HOUSE DOCKET, NO. 1062 FILED ON: 1/18/2017

HOUSE . . . . . No. 620

The Commonwealth of Massachusetts

PRESENTED BY:

David M. Nangle

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 health care cost transparency.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
David M. Nangle	*17th Middlesex*	*1/18/2017*
Rady Mom	*18th Middlesex*	

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HOUSE . . . . . No. 620

By Mr. Nangle of Lowell, a petition (accompanied by bill, House, No. 620) of David M. Nangle and Rady Mom for legislation to require the Commonwealth Health Insurance Connector to provide certain information to consumers about health benefit plans. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *1018* OF 2015-2016.]

The Commonwealth of Massachusetts

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

An Act relative to health care cost transparency.

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 176Q of the Massachusetts General Laws, as appearing in the 2014 Official Edition, is hereby amended by adding after section 18 the following new section:-

Section 18. The connector shall ensure that the following information about each health benefit plan offered for sale to consumers in the commonwealth shall be available to consumers in a clear and understandable form for use in comparing plans, plan coverage, and plan premiums:

(a) The ability to determine whether specific types of specialists are in network and to determine whether a named physician, hospital or other health care provider is in network;

(b) Any exclusions from coverage and any restrictions on use or quantity of covered items and services in each category of benefits;

(c) A description of how medications will specifically be included in or excluded from the deductible, including a description of out-of-pocket costs that may not apply to the deductible for a medication;

(d) The specific dollar amount of any co-pay or percentage coinsurance for each item or service;

(e) The ability to determine whether a specific drug is available on formulary, the applicable cost-sharing requirement, whether a specific drug is covered when furnished by a physician or clinic, and any clinical prerequisites or authorization requirements for coverage of a drug;

(f) The process for a patient to obtain reversal of a health plan decision where an item or service prescribed or ordered by the treating physician has been denied; and

(g) An explanation of the amount of coverage for out of network providers or non-covered services, and any rights of appeal that exist when out of network providers or non-covered services are medically necessary

(h) A carrier offering health benefit plans who knowingly falsifies or fails to file with the connector any information required by this section or any regulation promulgated by the connector related to this section shall be punished by a fine of not less than $50,000 and not more than $250,000.