HOUSE . . . . . No. 3875

By Ms. Balser of Newton, petition of Ruth B. Balser and other members of the General Court relative to providing financial protection for persons enrolled in health maintenance organizations. Insurance.

The Commonwealth of Massachusetts

In the Year Two Thousand and Three.

AN ACT REGARDING FINANCIAL PROTECTIONS FOR CONSUMERS ENROLLED IN HMOs.

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 176G of the General Laws is hereby amended by inserting after Section 3, the following:—

Section 3A.

(1). The following words as used in this section shall, unless the context clearly requires otherwise, have the following meanings:

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

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

"Cost-sharing", any fees paid by the insured for covered benefits including co-payments, co-insurance and deductibles.

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

"Deductible", the portion of an insured's covered expenses that must be paid by the insured before any coverage or portion of coverage begins.

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

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

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

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

(2) Any Health Maintenance Organization's health benefit plan that includes cost-sharing of any covered benefits shall include an out-of-pocket maximum on all such health benefit plans. The out-of-pocket maximum shall be no higher than $1000 per year for any individual or $2000 per year for a couple or family.

(3) Any Health Maintenance Organization's health benefit plan that imposes higher cost-sharing for specialist visits or tertiary care hospitals shall allow insureds with chronic illnesses or disabling conditions to pay the lower cost-sharing of the primary care provider or community hospital.

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

SECTION 2. (1) The Department of Public Health and the Division of Health Care Finance and Policy of the Commonwealth are hereby directed to make an investigation and study relative to the effects of high cost-sharing HMOs on affected parties. These

parties include hospitals, the uncompensated care pool, and consumers. In respect to consumers, the Department and Division shall analyze all relevant factors, including but not limited to access to care, utilization, financial costs and health status.

(2). The Department and Division shall report the results of the investigation and study and recommendations, if any, together with drafts of legislation necessary to carry out the recommendations to the Joint Committee on Health Care, Joint Committee on Insurance, and the House and Senate Committees on Ways and Means on or before January 1, 2004.

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