

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

SENATE No. 528

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:

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.