HOUSE DOCKET, NO. 3246 FILED ON: 1/18/2019

HOUSE . . . . . No. 1046

The Commonwealth of Massachusetts

PRESENTED BY:

Ronald Mariano

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 out-of-network billing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Ronald Mariano	*3rd Norfolk*	*1/18/2019*
Carmine Lawrence Gentile	*13th Middlesex*	*1/31/2019*
Steven Ultrino	*33rd Middlesex*	*1/31/2019*

HOUSE DOCKET, NO. 3246 FILED ON: 1/18/2019

HOUSE . . . . . No. 1046

By Mr. Mariano of Quincy, a petition (accompanied by bill, House, No. 1046) of Ronald Mariano, Carmine Lawrence Gentile and Steven Ultrino relative to out-of-network billing for certain medical services. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-First General Court
(2019-2020)

An Act relative to out-of-network billing.

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 111 is hereby further amended by striking out section 228, as appearing in the 2016 Official Edition, and inserting in place thereof the following 2 sections:-

Section 228. (a) As used in this section and in section 228A, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Allowed amount", the contractually agreed upon amount paid by a carrier to a health care provider for health care services provided to an insured.

"Carrier", as defined in section 1 of chapter 176O.

"Emergency services", as defined in section 1 of chapter 6D.

"Facility", as defined in section 1 of chapter 6D.

"Facility fee", a fee charged or billed by a health care provider, health care provider group or a hospital for outpatient hospital services provided in a hospital-based facility that is intended to compensate the health care provider, health care provider group or a hospital for the operational expenses and is separate and distinct from a professional fee.

"Hospital", as defined in section 1 of chapter 6D.

"Hospital-based facility", a facility that is owned or operated, in whole or in part, by a health care provider, health care provider group or a hospital where health care services are provided.

"In-network cost-sharing amount", as defined in section 1 of chapter 176O.

"Insured", as defined in section 1 of chapter 176O.

"Network provider", as defined in section 1 of chapter 176O

"Network status", as defined in section 1 of chapter 176O.

"Out-of-network provider", as defined in section 1 of chapter 176O.

"Prior written consent", a signed written consent form provided to a patient or prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-network provider rendering health care services, other than for emergency services, when said services are scheduled at least 24 hours in advance of the rendering of care, to such patient or prospective patient or, if that person lacks capacity to consent, signed by the person authorized to consent for such a patient or prospective patient. A prior written consent form shall be presented in a manner and format to be determined by the commissioner of public health in consultation with the division of insurance;; provided, that such consent form shall be a document that is

separate from any other document used to obtain the consent of the patient or prospective patient for any other part of the care or procedure; and provided further, that such consent form shall include: (i) a statement affirming that the out-of-network provider has disclosed its out-of-network¬ status to the patient or prospective patient; (ii) a statement affirming that the out-of-network provider informed the patient or prospective patient that services rendered by an out-of-network provider may result in costs not covered by the patient's or prospective patient's carrier or specific health benefit plan; (iii) a statement affirming that the out-of-network provider informed the patient or prospective patient that services may be available from a contracted provider and that the patient or prospective patient is not required to obtain care from the out-of-network provider; (iv) a statement affirming that the out-of-network provider presented the patient or prospective patient with a written estimate of the patient or prospective patient's total out-of-pocket cost of care for the admission, service or procedure; and (v) an affirmative declaration of the patient's or prospective patient's consent to receive health care services from the out-of-network provider, signed by the patient or prospective patient, or by the person authorized to consent for such a patient or prospective patient.

"Professional fee", a fee charged or billed by a hospital, provider or provider organization for professional medical services provided in a hospital-based facility.

(b) At the time of scheduling an admission, procedure or service for an insured patient or prospective patient, a health care provider shall: (i) determine the provider's own network status relative to insured's insurance carrier and specific health benefit plan and disclose in real time such network status to the insured; (ii) notify the patient or prospective patient of their right to request and obtain from the provider, based on information available to the provider at the time of the request, additional information on the network status of any provider reasonably expected

to render services in the course of such admission, procedure or service that is necessary for the patient's or prospective patient's use of a health benefit plan's toll-free number and website available pursuant to section 23 of chapter 176O to obtain additional information about that provider's network status under the patient's or prospective patient's health benefit plan and any applicable out-of-pocket costs for services sought from such provider; (iii) notify the patient or prospective patient of their right to request and obtain from the provider, based on information available to the provider at the time of the request, information on such admission, procedure or service that is necessary for the patient's or prospective patient's use of a health benefit plan's toll-free number and website available pursuant to section 23 of chapter 176O to identify the allowed amount or charge of the admission, procedure or service, including the amount for any facility fees required; (iv) notify the patient or prospective patient that in the event a health care provider is unable to quote a specific allowed amount or charge in advance of the admission, procedure or service due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall disclose to the patient or prospective patient the estimated maximum allowed amount or charge for a proposed admission, procedure or service, including the amount for any facility fees required; and (iv) inform the patient or prospective patient that the estimated costs and the actual amount the patient or prospective patient may be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service. This subsection shall not apply in cases of emergency services provided to a patient.

(c) If a network provider schedules, orders or otherwise arranges for services related to an insured's admission, procedure or service and such services are performed by another health care provider, or if a network provider refers an insured to another health care provider for an

admission, procedure or service, then in addition to the actions required pursuant to subsection (b) the network provider shall, based on information available to the provider at that time: (i) disclose to the insured if the provider to whom the patient is being referred is part of or represented by the same provider organization registered pursuant to section 11 of chapter 6D; (ii) disclose to the insured sufficient information about such provider for the patient to obtain information about that provider's network status under the insured's health benefit plan and identify any applicable out-of-pocket costs for services sought from such provider through the toll-free number and website of the insurance carrier available pursuant to section 23 of chapter 176O; and (iii) notify the insured that if the health care provider is out-of-network under the patient's health insurance policy, that the admission, service or procedure will likely be deemed out-of-network and that any out-of-network applicable rates under such policy may apply. This subsection shall not apply in cases of emergency services provided to a patient.

(d) Upon initial encounter with a patient at the time of scheduling an admission, procedure or service for an insured patient or prospective patient, an out-of-network provider shall, in addition to the actions required pursuant to subsection (b) and at least 24 hours in advance of care, when said care is scheduled at least 24 hours in advance of rendering the services: (i) disclose to the insured that the provider does not participle in the insured's health benefit plan network; (ii) provide the insured with the estimated or maximum charge that the provider will bill the insured for the admission, procedure or service if rendered as an out-of-network service, including the amount of any facility fees; (iii) inform the patient or prospective patient that additional information on applicable out-of-pocket costs for out-of-network services may be obtained through the toll-free number and website of the insurance carrier available pursuant to section 23 of chapter 176O; and (iv) obtain the prior written consent of such patient

or prospective patient in advance of the out-of-network provider rendering health care services. This subsection shall not apply in cases of emergency services provided to a patient.

Section 228A. (a) A hospital, hospital-based facility or a health care provider that charges or bills a facility fee for services shall provide any patient receiving such a service with written notice of the fee. The notice shall include the following: (i) a statement of disclosure informing the patient that the hospital, hospital-based facility, or provider has charged or billed a facility fee that is in addition to and separate from the professional fee charged by the provider; (ii) the amount of the facility fee charged or billed, or, if the exact type and extent of the facility fee is not known with reasonable certainty, an estimate of the facility fee; (iii) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient; (iv) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and (v) that a patient covered by a health insurance policy should contact the health insurer to receive information about alternative providers that do not charge a facility fee.

(b) A hospital, hospital-based facility, or a health care provider that charges or bills a facility fee for services shall provide the notice required pursuant to subsection (a) for any admission, procedure or service occurring more than 5 working days from the date the appointment is made within a reasonable manner as determined by the commissioner. For any such admission, procedure or service occurring 5 or fewer working days from the date the appointment is made, or if the patient arrives without an appointment, then the notice required pursuant to subsection (a) shall be given orally at the time the patient makes the appointment,

and written notice shall be provided to the patient prior to the service when the patient arrives at the hospital or hospital-based facility's premises.

(c) If a hospital or health system designates a location as a hospital-based facility the facility shall clearly identify the facility as being hospital-based, including by stating the name of the hospital or health system in the facility's signage, marketing materials, Internet web sites and stationery.

(d) If a hospital-based facility charges a facility fee, notice shall be posted informing patients that a patient may incur additional financial liability due to the hospital-based facility's status. Notice shall be prominently displayed on the website of the hospital, health system and hospital-based facility in a manner proscribed by the commissioner in designated locations accessible to and visible by patients, including in patient waiting areas.

(e) The notices and statements required under this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges. All notices under this section shall be available in all languages representative of that health care provider's patient population.

(f) The commissioner may promulgate regulations that are necessary to implement this section.

SECTION 2. Section 5 of chapter 176G of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out subsection (f) and inserting in place thereof the following subsection:-

(f) Pursuant to sections 28 and 29 of chapter 176O, a health maintenance organization shall provide or arrange for indemnity payments to a member or provide for the cost of emergency medical services by a provider who is not normally affiliated with the health maintenance organization when the member requires services for an emergency medical condition.

SECTION 3. Section 3 of chapter 176I of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) If a covered person receives emergency care and cannot reasonably reach a preferred provider, payment for care related to the emergency shall be made pursuant to sections 28 and 29 of chapter 176O and shall be made at the same level and in the same manner as if the covered person had been treated by a preferred provider; provided however, that every brochure, contract, policy manual and all printed materials shall clearly state that covered persons shall have the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever a covered person is confronted with a need for emergency care, and no covered person shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent, or be denied coverage for medical and transportation expenses incurred as a result of such use of emergency care;

SECTION 4. Section 1 of chapter 176O of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of "Emergency medical condition" the following definition:-

"Emergency services", as defined under section 1 of chapter 6D.

SECTION 5. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Facility” the following definition:-

“Facility fee”, a fee charged or billed by a hospital or health system for outpatient hospital services provided in a hospital-based facility that is intended to compensate the hospital or health system for the operational expenses of the hospital or health system and is separate and distinct from a professional fee.

SECTION 6. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Health care services” the following 2 definitions:-

“Hospital”, a hospital as defined in section 1 of chapter 6D.

“Hospital-based facility”, a facility as defined in section 228 of chapter 111.

SECTION 7. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Incentive plan” the following 2 definitions:-

“In-network contracted rate”, the rate contracted between an insured's carrier and a network provider for the reimbursement of health care services delivered by that network provider to the insured.

“In-network cost-sharing amount”, the cost-sharing amount that the insured is required to pay for a covered health care service received from a network provider. Cost sharing includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

SECTION 8. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Network” the following 2 definitions:-

“Network provider”, a participating provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds enrolled in any or all of the carrier's network plans, policies, contracts or other arrangements.

“Network status”, a designation to distinguish between a network provider and an out-of-network provider.

SECTION 9. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Office of patient protection” the following definition:-

“Out-of-network provider”, a provider, other than a person licensed under Chapter 111C, that does not participate in the network of an insured’s health benefit plan because: (i) the provider contracts with a carrier to participate in the carrier’s network but does not contract as a participating provider for the specific health benefit plan to which an insured is enrolled; or (ii) the provider does not contract with a carrier to participate in any of the carrier's network plans, policies, contracts or other arrangements.

SECTION 10. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Second opinion” the following definition:-

“Surprise bill”, a bill for health care services, other than for emergency services, received by an insured for the services of an out-of-network provider rendered at or by a network facility in the insured’s health benefit plan where: (i) a network provider is unavailable; (ii) the out-of-

network provider renders services without the insured's knowledge; (iii) services were referred by a network provider to an out-of-network provider without the prior written consent of the insured acknowledging the out-of-network referral or services and that such services rendered may result in costs not covered by the health benefit plan; or (iv) unforeseen medical services that require the services that are necessary to be performed by an out of network provider arise at the time the health care services are rendered; provided however, that "surprise bill" shall not mean a bill received for health care services rendered when a network provider is available and the insured affirmatively elected to receive services from an out-of-network provider.

SECTION 11. Section 6 of said chapter 176O, as amended by section 43 of chapter 228 of the acts of 2018, is hereby amended by striking out, in lines 28 and 29, the words "has a reasonable opportunity to choose to have the service performed by a network provider" and inserting in place thereof the following words:- affirmatively chooses to receive services from an out-of-network provider pursuant to section 28 and the out-of-network provider has obtained the prior written consent of the insured pursuant to section 228 of chapter 111.

SECTION 12. Subsection (a) of said section 6 of said chapter 176O, as so amended, is hereby further amended by striking out paragraph (8) and inserting in place thereof the following paragraph:-

(8)(i) a clear description of the procedure, if any, by which the insured may request an out-of-network referral; (ii) a summary description of the methodology used by the insurer to determine reimbursement of out-of-network health care services; (iii) the amount that the insurer will reimburse under the methodology for out-of-network services pursuant to sections 28; and

(iv) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services;

SECTION 13. Section 7 of said chapter 176O, as appearing in the 2016 Official Edition, is hereby amended by striking out, in lines 5 and 6, the words “and summarizing on its internet website for each such provider” and inserting in place thereof the following words:-, along with a summary on its internet website for each provider that shall include.

SECTION 14. Said chapter 176O is hereby further amended by striking out section 23, as so appearing, and inserting in place thereof the following section:-

Section 23. All carriers shall establish a toll-free telephone number and website that enables consumers to request and obtain from the carrier, in real time, the network status of an identified health care provider and the estimated or maximum allowed amount or charge for a proposed admission, procedure or service, and the estimated amount the insured will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier at the time the request is made, including any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits. All carriers shall create a mechanism by which the insured can request notice of the estimated amount in writing. Upon request, the carrier shall send the consumer written notice of the estimated amount the insured will be responsible for paying.

The telephone number and website shall inform the insured that the insured shall not be required to pay more than the estimated amounts disclosed in the written notice for the covered health care benefits that were actually provided; provided however, that nothing in this section shall prevent carriers from imposing cost sharing requirements disclosed in the insured's

evidence of coverage document provided by the carrier for unforeseen services that arise out of the proposed admission, procedure or service; and provided further, that the carrier shall alert the insured that these are estimated costs, and that the actual amount the insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service, except that the insured shall not be responsible for any additional payment caused by the carrier mistakenly identifying an out-of-network provider as in-network.

SECTION 15. Said chapter 176O of the General Laws is hereby further amended by adding the following 2 sections:-

Section 28. (a) When an out-of-network provider renders emergency services to an insured and such out-of-network provider is a member of an insured's carrier's network but not a network provider in the insured's health benefit plan, a carrier shall pay such out-of-network provider the in-network contracted rate for each delivered service; provided however, that such payment shall constitute payment in full and the out-of-network provider shall not bill the insured for any amount except for any in-network cost sharing amount owed for such service or services under the terms of the insured's health benefit plan.

(b) When an out-of-network provider does not contract with a carrier and such out-of-network provider renders emergency services to an insured, a carrier shall pay such out-of-network provider the greater of: (i) 115 per cent of the average rate the carrier pays for that service performed by a health care provider in the same or similar specialty and provided in Massachusetts, as determined by the commissioner of the division of insurance, and in consultation with the center for health information and analysis and (ii) 125 per cent of the Medicare rate for that service; provided however, that such payment shall constitute payment in

full to the out-of-network provider. The commissioner of the division of insurance shall indicate the types of claims to be excluded from the "average rate" calculation in this section, including the exclusion of public payer claims, and by excluding other claims which do not accurately reflect the valuation of provider services for commercial carrier plans. The out-of-network provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured received such service or services from a network provider under the terms of the insured's health benefit plan.

(c) When an out-of-network provider renders health care services, other than for emergency services, to an insured, the carrier shall pay that provider the greater of: (i) 115 per cent of the average rate the carrier pays for that service performed by a health care provider in the same or similar specialty and provided in Massachusetts, as determined by the commissioner of the division of insurance, and in consultation with the center for health information and analysis and (ii) 125 per cent of the Medicare rate for that service. Such payment shall constitute payment in full to the out-of-network provider. The commissioner of the division of insurance shall indicate the types of claims to be excluded from the "average rate" calculation in this section, including the exclusion of public payer claims, and by excluding other claims which do not accurately reflect the valuation of provider services for commercial carrier plans. The out-of-network provider shall not bill the insured except for any inpatient cost sharing under the terms of the insured's health benefit plan, provided however, that said provider may bill or collect from the insured amounts in addition to the in-network cost-sharing amount if the out-of-network provider has obtained the prior written consent of the insured pursuant to section 228 of chapter 111.

(d) An insured shall not be liable for the payment of surprise bills, shall pay no more than the in-network cost-sharing amount and shall not owe an out-of-network provider more than the in-network cost-sharing amount for services subject to this section if: (i) an insured receives covered services from a network provider and as a result or in conjunction with such services receives services provided by an out-of-network provider; or (ii) where referrals or preauthorization are required under the insured's health benefit plan, a network provider refers an insured to an out-of-network provider without the explicit written consent of the insured acknowledging that the provider is referring the insured to an out-of-network¬ provider and that the referral may result in costs not covered by the health plan.

(e) At the time of payment by a carrier to an out-of-network provider, a carrier shall inform the insured and the out-of-network provider of the in-network cost-sharing amount owed by the insured.

(f) If a carrier delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(g) Nothing in this section shall require a carrier to pay for health care services delivered to an insured that are not covered benefits under the terms of the insured's health benefit plan.

Section 29. (a) The division, in consultation with the center for health information and analysis, shall establish an efficient and simple dispute resolution process by which a dispute for a bill for emergency services or a surprise bill may be resolved. The division shall have the power to grant and revoke certifications of independent dispute resolution entities to conduct the dispute resolution process. The division shall promulgate regulations establishing standards for

the dispute resolution process, including a process for certifying and selecting independent dispute resolution entities.

(b) In the event of a dispute between the out-of-network provider and the carrier as to the amount to be reimbursed under section 28, the parties shall use the following dispute resolution process:

(i) An out-of-network provider or a carrier may submit a dispute regarding a fee or payment for emergency services for review to an independent dispute resolution entity certified by the division.

(ii) The independent dispute resolution entity shall make a determination within 30 days of receipt of the dispute for review.

(iii) In determining a reasonable fee for the services rendered, an independent dispute resolution entity shall select either: (A) the carrier's payment; or (B) the fee request of the out-of-network provider.

(iv) the independent dispute resolution entity shall confirm or deny whether the amount applied is applied consistently with the formula set forth in section 28 of this chapter.

(v) If the independent dispute resolution entity determines, based on the carrier's payment and the out-of-network provider’s fee request, that a settlement between the carrier and out-of-network provider is reasonably likely, or that both the carrier's payment and the out-of-network provider’s fee request represent unreasonable extremes, then the independent dispute resolution entity may direct both parties to attempt a good-faith negotiation for settlement. The carrier and

the out-of-network provider may be granted up to 10 business days for this negotiation, which shall run concurrently with the 30 day period for dispute resolution.

(vi) The determination of the independent dispute resolution entity shall be binding on the carrier and the out-of-network provider and shall be admissible in any court or administrative proceedings.

(c) Payment to the independent dispute resolution entity shall be as follows: (i) for disputes involving a carrier and an out-of-network provider, when the independent dispute resolution entity determines that the health care plan's payment is reasonable, payment for the dispute resolution process shall be the responsibility of the out-of-network provider; (ii) when the independent dispute resolution entity determines that the out-of-network provider's fee request is reasonable, payment for the dispute resolution process shall be the responsibility of the health care plan; and (iii) agreed upon during course of negotiation pursuant to subsection (a).