SENATE DOCKET, NO. 1405 FILED ON: 1/20/2017

SENATE . . . . . No. 528

The Commonwealth of Massachusetts

PRESENTED BY:

Jennifer L. Flanagan

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:	
Jennifer L. Flanagan	*Worcester and Middlesex*	
Jay R. Kaufman	*15th Middlesex*	*1/26/2017*
Marjorie C. Decker	*25th Middlesex*	*1/26/2017*
Patricia D. Jehlen	*Second Middlesex*	*1/27/2017*
Michael D. Brady	*Second Plymouth and Bristol*	*1/27/2017*
Jason M. Lewis	*Fifth Middlesex*	*1/31/2017*
Kay Khan	*11th Middlesex*	*2/1/2017*
John F. Keenan	*Norfolk and Plymouth*	*2/1/2017*
Paul R. Heroux	*2nd Bristol*	*2/1/2017*
Mathew Muratore	*1st Plymouth*	*2/1/2017*
Barbara A. L'Italien	*Second Essex and Middlesex*	*2/2/2017*
Carolyn C. Dykema	*8th Middlesex*	*2/2/2017*
Michael F. Rush	*Norfolk and Suffolk*	*2/2/2017*
Elizabeth A. Malia	*11th Suffolk*	*2/2/2017*
Stephan Hay	*3rd Worcester*	*2/3/2017*
Joan B. Lovely	*Second Essex*	*2/3/2017*
Michael O. Moore	*Second Worcester*	*2/3/2017*
Sal N. DiDomenico	*Middlesex and Suffolk*	*2/3/2017*

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By Ms. Flanagan, a petition (accompanied by bill, Senate, No. 528) of Jennifer L. Flanagan, Jay R. Kaufman, Marjorie C. Decker, Patricia D. Jehlen and other members of the General Court for legislation to increase consumer transparency about 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:

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

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

And by inserting after the definition of "primary care provider'" the following definition:-

"Provider group" means a medical group, independent practice association or other similar group of providers.

And by inserting after the definition of "terminally ill" the following definition:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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