HOUSE . . . . . No. 3931

The Commonwealth of Massachusetts

INITIATIVE PETITION OF JERALD N. FISHBEIN AND OTHERS.

OFFICE OF THE SECRETARY.
BOSTON, JANUARY 6, 2016.

Steven T. James
Clerk of the House of Representatives
State House
Boston, Massachusetts 02133

Sir: - I herewith transmit to you, in accordance with the requirements of Article XLVIII of the Amendments to the Constitution, an initiative petition for a law named “”The Massachusetts Fair Health Care Pricing Act,” signed by ten qualified voters and filed with this department on or before December 2, 2015, together with additional signatures of qualified voters in the number of 68,755, being a sufficient number to comply with the Provisions of said Article.

Sincerely,

WILLIAM FRANCIS GALVIN,
Secretary of the Commonwealth.

AN INITIATIVE PETITION.

Pursuant to Article XLVIII of the Amendments to the Constitution of the Commonwealth, as amended, the undersigned qualified voters of the Commonwealth, ten in number at least, hereby petition for the enactment into law of the following measure:

HOUSE DOCKET, NO. FILED ON: 1/6/2016

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The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

An Act Massachusetts Fair Health Care Pricing Act.

Be it enacted by the People, and by their authority, as follows:

SECTION 1. Chapter 176O of the General Laws of Massachusetts shall be amended by inserting after section 27 thereof the following new section:

Section 28 Fair Health Care Pricing

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

“Disproportionate share hospital”: For purposes of this section, any acute hospital that exhibits a payer mix where a minimum of sixty-three per cent of the acute hospital’s gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act, other government payers, and free care, as certified annually by the Center for Health Information and Analysis.

"Health Care Provider”: For purposes of this section, an acute care hospital licensed under the provisions of section 51 of chapter 111 and its contracting agents.

"Geographically isolated hospital": For purposes of this section, a "Health Care Provider" that is the sole acute care hospital within a 20-mile radius.

"Specialty hospital": For purposes of this section, a "Health Care Provider" that is defined by the Center for Health Information and Analysis as a specialty hospital, including but not limited to an acute care hospital that limits its admissions to children, to patients under obstetrical care, or to patients under oncology care.

(a) Every health care provider that provides covered benefits to a person must provide such covered benefits to any such person as a condition of their licensure, must accept payment by a carrier consistent with the provisions of this section, and may not balance bill the recipient of services 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 in a carrier's network or any health benefit plan shall not refuse to participate in the carrier's network due to the carrier's compliance with this section. Nothing in this section shall be construed to harm or diminish the quality of medical care provided by a health care provider organization.

(b) No carrier or health care provider shall enter into or renew a contract or agreement on or after the effective date of this act under which the carrier agrees to pay the health care provider at a rate that is not in conformity with the standards in subsections (d) and (e); provided, that the provisions of this subsection shall also apply to a health care provider that has been approved, certified or waived as a risk bearing provider organization pursuant to Chapter 176T of the General Laws.

(c) Carriers shall calculate the carrier-specific relative prices that the carrier has agreed to pay each health care provider determined using the provider categories and uniform methodology for price relativities established by the center for health information and analysis pursuant to section 10 of Chapter 12C and identified on a state-wide basis and by provider type. Carriers shall report their relative price calculations to the division of insurance annually. The division of insurance shall review and publish carriers' calculated relative prices within 90 days of receipt.

(d) No carrier or health care provider shall enter into or renew a contract or agreement on or after the effective date of this act under which the health care provider is reimbursed for a provided service at a relative price that is more than 20% above the carrier-specific average relative price for that service. However, this subsection shall not apply to contracts or agreements executed by specialty hospitals, geographically isolated hospitals, or disproportionate share hospitals.

(e) No carrier or health care provider shall enter into or renew a contract or other agreement on or after the effective date of this act under which the health care provider is reimbursed for a provided service at a relative price that is more than 10% below the average carrier-specific relative price for that service.

(f) For contracts entered into or renewed prior to the effective date of this act, but on or after July 1, 2016, the provisions of this act shall take effect upon the anniversary date of the contract.

(g) Any net savings beyond savings required to comply with subsection (d) of this section that are realized by the carrier attributable to the operation of this section shall be reflected in

reduced premiums, co-pays and deductibles that are charged to the carrier's subscribers. The division of insurance shall promulgate regulations to ensure that carriers are fully reflecting such savings in the premiums, co-pays, and deductibles charged to subscribers.

(h) Every health care provider that does not agree to participate in a carrier's network must accept a rate equal to the carrier-specific average relative price for any covered out-of-network charges.

(i) The division of insurance shall ensure that all provider rates developed as directed by this section are applicable to all products offered by each respective carrier, including but not limited to products covered by Chapters 175, 176G, 176I, 176K, and 176T of the General Laws. In performing its review, the division shall require that carriers entering into or renewing contracts with providers shall include in those contracts a provision allowing carriers to make available for the division to review each negotiated price for every service. The division shall publish consumer-friendly price information by provider, by service; provided, that the division shall also publicly report quality scores for every health care provider under contract with each such carrier for the provision of health care services; provided further, that such information shall be published on a web site in a conspicuous location and in a format that is easy to access and utilize by consumers. The information shall initially be published no later than six months after the effective date of this act and shall be updated at least annually thereafter.

(j) Nothing in this section shall prohibit a carrier from denying payment for unapproved services conducted by a non-network provider. Every out-of-network health care provider 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 for such covered out-of-network services, other than applicable co-payments, co-insurance and deductibles.

(k) The division of insurance, in consultation with the center for health information and analysis and the attorney general, shall promulgate rules and regulations as necessary to implement this section.

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

Section 12. A health care provider, as defined in section 28 of chapter 176O, shall not recoup or attempt to recoup amounts in excess of the amounts charged to carriers pursuant to section 28 of chapter 176O by increasing charges to other health benefit plans or other payers. The attorney general may adopt regulations enforcing this section, which shall include penalties for non-compliance.

SECTION 3. Chapter 175 of the General Laws is hereby amended by after section 108M inserting the following new section:

Section 108N. Health Care Provider Exemption from Fair Health Care Pricing

(a) Upon application by a health care provider, the division of insurance shall once annually determine whether such health care provider may receive an exemption from the provisions of Section 28 of Chapter 176O. The commissioner shall weigh the circumstances presented in an application against any potential for such exemption to increase health care costs. The division shall consider whether application of Section 28 of Chapter 176O would risk the

financial solvency of the health care provider or otherwise unduly impact patient access to the applying health care provider's services.

(b) The attorney general may review and analyze any information submitted pursuant to subsection (a) and may require any provider seeking an exemption to produce documents and testimony under oath related to the circumstances warranting an exemption to Section 28 of Chapter 176O. Any contracts provided to support such review shall not be a public record.

(c) The division of insurance, in consultation with the center for health information and analysis and the attorney general, shall promulgate regulations to enforce the provisions of this section.

SECTION 4. The division of insurance, in consultation with the center for health information and analysis and the health policy commission, shall annually conduct a study of the impact of section 28 of chapter 176O. As part of this study, the division may conduct one or more public hearings and receive input from interested parties. The division shall file a report annually with the clerks of the senate and the house of representatives on its findings and may make recommendations for legislation.

SECTION 5. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

SECTION 6. This act shall take effect on January 15, 2017.

FIRST TEN SIGNERS

NAME	RESIDENCE	CITY OR TOWN
Jerald N. Fishbein	44 Wilbur Avenue	Dartmouth
James J. Farren	110 Riverway, #2	Boston
Deona M. Brennan	27 Shipwreck Drive	Mashpee
Rodney Tariq Mohammed	29 Martin Street	Brockton
Judithann Corey	60 New London Avenue	Barnstable
Anestine E. Bentick	300 Park Street	Boston
Nadia Vilmont	306 Washington Street, #1	Boston
Tammy Hall	346 Dickinson Street	Springfield
Emilene A. Montoya	12 Duke Street	Lynn
Marcia Lyford	410 Forest Street	Raynham

CERTIFICATE OF THE ATTORNEY GENERAL.

September 2, 2015.

Honorable William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Room 1705
Boston, Massachusetts 02108

RE: Initiative Petition No. 15-19: Massachusetts Fair Health Care Pricing Act.

Dear Secretary Galvin:

I accordance with the provisions of Article 48 of the Amendments to the Massachusetts Constitution, I have reviewed the above-referenced iniative petition, which was submitted to me on or before the first Wednesday of August of this year.

I hereby certify that this measure is in proper form for submission to the people; that the measure is not, either affirmatively or negatively, substantially the same as any measure which has been qualified for submission or submitted to the people at either of the two preceding biennial state elections; and that it contains only subjects that are related or are mutually dependent and which are not excluded from the initiative process pursuant to Article 48, the Initiative, Part 2, Section 2.

In accordance with Article 48, I enclose a fair, concise summary of the measure.

Sincerely,

MAURA HEALEY,
Attorney General.

Summary of 15-19.

This proposed law would regulate the payments made by any non-government health insurance plan to health care providers for each medical service such that those payments would be no more than 20% above or 10% below the average price paid to all such providers by that health plan for that medical service. The proposed law defines "health care provider" as an acute-care hospital and its contracting agents.

The proposed law would require each health plan to calculate the relative price that it has agreed to pay health care providers for each medical service on a statewide basis and by provider type. A "relative price" is generally calculated by dividing the price paid to a particular provider for a medical service by the average price paid to all providers for that service. Health plans would report their relative prices to the state Division of Insurance on an annual basis, and the Division would publish this relative price data.

The proposed law would prohibit any health plan from entering into or renewing any contract with a provider under which the provider would be paid a price for a medical service greater than 20% above the average relative price paid by that health plan for that service. This provision would not apply to specialty hospitals (such as pediatric or oncology hospitals), geographically isolated hospitals (defined as the sole acute-care hospital within a 20-mile radius), and hospitals that derive at least 63% of their patient revenue from government programs like Medicare and Medicaid.

The proposed law would also prohibit any health plan from entering into or renewing any contract with a health care provider where the provider is paid a price for a service that is less than 10% below the average relative price paid by that plan for that service.

The proposed law would take effect on January 15, 2017, but would apply to contracts entered into or renewed after July 1, 2016.

The proposed law would require providers to furnish covered services as a condition of licensure and to accept payments consistent with the proposed law. Providers would be prohibited from billing the recipient of services for any additional amounts the provider would have received without the proposed law. Providers could not refuse to participate in a health plan's provider network due to the plan's compliance with the law. If a provider does not participate in a health plan's network, but provides out-of-network services, it would have to accept payment at the health plan's average relative price.

The proposed law would require any net savings realized by health plans attributable to this proposed law, beyond the cost of complying with its price regulations, to be reflected in reduced health

plan premiums, co-pays, and deductibles charged to the plan's subscribers and would require the Division of Insurance to issue regulations concerning this requirement.

The proposed law would prohibit providers whose prices are reduced as a result of the proposed law from charging more to other health plans or payers as a result and would authorize the state Attorney General to issue regulations on this point.

The proposed law would establish a process for providers to apply to the Division of Insurance for an annual exemption. The Division could consider, among other things, health care costs, the financial condition of the provider, and patient access to the provider's services.

The proposed law would require the Division of Insurance to annually publish hospital price information as well as quality scores for hospitals. The proposed law also would require the Division to conduct an annual study on the impact of the proposed law.

The proposed law states that, if any of its parts were declared invalid, the other parts would stay in effect.