HOUSE . . . . . No. 1107

By Mr. Cohen of Newton, petition of David B. Cohen for legislation to regulate public disclosure by health insurers. Insurance.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Ninety-Five.

AN ACT RELATIVE TO PUBLIC DISCLOSURE BY HEALTH INSURERS.

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. Chapter 175 of the General Laws, as appearing in the 1992 Official Edition, is hereby amended by inserting after Section 2B the following new section: —

Section 2C. Disclosure by Health Insurers.

(a) Definitions. The following words, as used in this section, unless the context otherwise requires or a different meaning is specifically prescribed, shall have the following meanings:

"Access", the insured's admittance to a health care system or to health care services within such health care system.

"Benefits", medical, surgical, or hospital services for which one is insured under a policy or contract of health insurance.

"Capitation", a method of payment for health care services whereby the provider is paid a fixed amount for each person served irrespective of services delivered.

"Commissioner", the commissioner of insurance.

"Derived economic disincentives", financial deterrents to an insured or a provider from using, performing, or ordering, or from not using, performing, or ordering, as the case may be, health care services, which deterrents are the implicit result of conditions imposed on a health care system by a policy or contract of health insurance.

"Derived economic incentives", financial incentives upon an insured or a provider to use, perform, or order, or not to use, perform, or order, as the case may be, health care services, which

incentives are the implicit result of conditions imposed on a health care system by a policy or contract of health insurance.

"Explicit economic disincentives", financial deterrents to an insured or provider from using, performing, or ordering, or from not using, performing, or ordering, as the case may be, health care services, which deterrents are either stated or otherwise obvious from the terms of a policy or contract of health insurance.

"Explicit economic incentives", financial incentives upon an insured or a provider to use, perform, or order, or not to use, perform or order, as the case may be, health care services, which incentives are either stated or otherwise obvious from the terms of a policy or contract of health insurance.

"Fee-for-service", a method of reimbursement for health care services to a provider based on payment for each specific service rendered.

"Health care", medical, surgical, or hospital services pertaining to the health of an insured.

"Health care system", the institutional framework for the provision of health care services to an insured as set forth in a policy or contract of health insurance.

"Health insurance", policies or contracts of insurance upon the health of individuals which provide medical, surgical, or hospital expense benefits whether on an indemnity, reimbursement, service, or prepaid basis, as described in General Laws Chapter 175, Section 47, Clause Sixth, Subdivision (d); or contracts to subscribers of hospital service corporations subject to General Laws, Chapter 176A, Section 6 or Section 8 or both; or contracts to subscribers of medical service corporations subject to General Laws, Chapter 176B, Section 4 or Section 6 or both; or contracts to subscribers or members of medical corporations subject to General Laws, Chapter 176C, Section 8; or policies of medical service corporations providing supplemental coverage to health insurance under Title XVIII of the Social Security Act, to the extent permitted under federal law; or policies or contracts of insurance upon the health of individuals contained in benefit plans which are based upon the Employee Retirement Income Security Act of 1974, to the extent permitted under federal law; or policies or contracts to subscribers or members of health maintenance organizations subject to General Laws, Chapter 176G; or contracts to sub-

scribers of any other plan for the delivery of health care to an insured, such as the plan of a preferred provider organization, whether or not such plan is subject to statute or regulation apart from this section.

"Insured", a person and his or her dependents covered under a policy or contract of health insurance.

"Insurer", any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds, fraternal benefit society, hospital service corporation, medical service corporation, health maintenance organization, or preferred provider organization, with whom a policy or contract of health insurance is made.

"Policy", any policy, plan, certificate, contract, agreement, statement of coverage, evidence of coverage, rider or endorsement which provides health benefits or medical surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis to the insured.

"Preferred Provider Organization", an organization or association for the provision of health care services to a defined population of insureds on a fee-for-service basis at established fees, which may or may not be at discount, by a designated panel or providers who contract with an insurance carrier, employer and/or an insured for such purpose, pursuant to which contract such insured enjoys a choice among providers, although at a financial disincentive to such insured as to providers outside the designated panel.

"Primary Care Physician", a physician licensed under General Laws, Chapter 112, such as a general practitioner, family practitioner, internist, obstetrician, gynecologist, or pediatrician, who has first contact care of an insured and assumes the overall coordination of the care of such insured's medical problems.

"Provider", a physician licensed under General Laws Chapter 112, a hospital, clinic, or other entity, person, partnership, corporation, or other organizational type which provides health care services to an insured.

"Specialist", a physician who practices a medical or surgical specialty and who generally does not have initial contact with an insured in the delivery of health care services.

"Utilization", the use of health care services by an insured under a policy or contract of health insurance.

"Utilization Control Mechanisms", the mechanisms and conditions that control and/or restrict access or the use of health care services in a health care system.

(b) Disclosures. Notwithstanding the provisions of any general or special law or the contrary, every policy or contract of health insurance delivered or issued for delivery to any person or entity in the Commonwealth shall have been on file for 30 days with the commissioner, unless before the expiration of said 30 days the commissioner shall have approved such policy or contract in writing as complying with this section. If within said 30 days the commissioner has not in writing approved or disapproved such policy or contract as being in compliance with this section, or as not being so in compliance, as the case may be, such policy or contract shall be deemed approved. Such policy or contract shall not be delivered or issued for delivery if the commissioner notifies the insurer in writing within said 30 days that in his opinion the form of said policy or contract does not comply with the provisions or this section, specifying the reasons for his opinion. However, any action or non-action of the commissioner as provided for in the preceding three sentences shall be subject to review by the Supreme Judicial Court, upon petition by the insurer or by any aggrieved insured, provider, or employer, and during any such review such policy or contract shall not be delivered or issued for delivery in the Commonwealth.

Every policy or contract of health insurance shall disclose in a clear, concise, complete, explicit, and understandable manner the following: —

(1) the health care services and any other benefits to which the insured is entitled,

(2) the restrictions on the scope of health care services and any other benefits to be provided, including the non-covered services and an explanation of any utilization control mechanisms which may restrict the insured's access to health care services,

(3) the locations where, and the methods in which, health care services and any other benefits may be obtained,

(4) the financial management of the health care system including:

(a) the method of payment to providers, whether on a fee-for-service, capitation, salaried, or other basis; and

(b) the method of payment to specialists referred by primary care physicians; and

(c) the financial obligations and financial risks, which obligations and risks are either stated or implicit in such policy or contract, upon providers in performing health care services covered under such policy or contract, and in ordering or not ordering such services, as the case may be, and

(d) the number of providers in the health care system as of January first of the calendar year in which such policy or contract is to be delivered.

(5) the effect of the financial management of the health care system upon providers including:

(a) the explicit economic incentives and the derived economic incentives to utilize or not to utilize the health care system; and

(b) the explicit economic disincentives and the derived economic disincentives, to utilize or not to utilize the health care system, and

(c) the explicit economic incentives, the derived economic incentives, the explicit economic disincentives and the derived economic disincentives upon primary care physicians, to utilize or not to utilize the services of specialists or other health care services and procedures which are ancillary to those performed by primary care physicians.

(6) the effect of the financial management of the health care system upon the insured including:

(a) the explicit economic incentives, the derived economic incentives, the explicit economic disincentives, and the derived economic disincentives, to utilize or not to utilize the health care system, including, without limitation, utilization or non-utilization of designated provider of a preferred provider organization and utilization of out-patient services; and

(b) the financial risks upon an insured in his or her decision whether to utilize or not to utilize health care services covered by such policy or contract.

There shall accompany, or be attached to, every policy or contract of health insurance, as part of the form of such policy or contract, a pamphlet or brochure containing in readable and understandable form, a short summary of the above disclosures.

Prior to contracting with an employer for the provision of health insurance to employees of said employer an insurer shall make available to said employer a sufficient number of copies of such brochure or pamphlet for the purpose of distributing same to each such employee and said employer shall give to such employees written and reasonably timely notice of such availability.

The commissioner shall promulgate rules and regulations as are necessary to carry out the provisions of this section. He shall also promulgate rules and regulations to require that, to the extent reasonably practicable and not otherwise prohibited by law, the advertising of policies or contracts of health insurance shall contain the disclosures required by this section.

Rules and regulations made pursuant to the authority of this section shall be adopted in accordance with the procedures of General Laws, Chapter 30A, Section 7.

SECTION 2. Section 14 of Chapter 176B of the General Laws, as so appearing, is hereby amended by inserting in the third sentence after the word "chapter", the words, "or in General Laws, Chapter 175, Section 2C".

SECTION 3. Section 2 of Chapter 176G of the General Laws, as so appearing, is hereby amended by inserting immediately after the words "Except as hereinafter provided in this chapter" the words: —or in General Laws, Chapter 175, Section 2C.