HOUSE DOCKET, NO. 427 FILED ON: 1/11/2013

HOUSE . . . . . No. 1004

The Commonwealth of Massachusetts

PRESENTED BY:

Carlo Basile

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 adoption of the accompanying bill:

An Act relative to controlling health care costs in the Commonwealth.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Carlo Basile	*1st Suffolk*

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HOUSE . . . . . No. 1004

By Mr. Basile of Boston, a petition (accompanied by bill, House, No. 1004) of Carlo Basile relative to health care costs in the Commonwealth. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act relative to controlling health care costs in 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:

SECTION 1. Chapter 176O is hereby amended by adding after section 27 thereof the following section:-

Section 28.

As used in this section, the following words shall have the following meanings:

"Alternative Payment Methods": Models of payment for health care services, as agreed to by a Carrier and a Health Care Provider that incorporate various degrees of risk sharing and reimburse the Health Care Provider for the provision and coordination of care for a range of covered services and may include prospective payments, blended capitated payments, shared savings, or other payment methods that promote improved coordination of care, higher quality, a reduction in inappropriate utilization, and lower costs.

"Health Care Providers" physicians licensed under the provisions of chapter one hundred and twelve, physician group practices, or a hospital licensed under the provisions of chapter one hundred and eleven and its agents and employees, or a public hospital and its agents and employees.

(a) Every health care provider, which provides covered services to a person must provide such services to any such person as a condition of their licensure, and must accept payment by a carrier consistent with the provisions of this section, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles. Any health care provider that participates

20 in a carrier's network or any health benefit plan shall not refuse to participate in the carrier's
21 network due to the carrier's compliance with this section.

22 (b) No carrier or health care provider shall enter or renew a contract or agreement on or
23 after January 1, 2014 under which the carrier agrees to pay the health care provider at a rate that
24 is not in conformity with the standards as forth in subsection (d)

25 (c) Carriers shall, utilizing claims-paid data, as filed annually to the Center for Health
26 Information and Analysis, calculate the carrier-specific relative prices the carrier has agreed to
27 pay health care providers determined using the provider categories and uniform methodology for
28 price relativities established by the Center for Health Information and Analysis pursuant to
29 section 10 of Chapter 12C, and identified on a state-wide basis and by provider type.

30 (d) No carrier or health care provider shall enter or renew a contract or agreement on or
31 after January 1, 2014 under which the health care provider is reimbursed at a rate that is above
32 the carrier-specific 80th percentile of health care provider relative price within each of the
33 applicable 4 geographic regions, as defined below; nor shall any carrier or health care provider
34 enter or renew a contract or agreement on or after January 1, 2014 under which the health care
35 provider is reimbursed at a rate that is below the carrier-specific 20th percentile of health care
36 provider relative price within each of the applicable four geographic regions, as defined below.
37 For the purpose of complying with the requirements of this section, carriers shall define the four
38 geographic regions as follows:

39 Region A (Western MA, 010 through 013)

40 Region B (Central MA, 014 through 016) and (Metro West, 017 and 020)

41 Region D (Merrimack, 018 through 019) and (Boston, 021 through 022 and 024)

42 Region F (South Eastern MA, 023 and 027), (Cape, 025 through 026)

43 (e) The requirements of the Section shall not apply to contracts utilizing alternative
44 payment methods between a carrier and a health care provider, whereby the health care provider
45 reports a Total Medical Expense that is less than or equal to the statewide median reported Total
46 Medical Expenses, as reported by the Center for Health Information and Analysis.

47 (f) For contracts entered into prior to the effective date of this act, the provisions shall
48 take effect upon the anniversary date of the contract.

49 (g) Any net savings realized by the Carrier attributable to the operation of this section
50 shall be reflected in the premiums charged to health plan eligible members.

51 (h) Every health care provider that does not agree to participate in a carrier's network
52 must accept a rate equal to the carrier-specific median relative price within the applicable
53 geographic region, as defined in subsection (d) for any covered out-of-network charges.

54 Nothing in this subsection shall prohibit a carrier from denying payment for unapproved
55 services conducted by a non-network provider. Every out-of-network health care provider must
56 accept payment by a carrier consistent with the provisions of this section, and may not balance
57 bill such person for any amount in excess of the amount paid by the carrier pursuant to this
58 section for such covered out-of-network services, other than applicable co-payments, co-
59 insurance and deductibles.

60 In any given year there shall be no net increase in premiums due to the operation of this
61 section. The Commissioner may promulgate regulations to monitor and ensure compliance with
62 this section 28.

63 SECTION 2. Chapter 93A of the General Laws is hereby amended by adding the
64 following section:

65 Section 12. A health care provider, as defined in section 1 of chapter 176O, shall not
66 recoup or attempt to recoup amounts in excess of the amounts charged to carriers pursuant to
67 section 28 of chapter 176O by increasing charges to other health benefit plans or other payers.
68 The attorney general may adopt regulations enforcing this section, which shall include
69 requirements for identifying and enforcing noncompliance and penalties for noncompliance.

70 SECTION 3. Chapter 12C of the General Laws is hereby amended by after section 22
71 inserting the following new section:

72 Section 23Health Care Provider Exemption

73 (a) Upon application by a health care provider, the executive director, in consultation
74 with the commissioner of the division of insurance, shall annually determine whether a health
75 care provider may receive an exemption from the provision of Section 28 of Chapter 176O. The
76 executive director shall weigh the criteria presented by the health care provider against any
77 potential for such exemption to raise health care premiums. Special consideration shall be given
78 to the potential impact on health care premiums. The center shall consider the following criteria
79 for exemption:

80 Whether the health care provider provides certain unique and specialty services; and

81 The provider's geographic location; and

82 Whether application of Section 28 of Chapter 176O would jeopardize the financial
83 solvency of the health care provider.

84 (b) All applications for an exemption to Section 28 of Chapter 176O shall be submitted to
85 the executive director no later than December 1 of each year. The executive director must hold a
86 public hearing within 15 days upon receipt of a health care provider's submission for exemption.

87 The executive director shall issue a written decision within 15 days after the conclusion of the
88 hearing. The attorney general may intervene in such hearings.

89 (c) The attorney general shall review and analyze any information submitted to the center
90 and may require that any provider seeking an exemption to produce documents and testimony
91 under oath related to the circumstances warranting an exemption to Section 28 of Chapter 176O.

92 (d) Any hospital or physician group practice that is part of a system shall file for an
93 exemption independently from the parent or other organizations comprising the system.

94 (f) The executive director may promulgate regulations to enforce the provisions of this
95 section.

96 SECTION 4. The division of insurance, in consultation with the Center for Health
97 Information and Analysis, shall conduct a study of the impact of section 1 (section 28 of chapter
98 176O) The study shall include, but not be limited to, an examination of the impact on carrier
99 provider networks, network adequacy, rates paid to non-participating providers, and the overall
100 impact on carrier member premiums. The division may conduct a public hearing and receive
101 input from interested parties. The division shall file a report with the clerks of the senate and
102 house of representatives not later than January1, 2015 on its findings and may make
103 recommendations for legislation.

104 SECTION 5. Section 28 of Chapter 176O is hereby repealed.

105 SECTION 6. Section 23 of Chapter 12C is hereby repealed.

106 SECTION 7. Sections 5 and 6 of this act shall take effect on December 31, 2016.