6B.

Section 1. As used in this chapter, the following words and terms shall, unless the context requires otherwise, have the following meanings: —

"Adjusted gross income", as defined in sections two and three of chapter sixty-two.

"Administering carrier", any state licensed and or federally qualified health maintenance organization, PPO, and other organizations that can meet predetermined control requirements.

"Child", a son or stepson, daughter or stepdaughter of an employee including a legally adopted son or daughter, and including those for whom a petition for adoption is pending.

"Confinement", confinement on an inpatient basis in a healthcare institution.

"Commissioner", the commissioner of public health.

"Copayment", the portion of a charge that is not payable by a third party payor and is the obligation of the covered individual to pay.

"Covered individual", one who is enrolled in the plan.

"Demonstration project", a health benefits plan to include not less than ten thousand and not more than one hundred thousand uninsured and/or underinsured individuals.

"Dependent", in reference to a dependent of a covered

individual, an individual over half of whose support, for the calendar year in which the taxable year of such covered individual begins, was received from such individual.

"Employee", as defined in section 3121 (d) of the Internal Revenue Code of 1954, as amended.

"Employer", an individual, corporation, or other private business entity, whether for profit or not-for-profit, which owns or operates a facility within the commonwealth, at least one year. The term employer for the purposes of this chapter, shall include those agencies established under the provisions of chapter thirty-two A, chapter thirty-two B and any employees' health and welfare fund which provides hospital expenses and surgical expense benefits.

"Family", an individual and his or her spouse if living and not legally separated under a decree of divorce or of separate maintenance and each of their dependent unmarried children who have not attained the age of twenty-three, and if nineteen years or older, are full-time day students at an accredited institution of learning.

"Healthcare institution", includes "Skilled nursing facility", "homehealth agency", "hospital", and "homehealth services", as defined in section 1861 of the Social Security Act.

"Healthcare provider", hereinafter referred to as provider, any person or organization licensed under the provisions of chapter one hundred and eleven, chapter one hundred and twelve and chapter one hundred and seventy-six G.

"Plan", the plan of operation providing health care services submitted by the administering carrier to the commissioner. Such plan may include the contracting by the administering carrier with any licensed health care provider or healthcare institution, with emphasis on those providers who serve significant numbers of uninsured or underinsured residents.

"Plan year", a period beginning July first and ending the following June thirtieth.

"Premium", the premium, enrollment fee, or such other comparable fee or periodic charge of the administering carrier for the health care coverage. For those enrollees who are employed uninsured, the administering carrier may institute a "sliding fee

premium" mechanism based on the financial means of the enrollee.

"Uninsured", any person or family with income no greater than two hundred percent of the federal poverty guidelines who are not medicaid or general relief or veterans' services eligible and who have no health insurance coverage.

Section 2. The commissioner of public health is hereby authorized and directed to enter into an agreement with an administering carrier as defined in section one, for a plan of operation to establish a demonstration project for providing of health benefits for residents of the commonwealth. Such plan shall include, but not be limited to, consideration of the following: the type and size of the population of the project group; contracts with other healthcare providers and healthcare institutions with emphasis on those that serve significant numbers of uninsured residents; incentives to employers and potential enrollees to participate in the project; the geographic scope of the project; and conditions for membership in the project plan. The commissioner shall also include in the agreement all other matters deemed relevant to the establishment of a project that will expand and improve the availability and quality of health care delivery of those uninsured or underinsured in the commonwealth.

Section 3. (a) The plan shall be established by a contract awarded to an administering carrier pursuant to section two, and shall pay to practitioners, health care providers and health care institutions on behalf of the individuals and families enrolled in the plan.

(b) Once every three years the commissioner shall award a contract to an administering carrier or administering carriers through the procedures established by this section.

(c) Prior to the commencement of the first plan year and every three years thereafter, the commissioner shall promulgate the specifications for a contract form for the administration of the project. The commissioner shall widely circulate the contract specifications among all potential administering carriers as defined in section one and any interested persons. At a reasonable time after notice is issued to the public the commissioner shall hold public hearing for the purpose of receiving comments on the

specifications and receiving proposed contractual provisions for the final contract form.

(d) After the hearing the commissioner shall promulgate final contract form in consultation with the commissioner of public welfare and the rate setting commission. The award decision shall be made by the commissioner of public health.

(e) The contract with the carrier selected pursuant to the provisions of this section may be extended for two additional one-year periods unless the parties to the contract are unable to agree to the terms of the extension. Prior to the end of the initial contract year and the second contract year, the commissioner shall furnish new baseline data and negotiate with the administering carrier any necessary changes in the terms and conditions of the contract, including any reasonable premium rate increases or decrease.

(f) The administering carrier shall deem any information obtained from any source concerning any enrollees in the plan to be confidential information in accordance with legal requirements imposed by federal and state governments under statute, regulations or grant awards.

Section 4. The term plan means a plan of healthcare benefits which satisfies all of the following requirements"

(1) The plan must be comprehensive, that is, must include a broad range of preventive and curative services and which must include, but not be limited to"

Outpatient services including prescription drugs;

Acute care inpatient services for an unlimited number of days;

Skilled nursing facility services for up to one hundred days per member per year;

Medically necessary home health services;

Mental health services — up to twenty outpatient visits of five hundred dollars whichever comes first and up to sixty days of inpatient services including substance abuse services;

Medically necessary durable mechanical equipment;

Ambulance services within the commonwealth.

(2) The plan may require copayments for services not to exceed seven percent of charge for service.

(3) The plan must be in writing.

(4) The terms of the plan must be communicated by the administering carrier to the enrollees.

Section 5. (a) Eligible individuals or families include:

Every individual or family:

(1) who is a resident of the commonwealth at least one year prior to date of application; and

(2) who is not eligible to enroll, through either spouse in the case of a family, in a health care plan offered by an employer; or

(3) does not have income sufficient to enroll in a health care plan offered by an employer; or

(4) who is uninsured as defined in section one; or

(5) whose adjusted gross income for his or its last taxable year preceeding April first of the calendar year in which the policy year, for eligibility is being determined, commenced was less than two hundred percent of the federal poverty guidelines.

(b) Eligible individuals or families shall be given a membership card by the administering carrier which shall be indistinguishable from membership cards issued to insured members of the administering carrier.

(c) Each enrollee's eligibility shall be reevaluated every six months.

(d) For the purpose of applying the conditions of eligibility under this section, all determinations shall be made in a reasonable manner after application date for enrollment.

(e) Any individual or family member who is required to make contributions for his coverage and who is an employee, as defined in section 3121(d) of the Internal Revenue Code of 1954, may require his employer to make periodic deductions from his wages, and remit each contribution to the administering carrier on or before the due date specified.

(f) Plan coverage shall immediately extend to any child born to up to age nineteen, or adopted by, any eligible family member subsequent to the day the application for enrollment was made, and shall continue in force until the date the family's coverage would otherwise terminate in accordance with this section.

(g) Any enrollee or dependent thereof terminated from this plan may enroll in any alternate plan licensed under chapter one

hundred and seventy-five, chapter one hundred and seventy-six A, chapter one hundred and seventy-six B, one hundred and seventy-six C or chapter one hundred and seventy-six G without medical examination or limitation of benefit coverage provided the enrollee applies for the new coverage within thirty-one days of the withdrawal of this plan.

Section 6. The administering carrier is hereby authorized to contract with and/or participate in any uninsured or underinsured pool established under the provisions of section seventy-four of chapter six A of the General Laws.

Section 7. The commonwealth, or any political subdivision thereof, will not impose any tax of any kind on or with respect to any premium, benefit, income, or other transaction or occurrence connected with the plan.