

**HOUSE . . . . . No. 2947**

**The Commonwealth of Massachusetts**

PRESENTED BY:

*Christine P. Barber*

*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 to increase consumer transparency about insurance provider networks.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Christine P. Barber</i>	<i>34th Middlesex</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>
<i>David M. Rogers</i>	<i>24th Middlesex</i>
<i>Jay R. Kaufman</i>	<i>15th Middlesex</i>
<i>Marjorie C. Decker</i>	<i>25th Middlesex</i>
<i>Jason M. Lewis</i>	<i>Fifth Middlesex</i>
<i>Chris Walsh</i>	<i>6th Middlesex</i>
<i>Jennifer E. Benson</i>	<i>37th Middlesex</i>
<i>Leonard Mirra</i>	<i>2nd Essex</i>
<i>Carmine L. Gentile</i>	<i>13th Middlesex</i>
<i>Ruth B. Balsler</i>	<i>12th Middlesex</i>
<i>Mike Connolly</i>	<i>26th Middlesex</i>
<i>Kay Khan</i>	<i>11th Middlesex</i>
<i>Kenneth I. Gordon</i>	<i>21st Middlesex</i>
<i>Paul R. Heroux</i>	<i>2nd Bristol</i>
<i>Mathew Muratore</i>	<i>1st Plymouth</i>
<i>Brian Murray</i>	<i>10th Worcester</i>
<i>Jack Lewis</i>	<i>7th Middlesex</i>

<i>Keiko M. Orrall</i>	<i>12th Bristol</i>
<i>Barbara A. L'Italien</i>	<i>Second Essex and Middlesex</i>
<i>Carolyn C. Dykema</i>	<i>8th Middlesex</i>
<i>Elizabeth A. Malia</i>	<i>11th Suffolk</i>
<i>Stephan Hay</i>	<i>3rd Worcester</i>
<i>John W. Scibak</i>	<i>2nd Hampshire</i>
<i>Joan B. Lovely</i>	<i>Second Essex</i>
<i>Sean Garballey</i>	<i>23rd Middlesex</i>
<i>Patricia D. Jehlen</i>	<i>Second Middlesex</i>
<i>Michael O. Moore</i>	<i>Second Worcester</i>
<i>Paul McMurtry</i>	<i>11th Norfolk</i>
<i>Natalie Higgins</i>	<i>4th Worcester</i>
<i>James M. Cantwell</i>	<i>4th Plymouth</i>

**HOUSE . . . . . No. 2947**

By Ms. Barber of Somerville, a petition (accompanied by bill, House, No. 2947) of Christine P. Barber and others relative to information on insurance provider networks. Financial Services.

**The Commonwealth of Massachusetts**

**In the One Hundred and Ninetieth General Court  
(2017-2018)**

An Act to increase consumer transparency about insurance provider networks.

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

1 SECTION 1. Section 1 of Chapter 176O of the General Laws is hereby amended by  
2 inserting after the definition of “network” the following definition:-

3 “Network plan” means a health benefit plan of an insurer that either requires a covered  
4 person to use health care providers managed by, owned by, under contract with, or employed by  
5 the insurer or that creates incentives, including financial incentives, for a covered person to use  
6 such health care providers.

7 And by inserting after the definition of “primary care provider” the following  
8 definition:-

9 “Provider group” means a medical group, independent practice association or other  
10 similar group of providers.

11 And by inserting after the definition of “terminally ill” the following definition:-

12 “Tiers” or “tiered network” means a network that identifies and groups some or all types  
13 of providers and facilities into specific groups to which different provider reimbursement,  
14 covered person cost sharing, or provider access requirements, or any combination thereof, apply  
15 for the same services.

16 SECTION 2. Chapter 176O of the General Laws is hereby amended by inserting after  
17 section 27 the following sections:-

18 Section 28. (a) (1) A carrier shall post electronically a current an accurate provider  
19 directory for each of its network plans with the information and search functions, as described in  
20 subsections (b) and (c). In making the directory available electronically, the carrier shall ensure  
21 that the general public is able to view all of the current health care providers for a plan through a  
22 clearly identifiable link or tab and without creating or accessing an account, entering a policy or  
23 contract number, providing other identifying information, or demonstrating coverage or an  
24 interest in obtaining coverage with the plan.

25 (2) A carrier shall take appropriate steps to ensure the accuracy of the information  
26 concerning each provider listed in the carrier's provider directories for each network plan and  
27 shall, no later than January 1, 2018, review and update the entire provider directory for each  
28 network plan. Thereafter, the carrier shall update each online network plan provider directory at  
29 least weekly, or more frequently, if required by federal law, when informed of and upon  
30 confirmation by the plan of any of the following:

31 (A) A contracting provider is no longer accepting new patients for that product, or an  
32 individual provider within a provider group is no longer accepting new patients.

33 (B) A provider is no longer under contract for a particular plan product.

34 (C) A provider's practice location or other information required under this section has  
35 changed.

36 (D) Upon completion of the investigation described in paragraph (a)(8), a change is  
37 necessary based on an enrollee complaint that a provider was not accepting new patients, was  
38 otherwise not available, or whose contact information was listed incorrectly.

39 (E) Any other information that affects the content or accuracy of the provider directory or  
40 directories.

41 A provider directory shall not list or include information on a provider that is not  
42 currently under contract with the plan.

43 (3) Upon confirmation of any of the following, the plan shall delete a provider from the  
44 directory or directories when: (A) a provider has retired or otherwise has ceased to practice; (B) a  
45 provider or provider group is no longer under contract with the plan for any reason; or (C) the  
46 contracting provider group has informed the plan that the provider is no longer associated with  
47 the provider group and is no longer under contract with the plan.

48 (4) A carrier shall periodically audit its provider directories for accuracy and retain  
49 documentation of such an audit to be made available to the commissioner upon request.

50 (5) A carrier shall notify providers listed as participating providers who have not  
51 submitted claims or otherwise communicated intent to continue participation in the carrier's  
52 network within the past six months. Such notice shall inform providers of the carrier's intent to  
53 determine whether the provider still intends to be in the carrier's network and to update the  
54 directory accordingly. Such notice shall be accomplished in accordance with provisions of the

55 contract entered into between the carrier and the provider regarding notice, if applicable. If the  
56 carrier does not receive a response from the provider within 30 days of such notification  
57 confirming that the information regarding the provider is current and accurate or, as an  
58 alternative, updating any information, the insurer shall remove the provider from the network. A  
59 provider may elect to remain in the network in reserve status if the provider is not accepting the  
60 carrier's insureds as patients but expects to open its practice again to such patients within the  
61 next 6 months. The provider shall notify the carrier of this election in response to the carrier's  
62 notice. A provider electing reserve status shall be omitted from the carrier's online provider  
63 directory and the quarterly update of the print directory until such time as the provider  
64 communicates to the carrier, by such means as they have agreed upon, the intent to again accept  
65 the carrier's insureds as patients. At that time, according to the processes and timelines set forth  
66 in this section, the carrier shall list the provider on its online and print provider directories. The  
67 carrier may, prior to removal, use other available information or means to determine if the  
68 provider is participating in the carrier's network, including any means delineated in the contract  
69 entered into between the carrier and the provider.

70 (6) A carrier shall provide a print copy, or a print copy of the requested directory  
71 information, of a current provider directory with the information described in subsection (d)  
72 upon request of an insured or a prospective insured. The printed copy of the provider directory  
73 or directories shall be provided to the requester by mail postmarked no later than five business  
74 days following the date of the request and may be limited to the geographic region in which the  
75 requester resides or works or intends to reside or work.

76 (7) For each network plan, a carrier shall include in both the electronic and print  
77 directory, the following general information: (i) in plain language, a description of the criteria the

78 carrier has used to build its provider network; (ii) if applicable, in plain language, a description  
79 of the criteria the carrier has used to tier providers; (iii) if applicable, in plain language, how the  
80 carrier designates the different provider tiers or levels in the network and identifies for each  
81 specific provider, hospital or other type of facility in the network which tier each is placed, for  
82 example by name, symbols or grouping, in order for an insured or a prospective insured to be  
83 able to identify the provider tier; (iv) if applicable, note that authorization or referral may be  
84 required to access some providers; and (v) reference to the phone numbers and websites  
85 available to insureds to obtain a cost estimate for a proposed admission, service or procedure.

86 (8) A carrier shall provide the directory or directories for the specific network offered for  
87 each product using a consistent method of network and product naming, numbering or other  
88 classification method that ensures the public, enrollees, potential enrollees and contracted  
89 providers can easily identify the networks and plan products in which a provider participates.

90 (9) The carrier shall include in both its electronic and print directories a dedicated  
91 customer service email address and telephone number or electronic link that insureds, providers  
92 and the general public may use to notify the carrier of inaccurate provider directory information.  
93 This information shall be disclosed prominently in the directory or directories and on the plan's  
94 web site. The carrier shall be required to investigate reports of inaccuracies and modify the  
95 directories in accordance with any findings within thirty days. Carriers shall report annually to  
96 commissioner on the number of reports of inaccuracies received, the timeliness of the carrier's  
97 response, and the corrective actions taken.

98 (10) For the pieces of information required pursuant to subsections (b), (c) and (d) in a  
99 provider directory pertaining to a health care professional, a hospital or a facility other than a

100 hospital, the carrier shall make available through the directory the source of the information and  
101 any limitations, if applicable.

102 (11) The provider directory or directories shall inform enrollees and potential enrollees  
103 that they are entitled to: (A) language interpreter services, at no cost to the enrollee; and (B) full  
104 and equal access to covered services as required under the federal Americans with Disabilities  
105 Act of 1990 and Section 504 of the Rehabilitation Act of 1973. A provider directory, whether in  
106 electronic or print format, shall accommodate the communication needs of individuals with  
107 disabilities, and include a link to or information regarding available assistance for persons with  
108 limited English proficiency including how to obtain interpretation and translation services.(b)  
109 The carrier shall make available through an electronic provider directory, for each network plan,  
110 the information under this subsection in a searchable format:

111 (1) for health care professionals: (i) name; (ii) gender; (iii) participating office  
112 location(s); (iv) specialty, if applicable; (v) clinical and developmental areas of expertise (vi)  
113 populations of interest; (vii) medical group affiliations, if applicable; (viii) facility affiliations, if  
114 applicable; (ix) participating facility affiliations, if applicable; (x) provider tier, if applicable (xi)  
115 languages spoken other than English, if applicable; (xii) whether accepting new patients; and  
116 (xiii) information on access for people with disabilities, including but not limited to structural  
117 accessibility and presence of accessible examination and diagnostic equipment;

118 (2) for hospitals: (i) hospital name; (ii) hospital type; (iii) participating hospital location;  
119 (iv) hospital accreditation status; and (v) hospital tier, if applicable;



120 (3) for facilities, other than hospitals, by type: (i) facility name; (ii) facility type; (iii)  
121 types of services performed; (iv) participating facility location(s); and (v) facility tier, if  
122 applicable.

123 (c) For the electronic provider directories, for each network plan, a carrier shall make  
124 available the following information in addition to all of the information available under  
125 subsection (b): (1) for health care professionals: (i) contact information; (ii) licensure and board  
126 certification(s); and (iii) languages spoken other than English by clinical staff, if applicable; (2)  
127 for hospitals: telephone number; and (3) for facilities other than hospitals: telephone number.

128 (d) The carrier shall make available in print, upon request, the following provider  
129 directory information for the applicable network plan:

130 (1) for health care professionals: (i) name; (ii) contact information; (iii) gender; (iv)  
131 participating office location(s); (v) specialty, if applicable; (vi) clinical and developmental areas  
132 of expertise; (vii) populations of interest; (viii) licensure and board certification(s); (ix) medical  
133 group affiliations, if applicable; (x) facility affiliations, if applicable; (xi) participating facility  
134 affiliations, if applicable; (xii) provider tier, if applicable; (xiii) languages spoken other than  
135 English, if applicable; (xiv) whether accepting new patients; and (xv) information on access for  
136 people with disabilities, including but not limited to structural accessibility and presence of  
137 accessible examination and diagnostic equipment;

138 (2) for hospitals: (i) hospital name; (ii) hospital type; (iii) participating hospital location  
139 and telephone number; (iv) hospital accreditation status; and (v) hospital tier, if applicable;

140 (3) for facilities, other than hospitals, by type: (i) facility name; (ii) facility type; (iii)  
141 types of services performed; (iv) participating facility location(s) and telephone number; and (v)  
142 facility tier, if applicable

143 (e) The carrier shall include a disclosure in the print directory that the information in  
144 subsection (d) included in the directory is accurate as of the date of printing and that insureds or  
145 prospective insureds should consult the carrier's electronic provider directory on its website or  
146 call a specified customer service telephone number to obtain the most current provider directory  
147 information.

148 (f) The carrier shall update its printed provider directory or directories at least quarterly,  
149 or more frequently, if required by federal law.

150 (g) In circumstances where the commissioner finds that an insured reasonably relied upon  
151 materially inaccurate information contained in a carrier's provider directory, the commissioner  
152 may require the carrier to provide coverage for all covered health care services provided to the  
153 insured and to reimburse the insured for any amount that he or she would have paid, had the  
154 services been delivered by an in-network provider under the carrier's network plan; provided,  
155 however, that the commissioner shall take into consideration that carriers are relying on health  
156 care providers to report changes to their information prior to requiring any reimbursement to an  
157 insured. Prior to requiring reimbursement in these circumstances, the commissioner shall  
158 conclude that the services received by the insured were covered services under the insured's  
159 network plan. In such circumstances, the fact that the services were rendered or delivered by a  
160 non-contracting or out-of-network provider shall not be used as a basis to deny reimbursement to  
161 the insured.

162 (h) (1) The contract between the plan and a provider shall include a requirement that the  
163 provider inform the plan within five business days when either of the following occur: (A) the  
164 provider is not accepting new patients; or (B) if the provider had previously not accepted new  
165 patients, the provider is currently accepting new patients.

166 (2) If a provider who is not accepting new patients is contacted by an enrollee or potential  
167 enrollee seeking to become a new patient, the provider shall direct the enrollee or potential  
168 enrollee to both the plan for additional assistance in finding a provider and to the division to  
169 report any inaccuracy with the plan's directory or directories.

170 (3) If an enrollee or potential enrollee informs a plan of a possible inaccuracy in the  
171 provider directory or directories, the plan shall promptly investigate, and, if necessary, undertake  
172 corrective action within 30 business days to ensure the accuracy of the directory or directories.

173 Section 29. (a) A carrier shall have a process to assure that an insured obtains a covered  
174 benefit at an in-network level of benefits and cost-sharing, including by assuring that the insured  
175 will not be subject to balance billing, from a non-participating provider, or shall make other  
176 arrangements acceptable to the commissioner when: (1) the carrier has a sufficient network, but  
177 does not have a developmentally, linguistically, or physically accessible participating provider  
178 available to provide the covered benefit to the insured or it does not have a participating provider  
179 available to provide the covered benefit to the insured without unreasonable travel or delay,  
180 including unreasonable appointment wait times; or (2) the carrier has an insufficient number or  
181 type of developmentally, linguistically, or physically accessible participating providers available  
182 to provide the covered benefit to the insured without unreasonable travel or delay, including  
183 unreasonable appointment wait times.

184 (b) The carrier shall specify and inform insureds, in plain language, of the process an  
185 insured may use to request access to obtain a covered benefit from a non-participating provider  
186 as provided in subsection (a) when: (1) the insured is diagnosed with a condition or disease that  
187 requires specialized health care services or medical service, including but not limited to the  
188 delivery of covered benefits in a manner that is developmentally, linguistically, and physically  
189 accessible and provides communication and accommodations needed by insureds with  
190 disabilities; and (2) the carrier: (i) does not have a participating provider of the required specialty  
191 with the professional training and expertise to treat or provide health care services for the  
192 condition or disease; or (ii) cannot provide reasonable access to a participating provider with the  
193 required specialty with the professional training and expertise to treat or provide health care  
194 services for the condition or disease without unreasonable travel or delay, including  
195 unreasonable appointment wait times.

196 (c) The carrier shall treat the health care services the insured receives from a non-  
197 participating provider pursuant to subsection (b) as if the services were provided by a  
198 participating provider, including by assuring that the insured will not be subject to balance  
199 billing and by counting the insured's cost-sharing for such services toward the maximum out-of-  
200 pocket limit applicable to services obtained from participating providers under the health benefit  
201 plan.

202 (d) The process described under subsections (a) and (b) shall ensure that requests to  
203 obtain a covered benefit from a non-participating provider are addressed in a timely fashion  
204 appropriate to the insured's condition.

205 (e) The process described under subsections (a) and (b) shall ensure that the particular  
206 service will be adequately and promptly covered out-of-network for the insured for as long as the  
207 carrier is unable to provide the service on an in-network basis, without interrupting an an episode  
208 of care or provision of care for chronic conditions.

209 (f) The carrier shall have a system in place that documents all requests to obtain a  
210 covered benefit from a non-participating provider under this section and shall provide this  
211 information to the commissioner upon request.

212 (g) The process established in this section is not intended to be used by carriers as a  
213 substitute for establishing and maintaining a sufficient provider network nor is it intended to be  
214 used by insureds to circumvent the use of covered benefits available through a carrier's network  
215 delivery system options.

216 (h) Nothing in this section prevents an insured from exercising the rights and remedies  
217 available under applicable state or federal law relating to internal and external grievance and  
218 appeals processes.

219 SECTION 3. Section 6 of chapter 176O of the General Laws is hereby amended by  
220 striking out the fifth paragraph and inserting in place thereof the following paragraph:-

221 (4) the locations where, and the manner in which, health care services and other benefits  
222 may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or  
223 service that is a medically necessary covered benefit is not available to an insured within the  
224 carrier's network, the carrier shall cover the out-of-network admission, procedure or service and  
225 the insured will not be responsible to pay more than the amount which would be required for  
226 similar admissions, procedures or services offered within the carrier's network, consistent with

227 section 29 of this chapter; and (ii) an explanation that whenever a location is part of the carrier's  
228 network, that the carrier shall cover medically necessary covered benefits delivered at that  
229 location and the insured shall not be responsible to pay more than the amount required for  
230 network services even if part of the medically necessary covered benefits are performed by out-  
231 of-network providers unless the insured has a reasonable opportunity to choose to have the  
232 service performed by a network provider.